HEALTH AND COMMUNITY CARE COMMITTEE

Wednesday 13 September 2000
(*Morning*)

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HEALTH AND COMMUNITY CARE COMMITTEE
20th Meeting 2000, Session 1

CONVENER

*Mrs Margaret Smith (Edinburgh West) (LD)

DEPUTY CONVENER

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

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING MEMBER ALSO ATTENDED:
Iain Gray (Deputy Minister for Community Care)

WITNESSES

Isobel Allan (Carers National Association)
Dr Iona Heath (Royal College of General Practitioners)
Maggie Keppie (Edinburgh Users Forum)
Dr Sheena MacDonald (Royal College of General Practitioners)
Alan McGinley (Carers National Association)
Dr Bill Reith (Royal College of General Practitioners)
Adrienne Sinclair Chalmers (Consultation and Advocacy Promotion Service)
Willie Twyman (Edinburgh Users Forum)
Lydia Wilkie (Food Standards Agency Scotland)

CLERK TEAM LEADER

Jennifer Smart

SENIOR ASSISTANT CLERK

Irene Fleming

ASSISTANT CLERK

Joanna Hardy

LOCATION

The Chamber

Scottish Parliament

Health and Community Care Committee

Wednesday 13 September 2000

(*Morning*)

[THE CONVENER *opened the meeting at 09:30*]

Community Care

The Convener (Mrs Margaret Smith): Good morning everyone. Welcome to this morning's meeting of the Health and Community Care Committee, at which we will continue to take evidence on the community care inquiry that we have been undertaking for some time.

With us this morning we have representatives from the Royal College of General Practitioners in Scotland, whom I welcome. Thank you for your written submission and for giving us your time this morning to answer our questions.

Please begin by giving us a short introduction. I will then open up the meeting to my colleagues to ask questions.

Dr Bill Reith (Royal College of General Practitioners): Thank you, convener, for inviting us here this morning. The Royal College of General Practitioners in Scotland welcomes the opportunity to give evidence to the committee in its inquiry. I will introduce myself and my two colleagues, and give an introduction to the college; my colleagues will introduce themselves and tell you a bit about their backgrounds.

I am a general practitioner in Aberdeen, and chairman elect of the Royal College of General Practitioners Scottish council. Dr Iona Heath is a GP from London and former vice-chairman of our United Kingdom council. Dr Sheena MacDonald is a GP and our honorary secretary, from just outside Melrose.

The Royal College of General Practitioners was founded approximately 50 years ago, with the aim of fostering and encouraging the highest standards of care in medical general practice. As a royal college, its primary interest lies in improving care for patients. We do that through working with our members. The college is interested primarily in education and research and has a long track record in trying to develop practice and working with others. To give you some idea of our scope, in the UK we have about 19,000 active members; in Scotland we have approaching 2,500 active members, which represents about 60 to 65 per cent of all Scottish GPs. Given the relative youth of our college, we have a higher number of younger GPs who are members. Those who are finishing training tend to sit our membership examination in high numbers.

Dr Iona Heath (Royal College of General Practitioners): I am a GP in Kentish Town in London. I am a member of the UK council of the Royal College of General Practitioners and chair its ethics committee and its task group on health inequalities. I have been invited to join my colleagues as a token English person, because I was a member of the Sutherland commission.

Dr Sheena MacDonald (Royal College of General Practitioners): I am a GP in Earlston, beside Melrose, where I have been for five years. Prior to that, I worked in Dunvegan on the Isle of Skye for nine years, so my interests in community care have a remote and rural slant. I am also a GP trainer and serve on our local health care co-operative management board in the Borders.

The Convener: If my colleagues will indulge me, I will kick off with a question to Dr Heath about Sutherland, before we move on to other issues.

What would be the impact on the delivery of community care services in Scotland if the recommendations of the Sutherland commission were not implemented in full and we followed a similar line to England?

Dr Heath: It would be a tragedy, for a number of reasons. For the first time, somebody's eligibility for free care would be based not on an assessment of their need, but on the job description of a specific health professional. That would be a bizarre situation, which would drive a wedge through the skill mix of nursing teams. Only the registered nurse time in the work of the nursing team would be provided free. Any work that was delegated to a health care assistant—such delegation has been a cost-effective development—would be means tested and charged for.

The great advantage of implementing the full recommendations would be that, to a large extent, that would get rid of the perverse incentives that exist around social and health care. Not implementing the recommendations in full would generate a new raft of such perverse incentives. Health authorities that are short of cash would try constantly to redefine nursing care. There is a continual push for nursing to become a more high-tech profession, so the nursing needs of increasing numbers of frail older people would fall out of the bottom of the definition of nursing care.

It is possible that there would also be a reverse perverse incentive to the people who run residential homes, in that they might employ registered nurses to do a wider range of tasks, on the basis that that care would be provided free. Anyone who has agonised over what is a health bath and what is a social bath has lived with the problem of perverse incentives for 25 or more years. Far from solving that problem, partial implementation will make the problem worse.

The reaction of the Royal College of Nursing to the plan in England is a sign that the problem is far from being solved. Even the Department of Health in England will struggle with this much more than it thought it would.

Malcolm Chisholm (Edinburgh North and Leith) (Lab): I agree that there are serious problems with the definition of nursing care—I was surprised that it was tied to what a nurse does. If nursing care and personal care were redefined according to the nature of the tasks, rather than according to who carries them out, would that alleviate some of the problems you mentioned? I am sure that in your view there would still be problems, but what would be the effect of such redefinition?

Dr Heath: We had a nurse member on the royal commission—Professor June Clark from Swansea—who argued persuasively that intimate personal care is a definition of nursing care as it should be conceived in relation to the health care needs of frail older people. The vast majority of frail older people do not need high-tech care of any sort. They need hands-on, physical care. They need a skilled eye that can detect deterioration, intervene early and identify opportunities for rehabilitation and where improvements could be made.

The dilemma concerning nursing and personal care is totally solvable, if we start by considering the needs that the older person has as a result of the degree to which their health is compromised. That, to me, is a health care need and a nursing care need. If we define nursing in that way, we get over the bulk of the problems between health and social care.

Dr Richard Simpson (Ochil) (Lab): I agree absolutely. The problem lies in defining the personal care boundary, if that is what we decide to do. How would you feel about going down that route? If we do so, it will probably be because Sutherland deals not with improving health care for the elderly as such, but with equity. That is our dilemma. If we say that we should apply the limited funds that are available to improving care of the elderly, how would the management of, for example, Alzheimer's disease—whether in the person's home, or in a residential or nursing home, or in hospital—fit into the system, if you were forced to go down that route?

Dr Heath: Before I am forced, may I take one last stand against that? The inequity issue is a running sore. The commission was set up because of the inequity issue. We felt strongly that the redistribution of wealth from rich to poor is the function not of a health care system, but of a taxation system. The function of a health care system is the redistribution of wealth from the well to the sick. What is being proposed is an underhand tax on frail older people. I would have to be dragged kicking and screaming down that route. It is very difficult to accommodate any decent level of care for Alzheimer's patients within a model in which social care is treated differently from health care. It is a gross injustice; it is in the mainstream of discrimination against people with mental health problems across the board; and it is superimposed on discrimination against health care for older people. Our defining condition was that, unless we could do something for people with Alzheimer's, our proposals would not be good enough.

Dr Simpson: I will not force you, because I agree entirely with what you say. If your main challenge is to create a system that is equitable, and given that we are still in the process of closing significant numbers of long-stay beds, what would your view be if the place of residence was the determining factor for payment or non-payment? Let me explain further. If, no matter a person's place of residence, that person paid for living costs, but personal costs and nursing costs were free, would that meet your objectives? That would mean the 17,500 long-stay beds being transferred out of the national health service into a new collective system in which the care would be managed by some new body.

Dr Heath: If we have to compromise, to come to some workable arrangement, what you suggest would come very close to being the most acceptable way of doing it. At least we could see clearly that it was based on a set of principles and that it was just. It would also get rid of the residual perverse incentive to keep people in long-stay institutions, which might not be the places where people would most want to be if there was not the financial incentive. So, yes, I would go with your suggestion. It is potentially equitable.

Dr MacDonald: I would point out some anxieties about Dr Simpson's suggestion, which may come from a more rural perspective. Many long-stay beds in rural areas are quite distant from district general hospitals and are in hospitals that are used by the GPs on a day-to-day basis. Historically, those beds have been used flexibly by the GPs. If there were 10 long-stay beds and five GP beds, and if there were only nine long-stay patients, the GP would use that extra bed flexibly to respond to an acute situation in the community when someone needed simple nursing care and not high-tech nursing care.

There is an anxiety among our community hospital colleagues that there is gradual erosion of the number of community hospital beds that might historically have been designated as long-stay beds. In my 10 years of working closely with the geriatrician, there was no question of my having to speak to him to ask whether I could use a bed at nights and weekends. If we were to lose that ability, that would be a cause for concern.

09:45

Dr Simpson: I emphasise that I am talking about a place of residence. I am chairing the first session of the Community Hospitals Association annual general meeting this year. I am absolutely in favour of community hospitals. The expansion of that area is fundamental to the modernisation of the national health service. Any proposals that I make with regard to long-term care are designed to make it clear that flexible use of our resources must continue. However, if the costing system does not change in relation to people's place of residence, the implementation of Sutherland will not improve care of the elderly one jot. That is a concern.

Mary Scanlon (Highlands and Islands) (Con): Are we returning to our planned line of questioning?

The Convener: Yes. We had a little detour to take advantage of Dr Heath's experience.

Mary Scanlon: Section 3.1.2 of the RCGP submission refers to a social work study from the University of Stirling that points to the GP in primary care as a starting point for care of the elderly. Section 3.2.5 takes that line further and says:

> "Practical experience has demonstrated that the only way of delivering effective community care is through primary care-led multi-professional working."

Throughout our inquiry, we have been thinking about better partnerships between social work and other agencies. You have come up with a different approach. Do you think that the local health care co-operatives should be given the central role in co-ordinating community care services in Scotland? If so, why?

Dr Reith: I will answer, then my colleague Dr MacDonald will make some comments about LHCCs.

For some time, our view has been that while the vast majority of people know who their doctor is, most people do not know what other professionals they have working for them. Apart from knowing who the nurse is, people tend not to be able to identify individuals, yet we see an enormous strength in people having that knowledge.

When the health centre in Aberdeen in which I worked for more than 20 years was built, we had accommodation for a social work team. That team did not take up the option of joining us then, but did when the accommodation was going to be used for something else. We had an effective liaison partnership with the social work team that for many years greatly benefited our patients and the social work team's clients until reorganisation led to the team's leaving the health centre, much to the detriment of our patients. When I meet those social workers now, they say how good it was when they worked alongside us in the health centre. The day-to-day working, the possibility of professional and personal contact, the extent to which we could share information and the fact that the patients knew we were working together were all enormously helpful. We think that that model would be a good way of moving forward. There is evidence that some LHCCs are moving down the route of having social workers attached to the LHCC.

Mary Scanlon: Sutherland suggests that there has to be a single budget to stop buck passing and bedblocking. Would you want to be the single budget holder in the LHCC?

Dr Reith: That would be an interesting model to consider. One of our concerns as GPs is that the structure and working of LHCCs means that we have no part to play in commissioning any services other than our own services. As a result, we do not have a role even in helping to influence secondary care services. We very much welcome investigating that situation, hand in hand with other agencies.

Dr MacDonald: The current experience of LHCCs is variable. Some LHCCs have social workers at board meetings, while others have no contact whatsoever with social work. The Edinburgh example could be described as facilitating care, instead of managing it, and LHCCs might have more of a role in facilitation. We might need to consider pilot work on joint funding; however, early signs on such work that has been done in Northern Ireland have not been entirely positive. Although there is much uncertainty in both professions about going straight to joint budgets, the experience of joint working has been very positive and, in the Borders, we have established linked social workers. That is working extremely well. The linked social worker comes into the practice regularly, and our patients' community care has been improved.

We have also considered a pilot of shared community care assessment, in which the lead person—whether nurse, health visitor or social worker—who delivers care to a particular client will carry out first-level assessment to prevent duplication. Short of shared budgets, that has been a useful exercise.

Mary Scanlon: Do we need a radical way ahead? Paragraph 3.1 of your submission says:

> "A number of issues have been highlighted as contributing to"

the problems

> "including intra-professional suspicions, professional demarcation and perceptions of status that tend to inhibit cross-agency working".

Are you saying that anything less than a single authority and budget would not be able to overcome such problems?

Dr MacDonald: At the moment, we would say no. We have evidence that closer working relationships and joint training—which, for example, has taken place for the care assessment—has facilitated better working and helped to remove some barriers. Those barriers are imposed largely from outside by different management structures and totally different organisations. Where organisations on the ground have been able to get together, they have worked very well.

On other barriers to closer working, we are also concerned about our different perspectives on the provision of care for client groups. In general practice, we provide a 24-hours-a-day, 7-days-a-week service that is extremely reactive and responds quickly to crises compared to the different time scales employed by our colleagues in social services. That difference impedes closer working, because we end up depending more on health service personnel and colleagues to get the care that we need at 5 o'clock on Sunday evening or midnight on Tuesday night.

We have discussed that issue over the past few days and have identified two potential barriers, one of which is bureaucratic. The other is the different ways of working, and we must resource bringing such practices closer together. That does not necessarily mean sharing budgets, but perhaps resourcing different stakeholders to bring them more in line with the way that GPs provide out-of-hours and emergency cover.

Hugh Henry (Paisley South) (Lab): May I follow on from that point?

The Convener: No; three members already want to follow up some of those points.

Ben Wallace (North-East Scotland) (Con): I want to expand on some points that you raised. The new NHS plan for England that came out in July sets up new care trusts to deliver health and social services. What is your response to that? How does it fit in with Sutherland, and how would it fit in with proposals that the LHCCs would deliver such services in Scotland?

Dr Heath: Care trusts have potential for the future, but improving the process need not rely on bureaucratic reorganisation. For years in primary care we have worked in cohesive teams with two management structures. General practitioners and their directly employed staff have worked closely alongside health visitors and district nurses who are employed by the health authority. Those are different bureaucratic structures with different lines of accountability, and we have made it work.

There are many examples of social workers being attached to practices—as in my practice and in Bill Reith's—where that arrangement has worked extremely well, because the social worker can work closely with the health personnel. Such an arrangement need not be predicated on a large reorganisation. There is some logic in trying to bring the two organisations closer together, but there is a problem with the democratic accountability of local authorities versus the less democratic nature—and probably less defensible nature—of health authorities, and how you make that work.

Another issue regarding working together is that when the idea of community care was first floated, it was always said that assessment would be done by both social and health services. The problem has been the trend for assessment to be more focused on social services, which focus on services and care needs. Often, there is no health input to the assessment, so there is no focus on health needs and, more crucially, no focus on the potential for rehabilitation. Social workers and district nurses must be brought closer together so that the potential for rehabilitation can be included in every older person's care plan.

Ben Wallace: So we should use existing bureaucracies, because if we create another one it will create another barrier just by its existence.

Dr Heath: There is room for bureaucratic change in future, but I do not think that we need to wait for such change. A huge amount of difference could be made, without waiting for bureaucratic change, just by making it easier for social workers and district nurses to be in the same place at the same time. You do not have to reorganise an entire management structure to achieve that.

Irene Oldfather (Cunninghame South) (Lab): I am interested in exploring the health dimension of community care. In practice, what can GPs do to ensure that elderly people are kept in the community for as long as possible and supported in their own homes? You mention rehabilitative care in your submission, and you have just spoken about it. What could be done to improve primary-care-led rehabilitative care?

Dr MacDonald: That is not GP-led care. The patients do not necessarily need a high level of

GP care, but they do need a high level of primary care input. If it takes three weeks to have a person with cancer assessed for a bath aid and to get an occupational therapist, we are unable to deliver good care to those patients. There are issues about resourcing of other members of the primary care team and making the team a more robust organisation through which we can deliver more intensive levels of care.

At the moment, our district nursing staff deliver little in the way of general nursing care. Provision of such care is delegated to care assistants, which is fine, but there is the concern that generic care assistants may miss health issues. At the moment, we do not have the staff on the ground to deliver more intensive home care. We are considering a local pilot to allow patients with severe strokes to choose whether they go into nursing or residential care or stay at home. If we are to support those patients to stay at home, we will have to make an infrastructure of professions allied to medicine, particularly occupational therapy and physiotherapy. We have no domiciliary physiotherapy in my area. That kind of rehabilitation—physios going into the home and seeing patients in their own environment—is something that we would have difficulty delivering at the moment.

10:00

Irene Oldfather: Do I understand correctly that you are satisfied that everything possible is being done by GPs to support individuals, but that the teams need to be boosted?

Dr MacDonald: That is variable. Some areas have a very high number of dependent elderly people at home and GPs might feel stretched, but there are not as many highly dependent patients at home as there could be. Many are in residential and nursing homes—that is where we are under pressure. We cannot deliver the best medical care to those patients within the current funding structure.

Kay Ullrich (West of Scotland) (SNP): I apologise for missing the start of the meeting. I want to be clearer about what you are saying about assessment. At the moment that is the responsibility of the social worker, as is the commissioning role. Do you agree with that or do you want to see that changed?

Dr MacDonald: We want to see much more health input into assessment so that the health issues are not missed and the continuing health needs of the patient are not lost. That is why I am encouraged by the pilot project in our area in which, after joint training, assessment is done by either health workers or social workers.

Kay Ullrich: So assessments can be done by either health workers or social workers. Do you see a need for somebody to have ultimate responsibility for assessment?

Dr MacDonald: In the pilot project, the responsibility for assessment lies with the key worker, who can be a health worker or social worker.

Dr Reith: Assessment could be a joint responsibility. If normal practice was for the GP and his or her primary care team to work more closely with social work—perhaps in an extended team—that would allow the discussion about the patient’s needs to be taken further than is usual at the moment. That happens in some situations, but not many.

This discussion highlights another inequity—availability of services seems to depend on where one lives. For example, my team and I have the benefit of a night nursing service—a tremendous benefit to looking after terminally ill patients at home. That makes a huge difference to the carers of those patients, but the service is not available everywhere. In many parts of the country there is no night nursing service, which must place intolerable burdens on the carers and the daytime primary care team.

Kay Ullrich: In evidence from across the country, we keep hearing about differentials in costs to patients for services. That should not be the case. Do you have any suggestions for sorting that out?

Dr MacDonald: That is probably a role for the local health care co-operatives. One of the advantages of LHCCs is that there is now an opportunity for GPs to come together in an umbrella organisation. A lot of the work we have heard about from LHCCs is concerned with inequities and variation in, for example, waiting times for out-patient and domiciliary physiotherapy—where that exists. We have previously not been able to bring the different professions together in one organisation to do that. We now have a structure and a unique opportunity. However, the template for the development of LHCCs was so blank that development has been locally led and the direction an LHCC takes depends on the individuals on the LHCC boards, so they remain variable.

Hugh Henry: Dr MacDonald commented on the problem of getting services when they are required—that echoes some of the evidence that we received during our visit to North Ayrshire, where there is a recognition that social work services developed from a different perspective and from modelled local authority conditions of service. Now, however, we are trying to develop community care in a much more flexible way that is not about nine-to-five working. Social work services in North Ayrshire accepted the need to change in response to that. Do you think that the system as it stands is capable of responding to the needs of those who require care?

Dr Heath made the point that there is an opportunity to get things moving without necessarily changing the bureaucratic structures. I recognise that we need to act now without waiting for big changes, but if you were starting from scratch, would you design the system to be as it is now? We must think in the long term, as well.

You both touch on fundamental issues of accountability. The matter is not just about co-operation—you have both said that there are good examples of co-operation. Who is responsible for the delivery of care and the management of budgets? Are we getting the best use of the scarce resources in the system?

Dr Heath: If intimate personal care was put back under the supervision of nurses, social services would again be free to concentrate on the quality of people's living conditions. That responsibility has disappeared, following social services' focus on the provision of personal care. Patients in their 90s regularly fall down and break their leg while they are trying to wash their net curtains because it is essential to their health and dignity that they have clean net curtains. They get up on a chair and fall off because there is no one to provide them with the sort of clean environment that they regard as essential to their self-esteem.

First, the shift of social services' focus to the delivery of what was previously nursing—and what, in my view, should still be nursing—has led to neglect of what was previously a social services responsibility for the quality of the places where people live.

My second point concerns the way in which early warning systems can be used to prevent people from getting worse. There is a huge difference between the situation of frail, older people who have any sort of input from relatives and that of frail, older people who are completely on their own. The difference in the quality of those people's lives when they are at home is a clear indictment of what goes on. Largely untrained social services care assistants are often the only people who go into those homes—which returns us to Irene Oldfather's question about whether GPs are happy.

The people who provide day-to-day care are often relatives, who are good at informing doctors and nurses if things go wrong. Care assistants are not good at that. That is not through any fault of their own, but because they get into a routine regarding how well a person is. They are not trained to examine situations critically and they do not have the emotional involvement that alerts a relative to the fact that things are changing.

The primary care service relies on someone who does not have that involvement and who has no direct contact with district nurses to provide the early warning system that tells it that things are going wrong. If care assistants could be moved so that they could work in unified teams that were supervised and supported by qualified district nurses, that would be a real breakthrough and would help to break down the barriers.

Eventually, care trusts that lie somewhere between the health service and social services must be the way forward. I am slightly worried by the ever-increasing extension of the democratic deficit in the health service. Care trusts would take another part of the care system out of the control of social services—for which local authorities are accountable—and put it into the less accountable health services.

Hugh Henry: Why would there be a democratic deficit if care trusts were not within the sphere of influence of local authorities?

Dr Heath: It is not clear how care trusts are to be managed.

Hugh Henry: Would care trusts being brought within the sphere of local authorities address your concerns about the democratic deficit?

Dr Heath: Yes.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): You said that there are some good pilot projects. Kay Ullrich and I heard about the integrated care project in Newmilns and Darvel, which started off as a pilot. It was interesting to see how general practitioners, district nurses, health visitors, social workers and other people in professions that are allied to medicine shared care with the home care workers. All those people were able to access patients' records, which were kept in the patients' homes. We were advised, however, that that created difficulties in terms of patient confidentiality, which is something that I am sure your organisation is often asked about. How can that problem be overcome?

Dr Reith: Confidentiality is a huge concern, not only for general practitioners, but for nursing and social work colleagues. The majority of GPs do not work regularly with social work colleagues, although doctors and nurses have managed to work through most of the confidentiality issues. In many practices—if not the majority—there is now pretty free, if not totally free, access for nurses to general practitioner records and vice versa. Many practices are working towards shared records and that is being progressed and facilitated by LHCCs, where good practice can be shared and encouraged.

Margaret Jamieson mentioned the project that she has seen—I would like to comment on that. Before I came here today, I took the opportunity to speak to our local director of primary care about some of the joint working that has taken place in Grampian. He is an interesting chap, because he comes from a social work background and has now transferred to the health service. He can, therefore, see the situation from both sides. He commented that there seem to be 1,001 projects with little pots of money being made available for them.

Pilot projects are important, because we need to try them and evaluate them properly and they are developed by people who are committed and who want to work together. However, as a project comes to its end, funding tends to stop and there can be great difficulties in rolling out the lessons that have been learned from the pilot into more general professional practice.

Margaret Jamieson: I am aware of the problems that you have outlined, but the project that Kay Ullrich and I learned about has been evaluated and will be rolled out throughout that council area. There will obviously be some problems; the model will fit some areas exactly, but it will need to be amended to suit other areas. However, it is interesting to note that it took only £15,000 to bring in information technology equipment and provide the appropriate training. If there is the will, it can be done. The benefit to colleagues in the acute sector is immeasurable.

Malcolm Chisholm: What can be done to increase GPs' awareness of and responses to the needs of individuals who have dementia and their informal carers?

On mental health more generally, I was interested in the section at the end of your paper, but I would like clarification on one point. Are you saying that all community psychiatric nurses should be attached to GPs? That is an area that we have not investigated in detail, so your comments would be welcome.

Dr MacDonald: There is a severe lack of educational opportunities for dementia training at undergraduate and postgraduate level. The centre at the University of Stirling is keen to raise the profile of dementia and we have a general practitioner from the Scottish council of the Royal College of General Practitioners who works with Alzheimer Scotland—Action on Dementia.

We are currently examining ways of raising the profile of the condition. We have just completed an educational package and held an excellent educational evening that was, unfortunately, poorly attended by general practitioners. Only four GPs from the entire Borders area attended that meeting, so we must encourage general practitioners to address issues such as dementia, in which they might not have great strength. That is another agenda, but it is one that the Royal College of General Practitioners is acutely aware of and we are taking forward learning needs assessment and learner-centred training for established general practitioners.

10:15

I cannot answer for the undergraduate curriculum. However, for general practitioners who are in training, we are considering using our phased evaluation project program—an interactive CD-ROM that we are encouraging registrars to use with a dementia package. A separate educational package that was developed by the centre at the University of Stirling in association with the Scottish Council for Postgraduate Medical and Dental Education has also just been launched.

We are well aware of the gaps in training, and Malcolm Chisholm was right to highlight that. Health professionals have to be proactive in that area, especially established principals, who deliver the bulk of care to dementia patients.

Dr Reith: The second question was about community psychiatric nurses who, by definition, work in the community. It has always seemed somewhat anomalous that the professionals to whom they most often relate are the consultant psychiatrists rather than the general practitioners. CPNs have an enormous range of skills and are very helpful to patients and their families and to the rest of the primary care team. They ensure the well-being of patients in the community who have significant mental health problems. Where they have linked in closely with primary care teams, that has been to everybody's benefit, because the general practitioner, the nurses and the CPN all have information about the patients—pooled information can be used collectively.

People often forget that more than 90 per cent of mental health problems are dealt with—entirely appropriately—within the primary care system and without reference to our specialist colleagues. By working more closely with the rest of the primary care team, CPNs could be even more effective. Of course, they must continue to maintain links with their specialist colleagues, but we think that their focus could be much more as part of the primary care group.

The Convener: I have a couple of questions that might pull in some issues that we have not yet touched on. What has been the impact on GPs of increased demand as a result of community care policies? We all assume that there has been an increased demand, but do you have concrete evidence of what the impact has been?

I would also like you to comment on the on-going need to transfer resources from secondary care to primary care, if primary care is to have an increased role in community care.

Dr Reith: I shall answer your second question first. We believe that the health care needs of the population must be better resourced. Everyone in general practice agrees that the secondary care sector is stretched. We suspect that this year there is the potential for a considerable shortage in beds—there is real concern about that. That puts pressures on primary care. If we have difficulty getting patients into hospital in an emergency, that places greater stress on our teams and on us.

The funding must follow the patient. If a service or activity that was undertaken previously by the secondary care sector is transferred into primary care, that must be taken into account in the funding of primary care. Primary care is not a sponge that can mop up everything. Overarching that is the need for increased funding for the health service as a whole.

Dr MacDonald: On the impact of community care, the major concern for GPs has been the number of patients who are in nursing and residential care and our lack of ability to provide a well-structured, proactive programme of care for those patients. Such patients are registered for general medical services and there are no additional resources that would allow us to provide the input that such patients would have received previously from medical staff in a long-stay geriatric ward. That has been a problem.

Another problem—

The Convener: I am sorry to interrupt. I ask members to stop whispering—it is extremely off-putting. Please continue, Dr MacDonald.

Dr MacDonald: The other way in which community care has affected people who work in primary care relates to the times when community care has failed us and when we have been unable to provide an intensive care package for a patient, whom we have then had to admit to hospital. That is not uncommon, especially at high-pressure times, such as in winter or during a flu epidemic. That is my personal view.

The two main areas of concern are nursing and residential care and the failure to deliver in acute situations where we might have been able to keep patients at home.

Dr Heath: The situation has led to a ratcheting up of the guilt that we carry around. We have much more responsibility than before and there is a stronger sense that we are failing people because we do not have access to resources. We sense that we are failing people in residential and nursing homes as well as patients at home. We live with an increasing sense of failure, which is not good for morale, and a feeling that there is a lot more that we could and should do.

The Convener: Thank you for giving us your time.

Dr Reith: Thank you for inviting us. If there is any other way in which we can help the committee in its deliberations, please let us know.

The Convener: We will be sure to take you up on that.

10:23

Meeting adjourned.

10:29

On resuming—

The Convener: Our next witnesses are from Carers National Association Scotland. I welcome Alan McGinley and Isobel Allan to the committee. Thank you for giving us your time and expertise this morning. Please start with a short introduction, after which my colleagues and I will ask you some questions.

Alan McGinley (Carers National Association): My name is Alan McGinley, and I am the assistant director of Carers National Association Scotland. I am accompanied by Isobel Allan, who is a member of our Scotland committee and, indeed, a carer.

I thank you for inviting us to give oral evidence today. Four years ago, Isobel and I went to London to give evidence to the Scottish Affairs Committee investigation into community care. The report arising from that investigation was well received by providers, users and carers. It is interesting to look at how far we have come since then.

I also thank the committee for getting me off annual meeting duties, as our annual meeting is being held today at Dynamic Earth. If I were not here, I would probably be running about with a roving mike, hoping that my braces did not ping in front of an audience.

This afternoon we are launching the fair deal for carers campaign, which is predominantly aimed at Westminster issues. However, even though the committee's brief is restricted by the devolution settlement, it is important to recognise that there is a broad range of issues not within your province that will impact on community care. The fair deal for carers campaign will illustrate some of those issues. It is built around a piece of research that we launched this summer, "Caring on the breadline—the financial implications of caring", which provides evidence that carers in Scotland

and the rest of the UK experience financial problems as a result of their caring. Seventy-nine per cent of carers say that they have been worse off since becoming carers. A key reason for that is the extra costs of disability and the costs of alternative care, which are very much within your game plan.

I hope that the key demands that we are presenting at today's meeting at Dynamic Earth will feature in your postbag and will influence the thinking of the committee at some stage. I will pass a copy of the research paper to the committee after the meeting.

In answer to your questions, we will try to address the question of what has been achieved since the Scottish Affairs Committee report on community care was published. We also want to get across the idea that caring is a multi-dimensional activity, of which community care is only one component. Changes to any of the other components can affect caring. It is your business how you deal with that fact, but we would like you to recognise it.

We recognise that the committee's brief is community care, older people and mental health, and we hope to address those issues today.

The Scottish Affairs Committee called for national care standards, regulation, stable funding for voluntary organisations. There have been clear improvements in those areas. In addition, there have been developments in areas that the Scottish Affairs Committee did not address, such as the national carers strategy and the strategy for carers in Scotland. The "Review of Services for People with a Learning Disability" is an example of original work by the Parliament and the Executive. It has authenticity and self-belief, as it was based on genuine consultation with users and carers, and it has worked up a head of steam. Such developments have to be accepted, not just as a positive gloss, but as genuine drivers for change for carers and the people for whom they care.

However, we also face the same problems that we faced four years ago. There are still anomalies in charging policies and the balance of care issues between residential and home care is predominantly the same as it was four years ago—it is not clear what aspects of the balance of care can genuinely be called respite. There are problems relating to integrated practice. We know that the Executive is trying to address those through the joint futures agenda, but there needs to be evidence of action. There is also the thorny issue of who pays for care. The Sutherland report has yet to be answered.

The axiom that carers are the backbone of community care is not just a rhetorical device. It is important that that be recognised in the committee's discussions and in its recommendations on the system and how people interact with the system.

The Convener: I am sorry that you are missing your annual meeting. I hope that by the end of our questions you will still think that it was better to be here.

Mary Scanlon: I am glad that you mentioned the "Review of Services for People with a Learning Disability". I, too, think that it is an excellent document. However, as you said, the level of care is determined by what is offered in practice. Since being visited this week by a lady about her son, I have been quite concerned about the difference between a stated care plan and unmet respite care. The reasons given for not meeting respite care needs are a lack of resources for social work, a lack of trained staff, and worries about cuts in Crossroads (Scotland). Will you outline what carers look for in the provision of good-quality respite care, and will you tell us about matching that up to the care plan? The care plan is helping to identify the need for respite care, but is it helping to provide that care as well?

Alan McGinley: I will take a broad shot at that, then Isobel Allan will answer in much more detail from her experience. There are a lot of buzz phrases to do with good-quality respite care—trustworthiness, reliability, continuity, joint experience for carer and user—all the stuff that we know about. The Patchwork Quilt report of a few years ago was a seminal report into respite care. It helped to build the case for respite care, although whether it has had a real impact has yet to be seen. The Patchwork Quilt report gave an image of what respite care could be—something that could cover people safely and keep them warm but that could also be torn apart or ill knitted. Attempts have been made to update it to an electric blanket, with some kind of safety kite mark on it as well. For us, respite care is more of a leaky hot water bottle, and I think that that is the experience of a lot of carers.

You asked about matching up respite care to the care plan. We expect the care plan to be the device by which respite care is delivered. However, we know that recording of unmet need does not happen—the systems do not allow it to happen at the moment. Therefore, there is not much information in the public domain to allow us to compare what people get with what they need.

Mary Scanlon: Are you saying that the care plan is basically a wish list? How can we meet the unmet needs to a greater extent?

Alan McGinley: The assessment process has to be an open dialogue, a consultation between the professional and the carer about what is needed. Whether it becomes a wish list is another matter, but the process has to record what is needed to help that carer to continue with their caring responsibilities if they so wish.

Mary Scanlon: The care plan that I saw, to which the carer had had an input, was extensive and excellent—absolutely first class. However, the needs were not being met. I have given you the reasons that people in social work gave for not being able to meet the needs for respite care. What advice would you give us to help us to make progress?

Alan McGinley: The extra investment in respite care through the carer strategy is a starting point. We need to monitor that, as we have not yet got the evidence back to allow us to understand whether that investment has been a driver for additional respite, or whether it has simply moved things around a wee bit. We have written to the Minister for Finance to suggest that that investment needs to be topped up year on year to allow the process to be one that builds up, rather than one that starts in year 1 but does not really continue through to year 3. Extra investment is critical to being able to deliver respite care that is based upon people's assessed needs.

Isobel Allan (Carers National Association): Good morning, everyone. My name is Isobel Allan and I am an unpaid carer. I am really thrilled to be here today. I care for my daughter, Susan, who is 20 years old. She lives at home and I have cared for her all her life. Susan has profound mental and physical disabilities, so what you are saying has a profound effect on our lifestyle. My daughter is totally dependent on her family and on those who look after her every need. That means every single need. She also has challenging behaviour, which is a fancy way of saying that she beats—and I am choosing my words very carefully because of where I am—herself in the face with her fists. She hurts herself quite badly.

As a carer, my lifeline is respite. Most carers would say that respite was at the top of their agenda. Trying to find respite is like trying to find gold. As Mrs Scanlon has suggested, you might have something on paper, but you have to check what the reality is. I am an unpaid carer and I love my daughter to bits. My husband and I will always want to care for our daughter, but with good support systems. We are not over-protective parents, but we need a good support system to be able to care for Susan. We want to be able to do really complicated and powerful things, such as sleeping at night for six hours. We would love those hours to be continuous. If I sleep for six hours, I think I have died and gone to heaven. Those are the important things that we are looking for in our lives, although they may be natural for other people. Respite care is one way of getting those things.

The process for getting respite care is absolutely crucial. I am the vice-chair of the South Lanarkshire carers network, which is working closely with South Lanarkshire Council to try to get the right assessment process.

There is something about the word assessment that conjures up all kinds of perceptions in people's minds, but for me it has a clear meaning. A proper assessment must assess what a person feels they need, not what someone else thinks they need; otherwise, the assessment falls short. Only the individual concerned can own their needs; an assessment must reflect what I say I need.

Whether an assessment can fulfil my needs is a different agenda. We find that cash-strapped councils are trying to fit people into the services that are available. Therefore, the assessment might be based on that terribly flawed process. In an assessment of my needs, I want to be able to see me. I want to be able to recognise myself and say, "Yes, Isobel, once a month you need a break of two or three nights".

My fear is that unmet need fails to exist in a service-led system. In other words, if the assessor decides what a person's needs are, there can be no unmet need—help me if that is not clear to anyone. If someone comes into your house to decide what your needs are, there can be no unmet need.

I feel for councils, as they must meet criteria that are established by the Parliament to win brownie points or to get extra money next year. There must be more transparency in the system, and councils should not feel that they are being penalised or punished for saying, "Look at the amount of unmet need we have." A long time ago, I heard an MSP say something very powerful that has stuck with me: councils should stop proving what they do and start improving what they do. I liked that statement. However, in order for councils to be able to do that, they must feel that they are not going to be penalised on another level.

While I try to see everyone's point of view, at the end of the day, I am the person who is at home with my daughter, and my needs must be assessed accurately to reflect what I want. I also want a separate process to assess accurately what I am not getting. Some way must be found of identifying that.

Kay Ullrich: Before I move on to the question that I am supposed to ask, I will follow up on what Isobel Allan said about respite care. Do you think that councils that have to make budget cuts have unfairly targeted respite care?

Alan McGinley: It is difficult to answer that question. The basic problem in the system comes when one is trying to identify whether respite is delivered in order to improve the carer's lot. It is difficult to tell whether respite comes through the assessment process or through the delivery of the service. For example, although Crossroads (Scotland) delivers a huge amount of respite hours, the organisation would say that most of those hours are not delivered following assessment of a carer's needs; rather they are delivered upon the basis of what a local authority must provide through the user assessment.

We think that councils are beginning to audit their services and to determine whether respite services are being provided on the basis of the needs of two people—the user and the carer—or whether they are being provided to fulfil some other function. A full audit has not been undertaken and, therefore, the baseline has not been established. As a result, it is difficult to know whether respite care is being targeted in the cuts. We hope that councils will do more auditing and, in many ways, we regret the fact that we did not press for guidance on that point.

Isobel has experience of an attempt to cut services, which may be of interest to the committee.

Isobel Allan: My services were cut because of the process that I described: the assessor determined how much respite I was to receive.

I have in-home and out-of-home respite, and both are beneficial. People come into my home to provide in-home respite, and that is what happened today—someone came to my home today to watch my daughter. That service is second to none, as it is possible to form a relationship with the person who delivers it. The provision of out-of-home respite care that I receive is relatively sparse. I have to send my daughter across the city to total strangers. I would not know who was looking after her if I met them today. There is not enough out-of-home respite care available. That will not be unfamiliar to anyone who has spoken to carers. As the mother of a totally dependent child, I am concerned about safety and good practice in respite care. However, that may be moving away from what the committee is considering.

Kay Ullrich: I am interested in point 6.2 of your submission, which refers to research published in 1997 that suggests that 82 per cent of carers have not asked for an assessment. To what extent does that correspond to your experience of carers in Scotland? Have things improved? Why are carers not asking for assessments?

10:45

Isobel Allan: One of the main reasons is that they do not know about them. People can ask only for what they know is available. The onus is on local authorities to inform carers that they have the right to an assessment; in the main, authorities are not doing that.

Another reason is that, unless a local authority has a good carers assessment process, carers will not ask for an assessment. My local authority was working with a users form that was totally unacceptable to carers. The questions on it were horrendous. Please do not think this rude, but it is true. When I did my assessment, I was asked whether I was incontinent or took drugs. I felt like saying, "Not right at this moment, but give me time". The assessment process was badly flawed because of the users form.

I also know of carers who refused their right to an assessment because they saw it as some kind of test, perhaps because they suffered from depression. In our local authority we are fighting to have an appropriate self-assessment carers form devised by carers.

Alan McGinley may have something to add.

Alan McGinley: The fact that carers may have to ask for an assessment is a fundamental issue. Isobel Allan described well the problems that carers may face. The legislation working group that is currently meeting the Executive is considering making it a duty on local authorities to offer assessments, so that carers do not have to ask for them.

Part of the problem is that research does not exist in this area. The only research of any substance is CNA's research, which is three years old and is based on our membership. We know that the Executive is committed to collecting new data on the level of assessment in local authorities but, as I understand it, those data will not be collected until next year, which will be too late to feed them into new legislation. At the end of the day, any new legislation on carers will have to be built around the assessment process. That is why we need the data now, but the Executive has let the timetable for collecting it slip.

We do not have the data to tell what is really happening. However, we have collected data on our own, in relatively unscientific ways, which suggest that the average number of carer assessments, even if it is in double figures, is only between 10 and 20. Councils such as Glasgow have been fairly up front about saying that such assessments are not part of the routine interaction between social workers and families. However, behind that there may be elements of good practice, because assessment should never be a bureaucratic process, although part of me thinks that we need a wee bit of bureaucracy so that we can identify when it happens. With good practice, assessment could be done in a fairly invisible way that delivers the goods for the family that needs the services. However, it is hard to tell where that is happening, as nobody is trying to spotlight it.

There is a need to get the information together, as we do not have enough of it. That has been a problem. Our 1997 research suggested that carers who access assessments experience an improvement in the level of services that they receive. We must get across the message that assessment has positive outcomes. The idea of care assessments was introduced when local authorities changed from the old regional structures to the new unitary ones. To that extent, they were part of the rebureaucrifying—I do not know whether that is a word, but I have made it up and it can go into the dictionary—that took place at that time. The implementation of the Carers (Recognition and Services) Act 1995 was stalled as a result of that. With the best will in the world, local authorities never got up the head of steam on the 1995 act that they might have wanted and from which carers might have benefited. We are still suffering because of that. New legislation may help to improve the situation, as long as it is done within the right framework.

Kay Ullrich: My final question is to Isobel Allan. What happens once an assessment has been done?

Isobel Allan: Once an assessment has been done, a care plan should be outlined. However, the care plan can appear like a wish list. To make it really effective and meaningful, we must marry the care plan with the resources that it requires. Respite for a carer should be once every four weeks, but it may have been cut. There should be a process for identifying that, so that it can be fed through the system. If there is not, the care plan is only words on paper. The plan says what a carer should be getting, but the reality may be different. There is no process that would enable people to see what else is needed.

Kay Ullrich: Is a key worker appointed?

Isobel Allan: A social worker or someone from a social work department is usually attached. They can provide assistance only based on what is available.

Kay Ullrich: So they are not responsible for managing the care plan?

Isobel Allan: Do you mean for trying to obtain the necessary resources?

Kay Ullrich: Yes.

Isobel Allan: To a degree they are, but it all depends on what is available. There is a tremendous difference between equality and equity. We cannot have equality for carers in regard to respite care and other issues, but we should have equity. However, that does not seem to be happening.

Irene Oldfather: I would like to pick up an important point that Isobel Allan made. I thank her for coming along and donating very precious time to the committee to share her experiences.

Isobel, you referred to an important distinction between out-of-home respite care and in-home respite care. I was reminded of a case that I dealt with, in which an 85-year-old lady was looking for respite care. In-home respite care was of no use to her, because she was absolutely exhausted and needed time to herself at home. Do you agree that we need flexible care packages to meet individual needs?

Isobel Allan: My husband has a theory that our marriage has lasted 32 years because we do not see a lot of each other. I am downstairs with my daughter while he is upstairs. I am being a bit flippant, but there are serious undertones to what I am saying. It would be nice for us to spend more time together. I also have a son at home, who when he is working finds it very difficult to listen to someone screaming through the night—and to his sister, if she starts. [*Laughter.*] Things can be very difficult in a family situation. We welcome out-of-home respite care, just so that we can do the ordinary things that other people do. There need to be flexible plans for all carers, because we are all the same but different.

The Convener: What is the view of the Carers National Association on the response in England to the recommendations of the Sutherland report and what would you like the Scottish Executive's response to be? This may be an unfair question but, if faced with a choice between the Sutherland report—and, in particular, what it says about personal care—being implemented and the same amount of money being put into extra respite, what would carers want?

Alan McGinley: I will start at the beginning and work my way through to that last question, because Isobel Allan and I may have different answers to it.

In our view, the critical recommendation in the Sutherland report is that relating to free personal care, which is not being implemented in England. That undermines entirely what the report intended to achieve. However good some of the recommendations that are being implemented are, such as that relating to the three-month disregard, the total package does not add up. It is like failing to put in the mortar with the bricks, which leaves the system very vulnerable.

Age Concern Scotland gave evidence to the committee last week. I agree with that organisation when it says that, if the Executive does not deal with the matter in the next few months, we will have to come back to it in 10 years' time to try to get a fair and equitable system in place. We believe that the report should be implemented in full. We believe that the money has been allocated. We sat at the feet of Stewart Sutherland last week and he was fairly clear that the money is there if the Executive has the will to use it.

My view—and I think that this would be the view of CNA Scotland—is that there is a choice between implementing free personal care and putting extra money into respite care. The important point in making that choice is that, if the system for implementing free personal care can be made to work, the other elements, including respite care, will flow from it. Investment in free personal care should precede extra investment in respite care as it would save a lot of carers from poverty and relieve the anxiety of a lot of families. It would create a system that people could work with rather than having a challengeable level of service that can disappear when the going gets tough. Older people with carers are often targeted by local authorities when they cut services, as we all know. They are a vulnerable section of society.

Isobel Allan: As a carer, I am a bit concerned about any charging policy that might be implemented in relation to the care of someone who, through no fault of their own, is ill, disabled or elderly. I look at the matter in a naive way. I keep thinking about community, social service and fundamental things like that. If I am being unkind, I think to myself that I am one of the best resources that the Government has. I cost the country nothing and save it a fortune. Of course, perhaps I have more flexibility as no one can fire me. Who knows what life means for me? However, I would be concerned about charges being levied on someone because they are sick, elderly or disabled or on a carer who has no choice in the matter, who is there because of love or out of a sense of duty.

We have a wonderful opportunity in Scotland to show that community care means what it says and that we care for people in our communities. I hope that this does not sound unkind, but if the Government can care for me—not take care of me, as I am a very independent woman and I can do that for myself—I can care for my daughter. That would help our community in a holistic way.

The Convener: Thank you. I could not have put it better myself.

Malcolm Chisholm: I was going to ask about charging, which has been covered to some extent. Alan McGinley, you used the word “anomalies”. Were you referring to the variations between different parts of Scotland or to something else?

Alan McGinley: There are two issues. One is that there is inconsistency across Scotland—perhaps I used the word “anomalies” too loosely. It is difficult to assess what is a right and fair charging policy based on current law because no one has taken it to the level of judicial review. Currently, carers who are spouses have their income assessed when the service package is being put together. We think that that should not happen, but the law is not clear on the matter. Unless that gets sorted out, the system will contain anomalies because other carers either do not have the same charge levied on them or should not have, although at least five local authorities in Scotland assess the income of non-spouse carers. The quirky workings of the system should at least be smoothed out and made consistent. However, we want consistency to mean not consistent charging but consistent lack of charging. That leads us back to Sutherland report and the proper implementation of the recommendations.

Irene Oldfather: Can you say something about the role of the general practitioner in caring? To what extent do GPs respond to the needs of carers?

Isobel Allan: I have only a personal view, but it comes down to how good a relationship the carer has with the GP. Perhaps there should be more statutory guidelines or whatever, but I have an incredibly good relationship with my GP, to the extent that I would think twice about moving house if it meant that I would lose that service. That says a lot about our relationship. It is crucial to my family. However, that is down to good will on the part of the GP. I do not know if anything is built into the system. Our GP services are great and ask about carers issues. However, the fact that they are asking suggests that there is a lot that they are unaware of.

11:00

Alan McGinley: Three years ago, we produced some research in a document called “Ignored and Invisible”. The title came from a carer who said that she often felt ignored by and invisible to the GP whom she shared with the person for whom she cared. However, that report also showed that about 72 per cent of carers thought that, of all health service staff, the GP had the most power to improve their lives.

I am slightly jaundiced about the GP issue. Some good work is being done in Scotland. The Princess Royal Trust for Carers has a programme, focus on carers, which tries to unleash the energy of GPs to support carers and create systems in practices that will get information to carers. A key question is, if the staff who set up the project and supported its initial stages leave, is there anything to drive the project forward? What Isobel Allan says is right: it comes down to the personality of the GP and how motivated they are. We have to find other mechanisms by which to haul GP practices and the rest of the health service into the orbit that local authorities have been in for a long time to ensure that they also deal adequately with carers.

One of the jaundiced views that we heard a while back was that, if a carer wants to get a GP interested in their case, they should send them something in an envelope with a golf logo at the top as the GP might think that it is an invitation to the British open. That would get them over the first hurdle. That is not fair on all GPs but it suggests that there is an issue that must be addressed. I am aware that a GP is sitting across the table from me.

Dr Simpson: No offence taken.

The Convener: We will have to recall the people from the Royal College of General Practitioners to give them a chance to respond.

Alan McGinley: I am talking about not only GPs but the range of health service staff—district nurses, receptionists and others. There is an issue of pre-practice training for everybody and continuous training throughout. That is where resources must be targeted and systemic changes must be made.

I think that the carers legislation working group is considering the capacity to haul health issues into their plans. I do not know if the group will be able to get that done, but it might suggest, for example, that health improvement programmes have to include elements relating to carers. Some of them do, but they are not required to by law. That might be a way of bringing health workers on board before practice changes through good experience.

Irene Oldfather: I want to return to one of Isobel Allan's points about carers. We want to deliver health services in the most cost-effective way, but I would like the GP to go to the carer sometimes, rather than the other way round. Have you come across any recognition that getting to the GP can be a problem for carers?

Isobel Allan: Again, that comes down to the carer's relationship with the GP. We have an incredibly good relationship with our GP and—perhaps because he is aware that I do not abuse his time—he makes space for us to the extent that, if my daughter is in hospital, he phones up to see how she is getting on. That is above and beyond the call of duty, but that is the kind of relationship we have.

I do not know whether this is the right place to say this, but I have a tremendous concern about my daughter. When she left the cocoon of the children's hospital at Yorkhill, there was nowhere for her to go. Remember that my GP can attend only to her day-to-day illnesses. The hospital embraces all the issues that affect her. If I had a wish list, I would like adults with severe disabilities—particularly those with communication problems—to have a named consultant, who would act as an advocate to feed them through to different service areas. I have found a surgeon who is incredibly good with my daughter and I am hanging on to him for grim death. I found out that a member of his family is disabled—it comes back to people having an empathy with one's situation.

My daughter is going into hospital tomorrow—I am glad that we are having this meeting today—and I will go into the hospital and live with her. I do that not because I want to, but because I have to, to be fair to the staff. My daughter needs 24-hour care or she will beat herself to a pulp. I have found a hospital that will accommodate my husband and me without giving us a lot of hassle—we will have a room or a chair or something. That hospital makes us welcome.

It is about sharing resources and things not being written in stone. Rules are there only as guidelines; it is important that individuals are prepared to shift their ground. The ward that my daughter goes into is now a male ward, but because all the staff know her, the surgeon still accommodates her in a side room. That is what we should be aiming for—letting people deal with the individual and not letting rules become written in stone. Please consider the adults as well as the children—there is nowhere for us to go.

The Convener: We need rules and strategies as an overarching umbrella.

Hugh Henry: You have touched on some of the issues and the impact of legislation. What impact has the national strategy for carers had in Scotland and what more needs to be done?

Alan McGinley: I am glad that you referred to the national strategy for carers, because it all begins with the UK strategy and its distillation in devolved issues in Scotland. At the moment, there is no match between what remains the responsibility of Westminster, what happens in Scotland and how the two work together strategically. The Executive is aware of that problem, which includes employment issues and the benefit system in relation to carers.

The strategy was developed, produced and implemented with much good will among carers organisations and the Executive. In particular, we commend Iain Gray on his stewardship, which was very helpful. Carers will say that that was important in giving the strategy authenticity and drive.

We do not really have the material to hand to say what impact the strategy has had. The joint futures group in the Executive is supposed to be collecting information on where the extra money is going and how it is being spent. Shared Care

Scotland carried out a rough and ready audit of what is going on, and concluded that there is genuine engagement on the ground in relation to the extra £5 million that has been put into the system. Several local authorities have said that where new services are being developed, others are being cut. There is no increase, but services are maintained at the same level with a greater focus on carers. That is problematic. We do not want carers to find themselves having to negotiate services out of existence to achieve the levels of service and support that they need.

The committee might find value in the short, clear report from that audit, which looks back to May to find out where we have reached. The report suggests that we are making progress, but that local authorities are experiencing some problems in levelling-up services. The auditing of existing services to determine whether they are services for carers has not been done. Only four or five councils are carrying out such an audit and if other councils do not do that, it is hard to say what they will be able to achieve in the next year.

We know that the Executive did not want to be punitive this year on how the councils spend the money. If the Executive is not punitive this year and there is no top-up next year, we might find ourselves at a stalemate. Most local authorities have been engaging with the strategy quite creatively. They have been trying to find a balance between infrastructure to support carer development and genuine service development, such as respite care. Perhaps they are topping up proven respite care services or developing new services. However, £5 million is not a lot of money. It was meant to be £5 million on top of another £5 million, which effectively disappeared when it was introduced in 1996. It is a small amount of investment and can act only as a driver towards carer services.

I am not sure about other areas of the strategy. The carers legislation working group and the NHS helpline are fairly settled features that do not demand too much attention. The review of the strategy after November, when the joint futures group begins to consider the material from the councils, will be important.

The Convener: We are running out of time, but we would like to ask a few more questions.

Margaret Jamieson: Are there particular groups of people who carry out informal care whose needs are largely unmet?

Alan McGinley: Yes, there are several such groups. I have thought about which groups it would be best to highlight. People have talked a lot about the situation for young carers, but I want to put that to one side because it has had quite a lot of attention recently. A key group is black and minority ethnic carers. Although the strategy is meant to deliver for all carers, there is no evidence to suggest that money is going into creating an infrastructure for carers in areas where there is a concentration of minority ethnic populations. We need to think that through to determine whether the strategy is the appropriate vehicle to develop services or support for those carers; another vehicle might be more appropriate.

Another group that should be considered, and which is of particular significance to the committee's inquiry, is carers of people with mental health problems. Those carers are often in the shadows; it is difficult to determine their needs and rights. We have the Millan committee's review of the Mental Health (Scotland) Act 1984 and, to some extent, the rights of carers may have been watered down in that. The nominated person system has been changed and carers may now have fewer rights than a nominated person who is not part of the family. We agree that the system needed to be reviewed, but we need to be careful that carers are not cut out—they are the ones that people go home to.

Last November, during the Parliament's debate on the strategy, there was an eloquent speech on the mental health carers. There is some good practice; the National Schizophrenia Fellowship does much good work with carers and tries to maintain a balanced overview.

There is also a rural dimension. The Highlands carers project has brought that into stark relief through some of its research. The issues around rural carers are fairly generic to rural issues—difficulties of access to transport and so on.

Low-income carers are another important group, although that is not the particular responsibility of the Health and Community Care Committee. The benefits that carers receive are paltry and bear no relation to the cost of care. The needs of black and minority ethnic carers demand work on development and perhaps a structural overview from the Executive. Mental health carers also need attention, because they are very much in the shadows.

Margaret Jamieson: What do carers want out of our inquiry? What would your shopping list be?

Alan McGinley: I will pass that question to Isobel Allan, as she is a shopper.

Isobel Allan: A shopping list? That is a nice idea—it sounds like Christmas.

What would I want? The first thing would be good consultation. Carers must be involved in anything that happens on carers issues. That is why today's meeting is a wonderful opportunity. Making decisions about someone's life when you do not live with the problem is something else.

There have been lots of positive moves, but to get it right, carers must be involved throughout the process, not just in consultation, but in decision making.

Respite, quality services and safety are at the top of the agenda. I am very concerned about the lack of safety in all areas for adults with severe learning difficulties. People such as my daughter should have the same rights as children. I appeal for national standards to be considered. My daughter cannot convey anything to me, so the safety standards for her need to be the same as for anyone else.

Those are the issues. It is academic, but we need the resources to address them. Carers are not a very demanding lot—I am not asking someone to work my 70-hour week—but we are asking for the little support that we need to continue to care for people.

11:15

Dr Simpson: Your evidence has been extremely powerful. We talk about the importance of the quality of a patient's journey. Is your main message that both individuals and their carers make that journey and that both need to be involved in the process?

Alan McGinley: Absolutely. Where there is a carer, there is a joint journey. There should never be a negative impact on either person. If a person who needs services wants a level of independence, it is not the role of carers and authorities to subvert that. It is a joint journey, but it is complex to negotiate in terms of services. Both sets of needs must be supported.

Dr Simpson: I note, and share, your concern about carer-blind assessments. I understand what is meant, but I do not think that that is the right term. Isobel described carers being allowed to participate in the care of the individual whom they look after within the hospital setting. Does she detect that such participation is beginning to be welcomed, or is there still a feeling that people can enter the hospital but they cannot do anything? Do people feel that they will not be able to participate? Does the hospital take over at the door? In other words, is it the case that the partnership that we tend to talk about does not really exist in people's attitudes?

Isobel Allan: Like all of life, it comes down to individuals—who is running what. The choices I have in that particular ward of that particular hospital with that particular surgeon are second to none. However, it was a whole different ball-game when my son was in a different ward of the same hospital. It comes down to the empathy, understanding and flexibility of the people who are there.

Dr Simpson: So, with your son you felt disempowered?

Isobel Allan: Absolutely.

Dr Simpson: But with your daughter you felt empowered?

Isobel Allan: Very much so.

Dr Simpson: That is the contrast. Thank you.

The Convener: I speak on behalf of all members of the committee when I thank you for your contribution, which has been powerful. Your evidence in particular, Isobel, was very personal. You live with the problems. I feel almost duty bound to give you the chance to name check your GP and consultant—I hope that you will give them a copy of the *Official Report* of this meeting—because you have obviously found two professionals who have helped you. However, that is nothing compared to the help that you give your daughter. As you say, you do an incredible job for us all as well. At the end of every session, I thank the people who have given us evidence. On this occasion, we genuinely appreciate your time—more than most. We know the sacrifice that is involved. Thank you very much.

Isobel Allan: Thank you.

The Convener: We will adjourn for two minutes for a comfort break and to let our next set of witnesses come in.

11:20

Meeting adjourned.

11:29

On resuming—

The Convener: We will begin again colleagues, as our third set of witnesses is here. They are from the Consultation and Advocacy Promotion Service and Edinburgh Users Forum. I will let them introduce themselves, as we have another special guest—possibly the first guide dog we have had in the chamber. No doubt there is some anorak somewhere who will be able to tell us whether that is the case.

I ask the witnesses to introduce themselves and to give us a short introduction. My colleagues and I will then ask questions.

Adrienne Sinclair Chalmers (Consultation and Advocacy Promotion Service): Good morning. In fact, there are two guide dogs in the chamber this morning, which is definitely a first.

I am the co-ordinator of the Consultation and Advocacy Promotion Service, or CAPS. With me are two members of Edinburgh Users Forum, Maggie Keppie and Willie Twyman. We have all used mental health services and both CAPS and EUF work towards providing a stronger voice for mental health service users. Of course, I cannot go without mentioning the yellow hairy thing on the floor here—Poppy the guide dog. I shall be asking her to take over when I forget my lines.

We are very pleased to answer members' questions today and to make a short statement before that. We will concentrate on a small number of topics: user research and evaluation; and information and advocacy. Although none of those topics is related to direct service provision, they are all vital in giving people access to good quality services.

I will start with user research and evaluation. The best way to assess the value of any given service or set of services is by finding out whether they meet people's needs—the best way to do that is to ask the people who use the services. Research into service provision has been done using traditional research methods that collect much data and many statistics, but do little to investigate people's personal experiences of services—or, indeed, lack of services.

More recently, some research projects—in which CAPS and EUF have been involved to an extent—have had a kind of add-on where service users have asked questions of other service users. Although that is an advance, it is not the answer to everything. The nub of the situation is to find out who decides which questions should be asked and whether service users get the opportunity to say what they feel is important to them.

We do not deny the value of sets of formal statistics and data. However, it is essential that such data go hand in hand with people's experiences. The combination of both sets of information allows people to make sound judgments about service provision. I suppose that today we are providing the committee with that more personal angle on mental health services.

Furthermore, any users who are involved in user research and evaluation should be representative of or accountable to larger numbers of service users. For example, what happens—especially in England—is that a number of individuals who have used mental health services set themselves up as private consultants. They pop up in one health board or another and they tell those health boards what service users want without talking to any local service users or service users groups. That has nothing to do with user involvement—it is tokenism.

I will hand you over to Willie Twyman, who will say a few words about information.

Willie Twyman (Edinburgh Users Forum): Thank you very much for the opportunity to speak to the committee. It is appreciated.

People say that there is a lot of information around, but it is not necessarily the information that we need. Often, when people are ill and have been hospitalised—or when they come out of hospital—it is very hard to get information on benefits or on the groups that operate in the area, because there is no co-ordination. For example, if a client who is attached to social work services needs to be attached to some other department, social work services have to write to the other department, which means that the client might have to wait some time before they are put where they want to be. Furthermore, it is easy for someone who is well to ask questions. However, for people who are not well or have been through a breakdown, their illness can affect their thinking.

As far as accessing information is concerned, we need people, not CD-ROMs, to talk to us. Although we have an in-touch programme that can be accessed through computers, that does not work for everyone, especially people who are not well. Sometimes it is very hard even to follow instructions for using computers.

For example, imagine looking through the Yellow Pages to find a restaurant. The Yellow Pages does not tell us how good the restaurant is. It does not say whether it will suit us, whether it has disabled access and so on. People need someone to explain to them what groups are in the area and whether those groups will suit them and their types of illness. Otherwise someone who suffers from schizophrenia might end up at a group that deals with depression.

Information is the most important consideration. As someone said, information is power and we cannot access the information that we really need. We can get help only if we ask for it. However, people who have been ill or have suffered a mental breakdown can have a relapse at any time. Many people worry about their housing situation if they have to be taken into hospital for a few weeks and have to deal with that situation when they are discharged. That only makes things worse. No one helps them to arrange appointments with a benefit officer. Such arrangements are often left to the individual, whose self-esteem has had a heck of a kicking after mental illness.

As I said, such information is not available on computers or CD-ROMs; people need to talk to someone who knows about these things.

Maggie Keppie (Edinburgh Users Forum): Individual advocacy is about improving our services and making individual and informed choices on issues such as medication and housing. However, although the need for individual advocacy has been accepted, we should not forget collective advocacy, which improves general standards and increases the range of services. Such advocacy is necessary because it gathers a broad range of experience and creates a strong voice. A group of people saying something is better than one person saying it on their own. Having a service user in a group, who does not represent a group of people is very—what was the word that was used before?

The Convener: Tokenistic.

Maggie Keppie: That was it. Only collective advocacy opinions on what works and does not work can help to target effective services. The only reason that we are speaking to the committee today is because we represent a user group.

The Convener: Thank you very much. We all have a hard time finding just the right word at the right time—I more than most, probably.

I now open the meeting up to questions from my colleagues. If witnesses have any problems with any of the questions, or if they do not understand where they are coming from, please ask.

Irene Oldfather: You have said rightly that the best way to find out about services is to ask the users and you have spoken about the difficulties of negotiating your way through the system when you are recovering from mental illness. In your members' experience, are there any positives about the present system? Is anything working for you in the present system? What are the negatives?

Maggie Keppie: Not keeping us in hospital and giving us some choices so that we do not have to leave home for care would be positive. The facts that the services depend on the diagnosis and the area that one lives in are negatives. Nothing is co-ordinated; there is a service here and a service there. Information is inadequate and there is no out-of-hours cover. The quality of the service depends on the attitude of the people who work in those areas.

Irene Oldfather: You mentioned that there is one service here and another there. Is the experience of your users that there is no joined-up working? Do you want one place to go for all the services?

Maggie Keppie: It is bad that living in Liberton means that you cannot use a service in Gorgie. Different areas do not all have the same services. Some services are good in one area—other areas have nothing. We need co-ordinated services so that every area has decent services and there is choice.

Adrienne Sinclair Chalmers: It is not merely a matter of having all the services available in one place. It is about people being able to choose what service they want to use and being able to access it. As Maggie Keppie said, different services are available in different areas of the city, but a lot of them are meant to cover only one area of the city, so someone cannot use them if they come from the other end of town. That seems daft—access to services should depend on what a person needs and wants, not on where they live or what diagnosis someone has given them.

Irene Oldfather: Maggie Keppie mentioned that no out-of-hours service was available. Is that peculiar to your area? I am aware that there are out-of-hours services in some areas.

Maggie Keppie: Out-of-hours services in Edinburgh run from 9 am until 9 pm. Most people have a crisis at 3 o'clock in the morning when they are on their own.

Irene Oldfather: Thank you. That is important.

Margaret Jamieson: The Scottish Executive has examined mental health and has introduced the "Framework for Mental Health Services in Scotland". Has that made any changes to service provision in your area?

Adrienne Sinclair Chalmers: The short answer is no. How many members of the committee have read the "Framework for Mental Health Services in Scotland"? I would ask you to stick your hands up, but that would be silly. Have you all read it?

Members: Yes.

The Convener: That response was not universal.

11:45

Adrienne Sinclair Chalmers: For members who have not seen the framework, it is about yay big. For Dot—the blind person in the gallery—yay big equals about three telephone directories.

I have not read it—for obvious reasons—but not for want of trying. The document says an awful lot. It says nice things about everybody having access to advocacy, crisis services being a good thing, little fluffy bunnies being cuddly and so on.

However, the document does not do a number of things. It does not refer to any time scales. It mentions no way of monitoring progress and it has no teeth. No one could say to the Executive, "You have not been providing this service. It was mentioned in the Scottish framework, so why are you not providing it?" For years, we have been saying that there is inadequate provision in this area or that area. The framework states that we should develop advocacy services, but people just say "Yes. So what?" There is no compulsion to do so.

Another problem is that the document has made it more difficult to provide good sets of services. It has created an individual—someone with a "severe and enduring mental illness".

That has a very specific and technical definition, which I will not go into, because sometimes it changes. If someone falls into that category, they have a good chance of getting access to services. If they do not, they stand much less chance. No new services are being developed to target people who do not have a severe and enduring mental illness. It is right that those people should have services, but they are being provided to the exclusion of services to many other people. Many people who do not fall into the severe and enduring mental illness category have their lives laid waste by the way that their mental health difficulty affects their ability to function in society.

We discussed the different ways in which services are provided in one city. We were given the example of Edinburgh, which is the example with which we are most familiar. In the City of Edinburgh there is no symmetry in the way that the care programme is being delivered. It is supposed to be about joined-up services, other add-ons and so on for people with a severe and enduring mental illness, but none of the psychiatrists can agree about what that should constitute. Some refuse to sign up to the programme because they say that they are doing what it entails already.

The framework has not made a great deal of difference to anybody, apart from the fact that it gives people an excuse not to deliver the types of services that we see as innovative and that would prevent people from experiencing severe mental distress.

Malcolm Chisholm: I declare an interest, as I am honorary president of the EUF, of which I am very glad.

One of the positive aspects of the mental health services framework is its emphasis on listening to users. If anybody is daft enough to ask why we should listen to users, we can give them all the answers, but we can say also that it is official policy to listen to users. That is a useful aspect of the framework. How much of a reality do you think that is and what more needs to be done to make it a reality?

Adrienne Sinclair Chalmers: Many people are interested in listening to what service users say and in supporting representative users groups and behaving as if they had read the framework. Some of them plan and commission services, but many do not.

East Lothian Council recently withdrew funding from collective user advocacy in its council area. It does not support that any more—it supports individual advocacy. It seems that that will form part of the recommendations of the Millan committee on the new mental health act. I do not see how a council taking money away from collective advocacy squares up with a commitment to user involvement. When that withdrawal of funding was proposed, we said that the council had an obligation to involve the service user, both under community care legislation and under the framework. However it had decided to do something else, and there was nothing that we could do to stop it.

Malcolm Chisholm: To what extent are you involved in the groups that plan services? Is the problem that you are not involved or listened to enough? I was interested to hear that a lot of the people whom you represent are not defined as having

"severe and enduring mental illness".

Adrienne Sinclair Chalmers: That is not necessarily the problem. Many members of the Edinburgh Users Forum—I imagine the vast majority—are in that category. People often make out that we always want to be fully informed, but we do not ask people for their full medical history when they want to take part in a user group.

Could you remind me of the first part of your question?

Malcolm Chisholm: I wanted to know the extent to which you were involved in the planning of services and so on.

Adrienne Sinclair Chalmers: We are not much involved in East Lothian, but a lot goes on in Midlothian. We have been consulting service users, because they are about to get some more money under the re-provisioning of a couple of hospitals in the Lothians.

In Edinburgh, we are involved up to the level of strategic development groups, which is very useful. However, decisions are not made at that level, but by the joint commissioning group. Many decisions are made at a level above that, which consists of the strategic development group minus the service users, carers and the voluntary sector.

We have several problems with the local primary health care trusts. The balance of power has shifted significantly. The trusts have control of an awful lot of the resources that are attached to mental health—80 to 85 per cent of the resources are concentrated in hospital provision, although 80 per cent of users live in the community.

A local trust might decide, for example, that although it is aware that the community care plan has identified crisis services and advocacy and there is a priority for service development, it will spend a million quid a year on assertive outreach teams. It might not bother to talk to anybody about that. My favourite joke on the subject is, "They call them trusts because you can't." There is no democratic control over what they do and that is not right. It is not just a question of service user involvement: carers do not have a look-in. The trusts might make their own decisions because they have the resources to do so.

Mary Scanlon: I am particularly concerned about ex-offenders who are being cared for in the community—people who went to prison but had no access to services during that time. They then leave prison but do not fall automatically into your user group. Are there other groups whose needs are especially badly met?

Willie Twyman: It might be easier if I go through a list of groups—Mary Scanlon mentioned ex-offenders. If somebody does not come under the category of severe and enduring mental health problem, it is nigh impossible for him or her to get access to services.

There are people with personality disorders, but we have been getting very angry about the fact that many diagnoses have been changed to that category. Many psychiatrists might tell people that they have a certain disorder and that there is not much that can be done for them.

There are people who have children. There is no provision for putting someone who has a mental health problem together with their child—that child will be put into care. That causes mental stress for both the child and the mother. As far as people with young babies are concerned, there is a small commitment to provide for that in the Royal Edinburgh hospital—about three beds—but those beds are booked months in advance. If somebody has post-natal depression, they will be separated from their child if they have to go to hospital, because there is virtually no provision for a child to go into a mental health hospital with its mother.

We should consider young people. We are aware of cases in which college kids have taken their own lives because the pressure is too much. We do not supply enough help to such people—there can be no argument about that. Many young people believe that they are too young to suffer from depression and that it is an old person's illness. That points to a lack of communication between us and young people—we should be telling them that they should seek help if they are under pressure.

My daughter ended up on anti-depressants for six months while she was at college, because of money worries and the pressure of exams. We had to talk to her over the phone and we had to approach her GP, who kindly wrote to the college, stating how ill she was. Her exams were deferred for six months so that she could get back on track and get her money problems sorted out. She has now passed her exams—she is through university and she has a good job. I had suffered from mental illness so I knew what to do. A lot of people, including mothers and other family members, do not know how to handle mental illness. Someone's nice young bubbly child can turn into someone who is not like their child, because she cannot speak and is solemn. It is the same thing with dual diagnosis. There is so much need out there in relation to so many different things and it is very hard to access the system.

Once someone is in, however—if they are told that they have a severe and enduring mental illness—the help exists and the outreach teams can help. If that person has not been given such a diagnosis, they will not get help from the outreach teams, because those teams are geared towards those who have been diagnosed as having a severe and enduring mental illness—they have been in hospital umpteen times and have got back out into the community.

Only one third of people with mental illnesses have resources spent on them. That third might include people who have problems speaking English. Services are generally not good, even for people with disabilities. There have been problems with people going to their GP. When a GP knows that a person has a mental illness, if the person visits the GP for another reason, the GP will often have a bad habit of putting that down to the patient's mental illness.

I will give the committee an example of a famous case—it is a true story. A member of EUF went to her doctor. She was extremely ill and was looking for help. She asked the doctor if she could see a psychiatrist, but the doctor told her that she was not ill enough. She then asked to see a psychologist, but was told that she was too ill.

The Convener: What you have said bears out what we found when we went round the country speaking to people. Crisis services and out-of-hours services seem to be quite patchy. When Mary Scanlon and I were in Inverness, we heard that although there was a crisis helpline that people could telephone, it did not provide an adequate out-of-hours service in the area. People need more than that. What sort of out-of-hours services do you think are needed and what would be most effective?

12:00

Maggie Keppie: Five years ago, CAPS published a crisis report based on a survey of users' needs. The three main points that came up were a crisis helpline, a crisis outreach team and a crisis house. The helpline would be for people who were a bit upset and needed somebody to talk to, but it would not be like the Samaritans, who are not able to give advice to callers. The outreach team would be available if, for example, it was 3 o'clock in the morning and a person who was feeling desperate needed someone to come and sit with them to see them through the crisis.

In most of the crises that people with mental health problems go through, the people have to be taken from their homes. If there was a crisis house with facilities for sleeping over—some people might need to go there only for 24 hours, while others might need to stay for 72 hours—that would provide a place to take time out. If we had those services, it would reduce the in-patient time in the Royal Edinburgh. Crisis services are not new. We have been screaming about them for the past 10 years. We did research five years ago, but we are still in the same position as before.

Adrienne Sinclair Chalmers: We have given the committee clerk a folder of documents for each member; it includes the research on crisis services that was done five years ago.

The Convener: Thank you very much for the extra information that you have given us in the folders, for your evidence to us this morning and for your interest in our inquiry. I know that it has not been an easy experience to come to the committee; this is quite a daunting room and, believe me, it can be daunting for the rest of us from time to time as well, so you are not alone. Thank you for your contribution and for sharing your experiences with us.

12:03

Meeting adjourned.

12:08

On resuming—

Subordinate Legislation

The Convener: We shall now consider a series of Scottish statutory instruments. We have a bit of a backlog of instruments, because during the recess and for a couple of weeks before it we did not consider any subordinate legislation.

The Deputy Minister for Community Care, Iain Gray, is with us, together with officials from the Food Standards Agency. The clerks have asked whether members have questions about any of the affirmative or negative instruments. Mary Scanlon has indicated that she would like more information about the instruments on paralytic and amnesic shellfish poisoning, a subject that the committee has considered in detail in the past. All the affirmative instruments that are before us today deal with shellfish.

Mary Scanlon: I do not pretend to be an expert on paralytic shellfish poisoning or amnesic shellfish poisoning, but as a regional member for the Highlands and Islands I will take the opportunity to ask two simple questions that are often put to me, although I am not sure whether you will be able to answer the second one.

First, I am told that 97 per cent of scallops are processed. There is a feeling that there is no danger to public health after scallops have been washed and processed, and that we should be testing them as they enter the food chain, which would mean that scallop fishing could go ahead. I understand that that is what happens in Ireland. I read an e-mail earlier this week that questioned whether the Irish were obeying the European directive on testing. I would like some clarification on that.

Secondly, I understand from fishermen that similar situations have arisen in Spain and Portugal, and that there has been compensation for loss of earnings and the devastation of rural communities. I am not sure whether that point comes under your remit.

The Deputy Minister for Community Care (Iain Gray): The committee has considered your first point on a number of occasions. The testing and monitoring regime that we impose is necessary to comply with the European Commission directive. The end-use testing that you describe would not comply with that directive, but we are sympathetic to looking at the testing regime. Discussions and negotiations are taking place to explore whether it would be possible to introduce a several-tiered testing regime.

I believe that research is being done, the results of which are expected soon, to compare the testing that you describe with the testing that is being used. That would be part of the consideration of whether a different testing regime would be possible. There is no quick fix; it would take time to negotiate a different regime. One aspect of that would be that, to ensure food safety for the public, we would have to have a strict regulatory regime alongside the testing regime. Neither the Executive nor the Food Standards Agency is close to pursuing that, but as things stand at the moment, we must comply with the directive.

The position has always been that compensation is not usually provided for the consequences of a naturally occurring incident; shellfish poisoning is a naturally occurring incident, arising as it does from algal blooms. Other countries may take a different view, but that has always been, and remains, the position in this country.

Mary Scanlon: Is it true that poison is removed by processing the scallops?

Iain Gray: My understanding is that that has not been tested. It would be proper to ask one of my colleagues from the FSA to comment.

Lydia Wilkie (Food Standards Agency Scotland): Processing does not remove the toxins. Even cooking does not remove the toxins—they remain at the same level—but, during the processing, the most toxic elements of the animal can be removed. That is why we might be able to go down the route of a formal tiered system.

The Convener: Thank you for answering those questions. I ask the minister to move each of these Scottish statutory instruments, beginning with the emergency affirmatives.

Motions moved,

That the Parliament's Health and Community Care Committee in consideration of the Food Protection (Emergency Prohibitions) (Paralytic Shellfish Poisoning) (Orkney) (No 3) (Scotland) Order 2000 (SSI 2000/266) recommends that the order be approved.

That the Parliament's Health and Community Care Committee in consideration of the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (Scotland) Order 2000 (SSI 2000/267) recommends that the order be approved.

That the Parliament's Health and Community Care Committee in consideration of the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No 2) (Scotland) Order 2000 (SSI 2000/291) recommends that the order be approved.

That the Parliament's Health and Community Care Committee in consideration of the Food Protection (Emergency Prohibitions) (Paralytic Shellfish Poisoning) (Orkney) (No 4) (Scotland) Order 2000 (SSI 2000/295) recommends that the order be approved.

That the Parliament's Health and Community Care Committee in consideration of the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No 3) (Scotland) Order 2000 (SSI 2000/303) recommends that the order be approved.—[*Iain Gray.*]

Motions agreed to.

12:15

The Convener: That is the end of business, as far as the minister is concerned. Minister, you are free to go if you wish, or you can stay and enjoy the delights of the negative instruments that we have before us.

The first negative instrument is the Meat (Enhanced Enforcement Powers) (Scotland) Regulations 2000 (SSI 2000/171). The Subordinate Legislation Committee sought clarification from the Executive on this matter, and drew to its attention the fact that there had been a number of instruments relating to it. The committee asked the Executive to find out what the FSA planned to do. The FSA is considering the matter, but has yet to consider whether consolidation of the legislation in Scotland would be appropriate—once something like five instruments have come into force, a decision has to be taken on whether it is better to consolidate them. The Subordinate Legislation Committee has asked us to draw those comments to the attention of members.

No motion to annul has been lodged, so the recommendation is that the committee does not wish to make any recommendation. Are we agreed?

Members *indicated agreement.*

The Convener: The next instrument is the Community Care (Direct Payments) (Scotland) Amendment Regulations 2000 (SSI 2000/183). The Subordinate Legislation Committee has no comments. No motion to annul has been lodged. The recommendation is that the committee does not wish to make any recommendation. Are we agreed?

Members *indicated agreement.*

The Convener: The next instrument is the National Health Service (General Medical Services) (Scotland) Amendment (No 2) Regulations 2000 (SSI 2000/190). The Subordinate Legislation Committee has no comments. No motion to annul has been lodged, so the recommendation is that we make no recommendation. Are we agreed?

Members *indicated agreement.*

The Convener: On the National Health Service (Choice of Medical Practitioner) (Scotland) Amendment Regulations 2000 (SSI 2000/191), the

Subordinate Legislation Committee had no comments. No motion to annul has been lodged, and again the recommendation is that the committee does not wish to make any recommendation. However, I intimated to the minister that one member of the committee—Irene Oldfather—wished to take up the matter with him privately.

Irene Oldfather: It is right and proper that general practitioners should not be placed at risk from violent patients. None of us would disagree with that, but we all know of patients who have been struck off GPs' lists for very little reason. Would the Executive be willing to consider strengthening or clarifying the criteria? In a patient-centred health service, that would strengthen and clarify patients' rights as well.

The Convener: I told the minister that you were concerned. If that concern is shared by other committee members, I am happy to write to the Executive to ask for clarification, because most of us, at one time or another, have come up against the issue in our surgeries and in comments from constituents. If members agree, I will write to the minister on the issue.

On the instrument, the recommendation is that the committee does not wish to make any recommendation. Is that agreed?

Members *indicated agreement.*

The Convener: The next instrument is the National Health Service (General Dental Services) (Scotland) Amendment Regulations 2000 (SSI 2000/188). The Subordinate Legislation Committee has no comments. No motion to annul has been lodged. The recommendation is that the committee does not wish to make any recommendation. Is that agreed?

Members *indicated agreement.*

The Convener: The Subordinate Legislation Committee has drawn the Parliament's attention to the defective drafting—which was acknowledged by the Executive—of the National Health Service (Professions Supplementary to Medicine) (Scotland) Amendment Regulations 2000 (SSI 2000/202). However, no motion to annul has been lodged, so the recommendation is that the committee does not wish to make any recommendation. Is that agreed?

Members *indicated agreement.*

The Convener: On the Processed Cereal-Based Foods and Baby Foods for Infants and Young Children Amendment (Scotland) Regulations 2000 (SSI 2000/214), the Subordinate Legislation Committee has drawn to the attention of the Parliament the delay of 13 days between making and laying the instrument, and the explanation by the Executive. The problem had something to do with the postal services between Edinburgh and Aberdeen. The delay in laying instruments before Parliament, and the delay that that causes in instruments coming to us, is an issue that we will address again when we consider how the committee has functioned over the past year. Members should have had, or will be receiving, an e-mail about that.

At the conveners liaison group yesterday, some of the proposed changes to committee procedures were laid before us by Murray Tosh, the convener of the Procedures Committee. I will circulate that information to members so that I can have their input on any changes that they would like the conveners liaison group to consider. The timing of statutory instruments is an issue that we have had problems with in the past, and I know that we are not alone in that.

On this instrument, no motion to annul has been lodged, so the recommendation is that the committee does not wish to make any recommendation. Are we agreed?

Members *indicated agreement.*

The Convener: The Subordinate Legislation Committee has made no comment on the Infant Formula and Follow-on Formula Amendment (Scotland) Regulations (SSI 2000/217). No motion to annul has been lodged, and the recommendation is that the committee does not wish to make any recommendation. Are we agreed?

Members *indicated agreement.*

The Convener: I am told that the Subordinate Legislation Committee's comments on the Tetrachloroethylene in Olive Oil (Scotland) Revocation Regulations 2000 (SSI 2000/229) will be available after the meeting. The Subordinate Legislation Committee considered the instrument only yesterday, and thought that insufficient footnotes were available. That point has been acknowledged by the Executive, and I hope that it will act on that in future, but that does not substantially alter the instrument. No motion to annul has been lodged, so the recommendation is that the committee does not wish to make any recommendation. Are we agreed?

Members *indicated agreement.*

The Convener: Thank you for your patience colleagues. I draw today's meeting to a close.

Meeting closed at 12:22.

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