# HEALTH AND COMMUNITY CARE COMMITTEE

Wednesday 6 September 2000
(*Morning*)

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## HEALTH AND COMMUNITY CARE COMMITTEE

### 19th Meeting 2000, Session 1

**CONVENER**

*Mrs Margaret Smith (Edinburgh West) (LD)

**DEPUTY CONVENER**

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

**COMMITTEE MEMBERS**

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

*attended

**WITNESSES**

David Brownlee (Age Concern Scotland)
Lindsay Burley (Scottish Health Boards Network)
Emelin Collier (Scottish Health Boards Network)
Linda Dunion (Age Concern Scotland)
Jim Jackson (Alzheimer Scotland—Action on Dementia)
Jan Killeen (Alzheimer Scotland—Action on Dementia)
Moira Paton (Scottish Health Boards Network)
Douglas Philips (Scottish Health Boards Network)

**CLERK TEAM LEADER**

Jennifer Smart

**SENIOR ASSISTANT CLERK**

Irene Fleming

**ASSISTANT CLERK**

Joanna Hardy

**LOCATION**

Committee Room 4

# Scottish Parliament

## Health and Community Care Committee

*Wednesday 6 September 2000*

(*Morning*)

[THE CONVENER *opened the meeting at 09:38*]

## Community Care

**The Convener (Mrs Margaret Smith):** Good morning and welcome to the first meeting of the Health and Community Care Committee after the recess. I hope that members had a refreshing recess; I will not call it a holiday, because I know that you have all been busy. We have flung ourselves to the four corners of Scotland to find out more about community care on the ground and we have more witnesses with us this morning to give evidence of how community care is working—or not—in Scotland.

I welcome our friends from Age Concern Scotland, Linda Dunion and David Brownlee. We have about 45 minutes to ask them questions. I invite them to kick off by making a short statement to the committee before members ask about some of the points that were made in Age Concern's written submission.

**Linda Dunion (Age Concern Scotland):** I thank the committee for asking us to come along and give evidence today. Members have received our original submission and our "We Care" petition, which has more than 10,000 signatures. David Brownlee and I would like to say a few words about some of the current issues. David will talk briefly about the problems that relate to care provision and charging and I shall address my comments mainly to the Sutherland report. We are aware that we have only about five minutes to do that, so we shall stick to our time limit.

First, I reiterate the need to implement in Scotland the recommendations of the Sutherland report. We feel that that would represent a realistic means of providing for the care needs of our older citizens in the longer term. In common with like-minded organisations in the voluntary and public sectors, Age Concern Scotland is disappointed that the Government appears to have cherry-picked the recommendations and has placed responsibility for care costs firmly on the shoulders of individuals, rather than on society as a whole. We feel that that attitude is short-sighted—we anticipate that the issue will need to be revisited within the next 10 years, because the problems will not go away.

We have the chance to develop a distinctively Scottish long-term solution. Age Concern Scotland has consistently pointed out that the powers to implement the Sutherland report rest overwhelmingly with Holyrood rather than with Westminster. In particular, we remain convinced that the introduction of free personal care would lift at a stroke the burden of anxiety that faces many people as they grow older and become less able.

It is clear to us that we have entered a period of transition from the institutionalisation of older people to supporting them to live independently at home for as long as they wish, and from disjointed and often inappropriate service delivery to more responsive joint working. Our concern is not that the developments are unwelcome—they are not—but that the scale, pace and full implications of the changes have not yet been totally appreciated or planned for. What, for example, will happen to the private residential care sector in the long term? If we are serious about enabling people to live at home with the level and type of support that they require, we must build up the options that are available, not only in terms of health and community care services but in housing, transport and other facilities in the community.

I stress the need for good research on which to base policies. In Age Concern's manifesto for the elections to the Scottish Parliament—of which I am sure members all received at least three copies each—we called on the Scottish Parliament to carry out an audit to establish the current levels, quality and cost of the care that is received by older people in every area of Scotland. The Royal Commission on Long Term Care called for longitudinal research to help monitor trends, make projections of need and cost, assess the effectiveness of preventive and rehabilitative measures and inform future policy making. Statistical information for Scotland, disaggregated to show geographical variations, is absolutely essential. The Health and Community Care Committee may also want to consider whether it has a role in commissioning such an audit and on-going research.

David Brownlee will say a few words.

**David Brownlee (Age Concern Scotland):** I am Age Concern Scotland's information officer and my remit is to advise people on income and social inclusion. I get a lot of inquiries from Age Concern members and other members of the public about problems that they encounter in community care provision.

There are many people for whom community care has been a success story. Unfortunately, there are a lot of others who have had bad experiences. Because of the nature of my job, I do not hear much about the good experiences and a lot of problems come to my door. It has become clear to me that community care in practice is far from being the user-led service that it should be. The service providers have too few resources to deliver an adequate service to those who need it.

The same themes tend to run through all the problems that I encounter, which are usually the result of a lack of accessible information about community care services. There can be poor administration and difficulties in pursuing complaints about services, and delays between assessment and provision of care. In some cases, despite a person's needs being assessed, no care is provided. There is also confusion in local authorities about charging policy and practice and Scottish Executive guidance. There is also inconsistency and unfairness in charging for services, both in residential homes and in domiciliary care settings. I have been trying to find solutions to those problems.

While preparing for this meeting, I spent a little time examining some of my community care cases. In a two-month period, I dealt with 15 cases in which there were specific problems with community care charging. I looked then at the Sutherland report and tried to identify whether those cases would have been resolved had the recommendations of that report been implemented in full. Ten out of the 15 cases would have been entirely resolved had the Sutherland recommendations been implemented. Two further cases would have been partially resolved as the result of the value of the individuals' homes or assets. The remainder would have been resolved if clear information—provided that the client had acted on that information—had been available to the client at the outset from the local authority.

09:45

Individually, the cases are tragic. They range from a council's insistence that a client cashed in a funeral policy to delays in communication between local authorities that resulted in a client receiving an avoidable £7,500 bill for care for her father. Collectively, those cases show that there are problems in the community care system.

Finally, I echo Linda Dunion's comments: the Sutherland report must be implemented as soon as possible.

**The Convener:** Thank you. I hope that this meeting will be a good experience for you, David. I echo your comment: people do not come to us often with good experiences. One reason why we went out to speak to people was to get a balance between the good and the bad, rather than merely hearing anecdotally that the system is bad.

I will kick off with a question on the Sutherland report. Some people take a different view from Age Concern and from many of the people in this room on the implementation of the Sutherland report. They say, "Why should we implement Sutherland when that means simply that a few thousand people in Scotland will be given a parcel of money for their own use? Is it not better to take that money, which would run to several million pounds, and put it into the community care structure, rather than pinpointing a few individuals?"

**Linda Dunion:** I would say that the problems do not affect only a few thousand individuals—they affect us all. We all hope to grow old, but we have no way of knowing what our care needs will be as we get older. Some of us will live healthily until we are very old and die in our sleep, while others will become frail and will need a lot of support for a number of years. The Sutherland report made the point well that, as a society, we are prepared to pool resources to pay for accident services, or pay for a health service and police on our streets. The principle of providing for those in our population who need that underpins the recommendations of the Royal Commission on Long Term Care.

On spreading the money more widely, I will return to the situation in which we find ourselves today. Older people believe that they had a contract—they expected to receive care throughout their lives. People are penalised when they need care services because they have become frailer as they have become older, but one would not be expected to pay if one had an accident and needed similar services. The system is inherently unfair, and that unfairness is based simply on age.

We appreciate that budgets never go far enough, but it appears that older people are being penalised in a way in which other sections of society are not. We believe that it is important for the Sutherland report to be implemented because there would then be equity throughout society. We all face growing old, and we should all share the risk and the cost of providing for our older citizens.

**The Convener:** I will pick up your point that implementing the Sutherland report in full would, at a stroke, lift anxiety from older people. There will be anxieties left. There will still be costs to be borne because people will still be assessed and they will still have to pay housing and living costs within residential care. Because of that, not all of the anxieties can be lifted at a stroke. However, what would the impact be if the recommendations of the Sutherland report were not implemented in Scotland?

**Linda Dunion:** If the recommendations are not implemented, the situation will continue in which older people—even those who have savings—are frightened to spend money because they think that they might have to pay for care later. The principle of contributing towards what the Sutherland report calls hotel costs—bed and board costs—is accepted by most people. Older people do not object to making a contribution to having their housework and shopping done. However, our research shows that people feel that the range of care that would be classified as personal care—help with eating, dressing and so on—is different.

If the recommendations were not implemented, the muddle that exists would carry on and the situation would have to be revisited. As long as people are being charged for what is often intimate personal care, they will use whatever savings they have and will, increasingly, face poverty. If we do not take this opportunity to resolve the situation—and Age Concern believes that it would be a long-term resolution—we will simply set some of some people's problems aside for a while.

**David Brownlee:** If the current system continues, the boundaries of the laws will continue to be tested both by local authorities and by individual service users who feel that they have been caught out by the unfairness of the regulations. Cases are regularly subject to judicial review, such as Yule v South Lanarkshire Council and Robertson v Fife Council. In those cases and others, individuals look to the courts to provide fairness and give answers that people cannot get from local authorities. People feel that they have been badly let down by local authority policy and practice—that will continue and will lead to difficulties for many people.

**The Convener:** Putting the issue of equity and fairness to one side—which you have dealt with well—what effect do you think that full implementation of Sutherland would have on the manner in which the system functions? Would it make for better delivery of services? If so, why?

**David Brownlee:** It would, because the system would be easily understood. The principle of paying for hotel costs but not for personal care costs is understood by us, by most people to whom we have spoken and by the committee. That is seen widely as being a system that could be implemented and that would be easier to run after an implementation period.

**The Convener:** I take it that you think that implementation would have an impact on the bureaucracy of the system.

**David Brownlee:** It could.

**Kay Ullrich (West of Scotland) (SNP):** In what way would the implementation of Sutherland alleviate the funding problems that are faced by local authorities?

**Linda Dunion:** There would have to be more money going into the local authorities to provide the care. We find the sums quite mysterious. We know that there has been a shift from older people spending fairly long periods in hospital towards them living at home. However, no parallel shift in resources has followed—there is a shortfall. There is already a mismatch. If a decision were taken to implement Sutherland—making personal care free—considerable work would need to be done to ensure that the money followed the people. One of the recommendations is that there should be better joint working—that is already under way and will make a big difference.

As I said, research is needed—we need to know what the picture is. At the moment there is no consistency, as I am sure members have found as they visited different places around the country. Where a person lives determines what they get and how much they pay for it. That mess will not be cleared up without the introduction of a more easily understood system that is uniform from the north of Scotland to the Borders.

**Kay Ullrich:** Would local authorities need more funding if personal care was to be free?

**Linda Dunion:** Yes, they would.

**Malcolm Chisholm (Edinburgh North and Leith) (Lab):** I want to move on to the section of your submission on the representation of consumers and national standards for care. How could the views of older people on the services support that they want to receive be heard more effectively?

**Linda Dunion:** There is a need to ensure that consumers' voices are heard at national and local levels. We are encouraged that the Scottish commission for the regulation of care will involve representatives of users and carers groups.

Our submission refers to the work that we have done in Fife with user panels. That is an interesting initiative because it involves people who would normally be regarded as housebound getting together on a regular basis to comment on local services. They even do something similar to the Health and Community Care Committee in calling people along to give evidence and to account for themselves—that can be anyone from a local authority official to a councillor—and that works extremely well. The feedback that we have received from the local authority is that discussions with the user panels help the authority to ask the right questions and to start from the appropriate point. We feel that that model should be considered.

We are moving towards the greater involvement of citizens in many different ways. The local authorities produce community care plans and many produce plans for older people services, all of which stress the importance of participation. We know that participation does not come cheap, but we must be imaginative and recognise that resources must be put into participation if it is to work. For example, if people on a low income have to travel to a meeting, they should be reimbursed for that. That is what is happening in Fife—people are picked up and taken to where the panels are meeting.

**Malcolm Chisholm:** You said that you were pleased that users and carers were to be involved in the commission for the regulation of care, but your submission also says that you would like

> "a national body which can act as an Ombudsman for individual complaints as well as scrutinising the quality and effectiveness of the system as a whole".

Do you see the care commission fulfilling that role or would there need to be a separate body?

**Linda Dunion:** No. That is a matter for investigation. Consider the model of the local health councils, which were set up to champion the interests of health service users. There is a need for an equivalent body to cover community care. The local health council model works well, and something equivalent would have a useful role to play in helping to ensure that community care services are up to scratch for the needs of the users.

**Malcolm Chisholm:** But you would not want the commission for the regulation of care to undertake that role; you would prefer a separate body to be established.

**Linda Dunion:** The body would have to have the independence that the commission, by its nature, will not have. I mean no disrespect to the work that the commission may do, but it is a different beast.

10:00

**Dorothy-Grace Elder (Glasgow) (SNP):** May I ask a supplementary? You referred, rightly, to the need for more research overall, but has any research been done into the cost of means testing, which is an expensive business? Sometimes doctors and others are paid for their part in the process. Do you have any indicators of that cost, or would you like the matter to be explored so that we can get a balanced picture of the cost of means testing?

**Linda Dunion:** I am not aware of any research. Are you, David?

**David Brownlee:** No.

**Mary Scanlon (Highlands and Islands) (Con):** You talked about a muddle, and we are gradually coming to the same conclusion. May I ask about the provision of information, advice and advocacy services, and barrier-free housing and transport, as part of a holistic approach? You mention such an approach in the conclusion of your submission. How do you feel about the progress that has been made towards an integrated policy response to the development of community care services in Scotland? Are we moving towards greater integration?

**Linda Dunion:** The short answer is yes. Initiatives are taking place in which the authorities are trying to get together to ensure that people who use the services do not have to chap on one door after another to get what they need. We are moving in the right direction. The political will exists to make things happen, and local authorities seem to want things to happen. It is only a matter of time before consumers feel real improvements.

This relates to my earlier point about managing change. I used to work in learning disability. When we closed down big hospitals, there was a well-managed process whereby the individual with the learning disability who was leaving a place such as Gogarburn was assessed, and the sort of life that they wanted to lead was discussed with them. Plans were made for what would happen with the staff in such hospitals. We were aware that a policy was being implemented and that the process was being managed. That is the missing link at the moment. We are in transition; if we do not recognise that fact and take charge of and manage the process, it will go wrong, at least for some people in some parts of Scotland.

**Mary Scanlon:** I understand what you are saying. The learning disabilities review, which is an excellent document, goes a long way towards addressing that gap.

In relation to services for the elderly, do you have experience of any examples of good practice that address the seamless transfer or co-ordination that we are talking about?

**David Brownlee:** I do not have a case study.

**Linda Dunion:** We have seen better practice in Perth, which is probably one of the better known local authority areas. Efforts are being made there to join together the services of the local authority and the health service, to ensure that people need only one port of call to get services. We have also had good reports from Dundee, where individuals are receiving a good level of service and where accessing services is easy.

As David Brownlee said, service provision is patchy; I am sure that you have found that yourselves. We tend to hear about the bad experiences. People come to us only when they need help, so it can be difficult to make judgments. We are considering practice in different local authority areas. In Fife, although the user panels have made criticisms, the strategy has made a difference. It seems to us that different strategies are making a difference in different ways.

**David Brownlee:** As far as I am aware, Perth is one of the few places in Scotland that has a service—set up by the citizens advice bureau—that has been set up specifically to address community care needs. I am not aware of other information providers at a national level in Scotland who have the level of expertise that is required to give full answers on community care issues.

**Margaret Jamieson (Kilmarnock and Loudoun) (Lab):** Mary Scanlon mentioned seamless care. We know that that is the way forward, but it has in-built financial barriers at the moment. Should the resource transfer be put into a pooled budget, or should we stay as we are?

**Linda Dunion:** The pooling of budgets into a single community care budget is quite complex; there is clearly a point at which you have to say that community care begins and health care ends, and vice versa. Having one budget for community care would certainly make life easier but, as you said, there are real barriers to doing that. Budgets are held by different authorities. To have one budget for community care would require a tremendous amount of work to establish what the community care services are, and when the community care budget kicks in. We have all heard about the dreadful health bath or social bath nonsense. If we are to get away from that, we must consider having some kind of pooled budget, but at the moment we are not aware of that working successfully anywhere. A lot of work will need to be done.

**Margaret Jamieson:** Would you advocate going down that road?

**Linda Dunion:** It should be explored. However, we need to work in the context of the bodies that exist at the moment. A proposal of ours that we would like to be considered is to have an authority that would be responsible for delivering community care. It would straddle what currently comes under health and social work. Local authorities and the health services would have to work on the practicalities of that.

Everybody wants to guard their own budgets. It is not up to us to dictate what people should do; but we can at least ask that certain avenues be explored to try to get away from some of the current problems.

**Margaret Jamieson:** That leads me to my next question. In England, the national plan has introduced the opportunity to create new care trusts; such trusts represent a new level of primary care trust with a broader health and social care role. Should we follow that route in Scotland?

**Linda Dunion:** Again, we should certainly explore that option. There is a blurred line between health and social care—that is what we are talking about. The health service is clearly changing: there is more emphasis on people accessing health services more locally. If that is to happen, we imagine that it would make it much easier to set up a new trust such as that, which would probably take charge of public health as well as health and community care in its own area.

**Margaret Jamieson:** Has your organisation evaluated what has happened in England?

**Linda Dunion:** No, not yet. However, we work closely with our colleagues in Age Concern England, which is a separate organisation. It has more resources than we do to do research.

**Mr Duncan Hamilton (Highlands and Islands) (SNP):** I have a brief supplementary question. I do not understand your position on this issue. You advocate a separate, independent body that pulls together the various strands of policy, and you are quite clear that the structure should be unified, but you seem to be much more reserved about saying that there should be a unified budget. What would be the point of having a separate structure that would pull it all together if we did not go down the same road for funding?

**Linda Dunion:** It is not reluctance to consider that as an option. We have to separate out the delivery of the service from the point of view of somebody who has needs that must be met—having a one-stop shop and putting in place the resources for that. It is about moving from the current position to where we feel that we want to be. At the moment, the structures are quite rigid and it is difficult to move towards having a single budget for community care.

Although we feel that there is a place for a body that would take an overview of community care services, which would improve the co-ordination of such services, we are talking about a continuum from health through to fairly low-level support in the home. As things stand, it is quite difficult to say where the cut-off point is, and to identify how we can begin to build a unified budget in a way that makes sense to the people who need the services and in a way, and at a pace, that the service providers can live with.

Questions on how to make that happen must come back to the service providers. We are considering the issue from the perspective of older people getting access to services and having their voices heard, and of ensuring the co-ordination of services. It is a tricky road from where we are today to the position of having a single community care budget. It is not that we do not want such a budget; we are simply aware that, technically, it will take some time to get it.

**The Convener:** Surely, as long as you get your definition right, you can say, “This will actually happen and will make a difference.” Colleagues have found projects round the country where pooled budgets have been set up in miniature. People have said, "Right, we will pool this money; we will pool that money; we will bring in this member of staff; we will bring in that member of staff; we will make the managerial team knit together." Those people might hate each other for 18 months, but eventually they will provide a service. When you go in and talk to them, it is not impossible to tell who is the health professional and who is the social work professional, but they are much more of a team, providing the service that the users need. In essence, that is what we need to do first before taking that approach to a grander scale.

**Irene Oldfather (Cunninghame South) (Lab):** One of the frustrations that I experience comes from the fact that projects often fall between two posts—they are neither health board work nor social work—yet they are vital in keeping elderly people, who are at the margins and vulnerable, in the community. I am thinking about lunch clubs, transport and barrier-free housing. I wonder how we can provide seamless care and recognise, for example, that lunch clubs and satisfying the nutritional needs of the elderly are vital to keeping them in the community. At the moment, many projects throughout Scotland are not funded because they fall between health board funding and social work funding. How could such projects fit into the structure and funding regime that you are thinking about?

**Linda Dunion:** That is a tremendously important point. We have not yet touched on the role of the voluntary sector. What you describe is precisely the type of role that local age concern groups play.

**Irene Oldfather:** Exactly. I have one such group in my constituency.

**Linda Dunion:** Preventive measures do not always mean someone getting a jag in their arm to stop them getting flu; we are talking about researching what enables people to live in the community without more intensive care being put in place. Funding for the voluntary sector's provision of such services has dwindled. Age Concern Cupar is being run by one woman and her sister, who provide a lunch club for 60 older people in the course of a week. They are working all the hours to make that happen. Their funding does not appear in the equation that is under discussion and you are right to hit on that as a problem.

10:15

You mentioned the need for aids and adaptations in housing, which we mentioned in our submission. I come back to my earlier point about knowing the picture as it stands. Members of the committee probably have a better overview of the situation in community care in Scotland than anybody else, because they have travelled round the country and examined it. We must examine the vagaries of different geographical areas—an older person who lives in Edinburgh has a different experience from someone who lives in Ballachulish. Without that overall picture, it is difficult to know where to put all the money into the pot to make it happen.

Transport and leisure services are also vital. Research that has been done in the States shows the preconditions to healthy aging, and some work is being done in England. We need to look for that in Scotland as well.

**Irene Oldfather:** The financial gap that the voluntary sector is filling is an important point for us to note.

A club in my area, which is run by volunteers, keeps in the community 35 elderly people who have few relatives who could provide them with support and assistance on such matters as nutritional needs. That is not recognised in anybody's budget.

**Dorothy-Grace Elder:** You would find wide agreement that, without voluntary sector input, we would be pretty well sunk. We rely too heavily on that sector and perhaps exploit it too.

The committee split up into teams during its visits round Scotland. West Lothian had effected a simple, beneficial change by pooling equipment stores between the NHS and the social work department, to avoid—and we would hear the same in any part of Scotland—two vans turning up with the same piece of equipment on the same day or no van turning up at all. Could we not make a start on practical matters such as that? Do we have to wait for a great plan to evolve? We could do something urgently now.

**Linda Dunion:** You are right that we do not need to wait for everything to happen from the top or for major policy changes. Progress depends on finding practical ways of making things happen. Giving people access to aids and adaptations and to equipment such as wheelchairs is a practical way of making progress. That does not cost anything and probably saves money. We would encourage people to do that.

**The Convener:** I must wind up the discussion at that point. Thank you both for giving us your time this morning and for your written submission. Thank you also for submitting your petition; we decided to take it on board as part of our on-going inquiry rather than consider it separately. I hope you feel, having spoken to us today, that we recognise the fact that there are 10,000 signatures on the petition. We also recognise the great concern among Scotland's older population on the issues that are involved.

I apologise to colleagues who still had questions to ask, but we must move the meeting along.

10:19

*Meeting adjourned.*

10:22

*On resuming—*

**The Convener:** Our next witnesses are from Alzheimer Scotland—Action on Dementia. I think that Jim Jackson and Jan Killeen are well-kent faces to most of us.

I thank you for coming and for the written submission that you gave us some months ago. You may begin with a short statement, after which members will pick up on what you have said and ask questions. You have about 45 minutes for this section.

**Jim Jackson (Alzheimer Scotland—Action on Dementia):** That makes it sound like an exam question.

**The Convener:** Do not say that—exams is a bad word here at the moment.

**Jim Jackson:** Thank you for the invitation to give oral evidence, in addition to our written submission, on behalf of the 61,000 people in Scotland with dementia, and their families and carers.

Dementia is not a recently discovered illness. It has long been recognised, but it has also long been misunderstood. Plato and Aristotle both considered mental decline as an inevitable part of old age. It is not inevitable: most of us will not get dementia. Dementia is extensive, however. In Scotland, 61,000 people have dementia and that number will rise, slowly but surely, to about 67,000 over the next 10 years.

The scientific advances over the 20th century have taken us from Alzheimer's early work before the first world war to more recent studies using brain scanners and high technology. What that all shows is that dementia—or dementias, to be more accurate—are illnesses, with a variety of causes. They are just like other illnesses and they are not an inevitable part of growing old.

There are many forms of dementia. Alzheimer's disease and vascular dementias are the most common, but there are also less frequent forms, such as Lewy body dementia, frontal lobe dementia and, unfortunately, the extremely rare but tragic Creutzfeldt-Jakob disease. All forms are characterised by the progressive decline in functions controlled by the brain. Most people will associate Alzheimer's and dementia with memory, but it is not just about memory: it is also about perception, attention and orientation. People with dementia often get lost. They might go to the supermarket and wonder where they are—although I often go to the supermarket and do not know where the baked beans are any more, because they keep being moved. That loss of orientation could happen when someone is driving, and that would be very unnerving.

Dementias also involve changes in emotion and personality, and the ability to do everyday things. For example, people might become unable to dress themselves. Of people with dementia, 70 per cent are in what we call the moderate to severe stages of the illness. Most people with moderate to severe dementia have major difficulty with self-care, and need continuous supervision.

Dementia is a critical test for community care and for the ability of the NHS, local authorities, the private sector and the voluntary sector to work together. The illness can last, on average, five to six years, but many people live with it for between 10 and 15 years. At the beginning, there is the diagnosis, with the fear and the shock that that brings. To paraphrase Dylan Thomas, someone who has just been given a diagnosis might ask, "How will I go into that last good night?" But the illness goes on. Increasingly, individuals need personal support, and the carers of people with dementia also need a lot of support. Eventually, the stage of long-term care is reached, and such care is essential for most people with dementia.

We believe that, all too often, the NHS and community care services fail people with dementia and their families. Although there are examples of excellent practice, and there are many dedicated staff in all sectors of the NHS and local authorities, they are rarely linked together in practice. The planning mechanisms often fail to reach their full potential, and access to services can be difficult.

We are therefore very pleased to have the opportunity to give oral evidence in addition to our written evidence.

**Irene Oldfather:** On page 2 of your submission, you say that you support free provision of personal care. What would be the impact if that recommendation were not implemented in Scotland? How would that affect your client group?

**Jim Jackson:** The first impact would be the continuing sense of unfairness and injustice. The care that people with dementia receive is the treatment. They need that care not just because they are growing old, but because they are ill—we are talking about a physical illness, with changes in the brain that affect behaviour.

The second consequence is more interesting. There is a lot of interest in pooled budgets and in health and social work departments working together. One of the obstacles to that is the fact that services funded by local authorities are currently means-tested, whereas health care is free. For example, people might want to provide a new putting-to-bed service for people with dementia. Who funds it—health, in which case it ought to be free, or social work, in which case it should be means-tested? We are back to our old friend, the medical bath or the social care bath. That problem makes it difficult to plan services.

The third factor is the continued confusion that results from the different charging policies of local authorities throughout Scotland. If someone has one relative in Glasgow and another in Edinburgh, they may find that they are paying at different rates for the same service.

10:30

**Irene Oldfather:** The NHS plan for England will provide for nursing care to be administered free of charge. You are saying that it is difficult to define nursing care for people with Alzheimer's and that there is a personal care element resulting from the illness from which they suffer.

**Jim Jackson:** We could define personal care as nursing care—indeed, that is what I propose to do. People with dementia need rehabilitation, stimulation and support. They need help with feeding, dressing, washing and bathing, and they may need supervision if they are at risk when left alone. Some people with dementia wander. Recently I heard about an older person who always wanted to go upstairs to look after the bairns, even though the children had long since gone. Because they were a little shaky on their feet, they were at risk of falling down the stairs.

If older people are agitated, distressed or restless, they may need reassurance. Those things do not need to be provided by a trained nurse. They can be provided by trained workers in a variety of occupations—occupational therapy, to name but one. If that is defined as nursing, that will be fine from the point of view of people with dementia. If it is not, we face the problem that the benefits of the proposals that have been made south of the border will be limited to a reduction in the cost of nursing home care.

**The Convener:** Kay Ullrich has a supplementary.

**Kay Ullrich:** Basically, you have answered my question. If the Executive follows the English plans, what hope do you have that the needs of people with dementia will fall within the definition of nursing care?

**Jim Jackson:** We do not really know. We have tried to peruse some of the material that has been issued by the Department of Health; it appears that nursing care is defined either as something provided by a nurse or as something done under a nurse's supervision.

**Kay Ullrich:** So it has been retained within the health service.

**Jim Jackson:** The problem is that the services to which I have referred do not need to be provided by a nurse or to be done under nursing supervision, although nurses may be involved. In many parts of Scotland, community psychiatric nurses do some of the tasks that I have listed. In "Alice's Adventures in Wonderland", the Queen of Hearts, I think, says something like, "I mean it exactly as I mean it to mean." If the Scottish Executive decides that nursing care for people with dementia should include the tasks that I have mentioned, we would see that as a positive step. There is a Scottish choice.

**Dr Richard Simpson (Ochil) (Lab):** As I see it, the problem is not with the type of care that is being provided, but with the intensity of that care. A frail, elderly woman without dementia may require some supervision going up the stairs, but she will not be going up the stairs every 10 minutes because she does not have dementia that makes her think that the bairns are still upstairs. Someone with dementia will require a more intense form of care. This is about the boundary between what constitutes nursing care in cases of dementia and what constitutes nursing care in relation to physical problems.

**Jim Jackson:** That is part of the complexity of the problem.

**Dr Simpson:** Are you saying that the only way of dealing with it is to make all personal care free?

**Jim Jackson:** No, I am not saying that, although we would like that. I am saying that if we list the types of care that people with dementia require as a consequence of having an illness, and if those are included within the definition of nursing care, that would be a positive step from the point of view of people with dementia.

**Dr Simpson:** That is exactly my point. The types of care that you would list apply to others, but less intensely. We are back to the argument about boundaries. One of our major problems relates to what constitutes health service care. Clearly, that is defined as care that takes place in an establishment owned by the health service; it has nothing to do with the type of care. Equally intense care is provided in nursing homes—sometimes even in residential homes—for dementia patients, as it is in NHS care. Should we now consider this issue in some other way?

**Jim Jackson:** The royal commission recommended that all personal care for all client groups should be free after an assessment of need. Whatever definition is used, there will be boundaries, and under the royal commission's recommendations the boundaries were the assessed level of need for personal care. Although we all have a need for personal care, we would not necessarily have a need for such care to be provided because of frailty or dementia. I cannot give a definitive answer to your question, other than to say that, if intensity is the issue, it would have to be assessed and a tool would be needed to do that easily. Wherever we end up, there will always be boundary issues; we have had them in the past and will have them in the future. The crucial point about boundaries is that, ideally, they should be easily understood rather than judged on a particular case.

**Malcolm Chisholm:** Your submission contains a comment that might be referred to quite a lot over the next month. You appear to say that the Scottish Executive should not "go it alone" over Sutherland and you refer to the

> "profound implications for other publicly funded services in Scotland"

if it does. Do you stand by that remark?

**Jim Jackson:** I thought that someone would ask that question. We gave our written evidence before the results of the public spending review were known. However, we now know that, over the next three years, there will be an increase of more than £3 billion in public expenditure through the Scottish block. Our arguments applied before that decision had been made. Although my arithmetic is probably a little shaky, if we take the figures included in the royal commission report and assume that roughly 10 per cent will cover the impact in Scotland, it seems fairly clear that, if the Scottish Executive had the will, it could fund the royal commission's recommendations from that extra funding without jeopardising other public services.

**Malcolm Chisholm:** I want to move on to a more general question. Will you outline the major current barriers to the provision of effective support to individuals with dementia and their carers?

**Jim Jackson:** The first barrier is that there is still not a full understanding of the complexity of the needs of people with dementia from the point of diagnosis through to palliative care. Moreover, there is little understanding of the need for comprehensive services.

The second barrier must be funding. For example, we are concerned about the postcode prescribing of new dementia drugs. I presume that health boards have the same intelligence sources as we have; however, when the new drugs come out, the boards raise their hands in horror and claim that they did not know that the drugs would be available and that they have no money in their budgets for them. The new treatments that are becoming available for people with dementia will require increased funding.

Increased funding is also needed to improve the quality of services. Although we welcome the Scottish Executive's intention to establish the Scottish commission for the regulation of care and the Scottish social services council, when it comes to the crunch we will need better-trained staff. Someone is going to have to pay for that.

Finally, the Accounts Commission and now Audit Scotland have repeatedly referred to the lack of information and data about how services are provided and who benefits from them. That is a major inhibition to the improvement of services.

**Mr Hamilton:** Before I ask you about carers, I have a quick question about your comment on the Scottish Executive going its own way. In your submission, you also say that responsibility for the shift in the way that services are paid for lies with the UK Government, not the Scottish Parliament. Perhaps you could say more about why you think that that is the case. Other submissions tend to take a different view. You mentioned that the money that will come on stream will never be used for that purpose. Presumably the responsibility for that lies with the Parliament and therefore the majority of the recommendations can be implemented.

**Jim Jackson:** Paying for long-term care is intimately linked to the social security budget, which is a UK budget. Some of the royal commission's recommendations and some of the Department of Health's responses relate to that funding process. If, ahead of the public spending review, the Scottish Executive were to come up with a solution funded entirely from the Scottish block, the fact that it would be spending more on one thing would mean that it must be spending less on something else. That is why we made that recommendation.

However, things seem to have moved on. One could argue that it was tactically important to ensure that the health block in England and Wales was maximised as much as possible, because on a pro rata basis that would benefit the Scottish block at a later stage.

**Mr Hamilton:** That ties into a whole different area.

You mention carers in the submission, but will you say more about the specific measures that would most effectively support informal carers in Scotland? What are the major issues? How can we ensure that the point that you make in the submission about individualised care is taken on board? How do the carers feed into the process?

**Jim Jackson:** The first thing that would benefit carers would be quicker access to appropriate services. At the moment, people often have to wait for an assessment and there are waiting lists for particular services. In some cases, there is an absence of services—advocacy, counselling, support and information may not be available in some parts of Scotland. Access to drug treatment is another example. Such treatment benefits people at the early to middle stages of the illness. If there is a six-month wait, it may be too late.

Continuity of care management would also benefit carers. We have found that different parts of Scotland have excellent services in specific aspects of care. There might be an excellent memory clinic and follow-on care, but then there is a gap in the system—the families get lost and have to start all over again when they need day care some years later. There needs to be a link all the way through the illness. We use jargon such as "protocols" and "local understandings", but we want clear recognition that people know who is responsible for what. Families should know whom to turn to. There should be a one-stop shop for whatever services they need.

Mr Hamilton has touched on an important point. One of the best ways for health boards and local authorities to improve their services is to listen to people with dementia and their carers. It is increasingly possible to talk to people with dementia in the early stages of their illness. In the past, the diagnosis was made so late and the illness had progressed so far that we would not have considered consulting people with dementia. It is still difficult, but it is possible in controlled, one-to-one circumstances. We need to listen to what people with dementia and their families are saying.

I find it a powerful experience to go to a conference and sit in the audience listening to a carer. It is humbling, but we all ought to do it from time to time.

**Margaret Jamieson:** In response to a question from Malcolm Chisholm, you mentioned funding. You claim in your submission that resource transfer has not facilitated the commissioning of new community-based services for people with dementia. What is necessary for that to happen?

**Jim Jackson:** For resource transfer to be better, there must be better identification of the services that might be lost. In that regard, we made the point strongly about respite care. We are concerned that much of the respite care that is provided by the NHS does not have that label on it. It is provided in long-stay wards or other wards. When the ward or bed place closes, we may not know that the respite care has been lost.

Secondly, there must be transparency of funding. I know that "transparency" is a jargon word, but it would be nice to know how much has been saved and how much is being passed to social work.

I am sure that the committee knows all about health improvement partnerships and trust implementation plans—HIPs and TIPs. My tip would be that all those planning mechanisms need to have some regard for respite care. Then we could see whether the resource transfer is leading to improved services.

10:45

**Margaret Jamieson:** Would it be beneficial if, rather than having each health board and each local authority arguing about what the level of resource transfer should be, we had a tool for measurement throughout Scotland and a national figure for every bed that is transferred?

**Jim Jackson:** That sounds a bit Stalinist to me.

**Margaret Jamieson:** I think that it might be needed, particularly in relation to Ayrshire and Arran Health Board.

**Jim Jackson:** I can see the attraction, but there is a disadvantage. When hospital wards are closed, the price that the land is sold for will be different in different parts of the country. Selling off the Edinburgh royal infirmary is different from selling off a facility in Ayrshire. The real amount that is transferred depends on local costs. The formula could perhaps be defined nationally, so that the transfer is appropriate.

**The Convener:** Before Margaret Jamieson gets us all out in the field, I will ask Kay Ullrich to ask a question.

**Kay Ullrich:** We were in Ayrshire on Monday. One of the problems that we encountered was that, although a hospital had closed in August, the area was still waiting for the resource transfer. That means that local authorities are having to pick up the cost without any idea of what money will follow the patients.

We thought that having national standards would be useful as there are huge regional variations on what resource will follow a closed bed. We have heard of anything from £8,000 a bed up to £32,000 a bed. That cannot go on. A person's needs vary not depending on where they live but on their condition.

**Jim Jackson:** I agree with that. I was part of a delegation that said that to the Scottish Affairs Committee some years ago. I would add that the resource transfer should be timeous. It is hopeless after the event, as local authorities will be picking up the bill for people in nursing homes right away, not at some time in the future.

**Kay Ullrich:** That has a knock-on effect on others who are on a waiting list for long-term care. We have evidence that a local authority is having to pick up the cost when it should have had the resource transfer money. The knock-on effect is obvious.

**Jim Jackson:** I am sympathetic to the idea of having a national sum, but certain practical objections would have to be worked around. Variation from a guideline figure might have to be justified. Evidence put to a number of committees over the years of the variation in the amounts transferred in relation to beds for particular people in particular client groups is not easily understandable from the outside.

**Kay Ullrich:** For example, a person with a certain level of dementia will need the same care whether they are in Edinburgh or Ayrshire. The cost of land should not come into it.

**Jim Jackson:** We need to take into account the capital element of the costs of a service. I would like to talk to people who know more about the proportional breakdown. We know that the money should be transferred timeously and transparently. I support that.

**Kay Ullrich:** I agree that transparency is the key. At the moment, we are punching in the dark.

**The Convener:** There is a case for having national guidelines, perhaps with a percentage swing either way, according to regional differences, although not to the level that we have seen in the past.

**Mary Scanlon:** I was struck by the point that you made about links throughout a patient's illness—probably the greatest link that any patient has throughout their life is their general practitioner. In your submission, you list some best practice examples, but only one of those involves a GP. Are local health care co-operatives making a significant impact in improving the co-ordination of service delivery?

**Jim Jackson:** The honest answer is that it is too early to say. However, the rather depressing answer is that I cannot give an example involving a GP other than the Midloch centre. The Midloch centre in Glasgow is an exciting project, not only because it has a specialist nurse, but because the doctors in the practice recognise the importance of monitoring the progress of the person with dementia and the need for close liaison with social work and other service-providing agencies, so that their patient is not only assessed, but gets services as and when they need them.

It has been suggested in some quarters that the GP practice could be the heart of a better service for people with dementia because GPs have so much contact with their patients. The counter-argument is that there is a lot of evidence that GPs do not fully recognise the needs of people with dementia. Indeed, the dementia services development centre has mounted a major educational programme for GPs to try to overcome that problem. The jury is still out on that. However, we know initiatives such as the Midloch centre—where they exist—make a difference.

**Mary Scanlon:** We keep talking about the NHS trusts and social work services. Do you think that GPs are being squeezed out of the equation? Why are GPs not at the heart of the service delivery?

**Jim Jackson:** That is probably because the guidelines for the new Alzheimer's drugs require such drugs to be prescribed by consultants because of the need for specialist diagnosis and follow-up. That means that the role of the GP is to pass patients on. However, consultants are now saying that GPs are making more referrals to the psychogeriatric service because that is the route to getting the drug treatments. Whether the GP service should be at the heart of the diagnostic service is an issue that could be fruitfully explored. The problem is that some forms of dementia are not at all straightforward and require the skills of a consultant. We must also ensure that we are not talking about people with illnesses that have symptoms that appear to be dementia but on closer examination are revealed to be something else.

**Mr Hamilton:** The best practice examples in your submission are interesting and good, but they are somewhat piecemeal. Structure is one of the many obsessions of politicians; you may be aware that in England there is a plan for new care trusts—primary care trusts with a broad remit. Is that something that you would support and what would a national structure be like in your ideal world?

**Jim Jackson:** We would welcome a move towards a structure that brings together what we see as the separate social work responsibilities and health responsibilities. However, we would be cautious because such a structure would have to be genuinely multidisciplinary, involving the other professions, such as occupational therapy, dieticians and a range of disciplines.

We would see much benefit in moving towards such a model. However, it would be wrong if it were led purely by doctors, who define everything in medical terms, as much of the care that is needed is a form of social care. We started this morning by trying to unpackage the differences between personal and medical care. Much care is provided in a particular way only if it is defined as social care, and would be funded under the English proposals only if it were defined as nursing care.

**Dorothy-Grace Elder:** Have you had any recent feedback on people's homes being sold to pay for care? That is particularly contentious in relation to people with dementia.

**Jim Jackson:** That is a long-standing concern, which is clear from evidence that we have taken from our members in the past five years, who feel that the whole system is unfair. The royal commission's proposal was to raise the thresholds, but people were still to be means-tested for their accommodation costs. As I understand the English proposal, there will be a modest return to the 1996 threshold levels, so I think that there will continue to be resentment.

**Mary Scanlon:** You have spoken about resource transfer this morning. Is better resource transfer the way forward, or should budgets be fully pooled to fund new merged agencies, such as a new umbrella agency to integrate health and social work?

**Jim Jackson:** On the whole, we would favour the new agency approach, although we are a little cautious. I am on record as saying that we all want to avoid mass reorganisations of the health service and local government because they are very disruptive. On the other hand, if budgets are pooled, who will have authority to decide how they are used? There are difficult decisions, especially if one is dealing with a fixed amount of money. If one wants to develop something new, something else has to go. Pooling makes that task easier, and additional funding makes it even easier, but it is still a difficult task.

If the royal commission's recommendation of free personal services had been adopted, the money that would have been available would have been easier to use. There would be quite a complicated system if some services were provided by the new trusts and were means-tested and others were not. For example, someone might be assessed as needing four days of day care. Two days might be provided by the local day hospital for no charge, and two days—means-tested—by the social work department or a voluntary agency. It is those inconsistencies that really confuse Joe and Jean Public.

**Mary Scanlon:** Therefore, you think that it is essential to have one new agency to co-ordinate and provide consistency of treatment.

**Jim Jackson:** I would not go quite so far as to say that it is absolutely essential. However, it appears that resource transfer has a whole set of historical problems, with which we are still living, despite the best efforts of the Scottish Office and now the Scottish Executive. Pooling budgets goes a long way. We are still waiting for a response from the Scottish Executive to confirm that pooling budgets is legal—that question was asked in an earlier consultation document. The logic is to create new agencies, but we need to do so on an evolutionary basis rather than taking a big-bang approach and putting all our eggs in one basket. That is the reason for an element of caution.

**Dr Simpson:** There are joint police boards, which pool things between different local authorities.

Taking the logic of your argument further, would the pooling of all resources that are related to long-stay care in a new agency be appropriate? That would mean that the health service would give up all aspects of long-term care, and the charges that were then levied would be only for living costs but would apply to everyone in the long-stay sector. That would be equitable and would produce some funds, which might allow a move toward free personal care for everyone in the sector and, in turn, reduce the administration and costs. Would that horizontal equity be a more rational approach in your new agency?

**Jim Jackson:** It may well be rational. It may be theoretically and logically consistent—indeed, it is—but the threshold of when to start charging people with dementia who are receiving long-term care in hospital for their accommodation costs is one that I leave to you as politicians to judge when to cross.

11:00

**Dr Simpson:** But you have argued today for equity, and you have argued consistently that there is no charging in the NHS—day care was the example that you gave—yet there will be charging in the day centre. If you are really arguing for equity, why do you not argue for equity for all citizens? Let us leave the sacred cow of the NHS alone for the moment. If you put all long-stay care under the new agency that you propose, it would become the new supported care agency, or whatever you wanted to call it. There could be a level charge for all care. I am not asking you to make the decision—politicians have to do so—but what argument would you put against that, apart from the shibboleth of the NHS not charging, which is to do with boundaries of care, which is exactly what you are arguing against?

**Jim Jackson:** I am starting from a position that my organisation has accepted in principle, which is that people should pay for their accommodation costs, and that that should be means-tested. To apply that process to what is currently the NHS component of long-term care is something on which we have not consulted our members. I will retreat to the position of saying that I would want to consult our members first. I understand the logic of what you are saying, but given the way in which people view their health service, I am concerned that they would find it difficult to accept.

The royal commission proposed that there would still be charges and means testing for the accommodation costs of long-stay care in what are currently nursing homes and residential homes. That seemed to me to be a step forward, which resolved some of the problems, but by definition we have created some new problems, and you have put your finger on an issue that it will be extremely interesting to explore, but which is also extremely controversial.

**Jan Killeen (Alzheimer Scotland—Action on Dementia):** It must be remembered that if people go into long-term care, they lose their pension.

**Dr Simpson:** The poorest people already pay for their NHS accommodation because they lose their benefits; it is only the better-off people who do not. I will not get into socialist principles, but there is a strong socialist argument.

**Dorothy-Grace Elder:** Go on, Richard.

**Margaret Jamieson:** Go for it.

**Dr Simpson:** If we are to have a Scottish solution that is different, and if we are to fund that solution without seriously damaging other care, we must look at new equity. Organisations such as your own are hugely capable of consulting on the matter, and are changing attitudes.

**Jim Jackson:** We would be more than happy to consult our members on those issues. Our starting point in arguing against some of the charges is that if someone is fortunate enough to live without dementia or other health needs, inheritance tax will kick in at £234,000. If someone has to pay for their long-term care, at present, they start paying at £16,000. It is important to work towards incremental improvements, which might be moving in the direction that you suggest. It is better to make improvements that benefit people here and now, or as soon as possible, than to go back to basics and reopen all the theoretical possibilities. That is not to say that we will be able to stop others doing so.

**The Convener:** I thank Jim Jackson and Jan Killeen for their contribution this morning, and for their written submission. I thank them for their time.

We will take a short break to allow our next witnesses to come in.

11:04

*Meeting adjourned.*

11:11

*On resuming—*

**The Convener:** I call the meeting to order.

Our third set of witnesses this morning is from the Scottish Health Boards Network. I ask the witnesses to begin by introducing themselves and giving a short statement, which will be followed by questions. Thank you for taking time to come to the committee to give evidence.

**Douglas Philips (Scottish Health Boards Network):** Good morning. I am Douglas Philips and I work with Argyll and Clyde Health Board. I am chair of the Scottish Health Boards Network on community care. I invite my colleagues to introduce themselves.

**Lindsay Burley (Scottish Health Boards Network):** I am Lindsay Burley, the chief executive of Borders Health Board.

**Moira Paton (Scottish Health Boards Network):** I am Moira Paton, head of community care with Highland Health Board.

**Emelin Collier (Scottish Health Boards Network):** I am Emelin Collier, community care development manager with Western Isles Health Board.

**Douglas Philips:** We welcome the opportunity to present evidence to the committee and hope that some of the information that we provide will be useful to you and stimulate debate this morning. At the outset, it might be worth making it clear that this is a view from Scottish health boards, as opposed to NHS trusts. We have submitted written evidence; we do not intend to go through all of that. However, perhaps you could bear with us while we touch on a few of what we see as the key issues.

In the introductory section of the paper, we talk about the need for health and social work services to be tied into a wider context. We are thinking of those issues being related clearly to the panoply of social inclusion issues. In particular, we stress issues connected with housing and accommodation, because those are fundamental to the community and to keeping people either in their home or in a homely setting in the community.

On the second page of our submission, we touch on some issues raised by the Sutherland report. Throughout the report, we have tried to emphasise that we want there to be fairness for all citizens in Scotland, however that can best be achieved. We are anxious that in the implementation of the Sutherland report one group is not disadvantaged with respect to others. That could be a particular client group or people living in a particular geographical setting. We would want there to be fairness across the country.

Setting priorities for funding and using the available spend in the best possible way are issues for discussion. For example, some people might feel that they cannot access respite care if there is a charge for it. We need to take account of that. I would be happy to come back to that point later.

Committee members will see from our submission that we believe that resource transfer, as it was originally set out several years ago, has perhaps served its purpose. We suggest that working in a more closely integrated way, with the prospect of pooling budgets, is a better way to proceed. Resource transfer has had its day: it could now be replaced with mechanisms or arrangements that do not encourage a them-and-us situation, but encourage simply an us situation, so that health and social care colleagues can work closely together and decide at local level the best use of the available resources.

Within existing systems, we can find better ways of making use of funding. Accounting must be done in a transparent way, using proper processes. To that end, we expect organisations such as the Accounts Commission to support the sort of new arrangement that I have described without the need for legal changes to be made.

In our submission, we have set out several points on the co-ordination of services between boards and local authorities. We can come back to them in later discussion, but I would like to reinforce one or two points now. We need to root services in the primary care team with the full involvement of social work staff. We must ensure that general practitioners and others in the primary care team in a local health care co-operative work extremely closely. Many already do so, but we would like to work even more closely together in future.

11:15

At the fourth bullet point in paragraph 5.2, we stress that joint training is crucial so that people who are delivering the services can understand the plans, the care assessment processes and the way in which integrated services are to be delivered. Joint training of practitioners, managers and others who are planning and leading the services is just as crucial so that they can give clear leadership to those who are delivering the services day by day.

On page 4, we touch on public involvement. That is a huge issue. To do it well—as we are all keen to do—we must accept that improving public involvement is resource intensive and that it often takes place not just in normal working hours but outwith those hours. To be done effectively, as the public would wish it, it will need to be adequately resourced.

We have not listed examples of best practice in our submission, but we would be happy to discuss local examples from our own practical experience. However, we make a point about who decides what is best practice. We comment on the number of groups or organisations that have the opportunity to inspect or to regulate care. We suggest that there might be scope to refine those arrangements, to integrate them better and to avoid any overlap or duplication.

On the last page of our submission, we touch on delayed discharges and the balance of care. There is no quick fix for delayed discharges—if there were, we would have found it by now. Available funding has to be dovetailed so that the best possible use is made of it at local level. At the moment, some funding comes through the health route and some through the local authority route, and it can sometimes be a bit difficult to ensure that it is all properly dovetailed. We need to ensure that that happens.

We welcome the additional resources, which are extremely useful. However, this is not a matter of using those resources simply to place people in nursing homes or in residential care: it is a matter of reinforcing the community care agenda and supporting people in their own homes when possible, and using some form of institutional care only when that is appropriate. Those decisions should be based on the assessed needs of individuals.

Lastly, on the balance of care, it seems to us that although, as we have said in the paper, health boards have a clear view of the number of long-stay care places that need to be provided within the NHS, and local authorities set out in joint community care plans their purchasing intentions for nursing home or residential care, there is probably scope for greater clarity on the total level of care needed across the spectrum, from hospitals, through nursing and residential care, to models of care such as very sheltered housing and care for people in their own homes.

We have some anxieties about joint community care plans and the extent to which, in one sense, they are being churned out. We need to make absolutely sure that the content is precise and accurate and reflects the joint intentions of partners working in a given locality.

I am not sure whether any of my colleagues want to reinforce any of those points or to add anything at this stage. I thank the committee for this opportunity.

**The Convener:** Thank you. Margaret Jamieson will pick up some of those points immediately and we will move on from there.

**Margaret Jamieson:** I was interested in your comments on resource transfer. I think you said that it had served its purpose. I certainly do not share that view, given the difficulties that several health board areas in Scotland have experienced. We discussed issues related to resource transfer, such as what happens when a hospital closes, with the previous group of witnesses. One hospital in Ayrshire closed on 1 August, yet no agreement on resource transfer has been reached with the local authority and the health board. That difficulty has been there for a significant period. Why do you believe that resource transfer has served its purpose, when your colleagues in local government are saying that it has not, because they are still waiting for the money?

**Douglas Philips:** I will start to respond to that question; my colleague, Dr Lindsay Burley, might want to add something.

As we said in the paper, we would not dispute the basic premise that money has to be identified from within the NHS when facilities close—the money needs to be put on the table. However, what happens with resource transfer is perhaps, in a sense, what you have just described. There can be a stand-off about how much should be put on the table and how much should simply transfer to the local authority.

I suggest that it is more useful if partners agree the level of investment locally—what it costs to run the ward, for example—our accounting colleagues then show in a transparent way the cost of running the facility and that is shared with all partners in the locality. The resource that is available can then be considered as well as the period over which it can be released, depending on the changes that an NHS trust will need to make to deliver the money. The phasing and amounts that would go, I suggest, into a joint pool, would then be agreed with local authority colleagues. There is then an opportunity to say what the priorities are for spending the pool in that locality.

I suggest that NHS trust colleagues would be keen to be round that table, because some of that money would be used on health care, and not only on social care. My experience is that social care colleagues are quite happy to see that, if the arrangement is transparent and open, so that they can see where the money is going and it is not simply a case of the service being reduced and their having to pick up both the service and some of the costs.

**Lindsay Burley:** I support the statement that resource transfer has probably served its purpose because I believe that in some places it is used as a battleground between agencies. In no way are we suggesting that we can simply go back to a time when the health service saved money, did not declare it and expected other agencies to pick up the tab.

I do not have anything to add to what Douglas Philips said about our proposal. There are parts of Scotland where the relationship between health boards and local authorities is strong, where there is trust and where resource transfer is used as a mechanism to put money that can be shared on the table. Unfortunately, there are places where that is not the case.

**The Convener:** There are obviously different ways in which budgets can be pooled, and joint work can be undertaken. I acknowledge your point about joint training, which I presume you would start at the earliest point and would not just be on-the-job training. How do you go about pooling budgets effectively? Can they be pooled from two totally separate organisations, or do you need to create another umbrella organisation, to provide community care in the widest possible sense?

**Douglas Philips:** It depends partly on the scale. The example from my locality that I can think of was when we closed a ward, and were keen to pilot a joint commissioning pool. For the value of the money concerned—about £250,000—we have set up a joint pool under the same accounting arrangements as those which we used for the resource transfer mechanism so that the respective finance colleagues in the health boards, in the trust and in the local authority concerned, are happy that an open accounting process will operate. Given that the money is currently health money, we will probably retain it in the health systems and use health accounting mechanisms for it. All the calculations, including all the expenditure statements, will be transparent and open for all.

Furthermore, we are delegating decision making about the use of the money to a joint project manager who is appointed to oversee the development of new community services in a particular locality. They will report back on their use of the fund to representatives of each of the three agencies.

The budgeting can be done within existing systems if everyone is willing to do that. Local authorities could lead in different projects.

**The Convener:** In going down such routes, or when using any other form of joint pooling that you are aware of in Scotland, have you come up against any legal problems?

**Douglas Philips:** To date, I have not come up against any legal problems, although my colleagues may wish to add to that.

**Moira Paton:** I agree. The problems are sometimes cultural. The key point is about trust, transparency and openness and the quality of the joint working arrangement. If that is historically based on trust, the accounting arrangements are such that one agency is effectively acting as a banker for the others. I am not aware of any legal barriers.

**The Convener:** What about confidentiality and data protection, for example? Do you have no problems there either?

**Lindsay Burley:** In my experience, those are issues that are raised by professionals who do not want to share, rather than real issues.

**The Convener:** So you do not believe that there is any reason why people cannot share information?

**Lindsay Burley:** I do not believe so.

**Kay Ullrich:** Margaret Jamieson explained that during our journeys around Scotland we discovered a health board in Ayrshire where a hospital closed on 1 August and that, to date, there has not been any resource transfer. That means the local authority has to pick up the cost but that it has not received the funding. It also means a serious knock-on effect on other people on the waiting list. Do you believe that there should be a method by which health boards can be held to account for that sort of foot dragging? It is not just a matter of expense for the local authority; it is a matter of expense for the people who are waiting for long-term care.

**Lindsay Burley:** I would not like to comment on a particular case that I do not know about. It depends on the time frame. If it takes a few months for everything to be sorted out, it may not be a big issue; if it takes a long time, there is really no commitment to transferring resources—

**Kay Ullrich:** The hospital in question has been due to shut for six years. It finally shut on 1 August.

**The Convener:** Let us stick to the general point.

**Lindsay Burley:** There are ways in which we are held to account: we are accountable through the Scottish Executive—previously the Scottish Office—and the management executive for what we do on behalf of health boards. I would have thought that there are already ways of holding health boards to account if resources that should have been transferred have not been transferred.

**Dr Simpson:** You propose that, when there is a closure, all resources should go into a common pool, but I invite you to look a step further. There are about 17,000 long-stay beds left. That number is declining—as your paper says—by about 7 per cent per annum. Why not transfer the whole of the long-stay provision into a joint board? The resource transfer issue would not then arise, as the joint board would decide on the most appropriate use of all its resources. The decision would not be cost driven or health service driven; it would be driven by the joint board with responsibility for supported care for the elderly.

11:30

**Lindsay Burley:** That is a very attractive idea. The one reservation that I would have—I speak personally rather than as a representative of health boards—is that it should not mitigate against a continued move towards care outside institutions. However, I do not think that that is what you are suggesting.

**Dr Simpson:** No. Absolutely not. The establishment of a joint board would make that movement more rapid. In any cost drive, the care agency—the joint board—would want to use all its resources to the greatest effect and without any corporate health needs being considered, which would drive the situation towards domiciliary care.

**Douglas Philips:** It depends on the local circumstances. I prefaced my earlier comments by saying that any change depends on the scale of the joint pool. People can be encouraged incrementally to move along that path if the attitude and culture is right in a given locality, but it would be difficult to impose a specific solution on the whole country, as people may still not be ready in a given locality. However, local initiatives have succeeded in taking the agenda forward.

**Mary Scanlon:** In paragraph 4.3, you suggest that

> “there is scope to move beyond joint commissioning and pooled resources, to one partner taking a lead role, or having a joint ‘Board’”,

which you have just discussed with Richard Simpson. Do you have some such project in mind? Who is the partner? Do you feel that that is the way forward and that we have had enough of joint commissioning and pooled resources? Does one partner have to take a lead role?

**Douglas Philips:** Things are at different stages in different parts of the country. Our network, with the Association of Directors of Social Work’s standing committee on community care, organised the conference to which we refer in that paragraph, which was entitled “Beyond Joint Commissioning”. We brought together a significant number of people—180 people attended, and perhaps many more wanted to attend—who are interested in joint commissioning. They wanted to know what joint commissioning is and what are the best examples of joint commissioning around the country.

Although we are still waiting for the written report—it will be issued soon—the feeling that came out of that conference was that we need to move from an attitude of “them and us” to just being “us”. People did not want to perpetuate the arrangement of joint commissioning, which implies two separate agencies; they wanted to move towards integrated commissioning, collaborative commissioning, or whatever name is best, whereby people commission in a single way. For example, a local authority could commission for learning disability services or a health board could commission for mental illness services; it would depend on the local circumstances as to which bid might stand the best chance of success and deliver the best care for people in that locality.

**Mary Scanlon:** It may not surprise you to know that we have received submissions and evidence from Age Concern and Alzheimer Scotland this morning. Both organisations put forward the idea of a new body to integrate the services. Is that what you are referring to when you say one partner, or are you considering one or other of the existing partners?

**Douglas Philips:** In part, we are seeing an evolution from where we are to where we might get to. We are watching very closely the Perth and Kinross project, and recognise much merit in all the work that is being undertaken there. The project works in those specific circumstances, although it may not be the solution for everybody everywhere else.

We are anxious about any more organisational change. Our practical experience is that when organisational structures, or the key people in them, are changed, joint planning and joint commissioning on all these issues are set back. We do not want that. Organisational change may be necessary and appropriate in some places, but joint agendas may be being achieved incrementally in other places.

**Moira Paton:** I support that. I can give members an example of the direction in which we are moving in the Highlands.

Our paper talks about commissioning rather than provision and some of the questions that were asked about joint provision provide exciting prospects. About six weeks ago, we agreed to bring all our people together in a joint team. One person will take responsibility for social work services, housing services, the NHS trust and the health board in respect of commissioning mental health services. Another person will take responsibility for those agencies in respect of learning disabilities and so on throughout the different client groups. That is just what happens to work—or, because of our history, what we believe will work—in the Highlands.

I support the point made by Douglas Philips that we are all at different stages. This is about horses for courses and what is best for the local population at a particular time.

**Mary Scanlon:** What are the key community care issues that require resolution?

**Douglas Philips:** That is a big question.

**The Convener:** You have a maximum of five minutes.

**Mary Scanlon:** You should consider my question in relation to more effective use of the community care pound.

**Douglas Philips:** My colleagues will want to add to my answer, but, off the top of my head, we want to be sure that assessment and care management arrangements are working well, that the services that are being delivered are based on the assessed needs of each individual and that local services are responsive and flexible. In resource terms, that means that local managers must have their own budgets and that they must be able to use those budgets flexibly, rather than be tied in to services. For example, home help services—good as they are—are appropriate for some people but inappropriate for others. It is therefore crucial that the use of resources locally should reflect people’s needs in that locality.

**Lindsay Burley:** I have a couple of comments.

We should cut out duplication and professional demarcation disputes, which still exist. We are still arguing about whether a bath is a health bath or a social bath. I have 15 or 20 years’ experience in this field, and that argument is nonsense.

As Douglas Philips said, we must have local services. The way primary care is developing in Scotland—through local health care co-operatives—provides us with a super opportunity to consider how we can delegate more of the health aspect of community care to a primary care level. Experience suggests that if the people who have to solve a client’s or a patient’s problems are brought together, the problems will be sorted in a much more cost-effective way than I could solve them.

**Moira Paton:** I would reinforce those comments. We should bear in mind the fact that one size does not fit all. There is still a tendency to fit people into services rather than fitting services around people. Resolving some of the fundamental issues that my colleagues have talked about would help to address that problem.

**Emelin Collier:** We talked about resources being intensive in relation to public involvement. I suggest that commissioning planners should also be able to go out and talk to service providers about changing how they operate. Perhaps not enough is being done to free up funds and to allow people to be a bit more innovative in local areas.

This issue affects the smaller health boards and council areas, particularly where, in general, only one person is trying to manage change across all care groups in the community care sector, which can be quite onerous in rural areas.

**Mary Scanlon:** I would like to ask a final question. We have talked a great deal about partnership and better working practices. In the Western Isles, the service is far better integrated than it is anywhere else. Do you feel that, with that integration, you have overcome many of the difficulties that are experienced elsewhere? Do you feel that the elderly benefit from the greater integration, openness, transparency and partnership working in the Western Isles?

**Emelin Collier:** In the Western Isles we have benefited from the fact that people have been stable in their jobs and have learned to work together. Culture is another very important issue. We have the same problems as our counterparts everywhere else in Scotland, in that we do not have enough resources to provide the elderly services people need in their localities. We have additional problems of geography. We have been able to make more rapid progress in dealing with other care groups, for whom there has been additional funding. That applies to mental health services and children's services, for example. At the moment, we have a joint working group of elected members and officers that is examining care of the elderly, as that requires additional resources. However, people work together very closely within the resources that they have.

**Irene Oldfather:** Before I ask the question that I was intending to ask, I would like to follow up on what you have just said. You have talked about rooting community care in primary care. Do you think that we can do that and still achieve a holistic service for elderly people? At the moment I feel that in my area it is difficult to get the health board to take a wider view and to provide funding for services outwith primary care or health functions. I am thinking about things such as the nutritional needs of the elderly, breakfast clubs, lunch clubs and assistance with transport. Often, those tend to fall between two posts. I wonder whether rooting community care in primary care will overcome that difficulty and produce a holistic view of elderly services.

**Lindsay Burley:** Maybe I am just an optimist in thinking that primary care can move in that direction. I also come from a part of Scotland where practices and communities tend to belong to one another. There is a great strength in that. The general practitioner is seen as a leader in communities. That is a responsibility and a privilege that we as health boards need to work with our colleagues in primary care to extend and enhance. Irene Oldfather was talking about community development activities. The health promotion department at Borders Health Board is located in the primary care trust and has achieved a good deal for older people as regards nutrition. It is not always easy for health promotion services and primary care providers—particularly GPs—to work well together. Part of health boards' job is to ensure that those relationships are enabled and not cut asunder.

My experience of the relationship with colleagues in social work and housing is that people working in primary care know their communities well. The optimist in me says that we should celebrate the strength of primary care, particularly in local communities such as small towns and villages. There are different issues in cities; it is too long since I worked in Edinburgh for me to comment on those.

**Irene Oldfather:** I would not disagree with you about the commitment of general practice and primary health care. The difficulty is empowerment. The health centre is 100 per cent signed up to the project that I am thinking about, but nobody sees it as a health function, even though it is in the HIP, the TIP and so on. There is simply not enough money to fund projects of that sort. We need to examine how we can empower people on the ground, so that they can make such projects work. It is no good talking about it theoretically. We must devolve power and resources to that level.

**Lindsay Burley:** That is what I am saying, too.

**The Convener:** Irene, could you ask your other question?

**Irene Oldfather:** No doubt the network has examined the NHS plan recommendations and the implementation of the Sutherland report in England. What are your views on the report and what would the network like to be done in Scotland?

11:45

**Douglas Philips:** As we said in our introductory remarks, we are keen to see fairness across the whole country, but we would be anxious about any client group being disadvantaged. We know that you have already heard from Alzheimer Scotland—Action on Dementia this morning and we have also heard that organisation's comments. We recognise that there is an issue about how much overall cake is available to be split up. If money is spent as the Sutherland committee proposes, it might have an adverse impact on health and social care, and we would not want that to happen either. In that sense, we want to have our cake and eat it.

We are anxious about any tinkering with the Sutherland committee report, because its work was well based and conducted with a good deal of clear thinking and understanding of the practical issues. However, the availability of funding is the key issue. Although we do not want existing health and social care spending to be hived off in a different direction, we are keen to see as many of the Sutherland recommendations as possible implemented in full.

**Kay Ullrich:** On delayed discharge, you have been fairly critical of the degree of integration that has been achieved by the Scottish Executive in its recent allocation of additional resources, both to the NHS and to local authorities. Could you evaluate the impact and effectiveness of those additional sums on the whole area of delayed discharge?

**Douglas Philips:** The first thing to say is that delayed discharge is not new. For some of us, it has been around for three years or more. In various planning documents, we have proposals as to how we might tackle it depending on the availability of resources. Sometimes it depends on disinvesting in existing services, such as long-stay wards, and putting the money on the table to use in a better way. The impact of that will be to reduce the number of delayed discharges and to place people in more appropriate care.

The fact that new money has come down through two separate streams—we did not know about the non-recurring money to social work departments when we knew about the additional health resources—created a bit of a hiccup at local level. That hiccup was not insurmountable and we have got over it, but we had specific spending plans for the money that we knew we had on a recurring basis, which we had already discussed with local authority colleagues.

Our expectation was that some of that money would go to social care and might, in the normal way, have been resource transferred to local authorities to invest in generic services that would help to cope with the whole problem. When the extra £10 million, and each local authority's share of that, was announced, we had to go back and revisit some of our plans to see what was still appropriate and how we might make best use of the total resources available.

It is a case of investing in community infrastructure. It is about turning off the tap, if I can put it that way, of people coming into the care system. We are commissioning community infrastructure on the ground and supporting people at home. We are considering new models of care, such as what is sometimes described as very sheltered housing, where people can still live in a home of their own but have a more sheltered environment and a bit more support from caring staff to allow them to continue to live there. That keeps turning the tap of people going into residential, nursing home and long-stay NHS care.

I do not know the details of the case in Ayrshire that you mentioned, but the infrastructure must be right for the new service before the old service is closed.

**Kay Ullrich:** Although the money is welcome, it is non-recurring and tends to be a piecemeal, quick fix solution, and you have already said that there is no quick fix solution. In allocating that money, the message seems to be, "Here's £100,000. Get 20 more folk moved." That is what has tended to happen across the country. Local authorities are telling the local papers, "Thanks for the money. We've moved 20 people and now we have only 90 on our waiting list."

**Douglas Philips:** The health funding is recurring money and the £10 million to local authorities is, as I understand it, non-recurring. As you suggest, the risk is that the money will be spent simply on buying more nursing home places, but that is not what we want to do when making plans with our local authority partners. That money can be useful in other ways, such as buying smart technology or other types of equipment to support people with dementia in their own homes. Non-recurring money is also welcome, but we would use it in different ways.

**Malcolm Chisholm:** I was interested in what you said about the uneven provision of nursing home places. You called for a population needs assessment. How much does that happen already? I recently read a report on nursing home places in Edinburgh and Lothian that said that the projection is downwards, despite people saying that there is presently a shortage of nursing home places. That is an interesting conundrum. Do you think that a population needs assessment would help to deal with the problem of delayed discharges? What would happen to the number of nursing home beds if such an assessment were carried out, given that the number of elderly people is rising slightly? Do you think that we will need fewer nursing home places over the next 10 or 20 years?

**Douglas Philips:** There is scope to continue to reduce NHS long-stay care and nursing home places and to develop alternatives to support people in homely settings in their own communities. However, we must recognise that there are regional variations. In some places, such as the Western Isles Health Board area and parts of the Argyll and Clyde Health Board area, there are very few, if any, nursing home places. In some of those places, one might want to commission more nursing home places. We must consider each locality separately—it is horses for courses—to assess what those local communities need. In general, however, there is scope for fewer nursing home places in total.

Having an agreed level of provision across the care spectrum would make the system more transparent to everybody—those who might have to go into care, those who provide care in the independent sector and those who work in the NHS. All those involved would have a better feel for the total care available in their localities.

**Lindsay Burley:** There is an apparent paradox between the falling demand for nursing home places and the claim that we still need more of them. When health services are under a lot of pressure to make quick fixes to get people out of hospital, the easiest way of doing that is to move people to another place. If that is done without appropriate assessment and rehabilitation, people will be moved into an institutional setting when they could have been moved back to their own homes.

There is a large market force driving some of the decisions being made in this area. I am not contradicting what Douglas Philips said—I agree that it is horses for courses—but some parts of Scotland have very few institutional places and manage to cope, so we must ask why other areas seem to need so many nursing home places.

**The Convener:** I must bring this part of the meeting to a close. Thank you all for taking the time to share your experiences and comments with us and for your written submission.

Item 2 is on the way our community care agenda inquiry is developing and on what the next steps should be. I would like to put on record my thanks to all committee members for going out during the recess to see what is happening across Scotland. All reports should now be ready to go to the clerks—that is a reminder to me, too. Thank you all again.

We have to think about two or three things. Our experts have suggested that we submit some questions to the Executive. Members will see those questions in annexe A of HC/00/19/4. They are mainly factual; there should not be anything political. They are intended simply to assist us in putting together our report. If members agree, we will submit them to the Executive prior to officials coming to the committee on 18 September.

**Mr Hamilton:** I agree that the questions are fine—but I would add a caveat. The paper says that the questions should be submitted and returned prior to the meeting. Can we ensure that they are returned at least three days in advance, so that we do not get them on the morning of the meeting?

**The Convener:** Do members agree?

**Members** *indicated agreement.*

**The Convener:** We must also consider the next set of witnesses. I am keen to get through all the witnesses and to get all the evidence together before the October recess. I will add one point about the list of possible witnesses. We have tried several times to get Perth and Kinross Council to come along. I would like to hear from that council because it is part of a national pilot scheme. If members agree, we could try to find a spot for that council—possibly on 18 September when we will be in Stirling.

**Kay Ullrich:** Why are we going to Stirling?

**Irene Oldfather:** I was not aware of that either.

**Dorothy-Grace Elder:** It would be better to go to Perth.

**The Convener:** The clerk has advised me that all committees are encouraged to have full committee meetings outside Edinburgh. A lot of other committees have already done so in the Parliament's first year.

**Margaret Jamieson:** Should not committee members make that decision?

**Irene Oldfather:** Yes—the suggestion should have been brought to the committee and we should have made the decision. I had no idea about the meeting.

**Kay Ullrich:** In Ayrshire, 18 September is a public holiday. I am a bit amazed, first, that we will have the meeting on a Monday and, secondly, that it is in Stirling.

**The Convener:** There is a problem because that date is also a public holiday in Edinburgh. I have to put my hand on my heart and say that I cannot remember how the meeting was organised. It might have been something that I agreed to prior to the summer recess—I cannot honestly remember. It was so many weeks ago.

**Margaret Jamieson:** When the committee meets outside Edinburgh, it should be for a specific purpose. We have talked about the Perth and Kinross project; Ben Wallace has joined us, so we could ask him whether he was able to visit the project during the summer and whether there were any obstacles. It seems that a wall is being built and that the people in Perth and Kinross do not want to talk to the committee. We want a Scotland-wide view so that we can find out about good practice.

**Ben Wallace (North-East Scotland) (Con):** I have had the opposite response from Perth and Kinross. Richard Simpson, I think, heard the initial presentation. I have written to the council in Perth and Kinross—it has kept in contact and has offered on a number of occasions to come and visit the committee.

**Margaret Jamieson:** But you were to visit the council during the summer recess.

**Ben Wallace:** Yes, and I have been in contact with it as well.

**Margaret Jamieson:** Have you visited it?

**Ben Wallace:** We want to get the council to come to the committee, and I have an appointment with it later this month.

**Irene Oldfather:** I would like to come back to the general principle that Kay Ullrich raised. We are being notified of meetings—not being consulted about them. Now we will have two meetings in one week. I am on two parliamentary committees and on the European Committee of the Regions—I need a wee bit of notice of such decisions.

12:00

**The Convener:** As for having two meetings in one week, members were e-mailed about that and only one member has so far said that that is a problem. I am trying to pull together all the evidence that we still need to take in the short period before the recess so that the clerks can get to work on compiling the report. There is a lot to be gained by doing that. I do not want to begin again in October with unfinished business and more evidence to take. That is why we are having the Monday meeting. It fits into a wider picture. The Executive will comment on the spending review on 20 September and will respond to the Sutherland report shortly after that.

The joint futures group will give its response some time in October and there will be other announcements after that. If the committee goes on too long without making its report, we will move out of the period when the issue is being discussed. There is no way—because of circumstances—that we can bring our work forward so that we are not caught out in that way, but we want to ensure that we are in a position to produce a report sooner rather than later. If we start delaying meetings until after the recess, we will have lost the small opportunity that we have.

I have to put my hand up and say that I cannot remember when the Stirling meeting was arranged. I was probably consulted about it before the recess, but I cannot remember.

**Kay Ullrich:** Were you told to go to Stirling?

**The Convener:** As I say, I cannot remember.

**Kay Ullrich:** Did they say, "You shall go to Stirling"?

**The Convener:** The fact that committees should be moving out of the city has been discussed at the conveners liaison group.

**Irene Oldfather:** Surely that should have been discussed in the committee—surely this committee has a say.

**Margaret Jamieson:** We are equal partners in this. We are saying that we do not think that going to Stirling is a good use of our time. The cost involved is unacceptable and Jennifer Smart should cancel the meeting because some of us will not be there.

**The Convener:** The clerk has reminded me that information that this was going to happen was circulated to all members some time ago.

**Margaret Jamieson:** It is a fait accompli.

**The Convener:** I am not aware that anyone, at the time the information was circulated, said that there was a problem.

**Margaret Jamieson:** We were not asked for our views. That is our point.

**The Convener:** This has not come about because we said that we wanted especially to go to Stirling.

**Margaret Jamieson:** So we have to do what we are told.

**The Convener:** This is part of a wider move to ensure that the committees of the Parliament work outwith Edinburgh.

**Kay Ullrich:** Would not it be better if we were going for a meaningful reason? Why Stirling? Why not Auchtermuchty?

**Dorothy-Grace Elder:** It is very much within the spirit of the Parliament—to which we are committed—that we perambulate round Scotland. We must take it or leave it. It would be good if the venue for the meeting could suit what the committee is working on at the moment. Had we imposed ourselves upon people in Perth and Kinross, we could have gone there.

**Margaret Jamieson:** Exactly.

**Dorothy-Grace Elder:** However, the clerks must have a big problem arranging accommodation. I hope that we are not going to be in town halls and rather upmarket premises all the time. I suggest that we book some premises in major housing schemes.

**Margaret Jamieson:** What—like Easterhouse?

**Dorothy-Grace Elder:** We are small in number and we could easily go to a local public hall.

**The Convener:** Work has been done in the conveners liaison group on suitable venues in Scotland, taking on board the particular needs that committees have for the *Official Report* and other things. A small number of places were identified as being suitable and affordable. Some were in Glasgow, but other places that were considered were not suitable for committee needs. Another suitable place that was identified was Stirling. I do not have the papers with me, so I cannot tell members the other places that were considered.

Many places were discounted because of a range of problems that included, for example, the noise that a boiler made. Decisions on meeting places were not made on the spur of the moment. We did not say, “Oh, there’s a meeting place—we’ll just meet there.” The needs of committees had to be considered. There is also the need for people to be able to come to see the committee at work.

**Mr Hamilton:** I have three separate points. Let us not revisit the argument over whether the Parliament should travel: everyone agrees that it should. The issue is a specific meeting. We are tied to the meeting on 18 September, so let us simply accept that. However, we should put down a clear marker that, from now on, the committee members will decide where they are going, why they are going, and whom they will meet—the meeting will not simply be presented to us.

That is an issue that we can talk about, but I am more concerned about what has been said about pushing the inquiry to a conclusion. We want to do that quickly, but the convener has given us a reason for not proceeding with haste. The convener refers to 20 September and afterwards, when the Executive will come back to the committee and say what it plans to do. If we want the report and all the work that we have done to be meaningful, we should find out what the Executive has to say and add that to our evidence. That will ensure that we respond to the most up-to-date situation rather than to a report that is out of date within a week. I suggest that we postpone reaching our conclusion.

**The Convener:** There are two or three ways in which we could proceed. It is a matter of who we ask and when we ask them. Originally, I had hoped to take care of the evidence-based part of the report prior to the October recess, as that seemed a natural break. However, when officials of the Executive come to speak to us on 18 September or—I spoke to officials about this matter yesterday—the Deputy Minister for Community Care comes to speak to us on 4 October, we will not be able to get the full story in either case because the Executive will not have made all of its announcements.

**Mr Hamilton:** Precisely.

**The Convener:** The committee must agree to delay its conclusion and continue to take evidence after the October recess. That is the choice that committee members have to make.

**Mr Hamilton:** It would be wrong of us to do otherwise. I cannot imagine why the Scottish Executive is coming to the meeting on 18 September in Stirling, of all places. If the Scottish Executive is to attend our meetings, why not invite the Executive and the deputy minister when we have all the facts and have formed our thoughts cohesively, as a committee? Let us then put the matter to the Executive and get a resolution. If that means that we delay for a month what will already be a multi-month inquiry, so be it. I propose that formally.

**Malcolm Chisholm:** It is a good ambition to take as much evidence as possible before October. I suggest that we do that, with the exception of inviting the deputy minister. We could ask him a lot of questions that do not concern the Sutherland report, because there are lots of other issues. If we are going to invite him to attend only once, we could do that on 4 October.

I suspect that the Sutherland announcement will be made that week, but it will still come after our meeting on the Wednesday morning and might well come after the recess. Provisionally, we could hold over the meeting to which we invite Iain Gray and his officials. Let us try to finish with the rest of the evidence taking—we are beginning to come to some conclusions.

Ultimately, we should not change what we think because of what the Executive thinks, although we might want to respond to what the Executive says. I still hope that we can get everything done by the October recess, except taking evidence from the Executive.

I am sorry that I missed the beginning of the discussion about Perth and Kinross Council. Could we invite witnesses from Perth and Kinross Council instead of the civil servants to the 18 September meeting?

**Mr Hamilton:** That is a good idea.

**Irene Oldfather:** The committee agreed before the recess that we wanted to hold a meeting in private to consider the working procedures of the committee and to deal with some of the issues that have arisen today.

**Mary Scanlon:** That has been suggested by the clerk, from whom I received an e-mail this week. Is not that meeting planned for 20 September? I agreed to that private meeting.

**The Convener:** No. The meeting on 20 September is a private one in which we can begin to pull together what we have done during visits and so on.

The conveners liaison group is undertaking some work on the way in which committees function. I have said that we should hold a meeting at some point to discuss how things have worked in practice. I have no objection to such a meeting. The question at this stage is how to find the agenda time for that. I have tried to ensure that we finished the community care review evidence-taking sessions prior to the October recess. That seemed to be a natural break in which the clerks could pull together the various bits of work that the committee has undertaken.

I have no problem with finding a space on any agenda, if we can do that, for a discussion about the way in which the report procedure has been carried out.

**Mr Hamilton:** Let us return to the issue of reaching a committee decision. Malcolm Chisholm's position is correct. We can try to take all the evidence by the October recess, but can we reach a decision to return to the civil servants and the deputy minister after that? Can we agree also not to write the report, or even get to the substantial point of the report, before that is done?

I do not accept that the committee should arrive at its views and then go head to head with the Executive. The Executive might have lots of interesting things to say, which might modify our views before we proceed with the report. I would consider that part of the taking of evidence.

**The Convener:** I am happy to accept Duncan Hamilton's suggestion. Irene Oldfather wanted to make a point, but her contribution then moved on to another issue.

**Mr Hamilton:** So is it agreed to?

**The Convener:** We should find as early a space as possible on an agenda to consider the workings of the committee.

**Mr Hamilton:** Is the action that I suggested agreed?

**Margaret Jamieson:** I agree with what Duncan Hamilton proposes.

**The Convener:** Can members bear with me for a minute? I am picking up on the point that Irene Oldfather made about the need to examine the workings of the committee and the way in which it has functioned. If members all agree, we will find a spot on the agenda to do that as soon as possible.

On the issue of the community care review, a number of points have been raised. Do committee members want to take evidence from Perth and Kinross Council?

**Members:** Yes.

**The Convener:** That is one suggestion. Do we want to take that evidence in a formal session, at which representatives would come to speak to us?

**Members:** Yes.

**The Convener:** I heard some muttering from members around this table, suggesting that we should go and visit the council. I am just trying to clarify that.

On the key point of timing, Malcolm Chisholm and Duncan Hamilton have suggested that we should hold off until after the recess to have the meeting with the Deputy Minister for Community Care and his officials. Is that agreed?

**Members** *indicated agreement.*

**The Convener:** Those are the three actions that we need to take in relation to that discussion.

**Margaret Jamieson:** No. We need to go back to the meeting on 18 September. I understand that the chamber desk will be closed on 18 September, which will cause inconvenience to Parliament staff who must travel to Stirling. It is also a public holiday in Ayrshire.

**Dorothy-Grace Elder:** It is not a holiday in Baillieston.

**Margaret Jamieson:** We will have the meeting in Baillieston the following Monday, in that case. There must be a bit more understanding and co-operation. Members would like to be involved before decisions are made—

**The Convener:** Every member of the committee was told that there was a possibility that the committee would be going to Stirling—nobody said that there would be a problem.

**Margaret Jamieson:** No. That was because we understood that the meeting would take place on a Wednesday. Nobody said that we could not meet on a Wednesday.

**The Convener:** I understand that Parliament staff are not on a public holiday on that day, although that may be an issue for Executive staff. The chamber desk will be open. Most people are happy to move a parliamentary committee outside Edinburgh and that is what Parliament is trying to do.

**Margaret Jamieson:** We do not have a problem with that. Do not twist my words. We are objecting to a meeting on that Monday.

**The Convener:** Committee members were given a date some months ago. I confess that, at that point, I did not know that it was a public holiday for certain people in Edinburgh and Ayrshire.

**Kay Ullrich:** We have never discussed whether we are willing to meet on Mondays.

Nobody has any problem with travelling, although I would prefer to go for a specific reason, rather than merely being seen to be there.

**The Convener:** The conveners liaison group decided that committees that were meeting outwith Edinburgh had to do so on days on which committees did not usually meet in Edinburgh. That is because of resource considerations, such as official report staff and other staff. Several reports about the difficulties that that stipulation causes have been submitted to the CLG, which contains members of all parties. There are issues about the type of venues, the use of official report staff, staff time and so on. The question of what can be done outwith Edinburgh has been examined in detail. It seems that there is not the same option of meeting and using members of staff outwith the confines of the Parliament on Wednesdays as there is on days on which committees do not usually meet.

12:15

There are organisational issues to be considered. It is not just a matter of deciding to slot in an extra day. There is a wider discussion to be had about the resourcing of Parliament to allow us to do such things on the days on which we usually meet. However, that is what the CLG has been told.

**Kay Ullrich:** Was the Scottish Pensioners Forum asked whether it would prefer to give evidence in Stirling or Edinburgh? Are there cost implications for it in going to Stirling?

**The Convener:** The Scottish Pensioners Forum has not confirmed its attendance yet. However, I understand that witnesses can claim expenses from Parliament.

**Kay Ullrich:** If the forum has not confirmed and the Executive is not coming, why are we having the meeting?

**The Convener:** Members have said that they do not want to hear from the Executive until after the October recess. If we decided to cancel the meeting on 18 September, we would have to find a space elsewhere for witnesses from the Scottish Pensioners Forum and Perth and Kinross Council. If members are happy to do that, I will discuss it with the deputy convener and the clerks.

**Kay Ullrich:** Now we know that the Monday meeting is not essential because nobody is coming.

**The Convener:** Two groups of witnesses are still meant to be coming. We have to find another slot for Perth and Kinross Council. The deputy convener, the clerks and I will find time to arrange that. That is agreed.

**Ben Wallace:** Have we agreed to bin the meeting on Monday 18 September?

**The Convener:** Yes. I do not know whether that is the technical term, but we have agreed not to go ahead with the meeting on 18 September.

**Margaret Jamieson:** It must be an Army word.

**Ben Wallace:** It is.

**Dr Simpson:** While we are discussing logistics, I will add to the problems. The timing of the flu report—which I was asked to do some time ago—is important because we are about to enter the flu season and, although the report is mostly concerned with the long term, some aspects of the report are relevant to this winter. I have some amendments to make to the draft that the clerks have, but the report should be ready within the next week. Perhaps discussion of the report should be slotted into our agenda sooner rather than later, because its relevance will decline as the autumn progresses.

**The Convener:** The other consequence of what we have just decided is that we will not hear from the minister on 4 October. If we cannot fit the flu report in before then, there will certainly be a slot for it on 4 October. Members should leave it with the clerks and me to work out the best way of organising our agenda—obviously, we have to talk to members about diaries and so on. We will try to ensure that we have covered the flu report before the recess.

**Margaret Jamieson:** Can we set aside a time for a private discussion on how the committee operates? We have asked for that about three times.

**The Convener:** We will try to find times on our agenda before the October recess for everything that we have discussed under this item.

**Dorothy-Grace Elder:** Would you clarify the situation regarding the meetings on Monday 18 September and Wednesday 20 September? Are we back in limbo?

**The Convener:** The meeting on 18 September will not go ahead.

**Dorothy-Grace Elder:** Can we vote on that?

**Margaret Jamieson:** We have a consensus.

**Dorothy-Grace Elder:** Have we?

**The Convener:** If we do not have a consensus, I am happy to hold a vote.

**Margaret Jamieson:** There is no business to be done, so we would be going to Stirling only for the shopping.

**The Convener:** I propose that the meeting scheduled for 18 September be cancelled.

**Dorothy-Grace Elder:** I will oppose that.

**Kay Ullrich:** What is the proposed business for 18 September?

**The Convener:** As matters stand, we would hear from the Scottish Pensioners Forum. It would also be an opportunity for us to speak to Perth and Kinross Council.

**Irene Oldfather:** As the forum has not confirmed whether it will attend, we could hear evidence from it on 20 September.

**The Convener:** We could. I move, which is supported by the majority of members—

**Dorothy-Grace Elder:** An engagement has been made and people have been troubled in some way.

**The Convener:** Please speak through the chair. Dorothy-Grace, do you wish to lodge an amendment to my motion?

**Dorothy-Grace Elder:** Yes. Although there should, perhaps, be a better system in future, we should stick with the meeting on 18 September.

I move, as an amendment to Margaret Smith's motion that the meeting scheduled for 18 September be cancelled, that the meeting should go ahead.

**The Convener:** Are we all agreed?

**Members:** No.

**The Convener:** There will be a division.

**FOR**

Elder, Dorothy-Grace (Glasgow) (SNP)

**AGAINST**

Chisholm, Malcolm (Edinburgh North and Leith) (Lab)
Hamilton, Mr Duncan (Highlands and Islands) (SNP)
Jamieson, Margaret (Kilmarnock and Loudoun) (Lab)
Oldfather, Irene (Cunninghame South) (Lab)
Scanlon, Mary (Highlands and Islands) (Con)
Smith, Mrs Margaret (Edinburgh West) (LD)
Ullrich, Kay (West of Scotland) (SNP)
Wallace, Ben (North-East Scotland) (Con)

**ABSTENTIONS**

Simpson, Dr Richard (Ochil) (Lab)

**The Convener:** The result of the division is: For 1, Against 8, Abstentions 1.

*Amendment disagreed to.*

**The Convener:** The question is, that the meeting scheduled for 18 September be cancelled. Are we agreed?

**Members:** No.

**The Convener:** There will be a division.

**FOR**

Chisholm, Malcolm (Edinburgh North and Leith) (Lab)
Hamilton, Mr Duncan (Highlands and Islands) (SNP)
Jamieson, Margaret (Kilmarnock and Loudoun) (Lab)
Oldfather, Irene (Cunninghame South) (Lab)
Scanlon, Mary (Highlands and Islands) (Con)
Smith, Mrs Margaret (Edinburgh West) (LD)
Ullrich, Kay (West of Scotland) (SNP)
Wallace, Ben (North-East Scotland) (Con)

**AGAINST**

Elder, Dorothy-Grace (Glasgow) (SNP)

**ABSTENTIONS**

Simpson, Dr Richard (Ochil) (Lab)

**The Convener:** The result of the division is: For 8, Against 1, Abstentions 1.

*Motion agreed to.*

**The Convener:** The meeting on 20 September was mentioned. Part of that meeting is to allow us to pull together the work that we have done during the summer. That is a substantial piece of work, which I do not want to be compromised on an agenda on which we overrun on other issues. I want members to have a chance to report back.

## Conferences

**The Convener:** We have received requests for members of the committee to take part in conferences. If any member has a particular interest in attending any of the conferences that are listed in the paper that has been circulated, they should say so.

**Mary Scanlon:** I have already accepted an invitation to attend the CVS Scotland conference in Aviemore. I will take part in the panel session there, although I will not be there for both days of the conference.

**The Convener:** That conference is on a Wednesday, so if other members wish to attend it they will have to be away from Parliament on that day. I suggest that it is enough that Mary Scanlon attends.

**Mary Scanlon:** I have accepted the invitation, but my attendance will depend on the business that is arranged for the chamber. I would have to pull out if there were a health debate on that day.

**The Convener:** All of us are in the same position. Aviemore is in Mary Scanlon's area, so it makes sense for her to go to the conference there, if she is happy to attend as the representative of the committee.

The conference on hepatitis C will now take place on 25 October. I am happy to attend that conference, with the proviso that I do not have to speak to Executive policy—originally the organisers had asked the minister to speak about Executive policy and so on. I will speak on some of the concerns of the committee on the issue. With that caveat, I am happy to speak at that conference.

The Lothian and Borders voluntary organisation forum, which is meeting in Perth, has asked whether a member of the committee will be in the audience—we are not being asked to participate. We will say that we will accept one place, and any member who is interested in attending can e-mail the clerks. If no member indicates that they wish to attend, I will try to attend. Is that agreed?

**Members** *indicated agreement.*

**Mary Scanlon:** While we are talking about junkets—

**The Convener:** Junkets? Can we ask for that word to be scratched from the *Official Report*?

**Mary Scanlon:** There is, in the committee, a tremendous interest in public health in Finland. I would like to register my interest in that project.

**The Convener:** The researchers have been working on the paper that we commissioned. I anticipate that we will get that quite early in the next term. We can consider then what action we want to take.

**Mary Scanlon:** I believe that there is some sort of open week in Finland in November during which people can visit various projects. I do not want that to slip from our minds.

**The Convener:** We will come back to the matter after the recess when we have the research note.

**Ben Wallace:** Is Mary Scanlon suggesting that we might want to visit Finland? From my experience of similar arrangements with the European Committee, I know that if we leave it until after the recess, we would probably not get approval to go because that process is lengthy. My approval took nine weeks.

**The Convener:** So far, we have had no difficulty getting the go-ahead for anything that we have wanted to do.

**Ben Wallace:** For visits outwith Scotland, the process involves the Parliamentary Bureau, the Scottish Parliamentary Corporate Body and the conveners liaison group. One group usually deals with it the week after another has.

**The Convener:** We have not debated the issue and if we ask for approval before we have done so, it might look as if what we really want is a trip to Finland. After we have seen the report from the researchers and decided whether we want to go to Finland, we will arrange that in our own way, and structure it around our needs. We should not simply hop on to something that is already going on. It might be that we are able to visit Finland for the open week, but we would have to make sure that we had a good reason for doing so.

**Dorothy-Grace Elder:** Could we ask an already hard-pressed person to get some detailed information from Finland on its projects?

**The Convener:** Yes. That is what the researchers are working on. I discussed the matter with them last week. They are doing research papers on the measles, mumps and rubella vaccine and on hepatitis C, as well as on public health in Finland. A lot of work is being done behind the scenes by the Scottish Parliament information centre's researchers.

## Organisations (Contacts)

12:30

**The Convener:** We have pulled together some of the approaches that have been made to the committee. A paper will have been circulated to members. I am happy to take comments on the subject today. Alternatively, members might wish to delay discussion of the matter until a later meeting and send comments to me by e-mail.

**Ben Wallace:** I predict that more and more representations will be made with regard to the acute services review. I suggest that, while we should not deal with them all at the same time, we should bear that in mind when we consider the acute services review.

**The Convener:** The basis on which we undertook work on petitions was that the job of the committee was not to make decisions on local acute services reviews or to cherry-pick issues relating to those services. If we did, we would not be able to get through our work. That decision will reduce the number of people whom the committee invites to come before it. We have made it clear all along what our position is.

I urge committee members strongly to look favourably on the request that we have had for a joint briefing session on the Health Technology Board for Scotland's clinical standards board and the Scottish Intercollegiate Guidelines Network. If members are anything like me, they will be confused about who does what. It will be useful for the committee to make early contact with the Health Technology Board for Scotland now that it has staff in place. We have had similar informal briefings in the past that have been useful, so I urge members to consider the request.

I invite members to e-mail the clerks on the issues in the paper.

**Irene Oldfather:** I agree about the Health Technology Board for Scotland. In relation to the approaches from the other bodies, it might be useful to think about asking members to volunteer to visit projects on behalf of the committee. That might be more useful than having organisations take up a lot of committee time. However, we should leave that until we discuss the committee's working procedures.

**The Convener:** In the past, I have made similar visits to organisations when we have not had sufficient committee time—it is often a better use of time.

**Mary Scanlon:** What is Nora Radcliffe suggesting about a possible subject for inquiry? Is she suggesting that we conduct an inquiry into the provision of medical services in Portsoy?

**The Convener:** Yes. I will tell Nora Radcliffe that we are here to conduct substantial inquiries into the provision of general medical services throughout Scotland and that, as much as we wish the people of Portsoy well, we would not get other work done if we individualised our inquiries as she suggests.

*Meeting closed at 12:32.*

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