HEALTH AND COMMUNITY CARE COMMITTEE

Wednesday 21 June 2000
(*Morning*)

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HEALTH AND COMMUNITY CARE COMMITTEE

18th 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 MEMBERS ALSO ATTENDED:

Iain Gray (Deputy Minister for Community Care)
Mr John Swinney (North Tayside) (SNP)

WITNESSES

Dr Gerry Burns (Eastern Multifund)
Brian Dornan (Down Lisburn Health and Social Services Trust)
Eric McCullough (Eastern Multifund)

CLERK TEAM LEADER

Jennifer Smart

SENIOR ASSISTANT CLERK

Irene Fleming

LOCATION

The Chamber

Scottish Parliament

Health and Community Care Committee

Wednesday 21 June 2000

(*Morning*)

[THE CONVENER *opened the meeting at 09:48*]

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

The first item on the agenda is a decision on whether we are happy to take item 8, on the content of the committee's annual report, in private. Like the other committee reports that we have dealt with, the annual report should be private until it is published. Is the committee happy to take item 8 in private?

Members *indicated agreement.*

Subordinate Legislation

The Convener: The second item is subordinate legislation. We have three negative instruments, copies of which were circulated to members on 7 June. No comments have been received. On the Animal Feedingstuffs from Belgium (Control) (Scotland) Revocation Regulations (SSI 2000/158), no motion has been laid recommending that nothing further be done under the instrument. The Rural Affairs Committee had no comment to make on it and after consideration of the instrument, the Subordinate Legislation Committee determined that the attention of Parliament need not be drawn to it. Therefore, I suggest to the committee that it should not make any recommendation in relation to this instrument. Is that agreed?

Members *indicated agreement.*

The Convener: On the Food (Animal Products from Belgium) (Emergency Control) (Scotland) Revocation Order (SSI 2000/159), no motion has been laid recommending that nothing further be done under the instrument. The Rural Affairs Committee made no comment on it and the Subordinate Legislation Committee is happy with it. Again, I suggest that the committee should not make any recommendation in relation to this instrument. Is that agreed?

Members *indicated agreement.*

The Convener: Finally, no motion has been laid that nothing further be done under the National Health Service (Clinical Negligence and Other Risks Indemnity Scheme) (Scotland) Amendment Regulations 2000 (SSI 2000/168). The Subordinate Legislation Committee is happy with it. Again, I suggest that the committee does not wish to make any recommendation in relation to this instrument. Is that agreed?

Members *indicated agreement.*

Petitions

The Convener: Members will recall that in response to a petition that we received two weeks ago, we agreed to write to the minister to ask whether the inquiry that she had instigated internally into people who had contracted the hepatitis C infection from contaminated blood products covered only people with haemophilia or whether the scope of the inquiry was broader.

We have received a reply from the minister in which she tells us that the inquiry, the results of which she expects to be published before the recess—a copy will be given to the committee so that we can consider it and decide whether we want to pursue the matter—will cover only haemophilia and the narrow group of people who contracted hepatitis C as a result of the difference between the blood screening programmes in Scotland and England.

Members will remember that for just over a year there were differences between the blood screening programmes in Scotland and England and that the minister set up the internal inquiry to examine them. We are left with the wider issue of people who believe that they have contracted the hepatitis C virus through blood transfusions in other ways.

The committee has to decide what it will do with the petition. Members will recall that Cathy Jamieson spoke to us on behalf of her constituent two weeks ago. We said that we would like to ask the minister to speak to us about the findings of her internal inquiry once they are published. Members may wish to put the wider subject into abeyance until we hear from the minister, or they may wish to make a statement about the matter today. This is our final meeting before the recess, so it will be after the recess before we are able to do anything.

Mary Scanlon (Highlands and Islands) (Con): I would like some clarification. The third paragraph of the letter from the Executive says:

> "Tragic though these cases are, the Minister is afraid she can see limited value in examining an issue on which we already know the outcome, and for this reason she does not intend to extend further the remit of this exercise."

Is the minister saying that she already knows the outcome of any exercise involving those who underwent routine operations, received blood transfusions and ended up with hepatitis C—that she knows that it would be a foregone conclusion—and that therefore they are not being excluded from this exercise? That is what I am reading into the letter. Compensation is a possibility at the end of the exercise. As I read it, it would appear that the people I have mentioned who have undergone routine operations will not be ruled out of the exercise

The Convener: I read it the opposite way. We should ask the minister for clarification on that.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): I agree. While we accept that there is hepatitis C among those who have haemophilia, it is also present among individuals who—as Mary Scanlon said—have had routine operations. I understand that the petitioner is in that group. Those individuals cannot be left in isolation. There is a problem. This letter is not helpful, because it does not clarify the matter. It keeps rolling together haemophilia and hep C. We accept that there will be people with hep C who are haemophiliacs, but there is a group that contracted hep C during the difficulties with the treatment of blood products. That is what we were trying to tease out from the minister. We should expand our letter and ensure that there is no dubiety in what we are pursuing.

Mary Scanlon: There is ambiguity.

The Convener: We can make use of the time available to us over the recess to get our own researcher to find further information for the committee about the manner in which people contract hep C and how they believe it is a direct result of national health service interventions.

Dr Richard Simpson (Ochil) (Lab): I wish to ask the minister whether we know exactly when it was established that hepatitis C was a problem. I wonder whether that information was already known and should have been picked up earlier by the Scottish National Blood Transfusion Service. Others suggest that the service may have been ahead of the game, but there are questions surrounding the treatment and examination of blood and whether it was done timeously.

If the blood transfusion service acted as soon as it was known that there might be a problem, it is unlikely that there will be compensation. At least, there can be no compensation as a result of negligence; it can—as the minister says—be viewed only as a tragic occurrence.

We should ask the Scottish National Blood Transfusion Service or Susan Deacon whether the introduction to the report that she has commissioned will include substantial background information on hepatitis C—not just related to factor VIII, but to general transfusions. If the report will do that, we should await it; if it will not, we should consider the possibility of asking one of our number to interview the BTS during the recess to get a report from it so that we can consider this as soon as we come back.

Mr John Swinney (North Tayside) (SNP): I thank the committee for giving me the opportunity to take part in this discussion. Some of my constituents have approached me on this subject over a number of years—I saw a couple of them on Monday. I am encouraged by what has been said so far. The feeling last year was that this issue was beginning to be opened up and that a broad approach was being taken to the inquiry. My constituents have expressed their concern that the issue is being narrowed down to a more limited remit than that which they had expected last year.

When a number of us met representatives of the Haemophilia Society and others last year, we discussed the Executive's inquiry. We were encouraged by the language the minister used at the time, but the fallback was that there may be an opportunity for the Health and Community Care Committee to consider further some of the background circumstances that have driven the issue.

The sentence in the Executive's letter that Mary Scanlon referred to troubles me enormously because we do not know the answer. I do not think that the investigation will answer the questions that my constituents are concerned about. I certainly hope that there will be output from the minister's inquiry, but I think that there should be further investigation.

There is a danger—I say this with the greatest of respect—in the department looking at its own performance. There is a need for external eyes to examine the circumstances surrounding this matter, because public unease could be tackled by some productive work by the committee.

10:00

The Convener: When several of us met representatives of the Haemophilia Society, they called for a full public inquiry. Their fears were allayed to some extent by comments the minister made to them about what the internal inquiry would involve. We must be aware that the committee has consistently said that we will look at the report that comes out of the internal inquiry, but not from the point of view of just accepting it. At that point, we will probably ask further questions about the findings and hear from the minister. If there are unanswered questions, we will probably have discussions with other bodies. It is critical that we see this as an on-going issue for the committee, based on previous statements that we have made on this matter.

Malcolm Chisholm (Edinburgh North and Leith) (Lab): The report is imminent. It seems inevitable that we will have to respond once we have seen what is in it. What struck me about the letter was that the distinction may not be between those who have contracted hepatitis C who are haemophiliacs and those who are not haemophiliacs: the distinction seems to be between those who contracted it between 1985 and 1987 and everybody else, whether they are haemophiliacs or not.

We will find out when we read the report, but from what the letter says it looks as if the report will focus on the factor VIII issue between 1985 and 1987. I read the controversial sentence at the end of the third paragraph to say that we know that lots of people contracted it through blood transfusions before then, but nothing is going to be gained by having an investigation. The issue is whether those people should get compensation. That is not an issue that requires scientific investigation; it is a matter of judgment whether we think people should get compensation when they contracted it through no fault of anybody, because nobody knew at that time that there was such a virus in the blood. In that sense, I do not think that the letter is as controversial as some members are making it out to be.

The Convener: Does Mary Scanlon want to make a point before she leaves?

Mary Scanlon: I would like to confirm the timetable. If the minister is giving us the report in the last week of term, or whatever we call it—I still think I am a teacher—

The Convener: I have told you that you are not getting that gold star, Mary; it does not matter how hard you try.

Mary Scanlon: Am I right in saying that a discussion and a visit from the minister on this matter will be on our agenda for the first week we return in September?

The Convener: It will certainly be on the agenda at the beginning of the new term. We do not have the report yet and this is our final full meeting before the recess. We will not be able to do anything until after the recess, but it will be available to us fairly early on and, as I suggested, we could make use of the time over the recess to get further information. I will write to the minister for further clarification on the points the committee has raised and ask the Scottish Parliament information centre research team to do more background work for us so that we have that in place for when we come back from the recess.

Kay Ullrich (West of Scotland) (SNP): Can I confirm that this is the committee's last full meeting before the recess?

The Convener: Yes, unless we have statutory instruments to deal with, in which case a certain number of us will have to come in for extra meetings. If you recall, we decided we would use the two other meeting days before the recess for our community care inquiry visits.

Dorothy-Grace Elder (Glasgow) (SNP): We have a duty to consider all the affected categories of patients. You might also consider contacting the Department of Health in London, convener, on this matter. If memory serves me right, and while we are discussing the contaminants in the blood not being known at the time, this matter stems from the importation of contaminated blood from the United States in the mid-1980s. It was known as skid row blood. We have a continuing duty to examine what happens in the UK—some of that blood was sent to Scotland—and to consider compensation.

Margaret Jamieson: I would like to clarify something. I am unaware that Scotland has imported blood from outwith the United Kingdom. I think that only in certain instances has blood been brought in from England.

The Convener: I am not aware of the particular case referred to by Dorothy-Grace.

Dorothy-Grace Elder: You are not old enough to remember.

The Convener: Thank you, Dorothy-Grace.

Dorothy-Grace Elder: There was a big scandal at the time.

The Convener: We could ask for some clarification on that. The research people would be able to tell us where blood products come from. I think that there have been some instances of foreign blood products being used in Scotland in the past.

Dr Simpson: As is obvious, we will all look at the report. Are you proposing that you, as convener, or Malcolm Chisholm, as deputy convener, will co-ordinate how we proceed over the recess? I am concerned that we might come back from the recess and want to look at the report but want a lot more information. Apart from talking to SPICe, there is the question of whether to talk to somebody during the recess.

The Convener: I was going to suggest that we ask SPICe for the research, that I write back to the Minister for Health and Community Care seeking further clarification as we have outlined today and that the committee grants me authority to seek, during the recess, any further clarification and information from various bodies that I feel would be useful to colleagues when we return to the matter following publication of the report.

I am not sure whether I have to be appointed as a reporter or whether I can get agreement on that now, from here in the chair. Is it agreed that I proceed as I have just outlined?

Members *indicated agreement.*

Dorothy-Grace Elder: I wish to add another point of information, again from memory. There was a controversy about the Conservative Government of the day not supplying enough money to the Scottish National Blood Transfusion Service, which very much wanted a heat treatment factor VIII centre to be set up. It was set up later, but the service wanted it set up earlier, when it became suspicious.

The Convener: That should all come out in a SPICe paper following the internal report. It would be the kind of thing that the minister's internal report would pick up on. We will return to this serious matter after the recess.

Item 4 on the agenda is the new system for petitions. Members will recall that, some weeks ago, the committee discussed its responses to petitions and the fact that it gets a large number of them.

I think that we have dealt quite effectively with many of the petitions that have come our way—we have been talking about hepatitis C this morning partly as the result of a petition. The committee has a good record of picking up on the issues presented to the Parliament by members of the public, but we are all aware that the committee has a heavy work load and a broad agenda from which to choose items itself, and must deal with the Executive work load that comes to us.

We have taken a decision on coming up with a more formal system for dealing with petitions and of giving committee members an early warning system of the petitions that are heading to us from the Public Petitions Committee. Do members have any comments on the paper relating to agenda item 4?

Malcolm Chisholm: I agree with most of what is in the paper, but I am slightly concerned by the last paragraph on page 1. Does it mean that we will consider petitions only every three months? If so, that is very inflexible. We do not know what is in some petitions. They may require to be examined more quickly than that.

The Convener: I echo that concern. I think it would be better to keep things more flexible. On Stobhill, for example, partly as a result of the good work that Richard Simpson did, we were able to respond to the request for work to be done very quickly—our report was back within the month. The fact that we did not keep the matter on our agenda for two or three months helped to keep up the pressure.

Hugh Henry (Paisley South) (Lab): I agree entirely that we need to be flexible and to be seen to be responsive—otherwise, why bother having petitions, as the immediate issue will often have been overtaken? Saying that petitions can afford to wait sends out the wrong message—that there is a lack of concern—but I still think that the fundamental issue, not just for this committee, but for all committees, is to ensure that only appropriate petitions filter through the system. Although there has been some improvement, I am not sure that we have got the process right. There is still a view that anything under the sun can come to the Scottish Parliament Public Petitions Committee. That is not the case. Unless we take a very hard line and say that we will examine only things that are appropriate and that we can legitimately affect, we will be snowed under.

The Convener: On behalf of the committee, I have written to the convener of the Public Petitions Committee on that point, asking that further sifting be done. Yesterday, the Public Petitions Committee had a discussion about beta interferon. I argued that the Public Petitions Committee should get further clarification of the points being raised by the petitioners before the petition is sent to this committee. I think most, if not all, conveners and members share the view that the Public Petitions Committee could be doing a bit more.

I take on board Hugh Henry's point about responsiveness, but the other point that was made yesterday was that we should be doing everything we can to encourage petitioners to see the Parliament not as a first resort, but as a last resort—once the range of other options that is often available to petitioners, but which they may not have tried, has been investigated. That has not been a problem with many of the petitions that we have seen—people have been quite good—but in other cases, people have seen a newspaper article and put pen to paper.

Hugh Henry: I am sorry, convener; my comment about responsiveness did not mean that I think we should respond to everything—rather, where appropriate, we need to be seen to respond quickly and urgently. I entirely agree that the Parliament should not only be a last resort, but that it should be used only if appropriate.

Irene Oldfather (Cunninghame South) (Lab): I agree with the convener and Hugh Henry. It is evident from the number of petitions that we simply note that there is something wrong with the system. If the system were working properly, we would consider the petitions that come to us in a lot more detail. I hope that the Public Petitions Committee will consider the process over the recess and put in place stricter guidelines on what can be submitted and what can not.

The Convener: The committee is working on new guidelines. Yesterday, a long, private discussion took place on the matter.

Kay Ullrich: I agree with everything that has been said. It is good that people can petition the Parliament, but we are in grave danger of devaluing the whole system because of knee-jerk responses—someone reads something in a Sunday newspaper and suddenly it becomes a petition.

The Convener: Richard Simpson had a suggestion about Malcolm Chisholm's point about the final paragraph on page 1 of the report.

10:15

Dr Simpson: We are going to be given the petitions early and we are being asked to comment on whether we should note them for discussion. If we recommend that a petition should be discussed, we should also have the option to say whether the matter is urgent. If we do not say that the petition is urgent, it should automatically go to the quarterly review. If two members think that a matter is urgent, we should treat it as urgent.

The Convener: That seems a sensible proposal. Are we agreed?

Members *indicated agreement.*

Invitation

The Convener: We have received a letter from the Minister for Health and Community Care inviting up to six members of the committee to attend the healthy Scotland convention on 3 July. Unfortunately, the deputy convener, Dorothy-Grace Elder and I have already organised community care visits for that day. It was incredibly difficult to find a date that suited us all and I would be loth to change it. I would like to deal with those visits as quickly as possible. Are there any other members who would be able to attend the convention and represent the committee?

I appreciate that it is quite short notice. I leave the matter open. If members' plans change, they know the invitation stands. I will investigate whether it would be possible for a member of staff to attend if we cannot send a member of the committee.

Dr Simpson: The convention cannot have been organised recently. We can thank the minister for the invitation but mention that it would be useful to have a bit more warning of such events—two weeks' notice is not enough.

Kay Ullrich: Perhaps a wee bit of forward planning would help.

The Convener: That is an acceptable point. We are all very busy. I am keen to build a good working relationship. In the future, it would be helpful to have warning of such events to allow members to play a full part.

I suggest that we take a break while I discover whether our witnesses from Northern Ireland have arrived.

10:18

Meeting adjourned.

10:44

On resuming—

The Convener: I have been informed that the witnesses from Northern Ireland are in a taxi in the west end and will be with us in 10 or 15 minutes' time. If members agree, we will now deal with item 8, which we agreed to take in private. That will save time at the end of the meeting. Unfortunately, it means that the hardy souls in the public gallery will have to bear with us and leave until we return to public session.

10:45

Meeting continued in private.

11:10

Meeting resumed in public.

Community Care

The Convener: Agenda item 6 continues our inquiry into community care, and we have three witnesses from Northern Ireland with us this morning. Committee members will recall that it became clear quite early on, in our informal discussions and in evidence sessions, that we could learn lessons from colleagues in Northern Ireland, where the system of integrated health and social care appears to function well. We decided that we would like to have some insight into that situation and we therefore invited some representatives from the Northern Ireland system to contribute to our inquiry.

Welcome to the Health and Community Care Committee. Please begin by introducing yourselves and giving us a flavour of what you do. You may make a statement about how the Northern Ireland system works, and we shall then ask you a series of questions.

Eric McCullough (Eastern Multifund): Thank you for your kind invitation; it is a pleasure to be here. I noticed that my name had been mis-spelled as McCulloch, and I pointed out the mistake to the chap who showed us into the chamber. I am not sure whether we came over here to take you over, or whether you intend to take us over—we can talk about that later—but I am one of those lochs from the north of Ireland that is spelled L-O-U-G-H. I have been told that the spelling must be accurate for the *Official Report*.

When I was first approached and asked to come across, my first question was, "Why me?" I am not in the health department, nor am I a civil servant, and I am no longer on the health board. I am in something called Eastern Multifund, which is a GP organisation; we have a couple of hundred GPs serving a population of 300,000. As you probably know, fundholding has gone in mainland UK, but we still have it in Northern Ireland for the moment, although it will go in due course. Some would say that, in England, it has been replaced by socialised fundholding on a compulsory basis, but that is a political debate that I could not possibly enter or comment on.

We are here as representatives of the delivery system. It is not a formal, official organisation and we are not here to justify processes or systems. We are here to tell you what it is like on the streets, and I understand that that is what you wanted to know.

Time is short, so I shall get on with the introductions. I am Eric McCullough, chief executive of the GP organisation, but during the 1970s, 1980s and 1990s I worked in various trusts and health boards and was involved in the introduction of our integrated service in 1973 and of general management in the late 1980s.

Brian Dornan, on my right, is a social worker by training and is director of community services in the Down Lisburn Health and Social Services Trust. He is an expert on the delivery of integrated care in a reality position, and he will talk in more detail about the structure of his trust. His trust area is like a micro-version of Northern Ireland, in that it has urban and rural delivery. Brian is also responsible for hospitals, community health and social services, so it is a totally integrated trust.

On my left is Dr Gerry Burns, who is a general practitioner in a very deprived inner-city area of north Belfast. You can imagine what that means, because I know that parts of your world are similar.

I will speak a little about the history of integration and some of the themes that we might allude to. Structure in itself will not deliver—that is the first, core issue. We have had what is often referred to as an integrated structure since October 1973—for almost 27 years—yet, even today, there are pockets where integration has not really occurred. My colleagues will give examples of where integration has been good, where it has been bad and why it has not happened.

11:15

Culture and behavioural patterns, rather than structural issues, should be dealt with first. The structure can facilitate integration, but it will not automatically deliver it. In 1973, when the troubles were starting and there was a need to change the structure of local government, it was decided to integrate health and social services. However, there was a debate on whether social services should link more with housing or education, rather than with health. There was also some opposition to the medical model that was decided upon, which was lifted from the UK system of a medical model. Some social workers were, quite rightly, opposed to that concept. Some modelling was undertaken to reflect geographical circumstances.

Some of the organisations were interlinked, such as hospitals being interlinked with social work and community health. In the beginning, in 1973, all health boards were arranged as integrated packages, with acute hospitals linked with health and social services in the community. However, eventually, it was decided to cut out of that arrangement the large acute hospitals, particularly the teaching hospitals, for the simple reason that acute services tend, even to this day, to dominate resourcing. That is another theme because, if there is an emergency in acute services, you can rest assured that, at the end of the day, community services will tend to fund that emergency, given its greater immediacy.

My colleagues will put the case to you that you must look after community services. Acute hospitals are always under pressure. Waiting lists are up because community services have neither the capacity nor the ability to deliver, as they have not had proper resourcing. While we have discussed removing resources from the acute sector and putting them into the community, that objective is not achievable. You need to build up the resources in the community and almost let the acute services wither on the vine, if I may use that phrase, as the resources move across. We will allude to that theme later.

Another, more recent theme is the capacity for innovation and diversity—allowing local organisations to reflect their needs, as opposed to imposing a fixed model on them. In 1973, a fixed model was imposed on everyone: one solution solved all problems. Now, we say, “If the Down and Lisburn geography requires X and the north Belfast geography deserves Y, that’s up to them,” but that is in an agreed context of parameters and outcomes.

Therefore, in many ways, we have not achieved much. In 1973, we also had the problem of corporateness—nursing was in one strand, social services in another, medicine in another and management in another—which enabled the various players to remain demarcated. In the beginning, there was even ring fencing of social services budgets, because of the fear of the big, bad hospital taking all the money, which sometimes happened. We had some protectionism and demarcation disputes, whereas now we have learned that fudging the edges is a better way of moving forward.

I do not want to say that it is all bad, and I do not want to emphasise where the problems are, leaving you with the view that things are not going tremendously well in much of Northern Ireland. However, if we do not discuss some of the problems, you might fall into the same traps. Please do not take my contribution as an absolute criticism of our system—we would thoroughly recommend it and we confirm that there are pockets of excellent practice.

Therefore, in the beginning, some overlap was planned, but the professional groupings remained as they had been. Then, eventually, we introduced general management towards the end of the 1980s.

That was the beginning of real integration. When general managers took over and became responsible for the total provision of care, they did not look at the outcomes in terms of what social services, medicine, or nursing thought. At that time, we were very fortunate in that we had nurses, doctors, administrators and social workers who became general managers—they came from a range of backgrounds and brought that wonderful diversity to their new positions.

Brian Dornan has submitted a paper, which you have no doubt read. He will add to that now, and then we will be happy to answer your questions to the best of our ability.

Brian Dornan (Down Lisburn Health and Social Services Trust): I am director of community services in Down Lisburn Health and Social Services Trust. I am responsible for primary care services, services for the elderly and children’s services. I am a social worker by profession.

Since Down Lisburn trust was formed in 1990, we have put considerable emphasis on trying to do more with the tremendous potential of integration in Northern Ireland. I had been assistant director of social services in the organisation in which I was working, which had been formed from a merger of two other organisations. It was only when we examined our system as multidisciplinary colleagues that we began to realise that we could do much more and that that could be quite exciting.

We started by considering primary and community care services. We identified three principles that we felt should underpin the service. First, we thought that services should be planned, organised and provided as locally as possible to people’s homes. We believed that people wanted services close to home if they could be provided there. We also felt that professional staff who were based in local communities would be much more in touch with local needs and communities. Secondly, we felt that it was important that primary care teams should have the full range of skills to meet the needs of the local community as far as possible. We analysed the needs for service, particularly of elderly people and people who used services most, and found that there was no very clear distinction between health needs and social needs; most people who had significant needs were using both health and social services simultaneously. That led us to conclude that we needed a more broadly based primary care team.

The third principle was that we should base our service not on general practitioners but on the GP practice list. We needed to find one common group of service users on which to build our service. We thought that the one clear choice that people could exercise about their services was which GP list to join. That probably said something about where they wanted services, so we took the GP practice list as an agreed common group on which to base our services.

To translate those principles into practice, we undertook a pilot scheme in 1992 in Dunmurry, which is an area near Belfast. We asked a senior social worker and a nurse manager to develop a team to meet those aspirations, in partnership with the professional staff in that area. They called the model that they developed the practice-attached team—essentially the integrated primary care team. Those two people were enthusiastic about exploring the issues and were regarded by their professional peers as very professional people of good standing, who would ensure that professional issues were properly addressed. They developed the concept of the attached integrated team, in conjunction with the professionals working in the area.

The team is the right mix of professionals to meet the needs of the patients who are registered with the practice. It is the smallest number of individual practitioners who can meet needs—a team will not share two district nurses if one district nurse will do. The teams comprise district nurses, health visitors, care managers or social workers, treatment room nurses and other support staff. Some other more specialist staff such as care managers working with people with dementia might work between two, three or four teams. What is important is that specialist staff are full members of each team in which they work.

Where possible, the team has a common base. Ideally, those people work in the same team room. For instance, the district nurse and the care manager sit at adjacent desks if they work with the same group of patients. The team has a single manager, who is either a qualified social worker or a nurse. Other specialist staff, such as child care social workers, occupational therapists and psychiatric specialists are practice aligned, if they are not fully based in the primary care team.

In order to manage services locally, we grouped our primary care teams by natural geography. Typically, there are six teams for a population of between 25,000 and 30,000. The population of localities varies between 16,000 and 42,000—we based the localities on what was natural rather than on some formula. For each area, we have a community services manager, who leads around six teams, and an assistant in management, whom we call a primary care manager—the names are not important. What is important is that one of those managers is always a nurse and one is always a social worker. The senior manager can be from either discipline, but there is always a pair. We think that that is fundamental to reassure the professions that professional issues are being addressed in the long term, to give professionals the security of believing that both the health and the social care traditions will be respected and to ensure that professional standards are maintained locally.

The budget for community care is delegated to the community services manager and his or her team. As I said, the care managers are full members of the local primary care team. We give as much autonomy as possible to the local managers and teams. It seems to us that the community services manager and the primary care manager and the GP working together can bring together the three professions of nursing, social work and medicine. That should give us a more balanced approach to meeting need.

In using resources, teams are not constrained by any artificial demarcation. They can agree to move resources locally. The model of care that we have developed has changed not just primary care but specialist services. Services such as elderly persons' homes have been transformed into resource centres, which provide residential care as well as care for people with dementia. They provide day care seven days a week at the times when people want it. They provide a helpline; every single person who has a home-help service or a care package has the telephone number of the local resource centre and can ring in 24 hours a day, if something goes wrong with the care package. The centres can also provide emergency care if someone needs to come in for care, for example, over a weekend or overnight, until the care manager and the district nurse can correct the care package the next day. We have also used them to allow our hospital-at-home team to provide hospital-at-home services, if the patient's home is not satisfactory.

Essentially, my conclusion is that integration of health and social services is not an end in itself. It is of little value unless it makes a difference to the people who receive services and to the professional staff working together. We believe that it is fundamentally a way of empowering people to work together locally and of assisting people to exercise the choice of receiving care at home.

The Convener: Dr Burns, do you wish to make a statement, or are you happy to take questions?

Dr Gerry Burns (Eastern Multifund): I am happy to answer questions. I have no statement to make.

Malcolm Chisholm: I wanted to concentrate on the structures, but you have covered much of that already. I thank Eric McCullough and Brian Dornan for their presentations and all three witnesses for coming.

I would like some clarification of the local-national relationship, but first I will ask about relationships with other agencies. I notice that on page 3 of your submission you say that

> "Undue focus on health and social services links at the expense of other agencies"

must be avoided. How are housing and the other wider components of community care involved, and how is that involvement organised?

Eric McCullough: I will answer briefly. I mentioned earlier that when we first considered integration, there was a long debate about whether health and social services should be the entity. I have to admit that our links with other statutory agencies, including housing, training, employment and education, have not been as good because we have been in isolated silos of service. That is not to say that we never had communication. Of course there was communication, but it had to be worked at, and it did not follow naturally from the arrangement.

In recent times, however, quite a lot of work has been put towards communication with housing. Housing comes under a different ministry, and there is a housing executive for the whole of Northern Ireland. It is trying to develop the delivery of public housing through housing associations.

There are two models. One is the new concept of the health action zone, of which committee members are only too well aware. Secondly, action is being taken within the trusts to build a relationship with bodies that are not part of health action zones.

I will shortly hand over to Gerry Burns. One of the reasons for his being here is that he is a council member of the health action zone for north and west Belfast. I am sure that members have all heard of the problems that exist there. Gerry will tell you how the health action zone there is operating, with the involvement of a broad range of all the statutory and voluntary services. Brian Dornan could then mention what Down Lisburn Health and Social Services Trust is doing to try to achieve similar outcomes, but without such a formalised arrangement.

11:30

Dr Burns: The health action zones started only last year—Northern Ireland is behind England. There are only two of them in Northern Ireland: one is in a rural area, out in Armagh, and the other is in north and west Belfast. North and west Belfast is the most deprived part of Northern Ireland, so we have many social and medical needs. As you are aware, social problems impinge greatly on medical problems—the two are related.

The health action zone in north and west Belfast represents the bringing together of a range of agencies. Eric McCullough has already alluded to housing; training, the environment, education and health are also involved. Because the zone has only just been started, a body of work has not yet been done. The other problem is, as ever, funding and resources. The work has to be carried out with existing resources, as no extra funding was allotted to the health action zones. Each of the agencies, if they are allowed to, can put some money into whatever projects arise.

Three projects are now in hand, embracing the various agencies. One relates to the traveller population of west Belfast. The second relates to millennium babies. There is to be special compensation or whatever to everyone born in 2000. The third is the elderly. There is a growing elderly population in north and west Belfast.

This is the first time that all the agencies have come together, and our theme is one of building relationships. We are in the process of doing that now, so we would have to report back on that at a later date.

The Convener: I am finding it quite difficult to hear this morning. I am not sure whether it is the sound system, or whether it is just because the witnesses are more softly spoken than we are here, but if we could increase the volume somehow, it would be beneficial.

Brian Dornan: One of my concerns about the integration of health and social services has always been the community care agenda. In my view, we generally do less well in Northern Ireland in our links with housing, education and similar statutory agencies. I think that that is because we have spent quite a lot of time working hard on the health and social services linkage.

We are now working hard on correcting that balance. With the development of community care in the 1970s, it has been increasingly important to strengthen our links with housing, and we have been working hard with education.

That has led us to certain mechanisms: our senior management team will now meet on a biannual basis jointly with the senior management team of the local education board. Below that is a joint working group between the two agencies. That meets bimonthly to develop areas of collaborative work. We are moving towards making some joint appointments between the two agencies, including that of a development officer. We are also beginning to fund a number of projects jointly.

That is all happening from a low base. If anyone is thinking of bringing health and social services together, one of my concerns would be to ensure that other things are not lost in the process, and that the other linkages are recognised as equally important.

Malcolm Chisholm: I am also interested in clarification of the local structures in particular—I am clear about the national structures. You probably covered this, and I might not have entirely picked it up, but you began by saying that arrangements are based on a GP practice. In a way, that suggested problems with regard to scale, and to the fact that a GP practice is not necessarily based in one locality. I think that you then went on to discuss groups of GP practices. It would be helpful if you could clarify that aspect of the local structure.

Brian Dornan: I have left a little green book with the clerk, which gives a little more information. There is a team around each practice, and we bring together up to eight teams for a geographical locality. A management team of two people would be responsible for the geographical locality, and the budgets would be identified for community care and for other services on the basis of the geographical locality and its characteristics.

The staff are based together, working with GP practice groups. That all means that there can be a certain amount of geographical criss-crossing, but there are benefits to that. It works tremendously well in rural areas, where there is a significant geographical link with the practice population.

The Convener: You are talking about a structure at the local and community end of things, rather than at the acute end of things. What are the links to the acute sector? What changes have there been as a result of the integration at the community end?

Brian Dornan: In our area, we manage two local hospitals, which provide secondary but not tertiary care. They are run by a separate directorate within the trust—although we are beginning to query whether that is the right structure.

We have monthly or six-weekly hospital-community liaison meetings. They involve me and my colleague director from the acute service. They involve the senior management of the hospital, including the head nurse, the managers from the various localities and the community services managers, who manage primary care. We examine issues arising between the hospital and the community. Discharge is one of the major current issues that we are discussing. At the next level, one of the community managers meets the hospital manager every week. The community manager also manages the social work team in the hospital.

One of the differences resulting from such an arrangement is that we might take a decision, for example, to prioritise community care money to facilitate hospital discharges. That would lead to a discussion in hospital about the use of funds and the prioritisation of where funds are used, to keep the hospital system working effectively.

Hugh Henry: You mentioned the budgetary side of things. How are major allocations identified and distributed from the Northern Ireland Executive? How are allocation decisions made locally? When are the funds distributed from the Executive? Is there a separate budget line for health and another line for social care? In that context, how do you view pooled budgets? Do you use that concept in your area?

Eric McCullough: There is a lot of detail to the work, but I will try to paint a broad picture. Perhaps you should speak to the director of finance of the department of health, social services and public safety, which includes the fire brigade. When the Assembly started, it decided that it would negotiate with each of the various ministries to get money for health and social services. That money is distributed to the four health boards according to population, on a weighted capitation basis that reflects poverty, age, deprivation and the other usual criteria. Some elements such as moneys for primary care through general practitioner services have to be ring-fenced and identified, and there are both cash-limited and non-cash-limited budgets. However, basically the money goes to health boards as a lump sum.

The health board determines, within Government policy, how that money will be distributed. It commissions services from the provider trusts and decides what money should be put into mental illness, acute services, tertiary referral services and so on. As we still have fundholding, a proportion of the money goes to individual or group practices for them to commission acute and community services directly.

Once the money has been given to the trusts, they are held accountable for delivering a package of services. The money is given for a specific task, rather than simply for social services and health. It could be for the elderly or for acute services. Brian Dornan will now say what happens when the money arrives at the trust's door.

Brian Dornan: There would be discussion between the commissioning board and the trust concerning the use of funds. The board would have fairly clear views about allocations to particular programmes and would not be happy if significant amounts of money were moved between programmes of care. However, the boards have delegated to trusts considerable responsibility for commissioning community care services, so the trusts have a fair amount of freedom in deciding how money for community care should be used. We have to report separately on community care money because, following the 1993 reforms, there was a concern that those funds might drift into other areas.

Hugh Henry: But there are still separate budget lines.

Brian Dornan: There are separate budget lines. We would then delegate budgets down to our locality managers, who have a degree of freedom in how they use funds. For example, we use community care money to fund a hospital-at-home scheme, which could be classified as a health service as it is in lieu of hospital care, but is funded by what one might regard as transferred social security funds. We make it quite clear to our area board how we are using the funds, and it is happy with the arrangement. The board will, therefore, agree to fund changing use. We have also used what could be regarded as social work funds to employ an additional psychogeriatrician. Decisions of that sort have been supported on a multidisciplinary basis.

Eric McCullough: People are under great pressure to devolve more budgets and control to a local level. The aim is to have budgets that reflect local circumstances but are viable in scale.

Brian Dornan: There is no absolute distinction between a social work budget and a health budget. The commissioning board tends to plan in terms of services for older people, services for children, mental health services and so on. It would normally require us to report on the use of funds within those pockets.

Eric McCullough: This is not about the local authority and health boards putting money into a central pool. There is one budget entity.

Margaret Jamieson: Do you impose a charge on individuals who require social care? At the moment there are difficulties when someone is termed as requiring a social bath, rather than a medical bath. How do you deal with that issue?

Brian Dornan: That is an extremely interesting issue. Northern Ireland is one of a handful of areas that do not impose a charge for most social care services. We charge for the home-help service for people under the age of 75 and for other services, such as the meal service. However, nearly all social care services are not charged for. There is no charge for day care or for the intensive domiciliary care package provided in lieu of nursing home or residential care.

That has quite interesting effects. It can be argued that it creates an incentive for people to consider care at home. I have no problem with that arrangement, and my trust supported its continuation. We understand that, typically, about 9 per cent of the costs of care are recovered through charging policies. I suppose that the main purpose of charging policy is to dissuade people from taking up services in the first place. However, if people are opting for care at home, that often means that the family is making a contribution to community care. The care provided as a community package is not the total package of care provided in a nursing or residential care home. We are happy to work with the incentive to which I referred. If someone has been comprehensively assessed and is eligible for residential or nursing home care, we will on principle always offer them a choice between care at home and care in an institutional setting. Around 50 per cent of older people in our area choose care at home. There are significant variations across Northern Ireland, but the overall figure is around 40 per cent.

11:45

Margaret Jamieson: You assess the client, but do you also assess the needs of the carer?

Brian Dornan: We are required to offer carers assessments. I would not say that we do that particularly well. The honest answer is that we are trying to make improvements.

Eric McCullough: The issue that Brian Dornan has been talking about—whether we pay for the social bath or the health bath—is vital. The arrangement that has been described is a compromise that we had to come to terms with some time ago. Our legislation reflects UK legislation, and the national view is that, although health care is free, social services should be paid for. Brian Dornan has indicated the benefits of having one funding source and of having the family make a contribution. However, the arrangement is a compromise between two competing funding streams that we have cobbled together.

Dorothy-Grace Elder: Can you make it clear that you are referring to the home-help service as well as to social personal care?

Brian Dornan: I am also referring to the home-help service. If someone is aged 75 years or older, there is no charge for the home-help service. Nearly all the users of the home-help service are over 75.

Dorothy-Grace Elder: Is there any means-testing before the age of 75?

Brian Dornan: Yes. A standard scheme operates throughout Northern Ireland for the home-help service. There is the same charge, regardless of the authority area in which people live.

Dorothy-Grace Elder: Has any research been done into—or do you have a rough estimate of—how many people have been kept out of long-stay hospitals or other institutions because of the free facilities for over-75s? In other words, how many people have been able to remain in their homes?

Brian Dornan: I know of no research into that specific issue, so I can only give you my views and those of my professional colleagues. We feel that there is a clear incentive for people to consider care at home. We also feel that that is not coercion, because most people prefer care at home. We believe that, if Government policy is to encourage care at home, it is valid to provide that incentive. When the Conservative Government was considering the introduction of charges, we were unhappy about that.

Dorothy-Grace Elder: Do you have even a rough idea of the percentage of people who were able to stay in their homes because of this arrangement and who might otherwise have ended up in institutions?

Brian Dornan: I understand that 40 to 45 per cent of older people are taking their care at home. It would be impossible for me to tell you how many of them are doing so because of the incentives that are in place.

Dorothy-Grace Elder: Are you saying that 45 per cent of the over-75s are in their own homes?

Brian Dornan: I am saying that 45 per cent of people over the age of 65 in Northern Ireland who have been assessed as being eligible to go into a care home are choosing to remain in their own homes.

Eric McCullough: That is a crucial point.

Dorothy-Grace Elder: It is a good figure.

Brian Dornan: Actually, I would prefer the figure to be checked.

Dorothy-Grace Elder: Perhaps you could write to us later.

Brian Dornan: A report has just been produced by the social services inspectorate at the request of Ms De Brun, the new Minister of Health, Social Services and Public Safety. It picks up a number of shortcomings in our system, so it may be of considerable interest to you.

I believe that the overall figure is somewhere between 40 per cent and 50 per cent. Our figure is 50 per cent—on that I can be clear. We have experienced increasing financial pressures over the past three years or so, which tends to lead to a focusing of resources on people who are being discharged from hospital. That has resulted in a slip in the percentage of people who are maintained at home. That concerns me—I am concerned that we are intervening at a later stage and therefore perhaps ending up with more people moving towards residential care. However, that again is an impression.

Dorothy-Grace Elder: Thank you—your

comments have been valuable.

The Convener: We will get clarification on those figures through our researchers and clerking team.

Eric McCullough: It might be useful for a general practitioner to reflect on the point about—

The Convener: We have a number of questions that are specifically about the role of GPs, so your answer could perhaps be wrapped into the answers to those questions.

Dr Simpson: I was impressed by Mr McCullough's comment that structure itself will not deliver. In your paper, Mr McCullough, or in Brian Dornan's statement, it was said that the introduction of general management in 1990 led to changes. What changed? You are saying that the barriers are more than just structural. What measures did you take—for example, in training—to overcome the cultural barriers?

Eric McCullough: I will answer first, and then let Brian Dornan answer in more detail. At that time, I was with the Eastern Health and Social Services Board in Belfast. One of core criteria for determining what needed to happen and what the role and function of the new organisations would be was that patients should be considered holistically. When someone lives in a house, they want all the services that they need and they do not really care who, or what agency, comes to them—they just want a package of care with the minimum number of people involved. That was what drove us. We wanted to know how we could create a system or mechanism that would deliver what was required, rather than just saying, "This is what social services will do for you, this is what nursing will do for you, this is what medicine will do for you, and this is what the housing department will do for you."

Creating that system took significant effort. Brian will talk about the detail. At a more general level, we had to consider removing the fear—and I use the word "fear" intentionally—of the various professional groups that they would be subsumed and that the quality of their professional delivery would be diluted as a result of everything being mixed and social workers having to do this, nurses having to do that and so on. We began to focus on the individual and to blur the edges and remove the demarcation between the different services. That has taken many years. We had to start at the top and show that the organisation would be predicated and designed on that holistic basis.

Brian Dornan: Senior managers such as Eric McCullough helped people such as myself to come out of our professional boxes. A lot of facilitation was done among senior nurses and senior social workers. Nearly all the managers, directors and chief executives in the health and social services in Northern Ireland were from professional backgrounds or from national health service administration. We were helped to begin to ask questions.

We then tried to create opportunities for people to work together. We gave recognition to people who were working together. For instance, in our pilot project, we involved John Ovretveit, who at that time was at Brunel University and who was interested in work on quality. We said that what we were doing was about the quality of service—I think that that engaged the professionals more. We spent a lot of time going at the professionals' pace; we did not push things too fast, because we felt that we had to have consent for the changes that we were trying to make.

We felt it important that people stopped thinking only about the unidisciplinary team that they were in. We did not say that that team was not valid—it still existed—but we wanted people to identify also with the new, multidisciplinary team. We had to assure people that there would be equity of esteem among the different disciplines. Where people have come to work together and have developed personal relationships, trust tends to develop, but in some areas there are problems in ensuring that each profession respects the other. That has to be worked on. Any attempt to say that primary care is provided by a primary health care team would be unfortunate. This is not about health; this is about health and community care. That message has to be got across.

Part of the reason for building in the guarantee that a social worker and a nurse would always be in partnership in management was to reassure both the health people and the social work people that, over time, we would respect their needs. We also had to set up unidisciplinary training arrangements, so that if a community psychiatric nurse or a care manager went out and worked at a location where there might be only one or two other people from his or her profession, they would still be able to meet colleagues from their own profession and have professional development opportunities. We also built in opportunities for professional and clinical supervision, for example, across different areas.

Dr Simpson: I would like to ask Gerry Burns a question. Experiments have been tried here with social work attachment, but the social workers go back into the box of their own discipline. They often regard the GPs as being too dominant. One of you said that pushing the medical model as paramount would be counterproductive. How did you overcome such barriers in creating your multidisciplinary team?

Dr Burns: Where I work in north and west Belfast, we do not have the same degree of integration as Brian has in Lisburn. We have a primary health care team. We are quite well integrated with the nursing staff and we work very well. The nurses are attached to the practice, so we have a working relationship with them.

If we have a social service type problem, we have to contact the local social services office and talk to the duty social worker, who will not always be the same person. In north and west Belfast, there has never been true integration with the social services. There has been proper integration between the doctors and the nursing staff, but not with the social services.

Dr Simpson: That sounds much closer to what happens in Scotland. How do you move from where you are to where Brian Dornan is? How do we learn from him?

Dr Burns: The first thing to do is to start meeting people. A recent development in general practice in Belfast has been co-operatives—you have them over here. Prior to that, a lot of GPs did not talk to one another. They now all work together because they have networked at the co-ops and are not afraid of one another. The fear does not exist any more that, for example, other GPs will take their patients. If we start meeting social workers and start networking together, that fear will go. Everything in health and social services is moving towards a multidisciplinary model. The old medical model is slowly but surely moving sideways. We are aware that, especially in deprived areas, social problems constitute a big part—and a big cause—of our work load. Unless we start to work on all those things together as a team, we are never going to make any difference. The lesson that I have learned is that we have to start talking to one another.

Brian Dornan: In a number of parts of Northern Ireland, one can go and see good practice of integrated working. One of my greatest frustrations arises from the fact that that is not generalised. There is a place for central Government and for the Government departments to look at good practice and give a steer, saying, “Here is something that has worked, and we expect health and social services organisations, and GPs, to deliver this model.” Devolution is helpful, and I very much appreciate having the freedom to do the things that it allows, but why not try to generalise good practice across the devolved areas?

Margaret Jamieson: We are aware of the individual training that those in social work, the medical profession and nursing receive. Can you give us details of the multi-professional training that is available?

Dr Burns: We have made a start on multi-professional training, but there was none for an awful long time. It used to be that we would all study the biological sciences together at university before going off on different career paths. Now, a mixture of doctors and nurses undertake multi-professional training, although social workers tend not to. The training is organised at the level of boards and trusts rather than at a university level, but the concept would be more ingrained if the training were provided at university.

12:00

Irene Oldfather: You have said quite a bit about how the GPs fit into the system. The team is led by a general manager but the GP is pivotal to the system. How do you think that GPs contribute to that integrated working structure? Have you identified any difficulties with clinician-management conflicts? I would have thought that having the manager above the doctor might pose some problems.

Brian Dornan: The manager does not manage the GP, who, as in Scotland, is an independent contractor. In some instances, the GP does not participate tremendously in the functioning of the team because he or she has the freedom not to. Generally, however, GPs like the model and tend to work quite closely with the team. However, I recognise that the current contractual arrangements, and the lack of any steer, could cause difficulties in the implementation of the model.

Irene Oldfather: What role do the GPs play in the planning of community care?

Brian Dornan: GPs have felt excluded from that but have begun to take more interest. There are five commissioning pilots in Northern Ireland, two of which are in our area—one in Lisburn and one in Newcastle. The Lisburn group has focused, among other things, on services for older people. The working group is chaired by a social worker who is a member of the commissioning pilot, but the group is fully multidisciplinary. I am part of the group and it has been interesting to watch how the different professionals—GPs in particular, as nurses tend to be better informed—have become a lot more aware of the issues surrounding the design of community care services and the interface between community care and secondary care. If we get arrangements that bring together co-operatives of GPs with proper respect for the other professions—equity of esteem is important—the situation would be interesting and I would be optimistic about it.

It has been wonderful to hear senior social workers telling off GPs. Such people would not have had the courage to do that outside the commissioning pilot. The system has created more honest communication and a greater opportunity to challenge people. All of that is healthy.

Eric McCullough: Access to resources is important. Scotland has a new health model, which is different from England's. What we are talking about is creating a power base in the locality and getting people interested in how the resources will be used. People on advisory groups to health boards tend not to be interested in that method of working.

In England, the primary care teams involve a range of people who work in the community. They are given responsibilities and the resources to work with. If that does not happen, the same level of involvement will not be achieved. I am involved in the primary care group in Lisburn and it is wonderful to see—after only a year—the coming together of the professions. The people of Lisburn are getting a better service. A member of a group that was working on palliative care said that Lisburn was a wonderful place to die in—the point being that the health service was wonderfully caring and sensitive and looked after the family and the individual. That is the outcome that we want. Perhaps Gerry Burns would like to comment on what it feels like to be a GP in the system.

The Convener: Before he does, I think that Malcolm Chisholm has a relevant question.

Malcolm Chisholm: I do. It is interesting to consider the differences between the systems in Scotland and England and I want to work out where Northern Ireland's system fits in. Do GPs have budgetary powers in groups? Northern Ireland is moving away from individual fundholding but I do not know whether you are moving towards the English model of primary care group funding.

Dr Burns: I do not know, either. We are still waiting for our Government to tell us. We are in limbo at the moment. We are still fundholding, and we have been told that that will be the case until 1 April 2001 at least—that might mean that the system would continue for a year after that. We have our ideas about what should happen and acute hospital trusts have their ideas about what should happen. The situation is up for grabs.

Eric McCullough: We are extremely concerned by the fact that we are in a limbo—that is a demoralising position to be in. Fortunately, we have the pilots that were introduced to involve people as part of the cultural change that we talked about. All the GPs involved in the Northern Ireland primary care group—along with nurses and social workers—have put papers to Bairbre de Brun, who has taken over again as the Minister of Health, Social Services and Public Safety. They want to emphasise the importance of resourcing primary care—as it delivers services on the ground—and to recommend that secondary care should become a less dominant feature.

I have to watch what I say, because of where I am, but we think that Scottish GPs have been disenfranchised and have had their power base removed. They make up an advisory group on a voluntary co-operative that talks to a primary care organisation that tries to convince a health authority that holds the ring—as it were—and commissions from the acute side. The process is too centralist and the GPs are losing interest as they do not have ownership of the problem. They have responsibility for dealing with the problems and the desire to deliver solutions, but they do not have the power base. That is the view that I arrived at after considering the Scottish and the English systems, but I am sure that people in this room would debate that with me at length.

Margaret Jamieson: At the risk of further upsetting people, could you say whether there are pilots in Northern Ireland with salaried GPs? That might create greater integration than there would be if GPs were simply independent contractors.

Eric McCullough: The pilots do not have salaried GPs as such, although GPs are not offended by the idea, which could be appropriate at an appropriate time. Equally, however, there are benefits to the independent contractor status, such as the link to the individual. At the risk of offending someone, I will say that many GPs believe the independent contractor status to be almost a red herring; they are accountable anyway because public money is involved. The Government probably could not afford a salaried service, given the 24-hour-a-day, 365-days-a-year cover that is required. Gerry Burns might want to comment, given that what we are discussing affects his pocket.

Dr Burns: There is no salaried service in the commissioning pilots, which are looking at other aspects of health care. As we all know, health care and how GPs work will change over the next 10 years. One of the proposals is a salaried service, and I am sure many GPs will accept that if it is adequately resourced. At what level will it be resourced and what will be the balance between power and accountability?

Margaret Jamieson: What do you mean by power?

Dr Burns: The ability to do things that you think are right for the patient.

Margaret Jamieson: Surely you have that under your professional code.

Dr Burns: That ability is always tied to resources. At any time I will have a number of patients on waiting lists for operations that they cannot have done because hospitals do not have the money. The fundholding system provided a lever that I could use, to a certain extent, to get operations for people that I thought were in need. That is what I mean by power.

Margaret Jamieson: Exercising your clinical judgment?

Dr Burns: Yes.

Eric McCullough: But also resourcing it and making it happen. The hospital has its priorities but they may not match what GPs think is needed for their local population and their patients. Acute hospitals have debates on where investment should go, whether on tertiary care, on basics like hips and cataracts and so on. We are talking about power with a small "p"—the capacity to get something done for your patient rather than constantly depending on others.

Dorothy-Grace Elder: The more you talk, the more grateful we are to you for coming here today and taking time out of your very busy lives to do so. Do you feel that community care needs receive an equivalent priority to more acute conditions? Do you have any other innovative ideas or general input from Irish experience to give us, perhaps from the Republic?

Brian Dornan: I think that community care funding has lost out to acute care because of the pressures in acute care. I am not saying that anyone has done anything wrong, but money identified by the department last year for community care has been diverted by commissioning boards to meet deficits in tertiary hospitals. One of the dangers and one of the concerns of the social worker profession, which they share with other primary care professionals, about the integration of acute services with the rest of the service is that **Error! Not a valid link.**have a tendency to suck in resources. Having said that, I would nevertheless miss the opportunity to work in the same organisation with acute sector colleagues to try to solve those problems. Instinctively it feels right to be working together, but there have also been losses.

We are increasingly establishing links with the Republic, but I have no personal knowledge of forms of care there that we are thinking of introducing.

Eric McCullough: People will say to you that the acute sector has not robbed the community sector. In my experience—and, sadly, as my grey hair shows, it is over a long period—the acute sector has taken money from the community sector. All that is needed is a winter emergency. That is seen as an immediate need, whereas Mrs Bloggs's home help is not seen as so immediate.

A consultant in a bloodstained white coat saying "I can't deal with patients, they are lying on trolleys" wins out. I am not saying that is wrong, because that does need to be addressed, but we need to look beyond episodic events and saying, "This is a disaster, we must do something". We need to look at why winter emergencies happen and how they can be prevented—at how we can develop a community capacity that prevents winter emergencies and people having to go into hospital to lie on a trolley for 24 hours and that enables early discharge.

The acute sector always seems to be given priority in Northern Ireland and, I think, in the rest of the United Kingdom. We need to right that balance. Current thinking sees a primary care-centred service with the hospital as the secondary agent, although essential. Good community care offers people better access. They do not want to have to go by bus for 20 miles and lose a day's work. Maximising what can be done locally, appropriately, safely and effectively, with fewer, larger hospitals, is a more efficient and effective way of dealing with patients. Then the hospital is part of a continuum.

12:15

We do not have much in common with the Republic as a health care system but we do talk; for example, we talked to the Irish College of General Practitioners recently about what we have in common. Some pilot schemes have been run in border areas on how GPs and ambulance services can overlap. There are problems of funding and practice and accountability. That is happening but needs a lot of work.

The Irish system is totally different: only 32 per cent of the population is covered for free GP services and everyone else has to use an insurance or payment system. People are not registered with a specific GP—patients can go to a different GP each day. Patients have to pay up to £40 a month for prescriptions. There are still a lot of voluntary hospitals. But we do communicate.

Mr Duncan Hamilton (Highlands and Islands) (SNP): Brian Dornan mentioned rural provision. The Down Lisburn Trust report says that

> "Patients, clients and carers can now, within fifteen minutes of their home, access a team, which can mobilise services to meet most of their health and social care needs in their local community."

In Scotland we have a dispersed rural population. What challenges have you faced that we can learn from for rural Scotland?

I also want to understand how the system works. How is what happens assessed? What is the definition of success? Is there an agreement on that that is shared by all parties? Do agencies see success as fulfilling their role in, for example, social care, or is there a wider view, that it is about the patient and the end result? If so, who sets that target? Is it agreed or set from above?

Reference was made a moment ago to a situation where a GP was in dispute with another agency about priorities, perhaps with a hospital. It would be useful to understand where the control and final decision making lie. Who has the final call and resolves disputes over priorities and resource allocation, what are the reporting mechanisms that are in place to ensure that success or failure is being picked up, and how will you monitor and learn from experience?

The Convener: I appreciate that Duncan Hamilton has hit you with a number of questions. However, we need to be conscious of time. One of the ministers is waiting.

Mr Hamilton: Well, he can wait.

The Convener: Please try to keep your answers brief.

Brian Dornan: Much of our area is rural. There has been quite a big investment in buildings. One of the things that encouraged primary care professionals to become really engaged in the process was that they saw that change led to the trust changing its priorities. It became easier for me to obtain a good share of capital funds to develop health centres and community clinics, as opposed to our acute hospitals always sucking in those resources. We extended buildings right around our area. We developed two major health centre schemes at a cost of about £750,000 and we replaced four or five clinics, which cost about £200,000 each.

We have tended to adapt our buildings—knock holes in walls—to create big team rooms where people can come together and create clinical rooms where outreach services can be brought. We now bring podiatry and other services into these local clinics. As you go round our area, you will generally find a primary care base every five miles as you move from village to village or town to town. That has been important, but it has been a long process. As another way of solving the problem, we have come to agreements with GPs to rent accommodation from them so that we can base our staff in their buildings.

Eric McCullough: I will be brief, as I am conscious of time. I would need about three hours to answer that question.

On the concept of priority—who holds the ring and who decides who is the boss—the bottom line is that the health authority commissions services that it can afford to buy. It commissions—I am being simplistic—1,000 hip operations for a certain area and the consultant orthopaedic surgeons make decisions about the lucky 1,000 people that benefit. The other 500 people just have to wait until another time. That frustrates GPs, because they say, "I know that this person has more need than the other person." When they were fundholders, they had some opportunity to pull a lever to get something done. They could get some movement in the acute hospital sector. When the health authority says that it can afford 1,000 hips, if there is a need for 1,100, then that is too bad—100 people just have to wait. That is wrong.

We have been trying to create more clinician-to-clinician respect and communication to deal with clinical need and priorities so that the decision is a clinical one, not a financial one because the health authority has said it can afford only 100 hips as it wants to spend money on something else. If there is investment at local level, they can decide what is best for their community. A GP has a one-to-one relationship, so I consider what I can do for that patient as well as for the greater good of the community.

We have not solved all the problems in relation to questions that you have asked. We do not always learn enough, although we try. I would love to debate those matters at length with the committee.

Malcolm Chisholm: You refer on page 4 of your submission to research that indicates that a vast majority of GPs, care managers and district nurses say that the system is better and that there has been improvement. Have there been any other evaluations of the effectiveness of the integrated system? If you were to do further evaluation, what would be the key processes and outcomes that should be measured?

Brian Dornan: I undertook this piece of research myself, with supervision from the University of Ulster, because I regretted that, when we started this work, no one became involved in research and evaluation of what we were doing. I examined the evidence as to what were the indicators of team working and what were the attitudes of primary care professionals. I did not examine the issue of results for clients, patients or carers.

The indicators that I thought were interesting and worth examining, if we think that teamwork is beneficial in itself, included matters such as communication, frequency of face-to-face contact between the different professional groups, frequency of communication about work and satisfaction with the accessibility of colleagues. We found about 95 per cent GP satisfaction with the accessibility of social care professionals, and there was about 87 per cent satisfaction among care managers with the accessibility of district nurses.

We examined communication, perceived understanding of each other's rules and working practices that are responsive to other team members—people's assessment and the assessment of the other disciplines as to the extent to which you change practice to assist your colleagues. We also examined access to files and information systems of other disciplines. A single client health file for care management and district nursing, which we are currently in the process of introducing, will come out of that.

We examined the extent of shared philosophy and objectives. It was interesting to test the extent to which care managers felt that health promotion was part of their business and the extent to which team members perceived themselves as working in a team-like way with other disciplines. That was an open question near the end of my piece of work. One of the disappointments is that a lot of team members did not feel that they were working in a team-like way. It was interesting that district nurses were as likely to feel that they worked in a team-like way with care managers as with GPs. There are all sorts of challenges. Those issues would be significant ones to consider.

I did not examine client results. The only proxy that I took for that was the assessment by professionals of the benefits to clients. Very little research has been done in Northern Ireland. The health and health care research unit at Queen's University has looked around the fringes of those matters and about 10 years ago would have been expressing some disappointment and saying, as Eric McCullough has said, that not enough has been made of the potential.

Hugh Henry: Has the Scottish Executive contacted people like yourselves to discuss your experiences? The committee is considering this in a parliamentary sense. I would be interested to know whether the Executive is considering this as well. Before you go back today, will you meet anyone from the Executive?

Eric McCullough: On your last point, no, we will not meet anyone from the Executive. We came here at this committee's request. We are not the statutory organisation. That is why, when we were invited, we thought that you wanted people from the coalface.

There is communication between our Executive and your Executive; for example, the permanent secretaries in health get together regularly. I cannot tell you about what debate there has been or what examination there has been of what we are doing in Northern Ireland. I am sure that your clerk could find that out without too much trouble.

Brian Dornan: We have quite a lot of contact with colleagues in Scotland, for example, the pilot project in Perth and Kinross and South Lanarkshire. Recently, there have been quite a lot of contacts between provider organisations in Northern Ireland and those in Scotland.

Eric McCullough: It is more by accident than design; it is a voluntary agreement rather than a formalised approach through the Executive.

The Convener: What do each of you think has been the major advantage and the major disadvantage in the integrated system? You have 30 seconds each.

Eric McCullough: The advantage is that where it works, it works well. The person that benefits significantly is the consumer. I also believe that the staff begin to share each other's knowledge base and build up trust and respect with each other. That is the real advantage. The difficulties that we have found are breaking down the demarcation boundaries, removing the fear of the professions and reassuring the professions that this is not about the dilution of their expertise.

The outcome is greater than the sum of the parts. It is important to examine those relationships and spend time dealing with the culture and behaviour. Do not say, "Here is a system", start it on the 1 April and think that everything will happen. Build up to it, get the communications and use money for training and development. Try to get thoughts concentrated on the person that you are dealing with, not the staff needs. It has to be resourced, as we have mentioned.

Brian Dornan: I am dying to say community care for older people. I have never in my career had a debate about the social bath or the health bath. Not delaying care by not arguing is the big advantage.

Dr Burns: I deal mostly with nursing issues and the social aspects of integration. The main benefit has been the fact that we have attached staff whom people know personally and can build up a relationship with over a period of time. There are, therefore, direct lines of communication and problems can be dealt with properly and quickly.

12:30

The Convener: Thank you for taking the time to come over and give evidence to us this morning. Thank you for your answers and for your written submission. There may be some points of clarification that we would like to take up with you in relation to Dorothy-Grace Elder's questions.

Please carry our good wishes back home with you from this Parliament and from us, as representatives of our country, to your country. We have enjoyed having you here. Thank you for your time.

Eric McCullough: Hearing about it is one thing, but why not come and see for yourselves what we do? I extend an open invitation to you to come and see us.

The Convener: Thank you. We shall have to put that suggestion to the Scottish Parliament Corporate Body.

Dorothy-Grace Elder: Don't go using "Lisburn is a great place to die" as a tourist slogan.

Eric McCullough: Not with our record. [*Laughter.*]

The Convener: Thank you again.

Subordinate Legislation

The Convener: Moving on to agenda item 7, I welcome the Deputy Minister for Community Care, Iain Gray. We are grateful to the minister and his team for coming a little later than planned, because of our earlier delay.

We are discussing an affirmative instrument of subordinate legislation: the Food Protection (Emergency Prohibitions) (Paralytic Shellfish Poisoning) (Orkney) (Scotland) Order 2000 (SSI 2000/192). If members would like to ask officials about any points of clarification, they should do so now.

As no members wish to ask questions, I invite the minister to make a short statement on the purpose of the instrument.

The Deputy Minister for Community Care (Iain Gray): The debate concerns an emergency order banning the catching of certain species of shellfish. It is not unusual for the committee to consider such orders, but this one has some differences and I shall draw members' attention to them. The order applies to the waters in Scapa Flow in the Orkney islands, and it came into force at 16.00 on 14 June 2000. It prohibits the fishing of mussels, scallops, queen scallops and ensis—or razor clams as they are more commonly known.

The key difference between this order and many of the other orders that the committee has considered is that this one refers not to amnesic shellfish poisoning but to paralytic shellfish poisoning. PSP toxins have been detected in the shellfish at levels that are significantly above the European agreed safe level, which is 80 mg per 100 g. Some levels that were detected were as high as 159 mg per 100 g, twice the acceptable level.

Since 1990, emergency closure orders in those waters have been an annual occurrence. Although I expect that people in the shellfish industry will be disappointed by the imposition of the order, I think that they will not be surprised.

I move,

That the Parliament's Health and Community Care Committee in consideration of the Food Protection (Emergency Prohibitions) (Paralytic Shellfish Poisoning) (Orkney) (Scotland) (Order) 2000 (SSI 2000/192) recommend that the Order be approved.

The Convener: Do any members have questions for the minister?

Mr Hamilton: You said that imposing such orders has become an annual occurrence. I assume that Godfrey Howard and his team, the people who are researching amnesic shellfish poisoning, are also conducting on-going research into paralytic shellfish poisoning. Is that the case, and what steps are being taken? There is a lot of concern about when the end of the problem will be in sight for shellfish industry.

Iain Gray: Yes, it is the same department that is conducting the research. A number of research programmes on toxins in shellfish are under way, covering ASP, PSP and the third one, DSP or diarrhetic shellfish poisoning. The Scottish Executive spends around £600,000 each year on research and monitoring. Two new research projects were instigated earlier this year, so research is continuing.

To deliberately misunderstand the question—

Mr Hamilton: Surely not.

Iain Gray: On the question of when the end might be in sight, I know that Duncan Hamilton is aware that the orders have become an annual occurrence. It is worth pointing out that, in previous years, those orders have stayed in force until about October, so the same could be true of the order that we are considering today.

Mr Hamilton: Is the monitoring regime carried out with the same regularity as that for ASP?

Iain Gray: Yes, it is. The results are distributed every week by fax to all the fishermen's organisations. There is also a hotline number and the information is available on the Food Standards Agency website, so monitoring is conducted and reported regularly to keep the industry informed.

The Convener: The question is, that the motion in the name of Iain Gray be agreed to.

Motion agreed to.

That the Parliament's Health and Community Care Committee in consideration of the Food Protection (Emergency Prohibitions) (Paralytic Shellfish Poisoning) (Orkney) (Scotland) (Order) 2000 (SSI 2000/192) recommend that the Order be approved.

The Convener: That brings today's meeting to a close. I thank members and the minister for attending.

Meeting closed at 12:36.

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