HEALTH AND COMMUNITY CARE COMMITTEE

Wednesday 8 November 2000
(*Morning*)

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CONTENTS

Wednesday 8 November 2000

HEALTH AND COMMUNITY CARE COMMITTEE
† 25th Meeting 2000, Session 1

CONVENER

*Mrs Margaret Smith (Edinburgh West) (LD)

COMMITTEE MEMBERS

*Dorothy-Grace Elder (Glasgow) (SNP)
Hugh Henry (Paisley South) (Lab)
*Margaret Jamieson (Kilmarnock and Loudoun) (Lab)
*Mr Frank McAveety (Glasgow Shettleston) (Lab)
*Irene Oldfather (Cunninghame South) (Lab)
*Shona Robison (North-East Scotland) (SNP)
*Mary Scanlon (Highlands and Islands) (Con)
*Nicola Sturgeon (Glasgow) (SNP)
*Dr Richard Simpson (Ochil) (Lab)
Ben Wallace (North-East Scotland) (Con)

*attended

WITNESSES

Susan Deacon (Minister for Health and Community Care)
Anne Jarvie (Chief Nursing Officer)
Thea Teale (Scottish Executive Community Care Division)

CLERK TO THE COMMITTEE

Jennifer Smart

SENIOR ASSISTANT CLERK

Irene Fleming

ASSISTANT CLERK

Joanna Hardy

LOCATION

The Hub

† 24th Meeting 2000, Session 1—held in private.

Scottish Parliament

Health and Community Care Committee

Wednesday 8 November 2000

(*Morning*)

[THE CONVENER *opened the meeting at 10:00*]

The Convener (Mrs Margaret Smith): Good morning and welcome to today's meeting of the Health and Community Care Committee. Looking round the table, I see a few bleary-eyed people who must have stayed up last night in the mistaken belief that they would see the result of the American election. As somebody said earlier, we probably stayed up on the wrong night. I hope that we can keep everyone awake this morning.

Before we begin this morning's business, we have two duties to perform. The first is to welcome our three new members: Nicola Sturgeon and Shona Robison of the SNP and Frank McAveety of the Labour party. I am sure that you will all make a good contribution to the work of the committee. We are quite a good working team and have had a successful year and a half. I am sure that you will add to that success.

Before we go any further, I have to ask whether any of you have any relevant declarations of interest to make, such as directorships that might be related to aspects of health and community care. Do you have any such interests?

Members *indicated disagreement.*

The Convener: I take this opportunity to put on record my congratulations to our former deputy convener, Malcolm Chisholm, on his elevation to his new post of Deputy Minister for Health and Community Care. We all valued Malcolm's contribution as a member of the committee and as a colleague, and I am sure that he will do a good job in his new post.

On a sad note, Malcolm was due to answer questions at the committee this morning, but he cannot be with us today because of a family bereavement—his mother's death. I am sure that I speak on behalf of all colleagues in sending our best wishes and thoughts to Malcolm. The Minister for Health and Community Care has changed her arrangements to join us this morning, and we shall be speaking to her in a moment.

Subordinate Legislation

The Convener: I ask members to turn to item 5 on the agenda, which we can get out of the way while we wait for the minister.

The first two items of subordinate legislation are negative instruments: the Specified Risk Material Order Amendment (Scotland) Regulations 2000 (SSI 2000/344) and the Specified Risk Material Amendment (Scotland) Regulations 2000 (SSI 2000/345).

Copies of the instruments were circulated originally to members of committee on 6 October and I have received no comments from members about them. The Subordinate Legislation Committee commented on the provision of tables and on the number of amendments to the principal regulations, and the Executive has responded. The Subordinate Legislation Committee welcomed the Food Standards Agency Scotland's intention to consolidate those regulations, and drew the attention of the Parliament to the instruments on the grounds that the provision of a table of derivations would have been of particular assistance in explaining their effect.

No motion to annul has been lodged, so the recommendation is that the committee does not want to make any recommendation in relation to the instruments. Is that agreed?

Members *indicated agreement.*

Mary Scanlon (Highlands and Islands) (Con): What would a table of derivations do to help us understand the instruments? What benefit would that be to us?

The Convener: I think that that was just a point of clarification. I do not know whether the Subordinate Legislation Committee asked the question for a specific reason, or just to make things clear. My understanding of the response is that the whole question has now been taken on board by the Executive for future reference.

Mary Scanlon: The Subordinate Legislation Committee seemed to feel quite strongly about it. I do not know how having such a table would benefit us.

The Convener: The Subordinate Legislation Committee has raised the issue and, clearly, wants to pursue it. The response suggests to me that the issue will be taken on board in the future. Are we all agreed?

Members *indicated agreement.*

The Convener: The third negative instrument for consideration this morning is the NHS (General Dental Services) (Scotland) Amendment (No 2) Regulations 2000 (SSI 2000/352). The instrument

was circulated to members on 11 October and no comments on it have been received.

The Subordinate Legislation Committee had two comments on the instrument; one concerned defective drafting and the other concerned the consolidation of the principal regulations. The Executive has agreed to lay an amending instrument as soon as possible to rectify the defective drafting, and has stated that progress is being made on producing a consolidated print of the principal regulations. No motion to annul the instrument has been lodged, so the recommendation to the committee is that the committee does not wish to make any recommendation in relation to the instrument. Is that agreed?

Members *indicated agreement.*

The Convener: At the risk of confusing all the bleary-eyed people who are present this morning, I want to jump back to agenda item 1. Item 7 is consideration of the draft report of our conclusions and recommendations on the budget. Item 8 is consideration of the draft report of our conclusions and recommendations on the community care inquiry. Both those reports are private until they become public. Do members agree to take items 7 and 8 in private?

Members *indicated agreement.*

The Convener: Good morning, minister.

The Minister for Health and Community Care (Susan Deacon): Good morning.

The Convener: Thank you for agreeing to appear before the committee this morning. We have acknowledged the sad circumstances in which we are hearing from you, instead of from your new deputy. You will be responding to our questions on community care and giving evidence on subordinate legislation. I would prefer to get agenda item 4, on subordinate legislation, out of the way first so that we can concentrate on community care. Is that acceptable?

Susan Deacon: Yes.

The Convener: Agenda item 4 is consideration of emergency affirmative instruments. The draft instruments were sent out to members some time ago, together with a note from the Executive. Committee members have not raised any points with the clerks. Similar Scottish statutory instruments have been debated previously in the committee. Do any members wish to debate the instruments?

Members: No.

The Convener: I invite the minister to move the motions individually, so that we can deal with them one after the other. There appears to be no need for questions or debate on the issue.

Susan Deacon: As you said, convener, similar SSIs have been debated previously. I intend, therefore, simply to move the three motions that are before the committee this morning.

The Convener: You must move each motion separately.

Motion moved,

That the Parliament's Health and Community Care Committee in consideration of the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No 4) (Scotland) Order 2000 (SSI 2000/359) recommend that the order be approved.—[*Susan Deacon.*]

Motion agreed to.

Motion moved,

That the Parliament's Health and Community Care Committee in consideration of the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (East Coast) (Scotland) Order 2000 (SSI 2000/360) recommend that the order be approved.—[*Susan Deacon.*]

Motion agreed to.

Motion moved,

That the Parliament's Health and Community Care Committee in consideration of the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (East Coast) (No 2) (Scotland) Order 2000 (SSI 2000/370) recommend that the order be approved.—[*Susan Deacon.*]

Motion agreed to.

Community Care

The Convener: The next item on our agenda is questions to the minister on community care. I will begin by setting the discussion in context. As the minister knows, for some time the committee has been involved in an investigation into community care. We have taken a great deal of written and oral evidence from people across all sectors of community care. We have spent a considerable amount of time, including part of the summer recess, visiting projects throughout the country.

The committee is now at the end of that long inquiry and intends to publish its report in about two weeks' time. We are aware not only of speculation regarding the Sutherland report, but of the statement that the minister made to the chamber on 5 October. We want to move on from that statement and get more flesh on its bones.

First, I have a question about Sutherland. We have a committee view on the matter, and we all have our individual views, and you know that I believe that we should have gone for full implementation of the Sutherland report. There has been a great deal of speculation over the past few weeks following the debate in the chamber and the statement that you made. Can you give us the up-to-date position on implementation of the Sutherland report, with particular focus on personal care being paid for out of general taxation?

Susan Deacon: I am happy to answer that question and comment on the important issues that you highlighted, which have been a matter of considerable debate for us.

Before I move to the substance of my response, I will make, if I may, a few introductory remarks. First, as you acknowledged, Malcolm Chisholm extends his apologies. Having crossed the divide, he was keen to have this discussion with the committee. I am sure that there will be opportunities to have that discussion, and I am pleased to be here in his place. Secondly, I want to welcome formally new members to the Health and Community Care Committee; I look forward to working together with the committee in future. Jointly, we have begun to address a number of significant issues and I hope that that can continue.

My final introductory remark, which is relevant to the convener's question, concerns the two people who have joined me today. On my right is Thea Teale, the head of our community care division, who has not been to the committee before.

The Convener: She has managed to escape.

Susan Deacon: But she is delighted to be here this morning, and she will be happy to pick up any points that the committee wishes to be addressed. Also with me is Anne Jarvie, who is our chief nursing officer. As members will know, one of the key announcements in my statement to the chamber on 5 October was that the CNO would be taking forward a focused piece of work on the definition of nursing care and the assessment of need. That is pertinent to the convener's question. Either now or later, the committee may wish to question the CNO about that work.

On the main question about the Sutherland report, I set out a full response in my statement on 5 October. I will not repeat at length the detailed remarks that I made then. Suffice to say, I reiterate that the Executive's view is that the royal commission's report on long-term care was a milestone piece of work. The Executive studied the report carefully, and it has greatly informed our work in this area.

As members know, in my statement I announced a commitment to take forward the vast majority of the recommendations in Sir Stewart Sutherland's report, notably, for example, the introduction of universally free nursing care and additional support to enable people to stay at home. That will finally rebalance care from residential care to home care; the need to do that was addressed in the royal commission report. We are addressing that by improving services and standards of care.

One of the points that came up in the chamber, and which the convener raised this morning, was the royal commission recommendation that personal care should be provided free of charge. Again, as I said in my statement on 5 October, the main practical effect of that proposal would be to reduce the cost of care for those 7,000 or so Scots in residential care who are self-funding. I repeat that we agree with the principle of equity that underpins the recommendation. However, as I said in my statement, we believe that it would not be right to make that change now, when tens of thousands of older people have so many wider needs. In my statement, I set out a clear policy on spending for older people and I identified priorities within that policy. It is important to reiterate the point that we endorse the principle of equity on which the recommendation was based and that we are keen and determined to review the area continually. In the full response to the report of the Royal Commission on Long Term Care for the Elderly and in my statement, I set out details of on-going work that addresses issues relating to the care of the elderly.

Members will be aware that the new First Minister, Henry McLeish, has initiated a review across the Executive to consider how we develop policy. One of the areas that he has identified for

continued consideration is the Sutherland report, in particular the personal care recommendation.

10:15

The Convener: By confirming the same points as those that you made in your statement on 5 October, you are saying that you agree with the principle of equity and the question of fairness that was raised in that section of the Sutherland report. Are you saying that if funding were to be made available to your department, it would be able to go ahead with that recommendation, either in one big bang or as a phased programme?

Susan Deacon: We have never disagreed with the principle of the recommendation. Like any Government, the Executive must assess where there is the greatest need and identify priorities to meet that need. We carried out that assessment openly and transparently, as we made clear in the statement at the beginning of October. We have made substantial resources available to address need in relation to personal care. We have not closed the door on considering how to expand further services and support in that area; it is clearly open for development. However, at any moment in time, we must make an assessment of affordability and priority.

Nicola Sturgeon (Glasgow) (SNP): Over the course of the debate, we have heard reference to 7,000 people who pay for personal care in residential settings, who would benefit from the implementation of the Sutherland recommendation on personal care. Can you confirm that thousands of people who currently pay for personal care at home would also benefit and that the figure of 7,000 is somewhat misleading?

Susan Deacon: The figure is not misleading. The point that we have sought to make throughout the debate is that we must target resources to deliver the maximum possible benefit to the maximum number of people. Implementation of the recommendation on personal care would affect only a fifth of the total number of people in residential care.

The whole subject of charging for care of the elderly is enormously complex. Indeed, Sutherland acknowledges that that is one of the report's weaknesses. We could discuss the wider aspects of the impact of the Sutherland recommendations and the changes that we are introducing, but my general point still stands. In relative terms, only a limited number of people would benefit, at a substantial cost. That is a fact. It is right that the Executive makes that point.

Dr Richard Simpson (Ochil) (Lab): You kindly agreed to publish the remit for the group to be headed by Anne Jarvie. Has it been published yet?

Susan Deacon: We have agreed recently the remit and membership of the working group that the CNO will head. I recall Dr Simpson's question in the chamber on that issue and the commitment that I gave. As the CNO will confirm, I have asked that the information required be made available in whatever form would most suit members.

The Convener: We will come back to Anne Jarvie and the definition of nursing care.

Mary Scanlon: My question follows on from Nicola Sturgeon's point. At the healthy nation conference yesterday, that figure of 7,000 was mentioned. There is no doubt that, in future, more people will live longer and more people will suffer from dementia. That is mentioned in the Sutherland report and has been raised by Age Concern Scotland. I hope that the Parliament is making legislation not just for today but for the things that we can expect in future. Will the minister address that point?

I do not know where the figures come from but they are filed somewhere in the back of my mind—is it correct that 10,000 people are awaiting assessment and that 10,000 people have been assessed and are awaiting care? If that is correct, would not that make a difference to the figure of 7,000 that the minister keeps quoting?

Susan Deacon: Mary Scanlon makes an important point about planning for the future. She gives a figure of 10,000 for those who have been assessed and 10,000 for those who are awaiting assessment. She may have something else in mind, but I feel that the figures that she is thinking of relate to aids and adaptations. I have quoted those figures widely—we know that 10,000 people in Scotland have been assessed as needing aids and adaptations at home, but have not been given specific—

Mary Scanlon: They have also been assessed as needing home care. Until they have been assessed, we do not know what they need.

Susan Deacon: Quite. There are two categories. I would like to deal with this point, because it is salient to our discussion.

The Convener: The point is that a substantial number of people—whether the figure is 8,000, 10,000 or 12,000—wait for assessment and then, after they have been assessed, wait again for the service.

Mary Scanlon: Yes.

Susan Deacon: I agree that the point is important irrespective of the figure. I have most often heard those figures quoted in relation to aids and adaptations. We have said explicitly that there is a great deal of unmet need in that area. The fact that 10,000 people have been assessed as needing often very basic aids and adaptations but

have not received them is of enormous concern.

As Mary Scanlon said, a further 10,000 people are waiting for assessments; that is why the additional resources that we announced on 5 October to provide additional aids and adaptations are so important. Our figures show that as many as one in five people who are in residential care in Scotland may not need to be there if they were given the right support at the right time in their own homes. That is a travesty. We should not consider this from just a service point of view; it is much more important to consider it from a human point of view. Giving people the right support in the right place and at the right time is key. That is why we identified the priorities that were included in my announcement in October.

It is right to say that we should make plans for the future. In our spending review, we have considered a three-year period. We have attempted to align our resources as best we can with the needs over that period. In doing that, I hope that we are also contributing to long-term sustainable change. That is why the massive shift towards providing support at home is important. We must ensure that we address imbalances.

We are all aware of the range of needs that dementia sufferers have, the growing number of people with dementia, and the fact that we must develop our work in this area in future. That is one of the key issues that are being addressed by the CNO's group. Need must be considered not only in terms of physical support, but in terms of the wider psychological support that dementia sufferers need.

The Convener: I will ask Dorothy-Grace Elder and Irene Oldfather to ask their questions and the minister to answer them together.

Dorothy-Grace Elder (Glasgow) (SNP): Given that the minister is planning for the medium and long term, I am sure she will agree that a problem arises over not just the amount, but the security, of funding. The committee has heard much evidence about that. Several major projects on dementia and dementia day care in the home and in centres are threatened. One project in the east end of Glasgow cannot pay its wage bill of £11,000 this month. Before going ahead with medium or long-term projects, is the minister prepared to take steps to set up emergency funding for voluntary projects that get into problems?

The Convener: I would add this question: does the minister think that day care could become a statutory obligation for councils?

Irene Oldfather (Cunninghame South) (Lab): The minister mentioned a review of policies across the Executive and confirmed that the Sutherland report would be part of that. What is the time scale for that?

This morning, we are talking about delivering services as well as targeting resources. The committee is keen that flexible personal care should be tailored to individual needs. How will such services be delivered? The minister mentioned the specific needs of people with Alzheimer's. Are we talking about some kind of generic worker to deliver home care support? That would require a recruitment and training programme—does the minister have any thoughts on that?

Susan Deacon: I will do my best to address the range of issues that has been raised. A recurrent theme runs through Dorothy-Grace Elder's question and Irene Oldfather's question—the fact that many different agencies and professionals are involved in the delivery of community care services. We will never improve community care if we consider only one part of the system: we must consider all the parts and how they work together. I think that all of us here share that objective and I hope that we can build on that.

The joint futures group has done relevant work in getting local authorities and national health service representatives round the table. I know that the committee has been interested in the report of the joint futures group, so it is important that I put it on record: the JFG report has been completed recently and I expect that committee members will have it next week. It is a full report with a lot of recommendations that we will have to consider carefully before deciding how to proceed. Much of the group's work gets to the bottom of some of the blockages in the system that result in the system failing people. I look forward to dealing with that.

Irene Oldfather spoke about flexibility, which is a key issue. The services must be flexible, as must the work force. In community care—and in health services more generally—we have been asking how we can create that flexibility and how we can remove the demarcations, barriers and restraints that have stood in the way of putting the person at the centre when considering care services. We have not placed any boundaries around those discussions. Our starting point has always been to think of the person and of his or her needs, and then to decide how professionals and agencies can work differently and better. I am pleased that the professionals and agencies involved have worked very constructively with us.

Dorothy-Grace Elder asked about day care and insecurity of funding. We are mindful of that insecurity, and it is important that our spending review covers three years. The commitment that I made in my announcement for additional support for services for local authorities was not a one-year commitment but a three-year commitment. The mechanisms to underpin that—the joint

budgeting and the joint management of services for the elderly—are based on discussions with local authorities. Those are on-going measures and improvements to route the connections properly in how services are designed and delivered. We have also discussed the commitment on three-year funding for voluntary sector organisations, which is relevant. The Executive supports that.

10:30

Irene Oldfather's point—I am trying not to meet your eye, convener, because I know that you want me to wind up—concerned the review of Executive policy, for which the timetable was confirmed at Cabinet yesterday. I do not have that here, and I am loth to give details of dates off the top of my head. The Cabinet discussed the matter, but it is no secret. Broadly, each minister is examining his or her portfolio. Discussions are intended to take place over weeks, not months. I think I am right in saying that any announcements that are to be made on the back of those discussions will happen early in the new year. I hope that the committee appreciates that I give a big health warning on that information.

The Convener: In your statement to Parliament on 5 October, you said that

"by 2002 . . . all community care services for older people"

would be

"jointly managed and jointly resourced."—[*Official Report*, 5 October 2000; Vol 8, c 1015.]

At the time, I said that that was a challenge. How do you expect joint management and joint resourcing to be organised? What impact will that have on joint budgets? What measures will be put in place to ensure that joint management and joint resourcing are achieved?

I am aware that the committee has several questions to ask and has only between 30 minutes and 40 minutes at its disposal.

Susan Deacon: Given the time, and the fact that the joint futures group report will be published next week, I will answer those questions in relatively simple terms, while noting that the issue is complex, as you rightly say.

The announcement was based on extensive discussion with the Convention of Scottish Local Authorities. As the convener said in the chamber, the commitment is ambitious. However, we believe that it can be achieved. The sectors that are involved are determined to work towards it, because we know that the commitment must be met to facilitate effective delivery of the services.

Discussions with COSLA are continuing and are live. Many of the mechanics that the convener asked about are described in some detail in the JFG report. I suggest that committee members might have other questions to ask after they have considered that report.

The Convener: The problem is that we are attempting to finalise a report today. The minister will be aware that if we cannot see the joint futures group report until next week, it is difficult for us to know what we are working with.

Susan Deacon: I know that the committee discussed such matters with Iain Gray, who was Deputy Minister for Community Care and who did a vast amount of work on the subject. I give an assurance that the commitment was based on considered discussion of what needs to be and what can be done. As Iain Gray said on many community care issues, almost everything that we want to achieve is good practice somewhere in Scotland. In some parts of the country, great progress has been made on joint budgeting. We know that it can be done. Repeatedly, our problem with community care is that good practice is not universal. We are moving to the stage of universalising good practice, to which the joint resourcing and joint management mechanisms are key.

I will ensure that the JFG report is circulated to committee members as quickly as practically possible.

Nicola Sturgeon: You mentioned the complexity of, and variations in, local authority charging, which you covered in your statement on 5 October. What steps are being taken to deal with the variance in charging? What is the time scale for introducing the legislation that was mentioned in the statement? Once that legislation is on the statute book, in what circumstances will you use the power to issue guidance to local authorities?

Susan Deacon: I am glad that Nicola Sturgeon has asked about home care charging, because all our work has shown repeatedly that that is one of the great inequities in community care. Members will have studied the issue in detail. To give just one example, maximum charges vary across the country from £11.30 to £88 a week, which is a remarkable disparity. We have discussed that matter with COSLA, which, I am pleased to say, has identified that work needs to be done to reduce those variations.

I have said to the committee previously, in relation to the areas of responsibility of local authorities, that a balance needs to be struck between allowing local authorities to take decisions on the use of their own resources and addressing the inequities in various parts of the country. COSLA has been developing guidance on that. Its hope—and ours—is that variations can be reduced voluntarily by discussion among local

authorities. That mirrors similar measures that have been put in place in England.

We are about to legislate on the regulation of care, so we will take that opportunity to have reserve powers of direction. I cannot, therefore, answer the second part of Nicola Sturgeon's question, which asked in what circumstances we would use such powers. The point about having reserve powers to direct is that judgment would be used in future about whether it was necessary to use them. It is too early in the discussion process with local authorities that is being led by COSLA to answer that question. However, it would be equally wrong of us, given that we will legislate in this area in the coming period, not to address the matter and to have that power in reserve.

Nicola Sturgeon also asked about the time scale for legislation. A lot of work is being done on the regulation of care bill, which, as you know, was included in the legislative programme. More widely, we are considering the most effective and appropriate mechanisms for introducing legislation—in a range of different areas—that is required as a response to the Sutherland report and so on. As I understand it, it ought to be possible to address charging in the regulation of care bill. We are considering other issues, such as the provision of free nursing care and how best to legislate on that. Obviously, there is an issue about the wider legislative programme of the Parliament, but I am happy to provide further details to the committee when we are clearer on that.

Do you want to add anything on the legislative timetable, Thea?

Thea Teale (Scottish Executive Community Care Division): I think that that summarises it.

Shona Robison (North-East Scotland) (SNP): I have a question in two parts, relating to the sources and amount of moneys allocated to various areas in response to Sutherland, especially the money given to local authorities to address waiting lists for nursing home care and residential care.

First, how much money has been allocated to address waiting lists? Do you think that it is adequate? You were asked about the waiting lists in each local authority and you responded by saying that you did not hold that information centrally. However, I am aware that as from this month you will hold that information centrally. When we wrote to local authorities to ascertain where they stood on waiting lists, the information that we got back was interesting. In North Ayrshire, no funding package existed, but 99 people had been assessed as requiring residential nursing home care. In Edinburgh, that figure was 34; in the Western Isles it was 65; in East Ayrshire it was 87; in Falkirk it was 37; and in Perth and Kinross it was 97.

Interestingly, East Ayrshire said that the funding announced by the Scottish Executive would cover about 25 of the 87 people assessed as requiring nursing or residential care. That leaves more than 60 people without a funding package in that authority alone. What is going to happen with the funding shortfall? I recognise that you have announced funding that will cover some of the people on local authority waiting lists. What about the other people on the waiting lists who have been assessed as requiring nursing home or residential care but for whom no funding package is available?

Susan Deacon: I will do my best to touch on some of the main aspects of this complex matter, which we discussed to some extent the last time I was at the committee. Shona Robison used the phrase "waiting lists". I will seek clarification on this, but I assume that she wants to take us into a wider area. Obviously, delayed discharge is relevant to the issue of those in need of care, but I am not sure what figures are being cited.

Shona Robison: The waiting list figures include those assessed at home as requiring nursing or residential care and those assessed in hospital as requiring the same.

Susan Deacon: Am I correct in thinking that you are not referring only to the element of delayed discharge?

Shona Robison: That is correct.

Susan Deacon: As I said at the last meeting, delayed discharge is an enormously complex issue. In the course of our work, we have identified 42 reasons why that situation occurs in individual circumstances. The issue of funding flow—not just of total funding—is relevant, as are a range of issues, such as how discharge planning takes place. The same applies to the wider assessment of needs. Some work in the JFG report is relevant as well.

I should stress that the waiting occurs not only because of matters relating to available funding but because of the fact that the needs assessment process is not as effective as it could be. I acknowledge that funding is an important issue and I am pleased that Shona Robison acknowledges the fact that we have targeted funding to these areas. There is a limit to how prescriptive we can or ought to be about how local providers of care allocate the resources that we have allocated at a national level, but we have identified the issue as a priority. I am bound to say that the measures outlined in my statement at the beginning of October on additional support for people at home are relevant, as one of the causes of the problem is that people are not getting

support in the right place at the right time. That results in their ending up on a waiting list for residential care, perhaps inappropriately. We know that that is happening.

Mary Scanlon: I hope that the answer to my question will be shorter and more concise than that one and that I can remember the beginning of the answer by the time we get to the end of it. I would like more details on the local authority loans that are being made available for those who do not wish to sell their homes when they enter residential or nursing home care. I believe that the matter was raised on 5 October.

Susan Deacon: I am happy to answer the specific question that Mary Scanlon has asked. However, complex issues have been raised; to oversimplify them would be to do a disservice to the subject.

Councils already have the power to make loans against the value of the home to fund care costs. Our concern has been that the use of that power is inconsistent. From next April, as part of the package that was announced in October, we will be providing funds to enable councils to offer more such loans. That will provide a mechanism by which people can avoid the need to sell their homes when they go into residential care.

Mary Scanlon: What do you mean when you say that the use of the power has been inconsistent? If councils already have the powers, have any councils been operating the system to help the elderly? If not, why not?

Susan Deacon: It is difficult to say why not. I suspect that part of the answer is that, in the context of competing demands for attention and resources, authorities have chosen not to prioritise the issue. By putting additional emphasis on the area and by channelling substantial additional resources to local authorities for that purpose, we hope that wider provision can be made and that there will be less inconsistency in the system. Having committed to the principle, we are making progress on the detail of the development of policies and practice with local authorities.

Mary Scanlon: I do not understand this, as I am not familiar with the system of local authority loans. Is it similar to the system that operates when building societies release equity on the home so that, when the person dies, the house becomes the property of the building society? If it is, how does it fit in with joined-up government in relation to the stock transfer?

The Convener: Perhaps the official could give us a factual answer on how the systems work in practice.

Thea Teale: It is similar to the building society process whereby equity in a house is released into a loan and repaid at a later date.

10:45

Mary Scanlon: Are councils effectively purchasing houses that they could rent?

Thea Teale: No. The process does not put the house into the ownership of the local authority.

Dorothy-Grace Elder: Could a claim be made on the person's estate after death?

Thea Teale: Yes. That would be possible.

Dr Simpson: Minister, in your statement of 5 October, you announced the creation of 1,000 additional long-term home care packages and 22,000 additional weeks of respite care. You previously announced £10 million towards dealing with delayed discharges. That money was announced in June and released in October. You also announced that part of the initial £63 million to the health boards was to be used to deal with delayed discharges. How are you performance-managing all that to ensure that the targets are met? I appreciate that you may not be able to talk in specifics today—it would be unfair to expect you to—but would you be prepared to write to the committee about your hopes for the return on the £10 million to deal with delayed discharge and the proportion of the £63 million that will be used for delayed discharges?

Susan Deacon: Given the range of issues raised in Richard Simpson's question, I will be happy to give the committee more information in writing. I will give members some information now, however. The first question was about how resources that have been allocated this year are being performance-managed. We have endeavoured to strike a balance between enabling local providers of care to identify local priorities and ensuring that the additional resources that we have targeted for the general priority of delayed discharge do not go into a range of other matters.

Each health board developed a plan as to how the £60 million that was allocated to the NHS in July would be used. A key part of the requirement that we set was for the boards to say how they would work with other agencies to use the resources effectively to tackle priority issues, such as delayed discharge, waiting and winter. The resource was released once those plans had been developed and there was clear evidence not only of how money would be spent but, crucially, of the results that the boards intended to deliver from it.

Similar practice was followed in relation to the £10 million for local authorities, which, as I recall, was released in September. From next year, we will be moving towards a system of partnership agreements with local authorities in relation to care of the elderly. We are moving towards a

system in which we will measure outcomes rather than only considering inputs such as how much money has gone into the system. That is part of the continuing work with COSLA on bringing together the joint management and resourcing of these services.

The figures that I have given on the number of care packages and the number of people who will benefit from these measures are a reasoned assessment of what the resources will deliver across Scotland. We are now ensuring that the proper mechanisms and decision-making process are in place locally to deliver that change.

In some cases, we are setting standards that we expect to be established universally—for example, for rapid response teams in every local authority area in Scotland and for home maintenance programmes. In other cases, there will be more scope for local care agencies to be needs driven in the provision of support.

Dr Simpson: That is very helpful. It will be useful to receive all the bids and the targets that local authorities have set for themselves, in agreement with you, regarding the use of the money, so that we can hold them accountable through local democracy.

I have a further question on performance management. We have heard in evidence from Sir Stewart Sutherland and the local authorities that the proportion of grant-aided expenditure that is spent on care of the elderly is substantially lower than it should be. I am not concerned so much by the fact that the local authorities are using that money for children's services and other important services as by the fact that pressure is being put on the health boards, the health service and on home care because the money is not being used in the area of the budget in which the Government intended that it should be used. How do you propose to ensure that additional moneys that are now being released through the comprehensive spending review will be used to address the shortfall in the GAE application?

The Convener: Before you answer that question, minister, Margaret Jamieson has a supplementary question. You could perhaps answer both questions together.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): Minister, you mentioned the extra money that was made available for delayed discharges. Can you clarify the length of time that elapsed between the announcement of the moneys and their being disbursed? One side of the organisation says one thing and the other says something else. That relates partly to the point that Shona Robison raised about the disparities between North Ayrshire and East Ayrshire.

Susan Deacon: I am desperately racking my brains to give precise dates in response to Margaret Jamieson's question. Are you asking specifically about the NHS resources or about those for local authorities?

Margaret Jamieson: I am asking specifically about the £10 million that went to local authorities. Each member of the committee will have been involved in correspondence with individual authorities and health boards in trying to get through the mire that appears to cloud the issue of getting people into appropriate accommodation.

Susan Deacon: I would like to give you an accurate answer. If I get it wrong, I shall correct it subsequently. The original commitment to make the additional resource available to local authorities—the extra £10 million this year—was made in June, just before our summer recess. Thereafter, local authorities were, as I outlined a moment ago, asked to develop their plans for using that resource. The deadline for the submission of those plans was mid-September, and the resource was released at the beginning of October. I will check that and let you know if it is incorrect.

The Convener: Can you answer Richard Simpson's question now, please?

Susan Deacon: I beg your pardon.

It is important for care agencies to know that they are getting additional resources as far in advance as possible. In this case, they knew that from fairly early in the financial year. How planning takes place is a separate issue. However, it is important to note that all such decisions have been made for next year; health board allocations for next year are known.

In September, we made a commitment to local authorities to make recurrent the additional £10 million for delayed discharge. It is important to note that any issues about in-year decisions and allocations this year should not arise in the future.

I have already given part of the answer to the question on spending on care for the elderly as a proportion of GAE. We have agreed with local authorities a new approach for future years and we are implementing that jointly with local authorities and the NHS. Rather than simply ring-fencing the money—that is an option, but not one that is favoured by local authorities in general—the key is the performance management of the agreed outcomes in every local area. That is why the partnership agreements that are being developed in every health board area will be so important. There is a major shift in emphasis. In my statement in October, I said that

"we are supplying not cash with strings but cash for results."—[*Official Report*, 5 October 2000; Vol 8, c 1018.]

Given the substantial additional investment in the

system, it is right and proper that we should be aiming to achieve significant results and to monitor them effectively.

Mr Frank McAveety (Glasgow Shettleston) (Lab): Do you envisage introducing any legislation on joint working?

Susan Deacon: I am pausing for thought, because we do not want to introduce the idea of compulsion in relation to joint working and so are not planning to legislate on it. However, we are legislating to remove any remaining barriers to joint working. We have delved deep into the issue over the past year or so and have discovered that those involved in the delivery of care often have a sense that there are statutory or other barriers to effective joint working. The deeper we dig, the more we discover that such barriers are perceived, rather than real. In certain parts of the country, people have worked through that and have realised that there is not a problem. However, we recognise that, in some areas, the statutory arrangements may militate against joint working. The Perth and Kinross pilot project, with which the committee is familiar, has been invaluable in helping us to consider where the statutes may need to be amended to facilitate more effective joint working.

Margaret Jamieson: Richard Simpson spoke about the definition of nursing care and the new working group. I want to ask Miss Jarvie about the method, criteria, consultation and membership of that group and when we can expect to see some results from that work.

Anne Jarvie (Chief Nursing Officer): The minister made the point that, after today's meeting, we will ensure that all members of the committee get copies of the remit and membership of the group. However, it might be helpful for me to read out the remit, which is

"to consider and to report to the Minister for Health and Community Care on the issues involved in providing nursing care free of charge in all settings, with particular emphasis on developing a system which takes into account the assessment of need for such care, the relevance of professional roles and the necessary financial framework."

Members will notice that the remit does not include the word "definition". To define nursing would defy us all. There will always be an element of nursing that is indefinable. I have heard it likened to loving—some bits can be described, but other bits are known only through experience. That is what patients would say about nursing.

The Convener: You will be glad to know that we will not pursue that line of questioning.

Anne Jarvie: I thought that that would give the committee food for thought.

In particular, we are trying not to define nursing by describing a list of tasks, which would be relatively easy. However, there is concern about the care of people suffering from dementia and similar conditions. If we describe only the tasks, we will never capture what is involved in such care, so we are looking for assessment tools with which we can analyse and critique and which will help us to capture all aspects of care, particularly those hidden aspects that are associated with some of the very vulnerable groups, such as those suffering from dementia.

11:00

Margaret Jamieson: I ask for assurance that we will not use the tools that we used in clinical grading, which gave us significant difficulties, and that qualifications will not be used as a bar, because we all know that the service would not exist if we allowed only individuals with a specific qualification to do something. We need to take a holistic approach to the problem.

Anne Jarvie: It is not about who implements the care, but who assesses it, plans it, and evaluates its effect. We are taking that on board.

The Convener: Three members—Dorothy-Grace Elder, Shona Robison and Mary Scanlon—want to ask a question on this. I require your questions to be short; if they are not, I will stop you.

Dorothy-Grace Elder: Can we rewind to the protection of carers? I address my question to either the minister or Thea Teale. Will the protection of carers be built into plans for local authority loans—

The Convener: No. We have moved to the definition of nursing care, so we will concentrate on that.

Shona Robison: You said that you will not base charging on who does what and whether they are qualified. That is welcome, but you said also that you will not base it on the tasks that are carried out. How will it be decided what will be charged for and what will not? Could you give us a couple of examples of the assessment tools that could be used?

The Convener: We will take Mary Scanlon's question as well.

Mary Scanlon: In chapter six of the Sutherland report—and, of course, a nurse was on the Sutherland commission—there is a clear outline and discussion of personal care. The report says that

"It falls within the internationally recognised definition of nursing".

Do you disagree with that?

Anne Jarvie: I do not agree or disagree; it is all

down to interpretation. I hope that we can come up with a tool that will be able clearly to demonstrate that there is a difference between personal care and nursing care, but the difference is around assessment, planning and evaluation. The debate is around who does that; that is when the question whether it is personal care or nursing care becomes complicated.

Mary Scanlon: But you do not disagree with the definition?

Anne Jarvie: No.

The other question was about tasks. We have a good database in Scotland. The information and statistics division collects information every six months from the continuing care wards in the NHS, and also now from nursing homes and residential homes. We love to call such things ghastly names, so we call them SHRUGS and SCRUGS—Scottish health resource utilisation groups and Scottish care resource utilisation groups respectively.

An assessment is done of the dependency of every older patient who requires care, including aspects of dementia. Such tools are flexible and can be added to. For example, we are quite concerned about the nutritional state of older people. I am on a roadshow to raise awareness about that issue. ISD has said that it has a little information about nutrition, but that it would like people who work in that area to work with ISD to produce a more robust question on nutrition. The good thing about the tool is that it has ownership; it is already being used in hospitals, nursing homes and residential homes, so the staff understand it and understand the use that can be made of it.

Another tool that has been developed in Glasgow is Carenap, which stands for care needs assessment package. CarenapD—care needs assessment package for dementia—was developed first and now CarenapE, which is Carenap for the elderly, is under way. Local authority personnel and health personnel seem to find the tool useful, but it is still in the development stage, so we are looking at it as well as some other existing tools. We will decide which tool gives the most robust opportunity for us to measure accurately the needs of the people who we are trying to assess.

Margaret Jamieson: I want to take you back to my initial question. Do you have a time scale within which to complete your work on definition? What is the membership of the group?

Anne Jarvie: We have a time scale for reaching the point where we will be able to put something in legislation if necessary, which is the end of December. I have an open mind about whether I will have to recommend to the minister that we undertake more piloting before we launch for real in October next year.

As for the membership of the group, I will simply give the broad categories, and assure committee members that they will receive a list of individual members. The group will include Age Concern Scotland; Alzheimer Scotland—Action on Dementia; Help the Aged; representatives from unions, professional organisations, local authorities and the NHS; and people from the community care division and the Scottish Executive health department.

The Convener: That seems fairly comprehensive.

Anne Jarvie: We have set up two further sub-groups, one of which will investigate assessment and the other of which will consider the necessary financial mechanisms to ensure that we can pay for care once it has been assessed. Those groups will co-opt other experts as needed in addition to some of the groups of the main committee.

Dr Simpson: I welcome the approach that has been taken and am reassured by the fact that it will be based on assessment.

First, from the evidence that we received from Aberdeenshire Council, which has used CarenapE in an integrated way, we know that massive training needs will be associated with the programme. Secondly, I appeal for the programme to be linked up to the current assessment system. If it is simply imposed on top of what already exists, it will form another layer of diversion from clinical time. Although CarenapD and CarenapE are at an early stage, they are clearly valuable clinical tools. As I said, Aberdeenshire Council has used CarenapE, and it might be worth inviting a representative from the council to give a presentation to your sub-group on assessment.

Anne Jarvie: The nurse from Glasgow who was instrumental in developing the tool gave us a presentation and alerted us to what was going on in Inverurie in Aberdeenshire, in particular, where the tool seems to have been very useful.

I assured the committee that we would not set up another bureaucracy if we could avoid it and that we would be as pragmatic as possible about building on what already exists.

Irene Oldfather: It is important to note that we welcome the development on the nutritional needs of the elderly, which could make a difference especially for Alzheimer's patients. For example, it could mean the difference between people staying in the community or having to go into residential care. The committee has taken much evidence to show that, and I am very pleased to hear about that terrific development.

The Convener: That can be taken as a pat on

the back.

We must move on quickly as we have a packed agenda this morning. I have a question from Shona Robison about the sources of moneys that will be allocated to the programme and another point from Dr Richard Simpson on a wider funding issue.

Shona Robison: What are the sources of the money that will be allocated to various areas of expenditure, and how much will be allocated?

Susan Deacon: Most of my announcement relates to the spending review period, which starts from the next financial year. The exception to that is the money that is being made available in the current year for delayed discharge and aids and adaptation, both of which are being funded through the health budget's end-year flexibility resource that was committed to health-related spend.

Shona Robison: How much is that?

Susan Deacon: That amounts to £10 million for delayed discharge and £5 million for aids and adaptations in the current financial year. I shall check the comprehensive spending review figures for the remainder of the package, as I am loth to give you figures that I am not sure about.

The local authority allocations—in years 1, 2 and 3, respectively—are £30 million, £36 million and £60 million, plus the recurring £10 million a year for delayed discharge. On top of that, we have identified £25 million, initially, for the cost of providing universally free nursing care. I used the word "initially" in my statement because we recognise that our funding decisions may be informed by the way in which that work develops.

Shona Robison: Is that a guesstimate?

Susan Deacon: No. It is an estimate, not a guesstimate, if I can make that distinction.

Shona Robison: Based on?

Susan Deacon: Based on our assessment of existing numbers and needs, in so far as we can make that assessment prior to the CNO completing the work that has just been described.

Dr Simpson: I wonder what can be done to ensure a shift from the current situation, in which the majority of people who have community care needs are cared for in the community although the majority of the funding is applied to institutions.

As we introduce free nursing care—Anne Jarvie's approach will perhaps modify this—it looks as though nursing home care will become much less expensive and home care will become more expensive. The cost to the individual will decrease as we move towards more institutional care. NHS long-stay care is free; nursing home care will be made less expensive by the application of free nursing care; residential home care—prior to Anne Jarvie's telling us how it would be managed—looked as though it would not be nursing care and would, therefore, continue at the current level; and home care will be charged for, apart from the very small amount of primary care nursing that is involved. The costs of care for the individual will therefore drive care in the opposite direction to your policy. You want everybody to be in home care, as far as possible, but home care for the individual is the most expensive form of care under the present system.

Susan Deacon: We are not saying that we want people to receive home care. We want people to receive the appropriate care and we want a system that does not lead to people receiving inappropriate care. At the moment, far too many people receive inappropriate levels of care.

I hope that the whole package of work on which we have embarked—including the changes to home care charging that I mentioned earlier, the massive additional investment in home-based services and the work that the CNO and others are involved in—will provide two things: greater equity for individuals throughout the system and, crucially, appropriate levels of care for people. I cannot state strongly enough that that is one of the biggest problems in the system, which we must address. I hope that the Executive and the committee can work together on that. I am sure that your inquiries will help us.

Dr Simpson: I accept that point, and I have a final, related point to make. At the moment, a significant number of individuals who are self-funded or Department of Social Security-funded—although that number is declining—have not been assessed. They have put themselves into care because they felt that that was appropriate for them, whether it was appropriate or not. As soon as we introduce free nursing care—however that is defined—will you ensure that people in that group are reassessed, to determine whether they are in the appropriate place?

Susan Deacon: Do you mean people who are currently in care, rather than those who would enter care in future?

Dr Simpson: Yes. You said that, based on the SHRUGS data, a fifth of individuals are wrongly placed. Part of the reason for that is that, if someone is self-funding, they are not required to be assessed.

In Stirling district, there are 458 nursing home beds, but only 200 are funded. I know that that is not the same as the national average, but there are 258 non-funded individuals in those beds. Many of those people have not been assessed for care in nursing homes; they have simply decided

that that is where they want to be. If we are proposing to apply public funds to people in that group—which we are if we plan to give them free nursing care—will you ensure that, whatever assessments are introduced following Anne Jarvie's group's definitions, those definitions will be applied in allocating public funds?

11:15

Susan Deacon: I am grateful to Richard Simpson for that clarification. There are two separate groups: those who are currently in care and those who may enter into care in future after any changes in assessment and charging have been made. There are clearly transition issues, and we certainly do not want to do anything that would have an adverse impact on someone who is settled in a specific care situation at the moment.

The chief nursing officer's group, as part of its wider area of work, is considering the practical implications of that. Thereafter, matters will become more straightforward as changes are made and people enter the system afresh. We recognise the transition issues that have been identified and know that the situation needs to be managed sensitively over a period of time.

Dr Simpson: Thank you for that assurance. One of my big worries is that the amount of assessment that will have to be done will be even greater than before. Previously, people who were self-funded could simply make their own arrangements, but now that public money is to be applied to them to provide free nursing care, they will have to be assessed. That will place a massive additional load on the social workers, nurses and occupational therapists who carry out assessments.

The Convener: We already know that those people are under pressure. I think that we shall leave that last point as a comment rather than a question, as we have already gone 20 minutes over our time limit for this item. We could have asked the minister several more questions, but I am sure that committee members will have been heartened by some of the comments that she and her officials have made today. Thank you, minister.

Susan Deacon: If there are further points on which you would like more written detail, we shall be happy to provide that information.

Public Sector Ombudsman

The Convener: We come to the final item that will be taken in public, after which we will have a short break before continuing in private.

We are to consider a report entitled "Modernising the Complaints System—Consultation on Public Sector Ombudsmen in Scotland". The introduction and background to this item are explained in the papers that members have in front of them. What is being explored is the establishment of a one-stop shop to which members of the public could direct complaints against the Scottish Executive, the health service and local government.

In the past, we have considered petitions about the complaints system and have noted that we are not happy with the present arrangements. As a member of the Public Petitions Committee, I can say that a great deal of doubt seems to exist about which body people should apply to if they feel that they have not had a good deal from public services in general. There would be a lot to be said for clarification.

Given that a large volume of complaints would be about the health service, how do committee members want to pursue the question? Do we want to take part in the consultation exercise? We have a couple of options. We could hear evidence on the proposals on 13 December and formulate some conclusions, or we could appoint a reporter, who could report back to the meeting on 13 December. A wide range of witnesses is suggested in the paper; I do not think that the committee could cover such a wide range, but it might be within the scope of a reporter to contact and deal with all those people.

What are members' views on the matter?

Mary Scanlon: When will the Scottish Parliament information centre produce a research note on the matter? A research note could take the place of a reporter. I would like to hear evidence, but not from nine different organisations. A SPICe note would be helpful, and I propose hearing evidence rather than appointing a reporter.

The Convener: The SPICe note will be available by the end of the month, apparently.

Margaret Jamieson: I would be interested to hear from the commissioners and the ombudsman, who are incumbent. I have difficulties with the matter. I asked a member of my staff to phone up and get a supply of forms. The response was that we were not allowed to have them and that the constituent must make the application.

I do not think that we should involve the other

organisations. They will have to submit evidence as part of the consultation process. Mary Scanlon is right: we cannot go to everybody or we would be here forever. We should narrow our focus to deal with those groups that are involved in the health and social care aspects.

Mary Scanlon: I suggest that the health councils should be involved.

Margaret Jamieson: They do not pick up the complaints at this level. We must be careful about that.

Nicola Sturgeon: I agree with Margaret Jamieson; we should not see all the people on the list. However, bearing in mind the comments that have been made about the complaints process, it would be appropriate to take evidence from a public perspective. That would give us an understanding of how the public perceives the complaints procedure. Anything that we have to say on the matter should be informed by that view.

Dorothy-Grace Elder: I know that SPICe is heavily burdened, but it would be useful to commission some research on the situation in other countries. Are there useful suggestions from other countries? We remember when the ombudsman system came into being in Britain, but we hear anecdotally that the public is not over-satisfied with that system. It would be useful to get some information on how complaints are handled in America or Germany.

Margaret Jamieson: You might remember when the ombudsman system came into being, Dorothy-Grace, but I think that you speak for yourself.

Dorothy-Grace Elder: It is not that long since we stole the system from Sweden.

Dr Simpson: I agree with what has been said so far, but it would be a mistake not to have the Patients Association represented, as the individual patient is the problem. From the health service commissioner, we will have a view from the centre of how the system is working at the moment. If we also hear from Citizens Advice Scotland, the Scottish Association of Health Councils and the Patients Association, we would hear from a broad section. We should ask whether the group that represents general managers or the group that represents chief executives of trusts could give us a written submission on how they envisage the system interlinking with the current complaints system.

Margaret Jamieson: We seem to be adding to the list again. Can we ask all those organisations to submit something in writing? After we have sifted through the submissions, it may well be that we do not need to ask further questions of certain organisations. The list could grow and grow.

The Convener: We have decided that we want to take evidence. I concur with Margaret Jamieson's suggestion that the best way forward would be to ask for written evidence from all the bodies on the list as well as the Patients Association and the other group that Richard Simpson mentioned. What was its name?

Dr Simpson: There are two groups: one is a group of chief executives; the other is a group of general managers.

The Convener: That would cover all aspects. We could return to the matter before 13 December and decide which groups we wish to take oral evidence from. The written evidence would give us a basis on which to make an informed contribution to an important piece of work.

That brings the public part of this morning's meeting to a close.

11:23

Meeting continued in private until 13:07

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