HEALTH AND COMMUNITY CARE COMMITTEE

Wednesday 17 January 2001
(*Morning*)

£5.00

Produced and published in Scotland on behalf of the Scottish Parliamentary Corporate Body by The Stationery Office Ltd.

Her Majesty's Stationery Office is independent of and separate from the company now trading as The Stationery Office Ltd, which is responsible for printing and publishing Scottish Parliamentary Corporate Body publications.

CONTENTS

Wednesday 17 January 2001

HEALTH AND COMMUNITY CARE COMMITTEE
2nd Meeting 2001, Session 1

CONVENER

*Mrs Margaret Smith (Edinburgh West) (LD)

DEPUTY CONVENER

*Margaret Jamieson (Kilmarnock and Loudoun) (Lab)

COMMITTEE MEMBERS

*Dorothy-Grace Elder (Glasgow) (SNP)
*Janis Hughes (Glasgow Rutherglen) (Lab)
*Mr John McAllion (Dundee East) (Lab)
*Shona Robison (North-East Scotland) (SNP)
*Mary Scanlon (Highlands and Islands) (Con)
*Dr Richard Simpson (Ochil) (Lab)
*Nicola Sturgeon (Glasgow) (SNP)

*attended

THE FOLLOWING ALSO ATTENDED:

Mr Keith Harding (Mid Scotland and Fife) (Con)

WITNESSES

Malcolm Chisholm (Deputy Minister for Health and Community Care)
Paul Gibbons (Health Board Chief Executives Group)
Liz Lewis (Scottish Executive Health Department)
Neil McConachie (Health Board Chief Executives Group)
Jane Morgan (Scottish Executive Health Department)
Gill Ottley (National Care Standards Committee)
Angus Skinner (National Care Standards Committee)

CLERK TO THE COMMITTEE

Jennifer Smart

SENIOR ASSISTANT CLERK

Irene Fleming

ASSISTANT CLERK

Joanna Hardy

LOCATION

The Chamber

Scottish Parliament

Health and Community Care Committee

Wednesday 17 January 2001

(*Morning*)

[THE CONVENER *opened the meeting at 09:31*]

Regulation of Care (Scotland) Bill: Stage 1

The Convener (Mrs Margaret Smith): Good morning. We welcome the Deputy Minister for Health and Community Care and his officials. I invite the minister to begin by setting the Regulation of Care (Scotland) Bill in context. Why do you think it is necessary and what do you hope it will achieve? What are the general principles that the committee will have to examine at stage 1 and what consultation has been undertaken over the past year or so on the principles and policies outlined in the bill?

The Deputy Minister for Health and Community Care (Malcolm Chisholm): I am pleased to be at the committee for the second week running. Coming here every Wednesday morning is a bit like the old days.

The Regulation of Care (Scotland) Bill represents a huge step forward for users and providers of care services. It sets out a new system to ensure better protection for children and vulnerable adults and the highest possible standards of care for all users of care services.

The present system of care regulation does not ensure the best possible services for those who need them. There are many examples of excellent practice and the vast majority of staff involved work very hard to offer a first-class service, but the system does not guarantee independence or consistency and it lacks coverage and integration. Perhaps most important, it can lack a user focus and sometimes an effective means of ensuring proper protection for service users. Moreover, the system does not lend itself to fast and effective enforcement action when there are concerns about the quality of care services; it is cumbersome and sometimes ineffective. Past scandals in the care sector have shown that the system has not always worked as it should.

We have introduced the bill to address those problems. The changes will mean a better quality of care for all users of care services through the introduction of national care standards and an increasingly confident, effective and valued social work profession and social services work force. The Scottish commission for the regulation of care and the Scottish social services council will develop that work. The commission will regulate care services, replacing the fragmented regulation by local authorities and health boards with a more consistent and independent approach. The council will regulate the work force. It will raise standards, tackle abuse and bad practice and enhance the competence of the work force.

I should emphasise how many people the changes will affect. About 500,000 service users in Scotland—people who are using a wide range of different care services—will benefit from the changes. Those care services include early education, child care—including childminders—independent health care, boarding schools, care homes, day care for adults and home care.

More than 100,000 social workers and other social services staff in Scotland work extremely hard to provide those care services. Doctors, nurses and teachers have their own professional bodies, and it is only right that social care staff should have the higher profile and enhanced professional status that work-force regulation will bring.

The bill is not just the Executive's idea of how we should modernise care services; it is the result of extensive consultation. There has been close collaboration between the Executive, people who use care services, service providers and a wide range of other interest groups and professionals, through written consultation processes and a series of meetings and seminars. I know that, in giving evidence to the Local Government Committee last week, the Association of Directors of Social Work paid tribute to the openness of that process.

Such first-hand experience and knowledge of the issues has been vital to the development of the bill, and we have made a number of changes to our proposals with the benefit of that input. For example, the range of care services that are to be regulated by the commission has expanded considerably. Early education, nurse agencies, boarding schools and housing support services are among those that were added during the consultation process. It was also decided that, instead of a phased transfer, the regulation of all existing services should transfer to the commission from the start of its operation.

As for the work force, we have widened the groups of staff that are to be registered by the council in the first tranche and we agreed to protect the title "social worker". I am happy to expand on the changes that were made during the consultation process if that would be helpful.

I know that there is still some concern about a number of issues, particularly implementation matters, such as the location of the new bodies, how the transfer of staff will work and whether staff should be asked to work from home. We are doing considerable work in those areas. Officials met representatives of Unison last week to discuss the issues, and further meetings are planned. We will announce our detailed proposals on those and other downstream issues as soon as decisions are made.

I am happy—although perhaps that is rather a rash statement—to answer questions on any matters of concern to members.

Nicola Sturgeon (Glasgow) (SNP): I believe that we are to hear more this week about the bonfire of the quangos, yet the bill will create two new non-departmental public bodies. There has been some discussion, in the Local Government Committee in particular, about whether there should be one body or two. Can you explain why the Executive has chosen to opt for two bodies instead of one, given that some of the functions appear to overlap? In particular, could you give us some examples of the conflicts of interest that would arise if there was only one body?

Malcolm Chisholm: On your first point, non-departmental public bodies are indeed being reviewed, and we thought carefully about whether we should proceed with these bodies. However, as I said, the proposals had been the subject of consultation over a long period and there was unanimous acceptance that the bodies should exist in the suggested form. Most people who made representations wanted two bodies, although I accept that late in the day the Convention of Scottish Local Authorities proposed that there should be only one body.

Separation of the bodies will ensure that there is a clear distinction between the regulation of services and the regulation of the staff who provide those services. A more concrete way of thinking about the issue is to see that the focus of the two bodies will not be exactly the same. For example, the Scottish social services council will register field social workers, who will be completely outwith the sphere of the Scottish commission for the regulation of care. Parts of the commission's work, such as its involvement in care homes and in early education and child care, will be to deal with nurses and teachers—people whose primary registration is with their own professional bodies. The focus of the two bodies is therefore slightly different.

Section 44 of the bill will ensure that the two bodies work in harmony. The headquarters will house both bodies, so there is no question of the bodies being totally separate. However, the majority opinion, with the exception of COSLA, is that there ought to be two bodies rather than one.

Nicola Sturgeon: Some might say that the wording in parts of the bill is eerily reminiscent of the wording of the statute that set up the Scottish Qualifications Authority. Can you say a bit about ministerial accountability, in particular how ministers will exercise control over and be held accountable for the operation of the two bodies?

Malcolm Chisholm: The detailed issues of which ministers will be accountable are still to be finalised. If you read the bill carefully—as I know you have—you will see that there are references throughout to close ministerial control. At Christmas, I went through the bill and found that the phrase

"with the consent of the Scottish ministers"

is used many times. However, given that you were involved in the SQA debate, Nicola, I presume that you are thinking about section 1, on which I am sure there will be an interesting discussion in committee. I refer you to the important words in the section that make it clear that the commission shall, in the exercise of its functions, act

"in accordance with any directions in writing given to it by the Scottish Ministers".

Section 28, which deals with the council, contains a similar provision. I am sure that we will have detailed debates about the scope of that power of direction, but it is clear from the bill as a whole that ministers will have a strong oversight of the bodies.

The Convener: If my memory serves me correctly, it was suggested at a previous meeting that the commission would be accountable to the health minister but that the council would be accountable to the education minister—or vice versa. Is that still the case and if so, is not it a recipe for confusion?

Malcolm Chisholm: That idea has been floated, but no decisions have been made on the matter. We will have to think carefully about the precise way in which the accountability arrangements will work.

I apologise for not having introduced the Scottish Executive officials with me. Jane Morgan is head of the children and families team in the health department; Liz Lewis is the head of the regulation of care team; Roddy Macdonald is also from the regulation of care team; and Lynda Towers is from the solicitor's office. I hope that that illustrates the fact that a range of people from across the Executive are working on the bill.

The Convener: It is important that we are clear about where the accountability will lie in relation to ministers. Can you tell us when a decision will be taken on whether the lines of accountability will

run to one minister or to two? How do you think that the new set-up will increase accountability to service users?

Malcolm Chisholm: I accept that that is important, but I do not think that the decision has to be made immediately, as the lines of accountability do not have to be in place until the bodies are established. The other reason why a little delay might be helpful is so that we can take account of the general review of quangos, which will, clearly, consider accountability arrangements. We are giving careful thought to the matter and we welcome the committee's views.

The Convener: What about accountability to service users?

Malcolm Chisholm: The schedules show that we very much want service users to be involved in the bodies. The fact that they will be non-departmental public bodies gives service users an opportunity to be on their boards, which could be presented as another reason for having the bodies in that form. Service users have also been involved in the development of the care standards.

The Convener: What arrangements will there be to achieve effective communications between the two bodies and to ensure that shared information—which might be confidential—is clear? How will the differing functions be co-ordinated?

Malcolm Chisholm: I know that arguments have been advanced on that issue and that COSLA has been involved in the debate, but I do not think that any of the difficulties that might arise from the fact that there are two bodies would be solved by there being only one body. I do not think that any of the difficulties are insuperable. I have already referred to section 44, which places a statutory duty on the bodies to consult each other.

Mr John McAllion (Dundee East) (Lab): What do you think are the implications of the objective of financing the commission's regulatory functions through fees from 2004-05? I am particularly concerned about local authorities, which are major providers of residential care, purchasing about 80 per cent of the places in private nursing homes.

Malcolm Chisholm: If we consider regulation and inspection to be important, we must accept that they have to be paid for. The view has been taken that the cost of regulation ought to be explicit. That would have implications for local authorities and for private providers. Fees can and ought to be taken account of in future years when grant-aided expenditure is set for local authorities. People who are paying for themselves will fall into a different category. On balance, we believe that it is better for the cost of regulation to be explicit. An amount of public expenditure will eventually have to go towards that cost and I do not see it as some issue of principle that it should be allocated in one way rather than in another.

09:45

Mr McAllion: Is there not still a problem? According to the financial memorandum, local authority funding is to increase by just over 15 per cent over the next three years. Over the same period, the fees for regulation and inspection are going up at a rate of 10 per cent a year over the three years—30 per cent—and by an unspecified amount thereafter. The local authorities are losing £6 million in 2002-03, and again in 2003-04, because of the loss of their regulatory functions. Has all that been taken into account? Will there be no additional cost to local authorities? Will the costs be funded entirely by the Executive?

Malcolm Chisholm: The money lost by local authorities is money that is currently being spent on registration and inspection. It is part of the existing GAE that will be transferred.

Mr McAllion: Is not the problem that local authorities will have to find the £6 million or more?

Malcolm Chisholm: They will not have to find the money directly to run a regulation and inspection service, but they will have to find the money to pay the fees, which I have said should be taken into account when GAE for local authorities is set.

On the percentages, if local authority expenditure is increasing by 15 per cent, that is indeed a large sum of money. An increase of 10 per cent in the fees would be only a small proportion of the cost of residential or nursing home care; it would not be equivalent to the actual cost of a place in a residential nursing home rising by 10 per cent. I cannot quote a figure off the top of my head, but the overall cost to cover the fees would increase by a much smaller percentage.

Mr McAllion: The increase in fees is 30 per cent, not 10 per cent, over three years.

Malcolm Chisholm: That is true for the fees, but it does not translate into an increase of 30 per cent in the cost of each place.

Mr McAllion: The chief executives of the health boards have submitted a memorandum to the committee saying that a vicious circle could emerge—when fees are increased to finance the regulatory functions of the Scottish commission for the regulation of care, the providers will pass on that increase to local authorities and to the Department of Social Security, but there will not be any money to meet those fees. Has the DSS, for example, agreed to fund the increased fees?

Malcolm Chisholm: I was referring to local authorities, which will be the main bodies that are

affected by the proposals. Fees should be taken into account when setting GAE—

Mr McAllion: Is that over and above the 15 per cent increases that the Minister for Finance and Local Government indicated?

Malcolm Chisholm: I cannot speak specifically for the next three years. However, I will say that, as a general principle, fees should be taken into account.

Mr McAllion: Does the Minister for Finance and Local Government agree with you?

Malcolm Chisholm: I am stating the position as I understand it.

Mr McAllion: Perhaps we should bring the Minister for Finance and Local Government before the committee to find out what he thinks.

Nicola Sturgeon: There is some debate about whether any increases in local authority funding will cover the increases in fees. Like John McAllion, I am not convinced that they will; we will have to return to that issue.

I want to concentrate on the arrangements that you appear to want to put in place, which seem to be slightly cumbersome. You seem to be suggesting that the Scottish Executive will allocate increased funding to local authorities, which will then pay that money back to the commission, either directly or via private and voluntary care providers. Would it not make more sense and cut costs somewhere along the line if the Scottish Executive funded the commission directly? That would seem a much simpler way of doing things.

Malcolm Chisholm: That would be cost neutral for local authorities, but we also have to take account of the places that are funded privately rather than by local authorities. We think it important that the cost of regulation should be made explicit, as that would give prominence to this new initiative to improve the quality of care.

Nicola Sturgeon: Is not the system of charging an artificial exercise?

Malcolm Chisholm: I do not agree with that—it is not a terribly complicated exercise.

Nicola Sturgeon: It is a triangle of funding rather than a straight line. Somewhere, that will add costs and complicate a system that could be much simpler.

Malcolm Chisholm: The triangle might apply to local authorities, but they are not the only organisations that pay for regulation.

Nicola Sturgeon: As local authorities are the purchasers of 80 per cent of places in private or voluntary care homes, they are—one way or the other—the main players. You seem to be going round the houses and creating an over-complicated system so that there is an arrangement that is explicit. By funding the commission directly, you could cut out much of that complication.

Malcolm Chisholm: No doubt that argument will continue to be put. I am not persuaded by it at the moment, because I do not regard the system as particularly complicated or cumbersome—it is a system that we are used to in relation to local authorities.

Nicola Sturgeon: Local authorities that might have to find the funding from current budgets might disagree with you.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): I will ask about the funding of the commission in relation to those who operate voluntary and private institutions. At present, institutions that provide residential and nursing care need two certificates and are visited by two sets of inspectors. The institutions that must currently register twice will be better off under the bill, because it will require that the whole situation is examined and will require only one inspection to be made. To what extent has that been taken into account in setting fees?

Malcolm Chisholm: Clearly, the issue that Margaret Jamieson highlights—the importance of integration—is central to the bill. We have a fragmented system at the moment, so the bill will create a much simpler system. Would you repeat your question on fees?

Margaret Jamieson: There are a number of residential and nursing homes that must pay a fee to be registered with a health board as well as a fee to a local authority for a residential care certificate. How much of that has been added into the calculation of fees for one-stop registration?

Liz Lewis (Scottish Executive Health Department): Margaret Jamieson is right that private and voluntary sector providers that must currently register with the health board and the local authority and pay two fees will have to pay only one fee. Therefore, there will be a saving for some providers. That saving applies intermittently and we have not taken it into account explicitly in setting fees, but there will be a reduction for some providers.

On the question of who pays fees, three quarters of the services that the commission will regulate are in child care. For the majority of child care services, parents rather than local authorities pay the fees. Most of the services that are involved are day care for children, including childminders and so on.

Margaret Jamieson: I find it extremely strange that, in setting fees, you do not take into account

how many homes have double registration. That suggests to me that you have plucked a figure out of the air for the charge in year 1, which you will increase accordingly in subsequent years.

Liz Lewis: The charge is based on the cost of regulation. It is based on an estimate of the time that will be required to regulate different sorts of services and what the cost to the commission will be. Providers are being asked to pay the cost of regulating the services. The amount that providers pay at the moment is only one factor and it is not the main one.

Dr Richard Simpson (Ochil) (Lab): I will make two declarations of interests. I am a director of a nursing home company, which functions in England and will not be covered by the bill, and I advise three local authorities on matters that relate to adoption and fostering.

First, is it the case that, under dual registration, people pay on a per-bed basis as well as paying a flat fee? If so, the combination of those fees would not produce a saving.

Secondly, it is possible that the Sutherland recommendations might be implemented. That would introduce free personal and nursing care, so it would level the playing field on the cost of care. Will the minister reconsider the relatively cumbersome registration process for fee costs? Most of the money that is involved will go round the system; it will have to be administered en route by numerous people and will involve vast amounts of paperwork. The Executive figures show that only 7,000 people are in private nursing and residential homes at the moment. We could debate that, but that is the current level. The overwhelming majority of places—four fifths—are paid for under the state system. That figure will increase to 100 per cent if free care is introduced under the Sutherland recommendations. What will be gained from registration costs being met in this way? The only gain seems to be of vast amounts of paperwork and bureaucracy.

Malcolm Chisholm: I cannot speculate about Sutherland. Members will be aware that a statement will be made on some of those matters next week. I was surprised—if I heard him correctly—to hear Richard Simpson talking about 100 per cent of care being free. That is a misunderstanding about Sutherland.

Dr Simpson: No. There would be free nursing and personal care.

Malcolm Chisholm: Yes, but obviously charges would still be made, even if the Sutherland recommendation on free personal care were implemented. It would not cover the costs of all care, so I think that the mention of 100 per cent is slightly misleading.

Since most of Richard Simpson's question was hypothetical, it would be unwise for me to venture into that territory.

The Convener: The committee will have to reserve its right to come back to the minister on that point in the wake of next week's announcement. If there were movement on Sutherland next week, as Richard Simpson alluded to, that would have an implication for this and other aspects of the bill. Following the statement, the committee would have to consider those matters and any further work that was being done by the Executive.

Shona Robison (North-East Scotland) (SNP): I apologise if my questions have been covered before I came in, but I do not think that they have.

First, will the minister confirm that the increase in grant-aided expenditure funding to local authorities will not be ring-fenced?

Secondly, many members have talked about the cost and bureaucracy of recycling the money. Have officials costed the bureaucracy of the system compared with a directly costed system?

Malcolm Chisholm: I will deal with the first question. I have not been involved in the detailed work on fees, so I will ask Liz Lewis to address that point.

Shona Robison reminds us of an important point about GAE—for almost everything, it is not ring-fenced. Members may have views about that, but it is a historic fact, which has been confirmed by the new arrangements that are being evolved between the Convention of Scottish Local Authorities and the Executive.

It may be timely for me to repeat the point that I made during question time last week. It is not only a matter of the extra costs; it is also about how much local authorities currently spend on the elderly. I am continually surprised at the number of local authorities that do not spend up to GAE—or anywhere near it—on services for the elderly. We must give increased attention to that issue. That is slightly off Shona Robison's main point.

The increase in GAE funding to local authorities will not be ring-fenced because that is the usual way in which money is distributed through GAE. That is relevant to our discussion on services for the elderly and the committee's report on community care. We must be mindful of the extent to which local authorities spend on the elderly the money that they are given for the elderly.

Liz Lewis: The answer to the question whether we costed two ways of funding regulation is no. The ministers took the decision that funding should be through providers paying for the regulation of care. There were questions about the extent to which that was not realistic for child care,

for example. As the committee will know from the financial memorandum, ministers have decided that they will subsidise child care. However, we did not cost two ways of doing that. It might help to add to the figures that are available. As the committee knows, the commission will regulate about 18,000 services, of which 2,300 are care homes. Generally, users, parents or others pay for the other services. Care homes are important, but they are only one element of the work that the commission will do.

10:00

Mary Scanlon (Highlands and Islands) (Con): When we thought of our questions, we did not know what would be the headline news today, but perhaps that highlights a point. Why were adoption and fostering not included in the range of services that will be regulated? Will you consider doing that further down the line?

Malcolm Chisholm: The white paper said that adoption and fostering agencies would be regulated. Provisions to do that are still being drafted and will be introduced at stage 2.

Liz Lewis: The national care standards committee will start work shortly on care standards for adoption and fostering services.

Mary Scanlon: What is the timetable for that work? Will there be an opportunity for the committee to provide input on the standards?

Liz Lewis: The care standards committee will examine adoption and fostering in the third tranche of its work, which will start about Easter and finish during the summer, when a consultation paper will be produced.

Malcolm Chisholm: The standards are being developed alongside the bill—the first tranche on care homes and mental health services has been covered, but others are still being worked on. It was unavoidable that not all standards would be finalised before the bill was introduced. If we had had to do that, the procedures would have been slowed undesirably.

Mary Scanlon: How will the code of practice for employers be monitored and enforced? The health board chief executives group is concerned and says that

"in order to deliver improved care for people, the standards must be enforceable and measurable. Based on the drafts issued to date for consultation it is unclear that either criterion can be met."

Chief executives have serious concerns about whether the standards will be clear, enforceable and measurable.

Malcolm Chisholm: We have not reached the last word on the care standards. The formulation of the care standards has been an inclusive process. Fourteen groups have worked on them and produced the first tranche of draft standards, to which we have received quite a lot of responses. People accept that the standards have not yet been finalised. The intention is that the standards should drive up quality. We do not want standards to set a minimum level that people do not aspire to go beyond. That is why we are trying to capture quality indicators. Sometimes, they are difficult to quantify. The exercise is difficult.

Liz Lewis: An inspection methodology working group is being set up. People have responded to a trawl for members of the group, which will meet at the end of this month. It will consider how the commission will inspect through use of the standards and it will examine the matter that Mary Scanlon raised about how standards can be measured and evaluated.

Mary Scanlon: All members are naturally in favour of best practice and raising standards. However, if a care home did not attain the standards, would it be given a timetable for meeting them, a further inspection or would sanctions be imposed? Could such a home be closed down? What sanctions does the bill make available to ensure that homes reach and consistently maintain the standards?

Malcolm Chisholm: The central provisions of part 1, from about section 7 to section 17 or 18, set out the processes. Those sections have been welcomed and I have heard no substantial criticism of them. There are various stages. For example, section 9 is about improvement—notice can be given that a certain improvement must be made by a certain time, otherwise action will be taken. Section 11 deals with condition notices; if a home or other care service has been registered, the conditions may be changed. Sanctions would be available if those changes were not implemented. Section 16 deals with urgent procedures for cancellation of registration. At the moment that is a very difficult process, which is why people feel that vulnerable people do not have the protection that they need. Section 16 introduces a new procedure in cases where something is seriously wrong.

Mary Scanlon: Section 16 provides for application to a sheriff for an order and section 9—on improvement notices—talks about

"such reasonable period as may be specified in the notice"

I want to know how to firm up the process.

Malcolm Chisholm: That is an important point. A distinction can be drawn between the section 16 procedure and the other procedures. Section 16 provides for emergency procedure, when immediate action must be taken. The earlier sections deal with the more common procedures.

Mary Scanlon: Could section 16 be applied if a care home was given six months to achieve certain standards, but it did not achieve them?

Malcolm Chisholm: Section 16 would not be required in such a case, because the time would have been set in the improvement notice. If a service receives an improvement notice, the improvements must be completed by a certain time, or action will be taken. Section 16 will be used when we cannot wait for six months.

Mary Scanlon: I see. That section is for when circumstances are so bad that a home must be closed immediately.

Dr Simpson: There are three distinct groups. First, there are emergency situations—which you explained well, minister. Secondly, there are cases in which standards of care in a home might require improvement and notice might be given on that. Thirdly, the physical circumstances of the home may require improvement or perhaps major alterations—for example, to change from double rooms to single rooms, to provide en suite bathrooms or whatever. I am sorry to go into such detail, but the local authority fixes the majority of the income of the homes and the inspection teams will require improvements in quality. Will the minister take powers under the bill to ensure that the income that is provided to homes to help them meet the required standards will rise in parallel with the required improvements? If not, that will lead to more closures of homes, perhaps unnecessarily. Many care home owners are extremely worried by situations where that currently happens because the local authority is both the inspector and purchaser. The separation of those things will be important.

Malcolm Chisholm: We are back to money, which is obviously important. Some of the changes that Richard Simpson referred to could involve quite a long lead-in time. However, some of the details in the standards have not yet been finalised; for example, whether every care home should have single rooms. Discussion continues on that.

Representatives of the independent sector were on the national care standards committee and have endorsed the standards that have been drafted so far. They might be concerned, but they are obviously not over-concerned that it will be impossible for them to deliver. There is a continuing debate about the market for nursing homes and residential care and a lot of work will be done on that in the near future. Clearly, we need to consider the possible cost implications. However, the lead-in times and the acceptance by the independent sector of what has been agreed so far lead me to think that there is no need to be too alarmist—not that I am suggesting that Richard Simpson is being alarmist.

The Convener: Heaven forbid.

Dorothy-Grace Elder (Glasgow) (SNP): First, section 3 refers to ministerial powers to amend the definition of care service in order to add to the services that are listed, which seems a sensible and flexible provision. Will there be an on-going commitment that the philosophy of full consultation will prevail in future, if such changes are made? We can guess what types of changes may be made, but could you give us a few examples?

Malcolm Chisholm: Dorothy-Grace Elder raises an important point—I am sure that it has not escaped the committee's notice that there are references in the bill to orders and regulations that could change things. Last night, I received the submission that the committee got from the chief executives of the Scottish health boards. I was interested in their comment on page 2, which refers generally to the bill, but also states:

"In considering the Bill it is important to ensure that it remains sufficiently flexible to meet changing needs in the regulation of care and professional social work practice without the need for extensive and time consuming revision."

I suppose that they mean primary legislation. The submission continues:

"As a general principle as much discretion as possible must be given to allow changing circumstances to be addressed by Regulations, Directions and other secondary devices."

As I said to the committee last week when discussing the Tobacco Advertising and Promotion Bill and regulations, there will be consultation. Indeed, I have undertaken to write to Margaret Jamieson to give details of how that consultation will take place.

On Dorothy-Grace Elder's other point, I do not know whether we can predict the changes that will take place. If we could predict them, we could put them in primary legislation. The provision to amend the definition of care services exists because of future developments that we cannot predict. It is therefore sensible to have that kind of provision. The change of definition would be done by regulation. That would not only be consulted on; it would come before the Health and Community Care Committee, which would have the right to throw out such changes if members wanted to do that.

Dorothy-Grace Elder: So the philosophy of consultation would continue.

Secondly, on section 72, which is on page 15, and on subsection—

Malcolm Chisholm: What section are we on?

Dorothy-Grace Elder: Section 21, under inspections, and page 15.

The Convener: I am sorry, but could you clarify where you are, Dorothy-Grace?

Dorothy-Grace Elder: I should have said that I am on paragraph 72 on page 15 of the explanatory notes, which states:

"Subsection (11) makes it an offence for a person to intentionally obstruct an inspection under this section or section 22. The penalty on summary conviction is a fine not exceeding level 4 . . . £2,500 at present".

Was consideration given to making it an offence to have knowledge of ill-treatment or inappropriate behaviour but not to divulge it, either to the police, the Scottish commission for the regulation of care or the Scottish social services council? I think that you will agree that one of our best hopes for whistleblowing on bad behaviour and ill-treatment in care institutions lies with the staff, who might be afraid to come forward. While it is clearly an offence to obstruct an inspection intentionally, there is a concern that people will be afraid to tell authorities—in any shape or form, be it the Scottish social services council or the Scottish commission for the regulation of care or whatever—when they suspect that there is ill-treatment. Have you considered making it an offence for somebody who has knowledge of ill-treatment not to reveal it?

Malcolm Chisholm: At present that is not an offence. It would be covered by the code of conduct for the social services council. There would certainly be an expectation that somebody would divulge such information, but it is not written into the bill that it is an offence not to do so. I shall give further thought to that, but it is certainly covered by the code of conduct.

Dorothy-Grace Elder: I do not mean that we should attempt to intimidate staff, but knowing that it was an offence not to divulge such information might encourage staff to come forward and override their negative considerations about whoever is in charge.

10:15

Shona Robison: I have a more general question about inspections. One of the proposals is to reduce the number of mandatory inspections to one per 12-month period. At the moment, care homes are inspected twice a year. I understand that the change is concerned with directing resources to where problems exist—the thinking behind that being that care homes that are ticking along nicely will not require inspection more than once a year.

However, we can envisage a situation in which there is an 11-month gap until the next visit, during which standards in a care home could fall dramatically. Eleven months is quite a long time for standards to drop without any inspection taking place, with no alarms being rung or any alerts being given. What systems would be in place for monitoring, given that care homes will have on average only one visit a year?

Malcolm Chisholm: Once a year is a minimum. New providers and care homes that give cause for concern would, of course, be inspected more often than once a year. Much of the debate has centred on care homes, which are obviously extremely important. However, child care facilities are inspected only once a year at the moment, so it is only in relation to some care services that there will be a change. We must consider the fact that the change will enable inspectors to concentrate on the new services and those that give concern. That is the correct balance for the use of resources.

Shona Robison: Would the inspections be announced or unannounced?

Malcolm Chisholm: The bill makes provision for both. The annual inspection would be announced, but there is provision for unannounced inspections as well.

Shona Robison: If the regular, once-a-year inspections will be announced, there might not be any unannounced spot inspections.

Malcolm Chisholm: It is not made explicit in the bill that the annual inspection will be announced. Usually, it would be, but it certainly does not have to be announced. The bill says merely that there must be a minimum of one inspection a year.

Nicola Sturgeon: I share Shona Robison's concerns about the regularity of inspections. The system is being promoted as intending to improve the quality of care. Purchasers and providers will be expected to pay heavily for it. In some circumstances, people would not object to that, but the bill appears to provide for a system that is less rigorous than the current one. That is something that might have to be considered in greater detail.

My question relates to the provision whereby, in years when there is to be an inspection by Her Majesty's inspectors of schools of early education facilities, there will be no commission inspection. On the face of it, that might seem sensible, but the focus of HMI inspections is somewhat different to what the focus of commission inspections will be. What collaboration will the commission have with HMI to ensure that all bases are covered, regardless of which body inspects early education centres?

Malcolm Chisholm: I shall let Jane Morgan answer that question. The last time I did this kind of job, I did a lot of work on child care. I have an interest in the subject and some knowledge of it, but my knowledge is not as great as Jane Morgan's.

Jane Morgan (Scottish Executive Health Department): It will be very similar. HMI is about to start using a revised set of performance indicators, which cover care and education. It is explicit in the papers that have been issued so far that the care standards for the commission will be aligned closely with the new indicators, which are set out in a document called, "The Child at the Centre". The difference for HMI is that the indicators will pay more explicit attention to the structure of the curriculum.

Mr McAllion: I understand that the intention is that only one inspector will carry out an inspection. At present, two inspectors usually are present during an inspection. That is cause for concern. Why is the number of inspectors being reduced?

Malcolm Chisholm: I do not think that any decisions have been made on that issue. As has been mentioned, an inspection methodology working group is just starting up, which will consider the number of inspectors who conduct an inspection.

Mr McAllion: Could it be that two inspectors will still be involved in every inspection?

Malcolm Chisholm: That could well be the case.

Mr McAllion: When will we know? I would like to know the answer before the committee decides whether to support the bill.

Malcolm Chisholm: The issue has come up before in relation to some of the on-going work. I imagine that the group will have come to some conclusions by the time the bill gets to its latter stages. I do not imagine that there will be any conclusions in the next two months. I hope that John McAllion's approval of the general principles of the bill will not turn on that matter.

Mr McAllion: It may or may not. It would be helpful if we could get the information. We do not like giving blank sheets to ministers or to the Executive.

Malcolm Chisholm: We should have some idea by the time we get to stage 2 of the bill.

Margaret Jamieson: It will come as no surprise to Malcolm Chisholm that I will be asking about staffing issues. Could you talk us through the role of the current social work services inspectorate in the new set-up?

Malcolm Chisholm: That is a good question and one to which we do not have a final answer. The committee will be talking to Angus Skinner later and I am sure that you will ask him the same question. I can say that serious consideration is being given to the matter and that the role of the inspectorate will change.

Margaret Jamieson: We understand that the Executive wants to use the bill to build public confidence in the care work force by ensuring that quality standards are met. What are the implications for social work training of ensuring that staff are equipped to meet the standards?

Malcolm Chisholm: Money is already being given to local authorities for training. Part of the bill's intention is to drive up standards in the workplace. Are you asking me about funding specifically or about the arrangements for training?

Margaret Jamieson: I am asking about funding, but I am also thinking about training for those who provide care, irrespective of whether they fall under the professional register or the care register for non-professional staff. The minister will be aware that, in the past, significant emphasis has been placed on professional training and that, sometimes, no training has been given to those who are defined as non-professional. I am interested in the direction of the Executive's policy, as I am aware that some areas are moving towards ensuring that equity of training is available.

Malcolm Chisholm: I completely agree with the general point that Margaret Jamieson makes. One of the good results of the formation of the council is the fact that training will be given to a wider range of social services staff. I have the current figures for money for training. In 2000-01, local authorities will have spent £8.2 million of their core expenditure on staff training. Furthermore, in the same year, the Scottish Executive has made £6.2 million available through the training specific grant and through payments made under section 9 of the Social Work (Scotland) Act 1968. We expect that funding to continue and to cover a wider range of people than in the past.

Margaret Jamieson: Will certain councils require specific direction in that regard?

Malcolm Chisholm: There is provision for direction. That is one of the council's powers and it might well be necessary to use it in certain cases.

Margaret Jamieson: I want to move on to discuss the future planning of the work force and the registering of staff. Can we take the bill to mean that all staff will be registered from the outset? That is currently not specified in the bill. What will be the timetable for registering staff? Over the next few years, individuals will qualify in certain areas. Is the intention to start registration early in the process, when an individual qualifies?

Malcolm Chisholm: As I said in my opening statement, although the first two tranches of registration of the work force have been announced, the figures have been changed in view of the consultation—more people will be able to register quicker than was initially intended. There is no specific timetable for when everyone

will be registered; we are taking things step by step.

Margaret Jamieson: If you are setting training standards, would it not be in the best interests of delivering a service to the people of Scotland to pick up on the people coming out of educational establishments with the necessary qualifications and ensure that they are placed on the register at the outset?

Liz Lewis: As the policy position paper sets out, all professionally qualified social work staff, residential child care staff and so on will be in the first tranche. However, the council will register categories of staff as opposed to individuals and then will require staff in each category to become registered within a certain period. The first tranche will contain 12,000 people and the second up to about 60,000, which means that we will be well through the total number of staff by the end of the second tranche. That will take some time, but we hope that it will happen by 2006. There is concern that the council should not run before it can walk; we should take things in steady stages and see how the system works to ensure that we do not take on too much in the first tranche and find that the system is breaking down. We must ensure that we have a secure system, which can be used effectively.

Margaret Jamieson: Forgive me, but I am not talking about one specific group in the work force. The problem that has been identified is that there has been too much emphasis on one group of staff—social workers. Although we all accept that there must be appropriate registration and continuing professional development for that group, the council will be involved in work force planning and in setting training standards for all groups of staff, in particular the forgotten group in all this—the nursery nurses. There must be further development to meet the current training needs of those individuals. Would not it be in the best interests of driving up standards to indicate from day one to people who have completed their training that they are on the register? That would create an opportunity to maintain standards.

Liz Lewis: Nursery nurses involved in early-years education and child care will be in the second tranche, so they will be a priority.

Margaret Jamieson: En bloc, they will be a priority, but individual nursery nurses will qualify in year one. Why leave registration for a year? Much can be lost in a year.

Malcolm Chisholm: Clearly, there is a slight difference in the time scales. However, the point remains that there will not be only social workers in the first tranche. I think that people would agree that children's residential care workers should be included in the first tranche, because children's care is a priority and is a great concern for people. All child care workers will be in by the second tranche, which will cover a lot of the people Margaret Jamieson is concerned about.

I understand the point that is being made, which addresses things from a slightly different perspective. However, practical issues arise over how effectively or quickly registration can take place. It is still open to us to accelerate the process if that is possible, but it is probably most practical to do it in tranches.

10:30

Dr Simpson: I want to ask about the interrelationship between existing organisations and the proposed new commission. At the moment, a considerable amount of long-stay care is provided within the health service, although that is gradually changing. The Scottish Health Advisory Service provides inspection of those facilities. What will be done to ensure that the standards for long-stay care are uniform wherever people are? How will the new commission link with SHAS?

I want also to ask about the Mental Welfare Commission for Scotland and its involvement, outwith the health service, in the care of people with mental health problems.

Malcolm Chisholm: Under the new system, things will continue as under the present system. Meetings have been held with the bodies to which you refer, as we try to ensure that, where appropriate, there are, as far as is possible, common standards.

I am not sure whether you were going to ask a supplementary on the way in which services for continuing care will develop in future. Perhaps you will leave that for another day.

Dr Simpson: I think so, yes.

Malcolm Chisholm: At the moment, we accept that there will be different bodies inspecting particular groups of people. However, there has been, and will continue to be, contact. We will try to have consistent standards across the whole service.

Dr Simpson: There may be an opportunity for some commonality of function. Some savings could be made by combining the functions to some degree. That will be a matter for discussion, but I would suggest that it be considered.

One of the consequences—unintended, I think—of having a single registration system will be the loss of the residential qualification and of the nursing home qualification, which, at the moment, are important in determining income in the independent sector. With dual registration

systems, beds registered as residential home beds tend to be paid for on the basis of residential accommodation; those registered as nursing home beds are paid for on the basis of nursing home accommodation. Those boundaries are inappropriate and the bill recognises that. Taking the boundaries away recognises the fact that people move from one level of dependency to another. However, as a consequence, there will no longer be a uniform level of prices—because there will no longer be dual registration but single registration. How will you ensure that the purchaser recognises the dependency needs of individuals—in the nursing home sector in particular, but also, to a growing extent, because of dementia, in the residential home sector—so that the standard of care and the necessary funding are provided? What mechanism will there be to appeal against the purchaser in the event of their trying to purchase care at a lower level than is required?

Malcolm Chisholm: That is an interesting and important question. Clearly, there are many developments in that territory. I thank Richard Simpson for not referring for the second time to Sutherland.

The chief medical officer is working on the assessment of nursing care and is trying to consider it in a different way. Perhaps the key issue is trying to assess dependency levels. Interesting work is being done—some of which will be piloted in the near future—which will help to answer some of the questions that Richard Simpson asked. We need to examine the different assessment frameworks. Work has to be piloted and we must do more work in that area. Such an approach is consistent with a move towards single-care homes. We are trying to get beyond the crude categories that we have at the moment.

Dr Simpson: I welcome that.

Under any system, local authorities will remain the main purchasers of care and will continue to be providers. Indeed, under the bill, they will—rightly—be able to provide nursing home facilities, so they may become bigger providers of care. I want to be sure that there will be some sort of reserve power in the bill to allow for an appeal mechanism against purchasers who are also providers.

Malcolm Chisholm: You make another important point. I agree that we must have confidence in the system, which means that there should probably be some kind of appeal mechanism. I am not sure that such a mechanism has to be provided for in this bill, as there are other matters relating to long-term care that will require legislation. It may be that such issues should be dealt with later.

Dr Simpson: We will perhaps return to the issue at stage 2.

Mary Scanlon: We spent the best part of last year examining care in the community, in particular for the elderly. I was surprised to hear that 18,000 services would be regulated and that 2,300 of those would be care homes. What is the breakdown of those services? We are not asking about independent clinics and so on. I wonder whether we are concentrating too much on councils and health boards.

Liz Lewis: There are about 8,000 childminders and about 4,000 day care services for children, so three quarters of the work of the commission—

Mary Scanlon: There are 8,000 childminders and 4,000 nurseries or playgroups for children, which adds up to 12,000 providers, and 2,300 care homes.

Liz Lewis: There are about 550 adult day care services and a small number of other services that the bill will regulate. Roughly half the services that will be regulated will be childminders, a further quarter will be day care services for children and the balance will be made up, in the main, by community care services.

Mary Scanlon: I have a final question on section 24. I am trying to get my head round the independent clinics. How many of those will be subject to regulation under the bill?

Liz Lewis: There are very few such clinics in Scotland, but they are part of a sector that could grow in future.

Mary Scanlon: The majority of services that will be regulated are provided by childminders.

Liz Lewis: Yes, but clearly the amount of work involved in regulating a childminder is much less than that involved in regulating a care home or a major service, so I do not suggest that childminders will represent half the work of the commission.

The Convener: What steps will be taken to ensure that any new complaints procedures fit in with existing complaints procedures?

Malcolm Chisholm: Section 6 deals with complaints procedures. As well as the consent of Scottish ministers, subsection (3) requires that

"all local authorities and health bodies"

be consulted. There will clearly be extensive consultation on that important issue. I am not sure whether the question suggests that we should learn from existing procedures or ensure that we do better, but we are not committed to replicating what exists. There will be extensive consultation, and the consent of ministers will be required before complaints procedures are established.

The Convener: Some of the existing complaints procedures are under review anyway, and you hope to learn lessons from that review.

Malcolm Chisholm: I know that the committee has examined the complaints procedures for health bodies. The independent health care providers are concerned that the complaints procedures to which they will be subject may be different from the national health service complaints procedures. However, we realise that the NHS situation is fluid and recognise that improvements to its procedures are required. We must make progress on all fronts. We look forward to hearing about the committee's work on complaints procedures.

The Convener: I thank the minister and his officials for answering our questions. We will take a short break.

10:41

Meeting adjourned.

10:50

On resuming—

The Convener: For the next session of questioning, we welcome the chairman of the health board chief executives group, Neil McConachie, and Paul Gibbons. Good morning, gentlemen. Thank you for coming to give evidence to the committee on the Regulation of Care (Scotland) Bill. We have received the paperwork that you submitted to us, for which I thank you. You are allowed to make a short statement, after which we will ask you some questions.

Neil McConachie (Health Board Chief Executives Group): Thank you and good morning. The Scottish health board chief executives welcome this opportunity to present evidence to the committee on an important bill. I shall make an opening statement on behalf of the group, and I shall then be happy to answer your questions.

Paul Gibbons, who accompanies me today, is the chief nursing adviser at Argyll and Clyde Health Board and has a lot of experience in nursing homes. He is also the nursing representative for health boards and the sole health board representative on the ministerial reference group that has been involved in the preliminary consideration and preparation of this work. Mr Gibbons will answer any questions that members may have on specific points of detail.

The health boards welcome the major thrust of the bill, which is to enhance the protection of some of the most vulnerable members of our society. Boards can also identify with the twin regulation of care and of the social work profession that is proposed to achieve that. The regulation of both nursing and residential homes is some years old and is always worth updating. The establishment of the Scottish commission for the regulation of care should address many of the concerns that exist among those who are involved in care work, including the increasingly artificial divide between residential and nursing home care, which will be removed by the creation of the single-care home.

The national care standards should ensure that a person receives consistent care wherever they live in Scotland, which is extremely important. There will be consistency regardless of the nature of the operator who is providing that care. That should reassure national health service and social care staff who are working to commission and provide services for the affected client groups in the community that standards will be maintained. Health boards also welcome the proposals in the second part of the bill, to establish a Scottish social services council.

It is important to ensure that the legislation remains sufficiently flexible to meet changes in the regulation of care and professional social work practice without the need for extensive and time-consuming revision. As a general principle, we urge as much discretion as possible to be used in allowing changing circumstances to be addressed by regulations, directions and other secondary devices.

The committee has received my submission, but I shall highlight a couple of issues on which members may want to comment, which we think are important. The commission will have new and welcome powers to issue improvement notices, to impose conditions and to proceed urgently with the cancellation of registrations. Experience has shown that, if those powers had been available to the present regulatory authorities, standards in care homes would have improved more quickly than has been possible. That is well captured by the phrase, "Encouragement can be inadequate, but deregistration too severe."

The suggested powers may allow some movement that prevents deregistration and is slightly more forceful than encouragement. That is important when we consider some of the wording that frames the national standards. If we are to have something that is in between encouragement and deregistration, it is appropriate to have national standards. However, to deliver improved care, the standards must be enforceable and measurable. The draft standards that have been issued for consultation make it unclear whether either of those criteria can be met. In addition, what does the expression "taken into account" in section 5(3) mean for enforcement and measurability? For the standards to bite, the

commission must be able to insist on their implementation.

I will highlight a second point and then answer questions. For the commission to be effective from inception, it is essential that at least some of the NHS staff who work in regulation transfer to its employment. The health component is a relatively small proportion of the bill. If careful attention is not paid to the transfer of NHS staff who have experience of registration in health matters, the commission may be swamped by the size of the work that regulation and inspection requires. We recognise that it is difficult for detail to be progressed on that issue before the bill becomes law, but it is vital that the Executive maintains and where possible improves its communication with those key staff, to prevent their loss from the system. That is a possibility if those staff do not see an attractive and fulfilling career path in the new system.

Mary Scanlon: I will ask a general question, and in your reply, I would like you to address two points that are in your submission. What are the main implications of the bill for health boards? You have already given some of them.

You just made the point that your staff know the operators and senior staff of the homes that they regulate, that such relationships are beneficial and that the commission could disrupt those arrangements. I did not really like that negative tone. How can that potential disruption be overcome so that the transition is smooth for the homes, the staff and others?

On the final page of your submission, you talk about losing a statutory duty and a financial resource. You could not lose a statutory duty without losing a financial resource. Given that another body has taken the responsibility, surely you are at a standstill. Why is that a concern?

Neil McConachie: I emphasise that we welcome the bill as a whole and that we are not taking a negative tone against it. Health boards in 15 areas currently do the work, so there is a great deal of local knowledge and understanding. Relationships can be built because, daily, people work closely with the providers. If regional offices take on the work, as is being considered, people will become more distant from some of the providers and the relationships might be disrupted. Our concern is more a sensitivity about the balance between regional and local offices, and about losing strong relationships that have built up over time locally.

I entirely accept Mary Scanlon's second point. It is not listed under "Concerns"; it is merely listed under "Consequences of Enactment". You are right that as it is a statutory responsibility, it is inevitable that it will involve financial transfer. I would not say that it was a concern; rather it is a fact. Obviously, anything that reduces flexibility would cause us to reconsider how things are done.

Mary Scanlon: It would be very sad if we were to begin with comments that the provisions would be disruptive. Given the time for consultation and the lead-in time before implementation, perhaps we can get off to a more positive start. What should be done to ensure that there is a harmonious movement towards the new regulations?

11:00

Neil McConachie: I accept that you have read our comments that way, but they were not intended that way. We were simply trying to highlight the point that anything that increases geographical distance can weaken relationships, through travel and so on.

Mary Scanlon: If you think that geography is a problem, what would satisfy your interests, given that there will be five organisations for the whole country?

Neil McConachie: At that point, we have to fall back on the idea that within those five regional centres, people will have dedicated responsibility for a particular area, to ensure continuity of relationships. It is important that the people who are fairly far away from the regional centre see the same people and can build strong relationships. If the divisions of responsibility are not geographic, they might find that they have to deal with many different people. We must ensure that people have strong geographical associations in order to maintain local relationships.

Mary Scanlon: Are there any other implications for health boards that should be covered?

Neil McConachie: We are probably more concerned that the thrust of the bill should be towards the people to be looked after than we are about the implications for health boards. We see this as a step forward in ensuring consistency. The implications for health boards are secondary, as long as the experience that they have in working in the nursing home sector is transferred, to sustain integrity and ensure that the health component of the bill is suitably maintained and not diminished because it becomes a smaller part of a larger organisation. That is the bigger issue. We welcome the bill but we do not want the health component to be diluted.

Mary Scanlon: I am pleased to hear that you are putting patient care before the interests of your fiefdom.

Neil McConachie: That is why we work in the national health service.

Mr McAllion: You mentioned that you were concerned about the application of national care standards, particularly in relation to section 5(3), which includes the phrase "taken into account". Could you explain that further? Are you not encouraged by the fact that the section says "shall" be taken into account, rather than "may" be taken into account?

Neil McConachie: We could kick that point back and forward all day. We used it as an example of why the wording is important: "taken into account" could be interpreted quite loosely. I would defer that to the legal experts for consideration. If the commission made a decision and said that it had taken into account the national care standards, but the decision was challenged, it would be important to know what "taken into account" meant. How would the commission show that it had taken something into account? The looseness of the wording must be addressed so that it can be demonstrated whether something has been taken into account. We used one example to highlight that problem.

Mr McAllion: From my long experience of Westminster, I recall that Governments down there resisted bitterly any introduction of "shall" instead of "may". The Government here has accepted "shall"—that is encouraging. It is commendable that the bill opens up the possibilities of having single-care homes throughout Scotland and of an associated national standard.

Homes that hold health and social work registration are a rarity. You say that turning that concept into reality could be problematic. In what way might problems arise in creating a network of single-care homes? What has to be done to ensure that they become a reality?

Neil McConachie: I will ask Paul Gibbons to contribute, as he has greater experience in that area. From a health point of view, we need to consider situations in which someone starts off requiring social care and then, either suddenly or over a period, requires nursing care. Sometimes, if their health ameliorates, they might return to residential care. There is an ebb and flow.

There are implications for the commission's consideration of how someone who has moved from one category to another, of when they moved and of when they returned. Close work between the health community and the care community would be required in order to make decisions about the category that somebody was in.

The present situation seems more distinct, but to change the category of people who live in either a nursing home or a residential home almost means moving them to a different home, which is not acceptable.

Mr McAllion: Are you suggesting that there could be serious staffing problems in a single-care home, in its attempt to meet the fluctuating demand for residential or nursing care?

Neil McConachie: Staffing requirements could undoubtedly increase.

Mr McAllion: The people in those homes could be at different stages, and it would be impossible always to know the required staffing ratio.

Neil McConachie: I will now ask Paul Gibbons to address the matter, as he has more experience of the staffing requirements in nursing homes. Clearly, if people move about quickly between categories, the staffing requirements will have to be adjusted quickly.

Paul Gibbons (Health Board Chief Executives Group): Staffing and management arrangements will need to be addressed, but the more fundamental issue is to change the culture from that of residential homes and nursing homes to one of single-care homes. That will require a change both on the part of the public sector and private sector operators and on the part of the people responsible for assessing the need of people to go into single-care homes. That also applies to assessment of need once the person has got into the home. We should all welcome the fact that the concept of a home for life, which has existed for several years, will be realised through the changes that the bill will bring.

When a person goes into nursing home or residential home care or, in the future, into a single-care home, they will stay there for the rest of their life unless they need acute intervention by the national health service. That, from the user perspective, is the important thing.

Mr McAllion: Will it be the role of the Scottish commission for the regulation of care to ensure that the changes in culture and in staffing arrangements are in place?

Paul Gibbons: That is one of the key challenges facing the commission.

Janis Hughes (Glasgow Rutherglen) (Lab): Under the current system, working relationships have built up between the NHS and local authorities because of the joint working arrangements. How do you envisage those relationships being maintained under the new system, with particular regard to the regulatory framework?

Neil McConachie: I will ask Paul Gibbons to address the specific part of that question but, generally, the relationships between local authorities and health organisations are strengthening across several fronts as we move towards community planning with the various interactions that take place.

I have a lot of confidence that, in the wider arena and at all levels of the organisation, from leadership to the people working on specific areas of expertise, the generic strengthening of relationships will cope with any of the potential weakening that might develop as a result of the bill. The relationships and the trust between the various bodies will be there to help with any issues that arise. On a specific level, that will depend on those who have those areas of expertise keeping a close association. I am heartened that the strength of the relationships that are building at the moment will deal with those issues.

Janis Hughes: Do you see a need to put a framework in place to deal with that? Given your current experiences of your relationship with local authorities, do you see that continuing and being almost a courtesy thing, or might there be a need to put frameworks in place to ensure that there is a relationship and people are talking to each other?

Paul Gibbons: As always, the devil is in the detail.

A key issue that the commission will have to consider when it receives an application for registration is the on-going clinical care of people in the proposed single-care home. That will require dialogue with local general practices, dental practices and optical practices. I see the health boards and primary care trusts having a co-ordinating role in assisting the Scottish commission for the regulation of care in putting those arrangements in place. I would have thought that whoever the regional lead for the commission was would want to develop good relationships with local health bodies early in their tenure in the post.

Neil McConachie: This is probably a personal point rather than a representative one, but generally I am wary about jumping in to set up frameworks to force relationships to work in a particular fashion. Coming back to my earlier point, I think that as relationships grow, appropriate frameworks will be more easily identified before specific issues have been identified.

Dr Simpson: One of the consequences of the closure of long-stay beds and the shift into the independent and private sector has been concerns about the patchy nature of the medical cover provided in nursing homes. We hear much about regulation of care standards. As Paul Gibbons said, part of that will be about clinical standards. Would you be happy for the Scottish commission for the regulation of care to have a role in determining the necessary medical input, or should SHAS or the Mental Welfare Commission for Scotland have such a role? Good research evidence demonstrates that medical care of the elderly in residential and nursing home accommodation is patchy—that is being fairly polite about it. Generally, it has not been funded as it has come under long-stay care, although some health boards have separate contracts with general practitioners for it. How should that element of care be regulated?

Neil McConachie: My first reaction to that, without going into the structure of the NHS, is that the purpose of primary care trusts was to bring to primary care not an administrative aspect but a supportive management aspect that could consider and identify relationships with local practitioners that might suit the provision of care for the elderly.

My instinct is that we will end up with continued patchiness if the commission starts from a national level, because at that level it will be difficult to identify some of the local variants that will be required to meet the geographies across Scotland.

I accept the commission having a role if that role is developed on a bottom-up, top-down and meeting each other basis. To start off without the heavy involvement of the primary care trusts and the local practitioners in deciding what could reasonably be expected to be provided and funded on an individual geographical basis might be a step too early. If the commission were to be involved, I would hope that it would be after a period of extensive work by those groupings to come up with something that was locally practical. I see that as part of the move from administering primary care to putting in place supportive management.

11:15

Dr Simpson: Do you envisage the commission having a role in discussions with the other bodies such as primary care trusts—or whatever they are to be called—to agree standards and inputs locally and quantify them and to make sure that preventive work is done in residential homes, as it is not being done at the moment?

Neil McConachie: I do not know how involved in enforcement the commission would be, but it would be entitled to ask about the issues that you mention and be assured that the standard of medical coverage was adequate for the level of provision that was being made in an area.

Dorothy-Grace Elder: I want to ask about whistleblowing, which I raised with the minister earlier. We all know that, in order to root out abuse and bad practice, we need inside information from staff and, sometimes, visitors. Would you favour the setting up of a whistleblowing service at a local hospital board level or the setting up of a national whistleblowing service, perhaps directly under the control of the commission?

Neil McConachie: I am a great believer in the fact that matters are dealt with better at local level

and that they should be elevated to a regional or national level only if they cannot be resolved by discussions at that level. Only in extreme cases where resolution was not taking place and there remained strong concerns about the provision and its quality would I expect the matter to be bumped up a level. That may well be required and can be facilitated. The ombudsman is the final resort. Generally, I favour a local approach.

Dorothy-Grace Elder: How local might that be? Might it be a hospital trust or might it be a health board?

Neil McConachie: In relation to the services that will be regulated by the commission, "local" would be the local office of the commission. I do not think that the whistleblowing procedure of the commission would interact with the NHS. There have to be clear lines so that if someone in my position in a health board becomes aware of concerns in a care home or a regulated service, those concerns can be brought before the local office of the commission. The responsibility has to be with the commission.

Dorothy-Grace Elder: Do you agree that whistleblowing by staff needs to be encouraged more? We have heard that it is through such soft evidence that some serious cases of abuse have been unearthed. Do you agree that we need to do more to encourage people to come forward and to alleviate their fear that they might be intimidated?

Neil McConachie: I agree, but I would add a note of caution. There are always opportunities for disenchanted individuals to take advantage of opportunities for whistleblowing. However, I agree that any member of staff in a regulated service should have the opportunity to make their concerns known to the appropriate person, who would be a member of the commission.

Shona Robison: You made some comments about inspections and voiced your concern about the number of inspections each year. We questioned the minister about that. You also referred to single-handed visits. The minister was not in a position to confirm whether that was a definite proposal. Is it your understanding that single-handed visits, rather than inspections by two inspectors, are definitely proposed? If so, do you think that that is due to staffing or budgetary constraints? Why do you think that that has been proposed?

Paul Gibbons: That is a detail that is not yet clear. It is mentioned in our submission to flag it up as a potential area of concern. There are many homes where one inspector could go in and do an inspection issue report. There are other homes that will always need two inspectors in case they find something that is so seriously amiss that there needs to be an immediate cancellation. In my experience, it is unlikely that that situation would develop cold. There would normally be a series of incidents, complaints and issues leading up to that point, and the local managers of the commission would have to make a professional judgment as to whether one or two inspectors were needed.

We included that point in our submission to highlight it. As far as I am aware, no proposal at that level of detail has been agreed to.

Shona Robison: Am I right in saying that, in the normal course of events, you would not have undue concerns about a single-handed visit, but that you would want the flexibility for someone else to be brought in if concerns had been raised?

Paul Gibbons: That is right. If it came to the point of cancelling the registration of a home, there would have to be corroboration.

Margaret Jamieson: I would like you to address some of the staffing issues. Your submission says of the commission that

"it is essential that at least some of the existing NHS staff working in the field of regulation transfer to its employment."

You also comment on the number of regional offices, and express concerns about the consultation process, in which staff in the health sector feel that their views have been somewhat swamped by those of staff in the residential and social care services. What do you mean when you say that there must be consultation with existing staff? Do you mean your own NHS staff, or do you mean all the staff who will be transferring?

Paul Gibbons: At present, 13 of the 15 health boards have registration and inspection functions in relation to nursing homes. They vary in size from very small units in the Western Isles to units in Lothian and greater Glasgow with considerable numbers of staff. Within those teams and units there are a range of health care professionals, including nurses, pharmacists, dieticians who advise on nutrition, fire safety officers and people who advise on building. For the commission to run smoothly at the point of its inception, there is a need for some of those staff, if not most of them, to transfer into the commission to assist it in establishing its systems and in regulating the nursing homes that will transfer to it.

The comment in our submission about the overwhelming preponderance of social care is due purely to the fact that the considerable bulk of the services that are to be regulated by the commission will be non-health services. The two areas that are regulated by the NHS at the moment are nursing homes and private hospitals—the minority of the services that will be regulated by the commission. It is important that the need for those services to be maintained is not overlooked.

The Executive team that is implementing the proposals to establish the commission is working hard on consultation. It has issued two informative newsletters that have been circulated widely to staff in health boards and social work services departments. A series of roadshows are also being held, which address the issues surrounding the staffing of the commission. Those measures are encouraging signs, and staff are being persuaded at least to start thinking about the commission. It will be important to maintain and speed up the momentum as we approach the enactment of the bill and the establishment of the commission.

I do not know how the situation will pan out, but my only concern relates to the health care professionals in regulation and inspection teams. If there are no clear career paths for them to pursue, they may opt to remain doing other things in the NHS, rather than transfer to the commission. A clear career structure must be identified for health care staff in the commission.

Margaret Jamieson: Do health boards have an obligation to work out how much of the time of those who are currently undertaking registration is spent on registration? Safety officers, for example, are not engaged full time in registration work. Would it be in the interests of your employees to consider the proportion of their employment that is spent on registration work? For example, if somebody spends 60 per cent of their time undertaking registration duties, they would fall under the Transfer of Undertakings (Protection of Employment) Regulations. Would you have to consider whether that individual's employment could remain with the health board? What stage of negotiation are health boards at in determining the expectations of staff regarding the transfer regulations?

Paul Gibbons: You are right: we recognise our responsibility to our existing employees. Over the next year, we will have to take part in detailed discussions with the staff organisations and individual staff members. The staff of the NHS who are working on regulation and inspection functions know what is going on and know what percentage of their job relates to the regulation and inspection function. They also know what the options are likely to be. The Executive will need to trigger a great deal of discussion locally with staff organisations, staff and the health boards.

Margaret Jamieson: I will pick up on a matter that was discussed yesterday in the Local Government Committee. The trade unions expressed great concern over the minister's indication that the TUPE regulations will apply. They suggested that it would be to the commission's benefit if staff transferred under the regulations that applied to local government reorganisation, as that would provide greater security of employment and career progression for individuals who were transferring from local government and the health service.

Paul Gibbons: I do not know what those arrangements were; I was not involved at all. As a broad principle, health boards, as the employers of those staff, would support anything to enable their staff to transfer on the most advantageous terms.

Janis Hughes: I have a question on the consultation process in general. You mention in your submission that concern was expressed among your colleagues in the health sector that their comments had not been taken on board as much as those of other colleagues in the social care sector. Will you elaborate on the concerns that you have expressed that have not been taken on board here? Are there any areas that would be beneficial to the bill?

11:30

Neil McConachie: I will let Paul Gibbons pick up the specifics, but I must emphasise that the way that matter was presented is probably my responsibility. The very nature of what we are discussing means that health plays a smaller part; therefore, there is the possibility that it will be swamped by the sheer work that is required on other aspects, be they childminding or social care. It is probably my wording that has caused that concern to be more focused on than it deserves.

Janis Hughes: I accept that, but if you have any concerns this is your opportunity to tell us.

Paul Gibbons: The key point is that a large proportion of the vulnerable individuals for whom the commission will assume responsibility at the date of its inception will have significant health and nursing care needs. We should all—the Parliament, health boards, social work departments—do everything we can to ensure that the transition for the individuals who are in those homes is as smooth as possible.

The Convener: If there are no further questions, I bring this stage of questioning to a close. Thank you for your contribution this morning and for your written contribution, which we received in advance. We move now to the national care standards group.

Good morning, and welcome to the Health and Community Care Committee. Please introduce yourselves and give us a short statement on the role of the national care standards committee and what you have been doing. I will then open up the meeting to colleagues to ask questions.

I apologise for the lack of heating in this room. We are pursuing the matter. I am sorry if you find that there is a bit of a chill, but I hope that the chill

comes from the room and not from committee members.

Angus Skinner (National Care Standards Committee): I am Angus Skinner, the chief social work inspector, and I am here as the chair of the national care standards committee. Alongside me I have Gill Ottley, who is an assistant chief inspector, is part of the regulation of care project, and is heading up a group that will be looking at inspection methodology, and Jane McEwan, who has been the secretary of the national care standards committee since November.

The national care standards committee was first heralded in the white paper "Aiming for Excellence: Modernising Social Work Services in Scotland" which was published in March 1999 and acknowledged the need for the Scottish commission for the regulation of care to have care standards to inspect against from the moment it started operation. It could not take over responsibility from local authorities and health boards without an explicit statement of standards.

It was acknowledged that we should take a widely consultative approach to the development of the care standards. The committee now numbers more than 40 people and membership has been drawn from representatives of the national health service in Scotland; local authorities; health boards; the private residential home sector; the private nursing home sector; the voluntary sector; local authority social work and education staff; local authority and health board registration and inspection staff; the Mental Welfare Commission for Scotland; the Accounts Commission for Scotland; the Central Council for Education and Training in Social Work; Scottish Homes; the Royal College of Nursing; the British Association of Social Workers; the Social Care Association; various Scottish Executive divisions that are responsible for health, social care and housing; Unison; the Scottish Trades Union Congress; the Scottish Consumer Council; and the Scottish Care Association, which is a private sector organisation. Indeed, the membership of the committee grows each time we go through a further tranche of working groups, because the chairs of each working group become members of the committee.

The working groups, which eventually will number 14, have involved 150 people to date and have included users and carers. All our working groups, and indeed the committee itself, have significant representation from users and carers. We are keen to develop that even further in the year ahead.

The development of national care standards is designed to bring about new consistency, simplicity and clarity for service users and providers, clear independence of the regulatory function from the provision of services, and appropriate fairness, so that once national standards are in place, users across Scotland will be guaranteed the same standard of service no matter where they live.

At present, there is no requirement on the regulatory authorities to take into account the views of users or their carers, either in the standards used or in the regulatory process. Some—indeed, many—registration and inspection units in health and in local authorities already do that, but we have felt from the beginning that it must be given greater emphasis and priority. Given the size of the Scottish commission for the regulation of care's task—something like 0.5 million people a day depend upon the services that will be regulated by it—and the range of services that are involved, we decided early on to divide our work into different tranches. The work from the first three tranches was published and made available to you and others as a draft national care standards first tranche.

I emphasise that it is not our intention to end up with a series of sets of documents that reflect how the work has been done; our aim is to produce a single set of documents that are consistent with each other. We expect there to be a few common principles that cut across all services; we are currently searching for them. There will also be matters that are for the specific attention of service areas and that will reflect the work of the working groups.

The first draft national care standards were published on time at Easter last year. We made it clear at the time of publication that they represented work in progress. We received 130 responses which, by and large, supported our overall approach of focusing on people's quality of life and their experience of services. We have tried to ensure that those factors, rather than matters of process or factors that were easily measured rather than those that were more difficult to grasp, have driven our work. We have always been conscious that the standards need to be enforceable and clear for providers, users and the carers and relatives of users.

The responses to the first tranche indicated that we had not got several balances right. We probably did not have enough on many important health matters. Two local authorities said that we had not identified their interests. Some users and carers agreed with the general thrust of our work, which focused on the quality of life, but thought that some of the detail detracted from that. Such comments reflected the fact that we had published the standards as work in progress and sought to engage in as wide a debate as possible. We are continuing to do that in the second tranche, and we will revise the first tranche in the light of the

responses. I am happy to answer questions on that.

I will tackle the question of enforceability, which has already arisen. We have not tried to identify minimum standards, as it was clear from users, carers and all those whom we consulted that very few people want to receive a service that is regarded as a minimum service. However, it is clear that there are certain essential elements. In the final version of the standards, we expect to identify a number of things that are essential across all services and a number of things that are essential for specific services. Some of those will be contained in the regulations that will be drafted as a result of the bill, others will be attached in the standards. We expect that the standards that we regard as essential will be grouped around the regulations and that the further standards that identify areas of expected provision will also flow from that grouping.

As drafted, the bill requires the commission to take the standards into account. That seems to us to be an entirely appropriate approach. There are some things, which will be contained in regulations, that will be essential for each service or for a specific service. On other points, it is important that we do not inhibit diversity and innovation, or detract from the quality of life, by introducing a process that is too bureaucratic and over-regulated.

Experience over the past 20 years has shown that the soft evidence has often most clearly exposed the worst practice. Major scandals and shortcomings have been exposed not through the rigour of a bureaucratic regulatory process, but by carefully listening to the experience of the people who receive the services.

We plan to complete our work in the middle of November. Ministers are committed to publishing a final set of standards by the end of 2001, so that they can be available to all those who have an interest in them before the establishment of the commission in 2002. During the next few months, we will continue our work across the areas that we have not covered so far. We will then move on to consultation on costs, which we will deal with in two stages. Shortly after Easter, we will consult on the main essential issues on single rooms, such as the size of rooms, and on staff ratios and their cost implications. During the summer, we will conduct a further consultation on more detailed matters to do with the other aspects of the standards.

11:45

We are also developing this year a significant programme of communication and engagement with all the stakeholders. We will hold seminars in Edinburgh, Glasgow, Inverness and Aberdeen for registration and inspection staff in health boards and local authorities, and we will hold a series of training programmes for staff who are interested in transferring to the commission in April 2002.

I am happy to answer questions on what I have said or on other matters.

Dr Simpson: That impressive opening statement has answered at least three of the questions that I was going to ask.

You said that you hope to complete the consultation and publish the standards by the end of the year. Will that be on all of them or on the first three, which are out for consultation?

Angus Skinner: It will be on all of them. The only hesitation I have concerns the independent health care sector, on which we are holding meetings with the Clinical Standards Board for Scotland and others. Everything else will be published by the end of the year.

Dr Simpson: I have raised with other witnesses the health aspects of the standards, to which you referred. They are covered more clearly in the children's section of the initial published standards than they are for the elderly. How do you propose to develop the relationship between the general care standards and standards that are of a more clinical or medical nature? How will a commission progress that relationship through local frameworks, regulation or inspection?

Angus Skinner: Dr Sandra Grant, who is the director of SHAS, is a member of the national care standards committee, and SHAS members have been on most of the relevant working groups. Where possible, we are trying not to duplicate SHAS's work in the work of the commission. We are trying to agree on standards that apply to SHAS and the commission and to work collaboratively. The work of the Clinical Standards Board is, perhaps, rather different. When we consider independent health care matters, we will have to decide how to handle that detail. Elsewhere in the commission's scope, we hope that the best possible rationalisation of standard setting and regulatory frameworks will emerge from the process. We are actively pursuing that objective.

Dr Simpson: You said that you will consult on the consequences for staffing levels of single-care homes. Under the regulatory process at the moment, the staffing levels for residential care are different from those for nursing care. There will be significant implications for all sectors if residential and nursing care are combined into a single-care system in which the shifting levels of dependency of individuals are recognised. The system that we are entering is much more sophisticated and complex, but it puts the providers at risk of having

inadequate funds to meet the changing care standards or of being unable to cope with the variation that occurs. Have you thought about that issue in relation to care standards?

Angus Skinner: By ending the distinction between residential and nursing care, we are making a big shift in the traditions that have been around in Scotland. Elsewhere in the UK, that change has not been made as quickly or in the same way. However, the distinction seems rather anomalous compared with practice in much of the world. We have examined care standards not only in the rest of the UK, but elsewhere. For instance, Australia has made no such distinction for some years. There, a set of standards exists from which we have been interested in drawing in the first tranche. The approach to assessment there is of interest for the work that is being conducted on dealing with assessment.

You are absolutely right to say that the dependency level changes. If someone must move from their own home into another home for care, the aim of the process is to prevent them from having to move twice because of a change in their dependency level. Care should be flexible enough to be brought to that person. We look to learn from wherever we can about that. The chief nursing officer, who is a member of the committee, has a working group considering assessment, and we are working closely with her.

Dr Simpson: That is clear and it is to be welcomed. The most important change is that of focusing on the patient rather than on the functions. My concern is that care standards will reflect that change, but funding systems will not. Are you involved with the other side of the department in considering how the change will link to what will need to be quite radical changes in the funding systems?

Angus Skinner: We are working on such matters. As I said, the chief nursing officer is a member of the committee and some of Mrs Gill Ottley's staff are working with her on assessment and on the national care standards committee's work on standards. It is a major task to make all that coherent, but we are absolutely clear about its essential quality. We are in the business of using such joined-up thinking.

Dr Simpson: I have some slight concerns about the rapidity of the process. You hope to complete the care standards by November. Implementation will be quite difficult—I know that that matter is beyond the bill's remit. What is your feeling about the speed of implementation?

Angus Skinner: We could spend 10 years doing 16 PhDs on the issue, but that would probably not be the right way of progressing. The commission has been heralded for some time and a timetable for its introduction exists. Any delay to that would be unhelpful. We must stick with the timetable for the sake of the services and to give staff certainty. I think that we can deliver effectively.

The standards are not set in stone or concrete and can be reviewed every year. The commission will reflect on them in its first year of operation and will be able to recommend changes to Scottish Executive ministers, having consulted on cost. We expect the standards to be kept under review and to change every year.

Dr Simpson: My last question on determination of the standards concerns the physical disciplining of children, other than those who are in secure accommodation, which the report mentions. I oppose the decisions about childminders that have been made in England. Have you reached a decision on the matter?

Angus Skinner: The issue has been given some consideration and will receive more, probably in the early years of implementation. Eventually, a working group will consider care for all children, starting with those who are away from home overnight. It will bring together all the issues that relate to children who are in residential care, secure accommodation, hostels that are attached to secondary schools, boarding schools or elsewhere.

Mary Scanlon: The working group recommends direct access to local regulators and a national advice and complaints helpline and you recommend a whistleblowing procedure and a confidential helpline. People will have expectations about the level of care. How do we benchmark that and decide whether a complaint is legitimate?

You made a point about moving from consideration of the quality of accommodation to consideration of the quality of care during the consultation period, which is welcome. However, that leads me to wonder how you will measure the quality of care for the elderly or for adults who have learning disabilities and who are in a day care centre. I know that that task takes place further down the line, but expectations must be clear, or they will become a problem. For example, you can inspect the quality of a private and confidential independent clinic, but many of its clients will pay for their care and are not likely to be present when you visit. In those three situations, how will you measure the outcomes, which are the most important factors?

Angus Skinner: Some aspects are common, even across such fairly disparate settings as Mary Scanlon described. Considerations of decency, respect for people and other matters apply to children in secure accommodation as much as they do elsewhere. However, some matters are

specific. For such matters, our approach has centred on how we are trying to improve the quality of life of the people who use the services. We have tried to listen as carefully as we can to their expressions of their goals and their experiences of how services relate to their aims.

We have done that not only through the involvement of users and carers—which has been more limited than the committees and working groups would have liked it to be—but through the use of focus groups, which we commissioned and funded for the first and second tranche of working groups. We commissioned the focus groups through a competitive tender from an outside firm, and the groups have worked independently of the committee. The focus groups were asked for responses about how people experience the services, what they want and what they say about them. We are trying to ensure that those criteria lead the formation of the standards.

We are working the other way round from how we worked previously. We used to ask what we could measure, then consider what we could achieve for people's experience and quality of life. We are starting by asking how we can improve the lives of people in Scotland and then we ask what their experience has been. Half a million people—quite a lot—will be affected.

Many of the focus groups that considered services for older people expressed strongly the view that such people spend much time just waiting: for lunch; for someone to take away their tray; or for their relatives to visit. Experiences of deep boredom became apparent. For many older people—and for many of us too—having a bath is an important and nice experience. It is not one that is highly rated in service measures but, for many people, it is one of the remaining pleasures in life. Other people want spirituality to be considered. We are approaching such matters and are discussing them with colleagues in the health service.

It is hard to work back from that point to reach a clear, enforceable and measurable set of standards that will stand up in court and which will work, but we believe that such a route is the right one to follow. We are clear about the framework that we are heading for. We want to end up with measures that will be defendable.

Mary Scanlon: I appreciate what you are saying, but I feel that applying a measure to the quality of life is difficult. Given the complaints helplines and the whistleblowing procedure, how clearly can we set out a benchmark for the quality of life? I give again the example of adults who have learning disabilities and who attend a day centre. How will the system include them?

Angus Skinner: I will divide that question into two parts. First, how do we measure how well the service is meeting our requirements in terms of a person's quality of life? That is about considering what we are trying to achieve for a particular adult who has learning disabilities. It might be that the person seeks a sense of inclusion or belonging in society—the person wants a role that is meaningful or valued. It might be important to them to have friends and contact and that they are not always waiting for lunch or whatever.

There is a second and separate question in relation to concern about whether the person might be being abused or exploited in some way. There are issues—particularly with older people—surrounding the question of financial exploitation, which often goes undetected.

12:00

There are three approaches. There are issues about whistleblowers throughout the public sector. There is an element of a UK legislative framework to deal with that; there are several statutory complaints procedures in place and the commission's role in relation to complaints must not confuse the situation further. It is very important that if anybody has a complaint, there is no barrier to making that compliant and getting it heard and dealt with appropriately and independently. It is also important that people receive assistance in deciding who to complain to about what—that is not always clear. There is a range of different complaints mechanisms, which are not being done away with.

There is a question about the commission's role as a regulatory body that will be responsible for registration and regular inspection. It has a responsibility during its inspections to probe and uncover what it can about the reality behind certain experiences. Several years of difficulties have shown us that it is quite possible for abuse to go undetected. I know of one children's home that had a television crew in for a week to film a documentary—even the film crew did not uncover the abuse that was taking place and which later became apparent. Inspectors must have both the power and the skill to probe and follow up weak signals of possible abuse so that they can seek to ferret it out.

Mary Scanlon: That will take a tremendous amount of training. I have a question in relation to section 24, which you have not yet addressed, on the question of confidentiality and private and independent clinics. The two services that are mentioned in that section are termination of pregnancy and cosmetic surgery. People in such situations might not want to talk to you about their experiences. How do you interview them to ask them about the service, which is not the same as a residential home or children's home? Will those

clinics be obliged to give you a list of their clients, so that you can interview them on the service that they received?

Angus Skinner: The information should be made available. I would have to check that in respect of cosmetic clinics.

Gill Ottley (National Care Standards Committee): The services that Mary Scanlon is talking about are part of independent health care services. We found out rather late in the day that we were going to be regulating those services and we are not as far advanced in thinking through the systems that will apply. We have yet to consult extensively with colleagues in the health department about how that will be carried out under the auspices of the national care standards committee. Mary Scanlon's points are certainly valid and we will have to consider them carefully.

Margaret Jamieson: I want to go back to staffing issues. You said that there would be further consultation and that staff could decide whether to transfer to the commission. There are clear implications for the current employers—the local authorities and health boards. We have discussed with health board representatives the work that they are doing in determination of which members of staff should transfer. Do you believe that there is another option—that people should opt in and out? If so, who would pick up the tab?

Angus Skinner: No. I did not mean to imply anything in relation to employment issues. We are not the employers and do not handle employment issues. I said merely that we will ensure that people have adequate training. We envisage a three-part module being made available to any staff who are transferring or who are thinking about it. We have to have eligibility criteria for that training. However we cut it, some staff have a choice and we would not want to exclude them. We are keen to ensure that the skills in local authorities and health services are available to the commission. It is not necessarily right that being a registration and inspection officer should be a separate career—it is important that we draw on the current skills that are available in the 47 different organisations and bodies.

Margaret Jamieson: I am happy that you see that there needs to be a training element before the system goes live. However, there are other training elements that need to be provided for the staff who will have to implement the standards that you are working up. How will that be progressed and funded? We know that many staff members have been excluded from training in the past, because funding was insufficient and has tended to follow people who need to meet professional standards.

Angus Skinner: I can talk only about social work and social care staff; I am not in a position to comment on the health service side, which is slightly outside the remit of the national care standards committee. Expenditure on training by local authorities for social services and social care staff is about 1.9 per cent of the budget. The UK average for most industries is 3 per cent and Department for Education and Employment policy is that that is too low for 21st century society. There is a push to increase training expenditure.

I take Margaret Jamieson's point about the low levels of training that are available for many of the social care staff in residential and domiciliary services and, indeed, for many auxiliary staff currently working in nursing homes. Many of the divisions between those different types of staff will break down after the introduction of changes. For example, the distinction between a nursing assistant and a social care assistant is no longer tenable. There will need to be a programme to increase that drive and the Scottish social services council will have major responsibilities in that respect.

The white paper, "Aiming for Excellence", outlined the initial parts of a programme of reform of social work and social care education and training. The consultation paper was released towards the end of 1998. Later this year, we will publish another paper on the reform of social work and social care education in the context of the changes that will be brought about by the Regulation of Care (Scotland) Bill.

Margaret Jamieson: I know that there is provision for training in local authority and health board budgets, but that is not as transparent in the private and voluntary sectors. How are you going to ensure that individuals receive appropriate training?

Angus Skinner: The mechanism, which is one of the requirements of the Scottish social services council, will have to take a phased approach. The first phase will include residential child care staff, which has been an area of major concern over the past 20 years or so. We have invested in major contracts for setting up the new Scottish institute for residential child care, which will provide training for all residential child care staff. We are conducting a work force analysis on that basis.

Our expectation is that the Scottish social services council will be required to set a five-year timetable, during which all staff who work in private, voluntary or local authority residential child care or who provide services for looked-after children or children with disabilities, will be required to have specific qualifications and to register.

The question that would follow from that is whether the same system should apply to people

who provide services for people who have dementia and so on. We need to consider that. The Scottish social services council is required to have strategies in relation to education and training and work force planning, regardless of which tranche for registration the staff are in. The thinking behind that has been a desire to tie registration closely to education and training provision. Because a great many nursing auxiliaries in the private sector, domiciliary services and elsewhere are on the minimum wage, they will need to be quite clear about what benefit they will receive from paying the registration fee at the point at which they are asked to pay it.

The Convener: What will the role of the social services inspectorate be? The minister failed to answer that question earlier and passed it over to you.

Angus Skinner: We have made no presumptive decisions about that, but we were clear that there would need to be changes to the role of the social services inspectorate. The changes that need to be made will depend on the final shape of the bill and the work of the commission and the council. Early this year—probably next month—the inspectorate will produce the first annual report on social services across Scotland's local authorities. We expect that reporting function to continue.

It is important that the regulatory framework for the services is coherent, does not overlap and is not too weighty and that the systems work well together. We are in active discussions with Audit Scotland, SHAS, the Mental Welfare Commission and others about how that can be done. Obviously, we will take account of the commission—we do not expect to have a form of double jeopardy operating with the commission and the inspectorate. Account must be taken of the fact that there are aspects of the work of the inspectorate that the commission, as it is envisaged, will not cover.

The Convener: Could you give us a couple of examples of those aspects?

Angus Skinner: As it stands, the commission's remit is in relation to care services. The definition of care services is positive and inclusive, covering health, social work and so on. It will not cover the field services that are conducted by social workers in local authorities. On the issue of adoption, the commission will be responsible for the inspection of adoption agencies—whether run by local authorities or by voluntary organisations—but it will not be responsible for the inspection of the work of social workers in the field, except in relation to the work of adoption agencies. Consideration must be given to ways in which to ensure that that separation is successful. We are conscious of the considerable scope of the commission and the complexity of the tasks that it will take on.

Mr McAllion: I want to talk about the setting of standards that will ensure a certain quality of life for, for example, an elderly resident in a single-care home. In the standards documents that have been produced so far, you point out that an individual's sense of worth and identity will depend, to a significant degree, on the kind of stable relationships that they can build up with well-qualified and motivated staff in the homes. Anecdotally, we all know of private nursing homes that are not owned or managed by national organisations and which make profits by keeping staffing levels at an absolute minimum and by having low pay, which results in a high turnover of staff. In what way will the standards committee address that problem?

Angus Skinner: Staff turnover is an important issue, and the relationships that anyone—child or adult—builds with the staff are essential to making the experience what it is. We are trying to focus on that and are examining ways to ensure that the commission takes account of staff turnover in determining the quality of the service that users experience. That would probably be dealt with not in the regulatory framework of staff ratios and so on but in the grouping around the regulation of standards, which would be an indicator of how good or bad a service was.

12:15

Mr McAllion: Would issues such as the number of staff, the rota that is operated, the rate of staff turnover, the level of wage and how those indicators relate to those in homes that provide a good service form part of an inspection?

Angus Skinner: I would expect the rate of staff turnover to be part of the inspection.

Mr McAllion: Not pay? Pay is a critical issue. There will be a high turnover of staff if they are not paid well. If there is to be a stable complement of staff in a nursing home, they will have to be paid wages that will persuade them to stay there for a long time.

Angus Skinner: It is important that we are precise about the remit of the commission, which is to determine what should be provided, not how it should be paid. Quality is not the responsibility of the regulatory bodies; it is the responsibility of mainline management, whether it is in the public or the private sector, and should not be delegated to the commission. The commission's task is not to determine how outcomes can be obtained for users of services but to determine how good the outcomes are. Its interest is in the rate of staff turnover, not the level of pay. I am not disagreeing with the point that you raised but, for instance—

Mr McAllion: The issues are linked. I once walked into a private nursing home, where about 30 elderly people sat in a huge sitting room, and found that the only staff on duty were two young girls. There was no relationship between the girls and the elderly people—all the staff did was hand out cups of tea at a particular time in the morning. For the most part, the elderly people were left to doze in their chairs. That is not a decent quality of life for anyone and surely the commission should be interested in putting a stop to that.

Angus Skinner: That is absolutely right. The issue of staff having time to spend with people and having a good quality of relationship with the users of the service is at the heart of what we are trying to do. The question of what people are being paid is slightly different.

Mr McAllion: It is linked. The profit is made because low-paid and insufficiently qualified workers are looking after the people.

Angus Skinner: I am not saying that it is not linked, but I do not think that it is the responsibility of the commission to determine what that link is. That is the responsibility of those who provide or commission the services.

Mr McAllion: If the commission decided that a decent standard of care was not available, would it simply not allow the nursing home to continue to operate?

Angus Skinner: That would depend on the overall assessment of the nursing home. The issue that you raise would be one factor of many that would have to be taken into account.

Mr McAllion: Who should decide levels of pay in nursing homes? Should it be left to the market?

Angus Skinner: The issue of pay is complex. We have major provision for people with learning disabilities in Scotland in which no one is paid at all—the operation is a collective arrangement in which people partake of shared experience and share out the income for the organisation as a totality. The issue of pay is another step. I am not saying that it is not important, but getting into the detail of the best way of deciding such matters is not within the scope of the commission. I should stress that I am not for a minute suggesting that care should be provided without pay—I do not want to mislead you on that point.

Mr McAllion: I hope not.

Angus Skinner: Absolutely not. We are conscious of—

Mr McAllion: It seems to me that if we want the people in the homes to have a decent standard of life, the staff will have to have minimum standards, which must include what they are paid and how their qualifications are recognised. That cannot be left to private nursing homes.

Angus Skinner: There is a link, but I think that it would be in relation to the council rather than the commission. The council must consider what it requires in terms of qualifications and standing of staff and what it requires of employers in terms of their provision for staff and continual professional development. However, the council is not in a position to determine pay either.

Mr McAllion: What about contract compliance?

Angus Skinner: Again, there is a question of what the outcome would be and how it could be achieved.

Mr McAllion: Without decent pay, you will not get decent staff.

The Convener: John McAllion is saying that all committee members agree that, if you value your staff, you must show that in the amount of remuneration that you pay them as well as giving them better training opportunities. If we want the council and the commission to bring about a better motivated, better paid, better qualified, registered work force for social work, there must be some benefit for the members of staff. There will be a number of issues, but pay will be fundamental. You are saying that you are interested in outcomes, but we are saying that, frankly, you will get better outcomes if you have a better motivated work force, which comes from better pay.

You say that the commission will be there to measure the turnover of staff, on which pay would have an impact. It will also measure the basic level of service and whether it is being provided to an acceptable standard, which will probably also be directly related to the motivation of the work force. You say that some of those outcomes will be detected by the commission, but that you are not in a position to tell anybody that there cannot be a well-motivated, better trained, effective work force unless you pay a reasonable working wage.

Angus Skinner: I do not think that it is for the national care standards committee or for the commission to make any statements about what people should be paid; nor do I think that it is for me as chief social work inspector to say so. However, beyond the national care standards committee, there are questions about the work force and the reform of social work education and training. Conditions of service and pay for a well-motivated work force are very much part of that process.

In our review of residential child care in 1992, we said that pay and conditions were crucial in ensuring a competent, motivated, valued calibre of staff in residential child care. However, that is not a matter for the commission or for the national care standards committee. It is a question of

taking an overview of strategic issues in relation to a specific service.

Shona Robison: How far will the council and the commission go in addressing quality-of-life issues, such as the level of stimulation that residents should receive? It is well known that people with dementia can improve dramatically, or decline less quickly, when levels of stimulation are applied. You said that you were looking at the what and not the how. If you were to set such standards, one of the hows would be appropriate staffing levels to enable homes to provide the contact and high level of stimulation that, unfortunately, most homes are not currently in a position to do, often relying on outside volunteers to do that work. To what extent will the commission be setting those types of standards?

Angus Skinner: We expect to end up with a series of matters that are essential and are covered by regulations. Those will be the matters that are essential for registration and must always be there at the point of inspection. There will be a number of other matters on which people will take a balanced view. We may end up with a kind of ladder. If a home performed to a certain level on a specific criterion, it might get a gold star, as it were. Other homes might get a slightly different rating. That would be of specific interest at the point at which we consulted on costs and at which people commissioned services.

There is clearly a wide range of quality of provision. Our aim is to establish good-quality standards across all services, rather than to standardise. We do not think that there is just one model that all care providers should follow. Some things are essential, but there is then a whole series of choices about how best to meet the needs of older people in each locality. There are choices to be made by commissioners, ministers, the national care standards committee, local authorities, health boards and commissioning managers. Even a cook in a children's home has to make some choices on the number of people he or she is providing for, the quality that is wanted and the cost of meeting it. Those equations never finally go away; at the end of the day, they are political. My job is to set out the issues as clearly and constructively as possible and thereby to assist the decision-making processes.

Shona Robison: Your submission says:

"It is anticipated that the standards will rise periodically as resources allow".

Can you clarify that?

Angus Skinner: Yes, as resources allow and as knowledge improves. We have sought carefully to tie the standards in with evidence. Each of our working groups has received not only extensive information on UK and other international standards relevant to its area of work, but a research review of what appears to work and what is important. We will continue to do that and we expect the commission to be an evidence-based regulatory body. That is part of being a 21st century Government agency; we expect standards to change simply because people know better how to improve things. It is not just a question of cost.

Dorothy-Grace Elder: You remarked at the beginning of your address that you have 14 working groups and a committee of 40. I do not think that any of us envies you your task of drafting, and possibly redrafting, your report so that everyone agrees on it.

My first point follows on from John McAllion's question. We understand that you cannot set rates of pay, but the committee is obviously concerned about that. Most of us have had the sort of experience that John had on walking into that home. We already know that a high turnover of staff in any institution will be a cause for concern and one of the indicators that things are not well. Can you give us an assurance that, where they found that, inspectors would call for the pay sheets and full details of how much staff were being paid? Would they also ask for information about the ages of the staff and the hours at which the young and inexperienced staff had to be on duty? I do not think that it should be too difficult for you to give us that assurance.

Angus Skinner: I have no difficulty in giving you an assurance about staff turnover being looked at. Indeed, we covered that to some extent in our first tranche and can come back to it. With regard to pay, the national care standards committee would have to consider further exactly what the remit might be for looking more closely at pay.

Dorothy-Grace Elder: Would inspectors ask for the pay books of the institution to find out exactly what the position was? I also want to know about the age of staff and the shifts that they might be on.

Angus Skinner: Shifts are an organisational matter that would be considered if they gave cause for concern. However, there are many different models and we do not want to say that there should be just one standard model for shifts. It would be a question of looking at the cause of the difficulties in each case and at how the situation might be improved. It should not be difficult for the commission to examine shifts.

Dorothy-Grace Elder: Nor would pay slips be a difficulty. Where there is an unusually high turnover of staff, pay is obviously a factor.

Angus Skinner: It might be a factor. The task of the national care standards committee is to establish standards. The committee cannot say what people should be paid. Standards are about

outcomes and about people's experience of services.

Dorothy-Grace Elder: Nevertheless, you could investigate pay. If you were dissatisfied about high staff turnover, you could comment on how levels of pay affect turnover.

Angus Skinner: Let me go back for a moment to the important relationship between the council and the committee. If the council determines that a children's home requires staff with specific qualifications, but the home does not have staff with those qualifications, the commission would be absolutely right to examine whether the home was prepared to pay the going rate to attract the right staff.

12:30

Dorothy-Grace Elder: Does one of your 14 working groups cover whistleblowing?

Angus Skinner: No. The working groups focus on client experience rather than on process.

Dorothy-Grace Elder: I can understand that, but I am delighted to see that your advance statement concentrates on the principle of whistleblowing. I assume that that has come through from those whom you have already questioned—professional people and volunteers in the services who are concerned that they—

The Convener: Mary Scanlon asked Mr Skinner about that earlier.

Dorothy-Grace Elder: I wanted to ask only whether you would need three whistleblowing organisations with attached helplines, dealing with older people, people with mental health problems and children in care.

Angus Skinner: All the organisations that will come within the scope of the commission will have different whistleblowing attributes. The committee's approach, and that of the inspectorate as a whole, has been to ask about whistleblowing arrangements whenever possible. I do not think that we should set up additional arrangements. Different agencies need to stick to their responsibilities. Health boards and local authorities have their own complaints and whistleblowing procedures. The commission's task, and that of the inspectorate, is to ask what they are and to keep them in the open air.

The Convener: Thank you for answering those questions.

I ask our two reporters to e-mail me details of their work with other committees to date and of their plans for forthcoming work. I thank all colleagues for attending.

Meeting closed at 12:32.

Members who would like a printed copy of the *Official Report* to be forwarded to them should give notice at the Document Supply Centre.

No proofs of the *Official Report* can be supplied. Members who want to suggest corrections for the archive edition should mark them clearly in the daily edition, and send it to the Official Report, 375 High Street, Edinburgh EH99 1SP. Suggested corrections in any other form cannot be accepted.

The deadline for corrections to this edition is:

Monday 29 January 2001

Members who want reprints of their speeches (within one month of the date of publication) may obtain request forms and further details from the Central Distribution Office, the Document Supply Centre or the Official Report.

PRICES AND SUBSCRIPTION RATES

DAILY EDITIONS

Single copies: £5
Meetings of the Parliament annual subscriptions: £500

The archive edition of the *Official Report* of meetings of the Parliament, written answers and public meetings of committes will be published on CD-ROM.

WHAT'S HAPPENING IN THE SCOTTISH PARLIAMENT, compiled by the Scottish Parliament Information Centre, contains details of past and forthcoming business and of the work of committees and gives general information on legislation and other parliamentary activity.

Single copies: £3.75
Special issue price: £5
Annual subscriptions: £150.00

WRITTEN ANSWERS TO PARLIAMENTARY QUESTIONS weekly compilation

Single copies: £3.75
Annual subscriptions: £150.00

Standing orders will be accepted at the Document Supply Centre.

Published in Edinburgh by The Stationery Office Limited and available from:

The Stationery Office Bookshop
71 Lothian Road
Edinburgh EH3 9AZ
0131 228 4181 Fax 0131 622 7017

The Stationery Office Bookshops at:
123 Kingsway, London WC2B 6PQ
Tel 020 7242 6393 Fax 020 7242 6394
68-69 Bull Street, Birmingham B4 6AD
Tel 0121 236 9696 Fax 0121 236 9699
33 Wine Street, Bristol BS1 2BQ
Tel 01179 264306 Fax 01179 294515
9-21 Princess Street, Manchester M60 8AS
Tel 0161 834 7201 Fax 0161 833 0634
16 Arthur Street, Belfast BT1 4GD
Tel 028 9023 8451 Fax 028 9023 5401
The Stationery Office Oriel Bookshop,
18-19 High Street, Cardiff CF12BZ
Tel 029 2039 5548 Fax 029 2038 4347

The Stationery Office Scottish Parliament Documentation Helpline may be able to assist with additional information on publications of or about the Scottish Parliament, their availability and cost:

Telephone orders and inquiries
0870 606 5566

Fax orders
0870 606 5588

The Scottish Parliament Shop
George IV Bridge
EH99 1SP
Telephone orders 0131 348 5412

sp.info@scottish.parliament.uk

www.scottish.parliament.uk

Accredited Agents
(see Yellow Pages)

and through good booksellers

Printed in Scotland by The Stationery Office Limited

ISBN 0 338 000003 ISSN 1467-0178