HEALTH AND COMMUNITY CARE COMMITTEE

Wednesday 3 October 2001
(*Morning*)

Session 1

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HEALTH AND COMMUNITY CARE COMMITTEE
22nd 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:

Malcolm Chisholm (Deputy Minister for Health and Community Care)

WITNESSES

Professor David Bell
Professor Alison Petch
Lord Sutherland of Houndwood

CLERK TO THE COMMITTEE

Jennifer Smart

SENIOR ASSISTANT CLERK

Peter McGrath

ASSISTANT CLERK

Joanna Hardy

LOCATION

Committee Room 2

Scottish Parliament

Health and Community Care Committee

Wednesday 3 October 2001

(*Morning*)

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

The Convener (Mrs Margaret Smith): Good morning everyone and welcome to this morning's meeting of the Health and Community Care Committee—although the person in the chair is not feeling all that healthy this morning. Please do not let me breathe on anyone.

Item in Private

The Convener: Item 5 on our agenda will involve discussions on the budget with our budget adviser Andrew Walker. We are still at the draft report stage, so do members agree that that item should be held in private?

Members *indicated agreement.*

Subordinate Legislation

The Convener: Members were asked to indicate whether they wished to debate the affirmative instruments that we have before us this morning. No comments have been received, so it is suggested that the affirmative instruments will not be debated. Do members agree?

Members *indicated agreement.*

The Convener: Malcolm Chisholm, the Deputy Minister for Health and Community Care, is with us this morning. We will kick off with emergency affirmative instruments.

Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No 6) (Scotland) Order 2001 (SSI 2001/316)

The Convener: The Subordinate Legislation Committee had nothing to report on the order. Minister, will you move the order?

The Deputy Minister for Health and Community Care (Malcolm Chisholm): Would you like me to make a wee speech again or would you like me just to move it?

The Convener: You can make a wee speech if you feel like it. It is up to you.

Malcolm Chisholm: It would probably be much the same as the previous one, but I am happy to make it again if you want.

The Convener: You can either make your single transferable speech or we could just take it as read. We are happy to take it as read.

Motion moved,

That the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No 6) (Scotland) Order 2001 (SSI 2001/316) be approved.—[*Malcolm Chisholm*.]

Motion agreed to.

Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (East Coast) (Scotland) Order 2001 (SSI 2001/317)

The Convener: The Subordinate Legislation Committee had nothing to report on the order.

Motion moved,

That the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (East Coast) (Scotland) Order 2001 (SSI 2001/317) be approved.—[*Malcolm Chisholm*.]

Motion agreed to.

Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No 7) (Scotland) Order 2001 (SSI 2001/322)

The Convener: The Subordinate Legislation Committee had nothing to report on the order.

Motion moved,

That the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No 7) (Scotland) Order 2001 (SSI 2001/322) be approved.—[*Malcolm Chisholm*.]

Motion agreed to.

The Convener: Thank you, minister—that is you finished. We now move on to the negative instruments.

National Health Service Trusts (Membership and Procedure) (Scotland) Regulations 2001 (SSI 2001/301)

The Convener: The instrument was originally circulated to members on 13 September but no comments have been received. The Subordinate Legislation Committee reports that the instrument is "defectively drafted", because there is a repetition of provisions and because it leaves the position of associates of committee members "open to doubt". In addition, the explanatory note

"does not highlight the amendments made to the Regulations consolidated."

No motion to annul has been lodged, so the recommendation is that the committee does not wish to make any recommendation in relation to the instrument.

Mary Scanlon (Highlands and Islands) (Con): I note that the Subordinate Legislation Committee seems to have raised more than the usual number of concerns. I also note the Executive's response to those concerns. Is the Subordinate Legislation Committee satisfied with the Executive's response? It would be helpful if this committee were advised of the Subordinate Legislation Committee's opinion.

The Convener: Apparently this is simply a matter of interpretation and opinion: the Subordinate Legislation Committee has one opinion and the Executive's lawyers have a different opinion. We could certainly write to the Executive to indicate that we are aware of the Subordinate Legislation Committee's concerns. However, at present, because of the system, we are not really able to raise anything beyond that, because no motion to annul has been lodged. With the proviso that we will write to the Executive, are we happy to accept the recommendation?

Mary Scanlon: Yes, if we can assume that the Subordinate Legislation Committee's concerns have been addressed.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): I am concerned, because virtually every instrument that went before the Subordinate Legislation Committee last month was found to be defectively drafted. It concerns me that that committee is considering instruments but is not passing on information so that this committee has the same knowledge. That makes it difficult for us to come to a decision. What does the Subordinate Legislation Committee mean by "defectively drafted"? Has it run the instruments past lawyers?

The Convener: Yes.

Margaret Jamieson: So the Subordinate Legislation Committee has had legal opinion to say that the instrument is defectively drafted, yet the Executive says that its lawyers do not agree.

Mary Scanlon: Yes.

Margaret Jamieson: Well, that is lawyers for you.

Mary Scanlon: We are nodding the instrument through on the assumption that the Subordinate Legislation Committee is satisfied, but it would be helpful if the Subordinate Legislation Committee could notify us whether its concerns had been addressed.

Margaret Jamieson: Yes. We should know what concerns the Subordinate Legislation Committee has raised.

The Convener: There has been a difference of opinion between two sets of lawyers, but I suppose that we are meant to be considering the policy behind the orders, rather than the drafting, which is really the task of the Subordinate Legislation Committee.

Mr John McAllion (Dundee East) (Lab): I would like to talk about a policy issue, although I probably should have raised objections before. I am concerned about the conditions for being disqualified from membership of health boards—I think that the issue is covered by the second negative instrument, the Health Boards (Membership and Procedure) (Scotland) Regulations 2001 (SSI 2001/302).

As members will know, there has been an on-going saga on Tayside Health Board. At one stage, a number of board members were not dismissed but were removed from office by the Minister for Health and Community Care following inconsistencies in the behaviour of the general manager. No blame was attached to those board members, who are respectable people in Dundee and Tayside. However, under the terms of disqualification, those people would not now be able to serve because they have previously been

removed from a health board. As I say, there was no personal slight on them; there was just a need for a fresh start. The issue needs to be explored, but I do not know how we should go about that.

Margaret Jamieson: The issue involves an interpretation of dismissal. Those people were not employed.

Mr McAllion: The instrument says that a person is disqualified if

"they have resigned or been removed or been dismissed, otherwise than by reason of redundancy".

The Convener: Because John McAllion did not make those points in time, we cannot do anything about not going ahead with the instrument. However, we could raise those points in writing and ask for clarification.

Mr McAllion: That would be helpful.

The Convener: The recommendation is therefore that the committee does not wish to make any recommendation in relation to the instrument—with the provisos that we have discussed. Do members agree to that recommendation?

Members *indicated agreement.*

Health Boards (Membership and Procedure) (Scotland) Regulations 2001 (SSI 2001/302)

The Convener: The instrument was originally circulated to members on 13 September. No comments have been received from members. The Subordinate Legislation Committee reports that there are unnecessarily repeated provisions of the enabling act and that there is doubt over whether the instrument is technically intra vires. The instrument is also defectively drafted in that respect.

No motion to annul has been lodged. The recommendation again is that the committee does not wish to make any recommendation in relation to the instrument. I take it that members feel about this instrument as they felt about the previous one.

Members *indicated agreement.*

Scottish Social Services Council (Appointments Procedure and Access to the Register) Regulations 2001 (SSI 2001/303)

The Convener: The instrument was originally circulated to members on 13 September. No members' comments have been received. The Subordinate Legislation Committee reports that a failure in the preamble to mention the need for consultation constitutes defective drafting. The provisions do not appear to reflect correctly the stated drafting intention. As drafted, it is doubtful whether the provisions are intra vires. There are doubts over whether regulation 13(5) is intra vires in specifying a maximum fee rather than a fee. The regulation may also exceed the powers conferred by the enabling act in that it purports to delegate the setting of the fee to the SSSC.

We should ask the Executive for clarification on that final point. No motion to annul has been lodged, so the recommendation is that the committee does not wish to make any recommendation in relation to the instrument.

Margaret Jamieson: I do not accept what the Subordinate Legislation Committee has said. From the work that we undertook on the Regulation of Care (Scotland) Bill, it was clear to me that the setting of the fees would be one of the issues that the SSSC would address. We spent a considerable amount of time dealing with that issue.

The Convener: I agree. We should seek clarification, to ensure that our understanding of the matter is correct. Do members agree that the committee does not want to make any recommendation relating to the instrument?

Members *indicated agreement.*

Community Care and Health (Scotland) Bill: Stage 1

The Convener: The next item on our agenda is stage 1 consideration of the Community Care and Health (Scotland) Bill. Questions have been provided for us. I welcome Lord Sutherland, who is back with us again.

Lord Sutherland of Houndwood: I sometimes feel that I have no choice. I do not know whether the committee has the power to throw me into a dungeon at Edinburgh Castle if I do not turn up. That is my working assumption, so I come when bidden.

The Convener: If we do not have that power, we should think about acquiring it. We might not need to use it in the case of Lord Sutherland, but it could be useful when dealing with some people.

On the agenda for this morning's meeting is stage 1 consideration of the Community Care and Health (Scotland) Bill. We will be considering the general principles of the bill. Much of our work will build on the work of the Royal Commission on Long Term Care, which was chaired by Lord Sutherland. We discussed that work with Lord Sutherland during our inquiry into community care.

The three key principles of the royal commission were, first, that the state and individuals should share responsibility for current and future provision; secondly, that any system of state support should be fair and equitable; and, thirdly, that any system of state support should be transparent. Do you think that the provisions of the Community Care and Health (Scotland) Bill are consistent with those three principles?

Lord Sutherland: I will have to base my remarks on the report of the care development group, because this was a fairly late summons and I have not been able to examine the details of the bill as drafted. The royal commission's three principles are clearly recognised in the report of the care development group, which was chaired by Malcolm Chisholm. I hope that the bill has been drafted on the basis of that report.

The Convener: Do you think that the bill and the Executive's accompanying funding announcement, which was made by Angus MacKay on 28 June, go far enough to address the key issues that you highlighted? Do you think that the money is available to deliver what is contained in Malcolm Chisholm's report and what you foresaw as being required to deliver community care?

Lord Sutherland: The money that was signalled in June covers the next two years, but resources will be needed long beyond that to fund the implementation of the Chisholm working group's recommendations. Assuming that Angus MacKay's announcement was a signal that the appropriate sums of money will be available in the future, I believe that enough was set aside to fund the care development group's recommendations in the first two years of their implementation.

The Convener: Has the care development group worked through the correct assumptions about increased expenditure?

Lord Sutherland: I think so. An increase of about £100 million over 20 to 25 years is shown. The working group's assumptions built in increases in the cost of living and in inflation and included an element for unmet need or increased demand. As fleshed out in the bill, the assumptions are as reasonable as one could currently make.

The Convener: You have completed your work as chair of the Royal Commission on Long Term Care and have set out your recommendations. Are the bill and the care development group report as near as possible to what you imagined?

09:45

Lord Sutherland: Yes, although I would put that another way. I was pleased to read the working group's material and to see by implication that it would be developed initially by the committee in helping to draft a bill. I am pleased by the outcome.

Dr Richard Simpson (Ochil) (Lab): I want to turn to the definitions contained in the bill. As the bill reflects, the committee has adopted your approach in the use of the phrases "nursing care", "personal care" and what is termed "social care". A fourth term, "accommodation costs", relates back to the Social Work (Scotland) Act 1968. Does the bill require a definition of personal care?

Lord Sutherland: Yes. A difficulty that Westminster—if I am allowed to refer to that Parliament here—will face is that its definitions might not stand up to legal scrutiny. The committee must seek legal advice on whether the definitions in the bill would stand up in a court of law if the Executive were challenged on them. The definitions meet the principles that the royal commission worked on. As far as I am competent to know—which is not very far, because I am not a lawyer—I think that they will stand up in court, but I recommend that the committee has them cross-checked.

Dr Simpson: As we were discussing just before the meeting started, the bill does not spell out the principles on which it is based. I think that those principles should certainly be inserted into the bill and I wonder how you feel about that. Although

legislation has not traditionally taken that line, we have insisted since the Parliament's creation that the principles behind a bill should be included in that bill. Such a general approach should ensure that any future interpretation by the judiciary will refer to the bill's principles.

Lord Sutherland: As far as my amateur legal opinion goes, a general statement within which the interpretation of specific statements is made would make good sense. It would certainly help the population of Scotland to understand what the bill was trying to achieve. As I say, that is an amateur legal opinion; you are the political professionals.

Dr Simpson: That is very kind of you.

The Convener: Not everyone shares your opinion, Lord Sutherland.

Dr Simpson: Since the commission's report was published, I have constantly pursued the issue of the discrimination that would be caused by treating nursing care separately from personal care in relation to people with mental illness and Alzheimer's disease. Given that we are moving towards a single care registration system—we have passed the bill that introduces that measure—and that the care development group recommends a single care assessment system, do we need to define nursing care and personal care separately? Should we introduce a new term that embodies both aspects and makes it clear that people who suffer from frailty and illness and require additional attention should receive such attention under a single category?

Lord Sutherland: In this context, it makes sense to have the two categories brought together in a single definition. However, I do not know whether there is any other need in the health service for a separate division of nursing care.

For the purposes of the bill, I would be content, and indeed would see a lot of advantage in, a single definition that relates frailty—a useful word—to what is otherwise understood as medical need. The attempt in the past to push a wedge between those concepts has caused a lot of the difficulty; bringing the two together makes good sense.

Dr Simpson: We are still left with the issue of personal living expenses, which I think—it is not absolutely clear because the Executive is trying to relate this back to the Social Work (Scotland) Act 1968—is referred to in the bill as social care and accommodation costs. Do you think that the bill should have used the phrase "personal living expenses"—the term that you used and that is generally understood by the Scottish people—rather than simply making a significant number of revisions and amendments to the 1968 act?

Lord Sutherland: The implication of bringing the definitions of nursing and personal care together is that, when one uses terms such as "frailty", one must say clearly that what that applies to will not be means-tested, but that the rest will. That would be one way of drawing a reasonably sharp line. However, at least one side has to be clearly defined.

Nicola Sturgeon (Glasgow) (SNP): We are here to talk about the details of the bill, but the questions about funding that Margaret Smith raised are crucial to the whole issue. The money that Angus MacKay announced in June, which has been confirmed since the care development group report was published, assumes the continuation of attendance allowance payments to self-funders in care homes. Do you agree with the care development group's recommendation that attendance allowance should continue to be paid?

Lord Sutherland: I believe that it is essential that that sum of money is made available in one way or another.

Margaret Jamieson: I want to ask about the provisions on the extension of choice, which would include things like arranging residential care outwith Scotland. Do you support those provisions or do you think that we should extend them?

Lord Sutherland: The question of affordability comes into that, but it is immensely important that the provision of care, in the way outlined by the Chisholm working group—and indeed before that by the Royal Commission on Long Term Care—is secured. Whether one can afford to provide support outside Scotland is a matter of how far the financial boundaries of what is fundable can be extended. I suspect that no one quite knows yet how much all that would cost. I assume that you are referring to the possibility of paying support for folk who wish to move to England.

Margaret Jamieson: Yes.

Lord Sutherland: There may be good sense in initially having discretion for compassionate cases, where the rest of the family is there, for example. However, in my view that is a question of affordability.

Margaret Jamieson: Do the provisions relating to the deferred payment scheme and the extension of the direct payment scheme provide the choice that individuals should have?

Lord Sutherland: As far as I have been able to assimilate the provisions, yes, but I have not had time to do a detailed study of them.

Dr Simpson: One of the problems is that, once we define the personal living expenses—social care and accommodations costs, as the bill refers to them—the amount that is available for the other care that we have discussed will vary depending on the needs of the individual. The care

development group has rightly done some banding on that. However, with nursing care, for example, there will be people with high levels of dependency who would previously have been managed entirely in hospital at considerable cost. Should there be provision in the bill to ensure that, whatever the pooled budget arrangements, those people are funded appropriately?

The other issue that came up in our consideration of the Regulation of Care (Scotland) Bill was the inadequacy of current funding for Scottish care homes and, more important from my point of view, for the voluntary and charitable sector.

Lord Sutherland: It is essential, just to take the outer edge of the scenario that you have sketched, that there is no diminution of provision in hospitals for those who need intensive nursing support. The Community Care and Health (Scotland) Bill should not be taken as an opportunity to diminish that provision. However, I think that it will be an opportunity to ensure that the money spent under the heading that you are talking about is spent on those who need that kind of intensive care, rather than on those who cannot be found a place elsewhere. It is important that that provision continues. That will be dictated by medical need as defined by your colleagues.

The whole arena of the kind of provision provided by individual nursing or residential homes should be explored thoroughly over the next few years. I commend to you an interesting scheme in York. The Joseph Rowntree Foundation has created a scheme whereby, for people living in 130—I think—bungalows, care provision is built into the package that they purchase. That care provision ranges from fairly low-level needs being met in one's bungalow right through to a small, intensive care unit that is 200 yd from one's door.

The York scheme has been costed and actuarial studies have been done on it. I think that that model—defined and put into practice by the charitable sector—could be considered if there is future public sector investment. There will have to be investment—private or public—in the provision of residential homes. We should not rush ahead and assume that they must be like they are now. It is worth considering the York scheme and others around the country, including some in Scotland, that are variations of that scheme. I hope that there will be the opportunity, as investment comes on-stream, to consider different patterns of provision that take account of the change that the Parliament is going to support.

Dr Simpson: I should have declared that I am involved in a nursing home company in England, which the bill does not cover. Nevertheless, I make the declaration.

I agree with Lord Sutherland. My experience in Manchester, which is the area in which my company's nursing homes operate, is that people with high levels of dependence are now being managed in the independent charitable and private sector with much better quality of care. The care is highly focused in a domestic-type setting in which people do extremely well.

Lord Sutherland: I have one further comment, convener. One of my concerns is that, for the past six or seven years, there has been little investment in this area, because the position has been so unclear. Public, charitable and private sources have not seen ahead a picture that is clear enough for them to invest the money that, I think, will be necessary to meet the needs and for which recurrent expenditure is required. Scotland has raised a flag here, because those who are in the business, whether charities, public authorities or the private sector, will now be able to see a financial profile of what will be needed and what will be available to run such homes. I hope that the investment that has been lacking for the past few years will begin to come on-stream. It will take several years to catch up, which is a consequence of the speed of the decision making.

The Convener: That will dovetail with the implementation of the Regulation of Care (Scotland) Act 2001.

Lord Sutherland: Absolutely.

The Convener: People will be able to use that in community planning so that the whole picture is clear.

Margaret Jamieson made a point about arranging residential care for people outwith Scotland. A suggestion made by some of your opponents—if I can put it that way—is that, because we have suddenly a much more attractive set of proposals for long-term care in Scotland, we will be besieged by thousands of English pensioners who want to come here. Do you agree that that is a possibility? Do you think that the bill should specifically cover that possibility?

Lord Sutherland: There is an interesting short section in the care development group report. The group looked at a situation in Canada that is almost comparable to ours, in that different provinces have different levels of provision. According to the evidence, people do not cross borders in search of higher provision. They may cross borders in search of the sun, but I shall leave to members' judgment whether that will pull them into Scotland.

To be quite blunt, what you refer to was a scare story that was put about and that the newspapers picked up and quite enjoyed. One would need to keep an eye on the situation but, as someone has

already pointed out, having folks in small villages up and down Scotland that might otherwise become depopulated might be good for the local economy. I would not use that as an argument, but what the scaremongers have suggested is not going to happen.

The Convener: I agree with you on that.

10:00

Mr McAllion: The bill will provide those who care for adults or children with disabilities with a right to request an independent assessment of their needs, irrespective of whether the person they care for has been assessed. In the context of the commission's recommendations, will that change be adequate or does more need to be done?

Lord Sutherland: As with most things, the change that is proposed is a good start. What I mean by that is that asking how much support should be provided for carers is like asking how long a piece of string is. The commission considered the matter in some detail and believed that there was a huge need to support carers. Indeed, the main reason for one commissioner signing the alternative view was that he wanted help for carers to come first. On balance, the 10 commissioners took the view that the provision of care must come first, but that help for carers should increasingly be put in place as far as can be afforded.

Providing help for carers makes financial sense because if there were a major withdrawal of informal carers, the burden would fall on the state. There was a lot of evidence that many people wanted to provide the care and support for close family members or relatives, and that an occasional help, such as a night off every so often, would make a huge difference to their capacity to do so. My recommendation is that everything that can be done should be done, but the amount that would be adequate cannot be defined. That is the difficulty.

Mr McAllion: The problem is that the bill will not change the current law, which states that when local authorities are carrying out an assessment and deciding on what support to provide, they may provide support to carers but do not have to. I have constituents who, having come to Scotland five years ago with a very disabled son, are still struggling to get the kind of respite care that most societies would regard as minimal. The care has been unavailable because the social work department does not have the resources.

Should we lay down in law a minimum standard of respite care for carers, rather than leave it to individual local authorities, many of which are cash-strapped and do not have the money to support respite care?

Lord Sutherland: I wholly sympathise with and understand your point. The commission received a lot of evidence from various carers associations. In the end, we took the view—which I still stick with—that the first priority is to provide care. The provision of care will, in itself, lift the burden from many. In the context of long-term care of the elderly, the very fact that things will be provided that were previously not provided will lift some of the burden. It is never enough, but I am for securing beachhead No 1.

Mr McAllion: Is there no case for providing that a minimum level of respite care should be available to carers?

Lord Sutherland: Without a doubt there is a case. The issue is about affordability.

Dorothy-Grace Elder (Glasgow) (SNP): I am concerned at the closure of day centres that are attended by the adult children, some of whom can be up to 60 years of age, of extremely elderly parents. Could we not somehow make a recommendation on, or have some influence over, the number of such respite care facilities by basing it on the estimated number of the population who require such services?

Lord Sutherland: The closure of day centres is a retrograde step. A great deal of what is in effect respite support—as well as social context—is given through day centres. Social context is important if folk are not to become psychologically isolated as well as isolated in other ways. It certainly seems conceivable to me that you could ask local authorities, which are in receipt of major grants, what their strategy is for providing that kind of social and public support, which has a direct impact on carers as well as on those who are being cared for.

The Convener: One section of the bill empowers ministers to consider non-personal care aspects of care provision, such as day care centres and home helps, to try to get a more level playing field in charging by councils throughout Scotland. Do you welcome that?

Lord Sutherland: Very much so. I return to the provision of residential support communities and refer again to the Rowntree example. A great deal of such a community focuses on what I would call public facilities, rather than a day care centre that everyone will use. If they are beginning to think about long-term care, what kind of planning should local authorities be going in for in relation to public housing and public provision of care and residential homes? That is the kind of thing that can be built in at the planning stage at minimal cost, and the York community gives a very good example of how such provision can be funded.

The royal commission was not able to go into all the issues that it wanted to go into because we were given a strict time scale and had to report within a year, but those are the sorts of issues that we agreed with the relevant community groups to put down a marker on in the report, saying that more work has to be done. It would be a pity if the response were, "That's it, chums. We've done it. We've taken on board the report." Other lines of inquiry, including the two that have just been mentioned, have also to be pursued. We probably need further consideration of the same quality that the working group has done, and those further thoughts could guide policy and, eventually, legislation.

Shona Robison (North-East Scotland) (SNP): There are obviously concerns about local authorities' ability to deliver the appropriate level of care and about whether their budgets are adequate to deliver the good quality services that are required. One of the debates that is raging at the moment is about the ring-fencing of moneys for elderly care. Local authorities are, in the main, not happy about the ring-fencing of budgets, but in this case ministers have said that elderly care budgets will be ring-fenced to stop the practice of budgets being used for other priorities. What is your view? Do you think that there is a strong case for the ring-fencing of budgets in this case?

Lord Sutherland: Yes. I currently believe that it is important that the money that is allocated for that purpose is used for that purpose. There has to be a line of accountability. If the line cannot be drawn in any other way, ring-fencing will be necessary. Sadly, the evidence that the commission heard was such that it would lead me to support ring-fencing.

I am not criticising the good intentions of local authorities. They are all working on budgets that they find it hard to live within, but there was evidence of a drift of money in one direction, away from money set aside for the elderly to other equally important demands. If the intention of Parliament is that the needs of the elderly be dealt with directly, ring-fencing will be essential in the early years, until there is a cultural change in our society.

Dr Simpson: The Executive has announced that it will ring-fence the new money, but if there is no ring-fencing of grant-aided expenditure, more money could be taken out of GAE to compensate for the new ring-fenced money. The system does not reward local authorities that are already spending more than their GAE. When they get the ring-fenced money in, will they simply put it into the pot and take away the other money that they are spending? I do not think that ring-fencing of the new money will add anything to the situation. What we need is a long-term compact with the local authorities, by which they would demonstrate that they are moving on trend towards spending an amount agreed between the Executive and the local authority. That may vary up or down from GAE, but it would meet the need. The bill will demonstrate the unmet need.

Lord Sutherland: I accept that, as a matter of fact, the bill will not ring-fence money that is already in the system. The evidence is that that money is going into meeting other needs. Richard Simpson is quite right: if that money is not spent on the care of the elderly, we will end up substituting one pot of money for another. I hope that the committee will scrutinise that aspect of the bill and regularly ask for the appropriate figures.

Margaret Jamieson: I welcome that comment, Lord Sutherland.

Would it be helpful if we could obtain information on the authorities that spend up to the limit of their GAE on services for the elderly? That would make us more comfortable with the wording of the legislation as drafted. Is it possible for that information to be extrapolated for us?

Lord Sutherland: Yes. The committee has the opportunity to ask for that information. When the royal commission asked, we received information for England but could not get information for Scotland. Early on, I briefed ministers about that problem and inquiries have been made since then. It has been suggested that the information could be extrapolated. It would be unacceptable for the committee to be told that it could not be extrapolated.

Mary Scanlon: My question is on the same topic. Part 2 of the bill includes powers to enable greater joint working between local authorities and NHS bodies and a ministerial power to direct local authorities and NHS bodies to enter into joint arrangements. You were a consultant to the working group and, as I remember, you recommended a single budget, which the Health and Community Care Committee recommended too. You also highlighted the black hole of £750 million that was lost in the system. Given the above and the problems that exist with bedblocking and inappropriate care, do you think that the provisions go far enough towards meeting the royal commission's recommendations? Are ring-fencing, pooling budgets and joint working sufficient to address the problems that you—and we—set out to address?

Lord Sutherland: I attach a high priority to the pooling of budgets, however that may be done—and there are different ways of doing it. Unless a pooled budget scheme is set up, certain unacceptable consequences will follow. If budgets are not pooled, there will be a natural tendency for people to defend their own budget. I mean no

disrespect to the individuals involved, but the primary source of consideration will no longer be the person in need—it will be the administration of the bureaucracy of two different funding streams. All the evidence that we received showed that that approach produces terrible distress in individuals. They go to one source and are told, "It's not our money—go to them." The pooling of budgets was the royal commission's least-noticed recommendation. Although the Health and Community Care Committee noticed it, it received least notice in the press, yet I believe that it was one of our most important recommendations.

There are different ways of pooling budgets. We were asked whether we had a preferred route. To be honest, we did not have time to go into that issue. I am pleased to note that pooling budgets is an issue for the committee in its consideration of the bill, as it is a very important matter.

Mary Scanlon: Given the history of poor working relations between local authorities and NHS bodies, which you highlighted and which has come before the committee, will pooled budgets be adequate? Are you satisfied with the proposals on pooled budgets and joint working, given that you recommended a single budget, as did the committee, to address the major problems that confront us?

Lord Sutherland: There is some good practice in Scotland. Some local authorities and health authorities are doing good joint work, for which they should be commended. It is not all bleak.

The real issue is whether, once the pot has been put together, an individual—rather than a committee made up of equal parties—is given responsibility for using that money. Pooling budgets does not mean just building a financial pot; it means giving responsibility to an individual and making that individual accountable for delivering the provisions in the bill for which pooling budgets is supposed to be the adequate financial base. If that individual says that that approach is not adequate, the committee will have to take notice and decide whether the approach is right, wrong or indifferent. Control of the budget, as well as putting funding together in a single pot, is at issue.

Mary Scanlon: I have a further, if not entirely related, question. You mentioned the financial profile of nursing homes, residential homes and the lack of investment over the years. Given the known financial problems, including various bankruptcies, and taking into account the fact that money for personal and nursing care will be coming into the system, is there anything to stop such homes increasing their charges in such a way that the clients—the patients—will end up no better off?

Lord Sutherland: The homes can charge what they think necessary. It is, in part, a market: if they charge too much, they will not fill their places or rooms, and will go out of business. There is an element of market control. I have no doubt that some homes will charge different rates, depending on their level of provision. I do not think that one can or should attempt to prevent that. Equally, the message to those working in the private and charitable sectors, as well as those in the public sector, is that there is now a stream of money that they can build into their financial projections, and they should come up with sensible proposals and charging regimes. However, it is possible that they might put themselves out of business in that way.

10:15

Mr McAllion: I return to the important question of pooled budgets and joint working. I have come across cases in which elderly people whose primary need was to find a place in a nursing home could not get in because there were not enough places and because there was not the necessary social work department funding, so instead a more expensive home care package that could draw on Department of Social Security funding and housing benefit was put together. Surely that is a gross misuse of public money. Surely pooled funding and joint working must stretch between the Westminster and Scottish Parliaments, as well as between Scottish Executive departments.

Lord Sutherland: There is the issue of the so-called 21 point something million pounds—

Mr McAllion: But what about over and above that?

Lord Sutherland: I take a very simple view of this. The Parliament, the bureaucracies and the administrations exist to serve the community. We should find ways of spending the available money to meet the needs of the people. In this and in other cases, the fact that we have gone down one or another route—this has previously been the bane of the situation—should not be allowed to dominate the provision of care. That is what has happened in the past, which is why I agree that it is essential to look across the whole spectrum and to have a single point of entry into the system, a single point of assessment and a single point of commissioning and funding of the packages concerned.

Janis Hughes (Glasgow Rutherglen) (Lab): This is something of a catch-all question. Would you like the bill to contain any additional proposals to address some of the commission's recommendations that may not be sufficiently covered by the bill as introduced?

Lord Sutherland: One area of the commission's

recommendations that was firm in our minds—although we did not have time to develop it in detail—was to establish the mechanism for following up the bill, its impact and the provisions necessary for its implementation into the future. Our proposal was for a care commission. The proposed commission in fact had too many tasks; a number of them, in particular regulatory tasks, have already been taken up in Scotland.

However, an additional role is also required: it should be someone's responsibility—it may be that of a care commission, of the Health and Community Care Committee or of an individual or body appointed by Parliament—to examine what happens over the next few years on regularly spaced occasions, and to ask the Parliament whether the provision that is made into the future is adequate. Factors will change. Any projection—the care development group, the working group chaired by Malcolm Chisholm, opted, sensibly, for 20 years; we were required to go for 50 years—becomes like crystal-ball gazing after about 10 or 15 years.

We strongly believe that someone requires to be charged with the responsibility of reporting, for example, that measures are proving adequate and outlining the necessary changes in direction. I have no doubt that the bill will be good, but it will not be perfect and there will be a need for another look. The means by which the money is to be provided will, I have no doubt, be immensely helpful, and will take Scotland a long way forward. We need to think whether a re-steer is required in five years' time, however. That consideration could be given by this committee, but I think that that recommendation needs to be set more firmly into the Parliament's work.

Mary Scanlon: Do you feel that there are adequate incentives in the care development group report and the bill for local authorities to alleviate bedblocking and ensure that people receive the appropriate and unique care for which they are assessed?

Lord Sutherland: I guess that the matter is one of carrots and sticks. The carrot will be the fact that there will be real money so people will be able to think, perhaps for the first time, beyond balancing the next year's budget and the length of individual waiting lists. I hope that people seize that opportunity.

With regard to sticks, a group that is looking further down the tunnel of the future ought to be reflecting on whether there is a need to strengthen legislation and to query regulation and accountability if the objectives of the bill turn out not to be met. Someone needs to keep an eye on that because we are in new territory.

The Convener: On behalf of the committee, I thank Lord Sutherland for giving evidence and for all the work that he has done over the past few years. The committee was happy to do what it could to take up some of that work. We are pleased that we have had the chance to ask him another set of questions and that he has had the chance to say what he thinks about the bill.

Lord Sutherland: I thank the committee, because I have always felt that it is a group that is grappling with real problems. I know that many members, not least the convener, have given their support to developing the bill. That is appreciated by my colleagues south of the border on the Royal Commission on Long Term Care for the Elderly, who are looking up here with some envy.

The Convener: I welcome Professor Alison Petch. The tables are turned.

Professor Alison Petch: Yes.

The Convener: Last time the committee met Professor Petch she was our expert and assisting with our inquiry into community care, which Lord Sutherland referred to. Professor Petch is here to give evidence not only on the Community Care and Health (Scotland) Bill, but on her involvement as a member of the care development group, which is chaired by Malcolm Chisholm.

I will kick off with a question on the general principles of the bill. When we consider a bill at stage 1, we consider its general principles. We talked earlier about some of the principles of the royal commission, such as shared responsibility and whether the system can be perceived to be equitable and transparent. Do you believe that the bill, as far as you understand it, and the work of the care development group that is behind it, uphold those principles?

Professor Petch: The care development group discussed those principles, particularly equity, in detail. The group's report gives a statement that puts up front the principle—as we called it—of diagnostic equity. I believe that the recommendations in the report follow on from the primary principle of Lord Sutherland's report and work through to the principle of diagnostic equity.

We now need to ensure that we move beyond the debate on free personal care; the passion and energy that has gone into that has secured it. Your long-term involvement should be in securing the delivery of long-term services of the type Lord Sutherland has already produced examples of.

One of the regrettable aspects of the publicity surrounding the delivery of the report was the lack of emphasis on the fact that there is £50 million for the delivery and development of services in the community. Shifting the balance of care should be the essential focus. As long as the bill can ensure that the requirements of that are supported and

endorsed, that path should be set.

The Convener: Do you believe that the bill as drafted allows us the framework to begin that kind of expansion of community care and the sorts of ideas that Lord Sutherland has just been talking about?

Professor Petch: It certainly puts the elements in place. However, you must remember that bills such as this provide only the framework—the policy that you aspire to. There must be detailed attention at front-line practice delivery to ensure that, for example, the money is spent—we have already had some discussion of that—and that the joint working elements start to work.

You referred to the carer's assessment. Of course people should have the right to an independent assessment of their needs, but that is cold comfort if nothing is done about it. I would want to ensure that there is robust recording of elements of unmet need. I have no problem with any of the elements that are in the bill; it is what comes afterwards that will be vital.

The Convener: Do you think that the bill will put us in a better position to quantify the level of unmet need?

Professor Petch: I am not sure whether anything in the bill will do that. You might be able to strengthen the carer's assessment element to ensure that a system to record the elements that have been identified in assessments but that cannot be met is in place.

Nicola Sturgeon: You said, rightly, that any bill is only ever a framework and that it is the flesh on the bones that makes the real difference. I do not know whether you have had the opportunity to read the bill in detail; Sir Stewart had not managed to do that. Nevertheless, do you think that the bill is—even more than other bills—a bit too skeletal? Richard Simpson may return to these points later. It does not, for example, contain definitions of personal care or nursing care; it is very much an empowering bill. A lot of the flesh will be provided through regulations, which are made by ministers. Do you think that it would be a good idea to put more of the detail into the bill?

Professor Petch: When I was asked at the end of last week to come along here today, I printed out the bill and took it to read on a train journey. My first response was, "My goodness—is this what one's great thoughts are reduced to in legislation?" I am not an expert in legislative drafting, but the bill makes an extremely dull read. I tried to read the bill alongside the extra bits. The policy commentary is quite interesting. I would endorse any moves that can be made towards making more people-friendly legislation, although I am not an expert in that. I suspect that legislators would argue that the bill has to be very precise and well drafted, otherwise we might end up with the sorts of errors that were highlighted prior to this discussion.

Fleshing out and carrying over fuller explanations would be a good idea. One of the problems that has bedevilled some of the discussions on free personal care is the fact that people forget that care is to be provided on the basis of assessed need. We get debates that are contradictory. We had headlines about how only 8,000 people will benefit. That excludes the vast number of people who will be in the community rather than in care home settings. I would certainly support putting any of that in legislation.

10:30

Margaret Jamieson: As a member of the care development group, do you think that the group tackled its remit in its utilisation of the expertise of group members and in the consultation that was undertaken with service users, carers and those employed in social care?

Professor Petch: Being on the care development group was an interesting experience, which I enjoyed. It would not be patting ourselves on the back too much to say that we worked hard. In particular, the civil servants in the background worked hard to support us.

In the early weeks, we were quite taken aback by the breadth of the remit. We felt that everything that could possibly have been thought of to do with the support of older people had been written into the remit. However, having gulped, we moved forward on that. Obviously, we could not explore each of the avenues fully within the time available.

My one regret about the final report is that it does not, perhaps, give housing as great an emphasis as it was given during our discussions. If you read the report, there is not a great deal about housing. Lord Sutherland has already raised examples of good practice. There are many related issues, such as small-scale developments for people with dementia. We discussed that a lot, but I do not think that that is reflected in the report.

You asked about the consultation process. I was involved in three of the public meetings. We found them extremely helpful. Again, there was perhaps not time to reflect fully in the report the commentary that we gained from the 312 written submissions to the group. From reading the report—as is often the case with such consultations—you might not realise how much time and energy people put in.

As we gained momentum over the six months, we felt that the majority of the issues had been teased out and that we had reached a balanced assessment. If we had had more time, of course

we could have done more—but that would probably have made things even more complicated.

Margaret Jamieson: Do you feel that there has not been enough emphasis on how we deliver on future housing needs? Was it a missed opportunity?

Professor Petch: A reader of the report who is not fully au fait with the issues—perhaps some of your colleagues who are not so familiar with the community care agenda—might not realise how core are the roles of housing and alternative models of support within the community. Imaginative housing models—making use of, for example, the evolving technologies—are coming to the fore and they could be built on. I am sure that little bits appear in the report, but perhaps we were not able to put in the full extent of what we thought about. That is a personal reading.

Shona Robison: The care development group's final report was published on 14 September and the bill was introduced to Parliament on 25 September. Do you think that the timing of the introduction of the bill was appropriate, given the amount of time the Scottish Executive had to consider the group's recommendations? Do you think that there should have been more time to allow digestion of the report before the bill was introduced?

Professor Petch: I suspect that I am walking into a trap by answering that question.

I am not sure about the tie-ups and links between the report and the introduction of the bill—to what extent one built on the other and to what extent the bill was ready to run as soon as the report was published. Those things are not revealed to mere members of the group. However, it might have been better if people had had more time to digest the implications. When you come to the end of your deliberations, you might find that there are all sorts of other things that it would have been good to include in the bill. We must remember that bills deal with specific legislative implications and all our aspirations. Without detailed knowledge, it sounds as though more time would have been a good idea, but who knows?

Dr Simpson: I will put to you the same question as I put to Lord Sutherland: do you think that the principles behind our aspirations should be in the bill?

Professor Petch: That seems eminently sensible.

Dr Simpson: The bill must repeal sections of the Social Work (Scotland) Act 1968. In doing so, four elements appear in the text. I refer to nursing care, personal care, accommodation and social care.

I accept that you have not had much time to study the bill, but given that we are moving towards a single definition of care, a single registration process for care—we passed that in the Regulation of Care (Scotland) Act 2001—and the single system of assessment that you recommended, do you know what the group feels about having a single definition of care instead of what I regard as a false divergence, particularly in relation to people with mental health problems and Alzheimer's disease, between personal and nursing care? Do you feel that we should seek to repeal larger chunks of the 1968 act, with which I am only vaguely familiar, and that we should include a definition of personal living expenses, to which Lord Sutherland referred, rather than use the term social care and accommodation?

Professor Petch: My particular take on the disadvantages of talking about social care relates to our move towards joint resourcing and joint working. The danger in the layperson's response to talking about social care is that it is somehow distinct from health care. Given that we want to remove those boundaries to introduce terms that are contradictory to the more general thrust of practice, that is only likely to confuse.

It is the same old issue: if we were designing the system again, we would not start with the complex array of history that we have now. The suggestion that we might start again and be more radical about terminology sounds eminently sensible, although this is the first response to that suggestion.

Margaret Jamieson: You were here this morning when we asked Lord Sutherland about promoting choice. Current provision includes the deferred payment scheme, the opportunity to top up residential accommodation costs, arranging residential care outwith Scotland and extending the direct payment scheme. Do you believe that the bill makes sufficient provision for extending choice for individuals?

Professor Petch: In real day-to-day impact, the first three provisions are of minor importance. We need to focus on the direct payments initiative.

In debates on the issue, it has been said several times that direct payments legislation has been made and the take-up in Scotland has been pitiful. Making take-up mandatory should improve on that, but it does not guarantee that people will be able to take on board the reality of direct payments. A scheme has been funded to support the development of direct payments. Local authorities that wish to inhibit the development of direct payments—as they think that such payments challenge their own provision—must be resisted.

One of my students made a detailed study of the implementation of direct payments. She found one authority in Scotland in which people who used the authority's day care services were not allowed to apply for direct payments as that might challenge the viability of those units. We must take the longer view. Reference was made to maintaining day facilities. We must think about what kind of day support we want. We do not necessarily want the current models of large buildings and many people turning up for provision, for example.

I will give an example of good, person-centred and flexible day care provision. An older person with dementia did not like going to the traditional day care centre. Arrangements were therefore made for a support worker to accompany that person fishing one day a week—that was his day support. We must ensure that legislation supports that.

Our public attitude surveys are interesting. They show that about half of more than 2,000 people who were interviewed in the telephone survey would welcome direct payments. People did not know too much about direct payments, but they were given a notion of what they might be. However, direct payments were particularly welcomed by older people. That might be counter-intuitive. Some say that older people would be unable to do things. There is a danger of negative attitudes towards older people.

Margaret Jamieson: Is that not a symptom of a herd mentality that we have had for a long time in providing care to older people through specific services? We provide such services but do not consider anything else. We assume that doing so meets every person's needs and do not consider people as individuals who have different aspirations and different levels of dependency. Surely their care should be tailored to their needs and not to what is provided. Perhaps the debate is a welcome opportunity to challenge models that serve no purpose other than to house people during the day.

Professor Petch: Absolutely.

In encouraging the introduction of direct payments, it is essential that people avoid erecting an administrative bureaucracy. For some reason, people ask about the Netherlands. There, only 5 per cent of the budget goes to people on what are called personal budgets and there has been much heavy regulation as a result of a suspicion that people would misuse those resources.

By contrast, more than half the older people in Germany who receive home care have a not unrelated form of direct payment that is worth much less than the provision of services would be. The cash payment is of a lower value than the services, but it is provided with the minimum of regulation. The panoply of care management and regulation is not required. In the study to which I briefly referred, it was found that people had had to produce receipts for cinema visits by them and their personal assistants to satisfy the regulatory requirements of an authority.

10:45

Dorothy-Grace Elder: You gave an excellent example of tailored personal aid—the elderly gentleman who was taken fishing. I am sure that you appreciate better than any of us the fact that some who are protesting in Glasgow take the opposite view and say that that can be a cheapo solution, although that would not include the fishing trip idea because it is obvious that the man involved liked that pursuit and should continue it.

Those who protest talk about miserable visits and being trailed round shopping centres to window-shop in the rain. They think that such visits can be a cheap cop-out. The closure of some day centres is much resented because many carers feel that those for whom they care are safer in a day centre and have greater ease of mind than if they are with a stranger.

Will you comment on the difference in the situations and whether some local authorities might use the proposal as a loophole through which to make cheap arrangements instead of the proper arrangements?

Professor Petch: That possibility always exists, but we should think about two aspects. The first is a common phenomenon that relates to events such as hospital closures and can be readily translated to the closure of day care centres and other, similar, places: carers or individuals hear only that a threat to provision exists. They do not hear about the alternatives that might be in place. Any of us would fear a potential loss. The situation is similar to that in which guarantees are given that alternative resources are in place before existing systems are dismantled.

The second aspect is the fact that we must acknowledge conflicts. There are conflicts between informal carers and individuals. An informal carer may crave security and the knowledge that the person for whom they care is safely within the walls of a day centre, but we must enable that individual to have alternative experiences—although they would certainly not include trekking round a shopping centre. They need good-quality alternative provision, which may incur the taking of some risks, such as riding a bus alone.

Dorothy-Grace Elder: A balance must be achieved.

Professor Petch: Absolutely.

Dorothy-Grace Elder: Nevertheless, you might agree that local authorities could latch on to the proposal as a way of providing a cheaper and perhaps shambolic care choice in the long run.

Professor Petch: An argument was presented on why we believe it is extremely important that resources for older people should be ring-fenced. When people want to cut budgets, that temptation always exists.

Shona Robison: It might be useful for the committee—I would find it useful—if you provided us with some of your background information on direct payments, with examples of it working well, particularly internationally. Any information on some of the potential difficulties with direct payments that we must address would also be useful.

In a recent court case, although the dispute was between a person and their personal assistant or employee, the local authority was found liable. That ruling gave cause for concern among local authorities as they would seem to be the third party in the arrangement. I welcome direct payments, but that could be a major blockage to their being extended.

It would be extremely useful if you could provide us with background information on that subject.

Professor Petch: I will do that.

Mary Scanlon: I want to ask about the option to top up residential accommodation costs. Section 4 includes provision for that. Lord Sutherland mentioned that the residential accommodation market is smaller, which means that there is less choice than there was previously. In recent years, residential and care homes have had financial problems due to funding, lack of referrals or whatever. Is it possible that some homes might take advantage of the additional income for personal care and use that as an opportunity to increase charges? If that were to happen, the increase in funding would not result in individuals and families being better off.

Professor Petch: I am sure that Machiavellian home owners might try to do that.

One area that is extremely important is that of the majority of people who are cared for in the community. There is a danger that charging for non-personal care services in the community could be augmented or accelerated to produce the effect to which Mary Scanlon refers. The Health and Community Care Committee should put pressure on the Convention of Scottish Local Authorities to deliver its report on charging. We need to ensure greater equity in the charging system that will be applied in the community for non-personal care elements. Are people going to pay for day care places or for other non-personal care elements? What are they going to pay for domestic provision?

The Health and Community Care Committee has probably heard more times than it wants to about the enormous variation in charging that exists across Scotland. It is imperative that the opportunity is taken now to progress that issue. The care development group's report referred to that having been put on hold while we deliberated. My sense is that it has been put on hold for rather a long time. The Convention of Scottish Local Authorities needs to pronounce on measures to implement equity of charging, as far as it possible to do that.

I am aware that my reply has not quite answered Mary Scanlon's original question. Care home owners may well do what she has said they might do, but we need to remember that the care home sector is only half the story. We need to avoid the danger of a parallel process happening in the community.

Mary Scanlon: Is the system open to abuse in the community as well as in the care home sector?

Professor Petch: We put a proviso into the report to ensure that the introduction of free personal care did not have the ironic impact of people paying more than they currently do if agencies hiked up their prices for the non-personal care elements of their services. That could happen, but we tried to ensure that it would not happen in the short term. We need to get to grips with charging for the non-personal care elements.

Mr McAllion: The bill will amend the Social Work (Scotland) Act 1968 and the Children (Scotland) Act 1995 to give carers the right to have their needs independently assessed. Lord Sutherland described that as an important first step. You said that that will be cold comfort if nothing is done on the ground to meet those needs.

In my view, giving carers the legal right to have their needs recognised without giving them an equivalent legal right to have those needs met is a particularly cruel form of social legislation. Why should we not further amend the acts to which I referred and delete the provisions that state that local authorities "may have regard to" assessments? Why can we not say that assessments will be legally binding on local authorities?

Professor Petch: My response is to wonder what the teeth are in an act. Under a previous piece of legislation, people were supposed to have all sorts of entitlements to support at home. For example, they were supposed to have the right to transport to a day centre—but we know that such services are not being provided.

I know that there have been debates about whether we should have minimum requirements. For example, carers are entitled to two weeks' respite per year. I do not oppose that, but I reiterate the comments that were made earlier: we need to have systems in place to monitor whether such entitlements are met and sanctions that can be imposed when they are not. However, a right that exists but cannot be claimed may be slightly less cold comfort than no right at all.

We must beware putting people in boxes. That is particularly true of respite. People say that they want respite, but when plans to provide it are drawn up they tend not to correspond to carers' wishes. The care development group reported people saying, "It is all very well having the promise of two weeks next July, but I want to go off for three hours tomorrow afternoon because I am at the end of my tether." I would like there to be minimum standards that build in flexibility, but there is a huge gap between that aspiration and our current community support system.

Mr McAllion: Everyone accepts that there has to be flexibility and that people's individual needs cannot be provided for through law—there has to be some give and take—but if there is a statutory requirement on local authorities to carry out assessments for individual carers that will identify their needs, but no statutory requirement on them to meet those needs, what is the point of the assessments?

Professor Petch: I do not disagree with the member's point.

Mr McAllion: If there were a statutory requirement on local authorities to meet assessed needs and they were not meeting them, they could be taken through the courts. If the law were amended in the way that I suggest, there would be a means of enforcing it.

Professor Petch: We could get into a philosophical debate about what constitutes a need.

Mr McAllion: I am talking about agreed assessed needs. Under this bill, carers would have the right to have their needs assessed.

Professor Petch: An individual with support needs has the right to an assessment, but they do not have the guaranteed right to have those needs met.

Mr McAllion: Is not the weakness of all the social legislation that we have passed before now that we have not been prepared to fund the services that would meet the needs that are being assessed? At bottom, that is what is wrong at both national and local government level, is it not?

Professor Petch: Yes.

The Convener: John McAllion has made a very relevant point.

Mary Scanlon: Part 2 of the bill emphasises joint working and joint arrangements. In your reply to a previous question, you said that the bill provides a framework. In your view, do the bill's provisions go far enough in addressing the need for greater integration of NHS and local authority services?

Professor Petch: I am delighted that provision is being made for pooled budgets. However, I am not sure whether the new term "aligned budgets" that has emerged is a weasel way of getting out of pooled budgets. It might be worth keeping an eye on that.

It sounds like I am developing a theme, but I am concerned that there might be less preparedness for the measures at the front line than there is at the centre. From next April we will have joint resourcing and management of services for older people, which is an excellent first step. However, if one talks to people on the ground in some areas, one finds that delivery of that change is further away than six months hence.

11:00

The other matter about which I raise a question—which I urge the committee to keep under scrutiny—is the health component that goes into the pooled budget. In the care development group, we tried to ensure that attention was paid to the release of bed moneys and to the closure of long-stay beds, and that that money would go into the pooled budget. These are early days with pooled budgets and, at the moment, different people mean rather different things when they refer to them. We have tried to find examples of pooled budgets.

I cannot think of anything in the bill that could be tighter. I do not want to sound negative about joint working, because there is enthusiasm among agencies, building on some of the work of the joint future group, for proceeding on joint working. There needs to be careful scrutiny and tracking of the money in the pooled budgets. It should be ensured that people have not found a whole lot of secret pockets in which to stash some of the budget headings. We should move forward from there.

Mary Scanlon: Given your concern about the pooled or aligned budgets, and given John McAllion's points about unmet need, why did not the care development group opt for a single budget, which was recommended by Lord Sutherland and the Royal Commission on Long Term Care for the Elderly?

Dr Simpson: If I may add a supplementary point

to that question, the English have opted for care trusts. That is now included in English legislation, and allows for the budget to be pooled there.

Professor Petch: When first I heard about care trusts, I was quite enthused about them and I would have readily supported them. I think—I hope that David Bell will correct me if I am wrong—that one of our pragmatic reasons for not recommending a single budget in the first instance was connected to timing; we did not think that our time scale would allow us to proceed with a single budget. Since the early days, when there were heady discussions about care trusts, a lot of hassles and haggles have been encountered in England. In perhaps retreating a little from advocating a single budget, I ask whether we want yet more upheaval. I wonder if the structures are as important as the mechanisms and the various local arrangements. We should perhaps put much more emphasis on those. I link that with the emphasis that the report put on the establishment of robust outcome agreements. What is done at the beginning of the process is far less important than what happens at the end. We must shift the scrutiny because pooling the budget does not in itself guarantee improvement. Organisations might still muddle along, while not providing a very good service. Attention must be paid to outcomes and to what is actually done with the investment.

Janis Hughes: I will ask my catch-all question again.

In your opinion, are there any omissions from the bill? In other words, did the care development group make proposals that the bill does not take into account? Will you comment on Lord Sutherland's suggestion that there should be a care commission, or similar body, that would oversee the practice of the legislation in the longer term?

Professor Petch: I wish that I had had notice of that question, because I would have come to the committee with a shopping list. However, as I was not given notice of it, I will limit myself to an endorsement of Lord Sutherland's plea. This is really a summation of a lot of my references to the need for continuing and steady scrutiny.

Over the past few months, a number of us have referred to the tremendous amount of activity that there has been since the Parliament was established, which is to be commended. However, many people feel that they need to draw breath and ensure that the foundations that have been put in place are built on.

I will flag up the crucial issue of the future work force. The care development group report referred to that, but we were unable to wave a magic wand and produce instant solutions. Members can put their minds to that point, but I am not sure whether any of the bill's provisions address it. We are developing wonderful plans, but none will work unless we have the support of an available work force. Last week, I heard Melanie Henwood speak on "Future Imperfect?", which is her report of an inquiry that was conducted under the auspices of the King's Fund on the future work force that will provide community care and support. We should be able to capitalise on new and innovative sources of staff and provide the resources to give them decent wages that will compete with alternative sources of employment such as call centres. We should be able to provide training and generally enhance the status of the support that we ask people to give. I do not know whether members can work that into the bill—I will leave that to their ingenuity.

Janis Hughes: I welcome those comments. It is refreshing to learn that the care development group considered people at whom the bill is aimed and the more strategic view of how we are to provide care. Please feel free to jot down your shopping list and send it to us.

The Convener: If we receive a piece of paper with jam, cornflakes, bread and tea written on it, we will know that you have made a slight error and sent us the wrong list.

I thank Professor Petch for her evidence, for her work as the committee's adviser on our community care inquiry and for her contribution as a member of the care development group.

Margaret Jamieson will now take the chair.

The Deputy Convener (Margaret Jamieson): I welcome Professor David Bell, who has provided members with a written submission. I understand that his submission was e-mailed to us yesterday, but unless we were quick to pick up that e-mail this morning, we will have to rely on the comments that he makes this morning.

Dr Simpson: The first question is clear. Do you think that the Executive has made sufficient provision for free care?

Professor David Bell: In the papers that I sent round yesterday, I tried to examine the various steps in the costing that we used in the final report. There are greater and lesser levels of uncertainty associated with different parts of the costing and if members want me to go through that, I will be happy to do so.

Increases in costs will come about that have nothing to do with the policy of free personal care. The principal reason for the increases will be the demographic changes that will take place over the next 20 years. You will see from table 1 in my papers that the population of people over 85 will go up by 67 per cent. There is a small number in that age group now, so the increase might appear

a little more frightening than it ought to, but 67 per cent is a lot. The demographic changes have nothing to do with the policy of free personal care, but they are among the most predictable of the changes that will cause increases in the overall costs of care. That is because, by and large, the people who will be covered by the policy are already alive and we know pretty well the rate at which they will die.

We have also looked into health expectancy. People today generally have healthier lifestyles that in the past. Certain manual occupations with which there were many associated health problems are reducing in size, or have reduced over the past 20 years, and their associated problems will therefore be less prevalent in the elderly population. Some work that was done in Aberdeen suggested that, broadly speaking, about 0.25 per cent fewer of the elderly population will require care each year. However, that has nothing to do with the policy of free personal care.

The next assumption, about changes in the unit costs of care, determines to a huge extent the budget that we will need over the next 20 years. A decision that the unit cost would grow by 3 per cent would have made a substantial difference to the budget 20 years hence. The increase in the unit cost of care corresponds roughly to the long-term rate of growth of gross domestic product. It is a real growth rate in care expenditure per person. That unit cost is intended to capture some of the issues that we have already discussed, such as the changes in quality that people will come to expect over the next 20 years, and the increases in the cost of providing care. Alison Petch touched on that.

We must ensure that there are sufficient numbers of suitably trained care workers to provide the services that we are aiming to provide. A 2 per cent increase will make a big difference to the cost of care not in the first few years, but over the 20-year profile.

I turn to the issues that impact on the cost of the provision of personal care. We took into account two things that the Sutherland commission did not take account of. One of those was the substitution of formal care for informal care. The cost of that is largely unknown. The provision of care to the elderly in Scotland is dominated by informal care rather than by formal care. If there were a substantial substitution of formal care for informal care, there would be a substantial increase in costs.

11:15

We worked out a rough cost equivalent—I will not go into the details—of the value of the current provision of informal care and it came to about £200 million a year. We considered evidence from the USA about the substitution of informal care for formal care. A good experiment was carried out there, but of course theirs is a different culture and the results do not necessarily carry over; however, they were the best results that we could get hold of. The results suggested a switch-over rate of about 12 per cent, which implies an annual additional cost of £25 million. Members can see the figure in the report that is in front of them. I need to say a little more to clarify that. The 12 per cent of the £200 million came to £25 million.

Our consideration of the issue of unmet need was based on work that was carried out in Aberdeen. We examined a couple of surveys and work that was done in Glasgow. The figure of £25 million came out of that work as the amount that should be set aside for the increase in demand for care. That makes a total of £50 million. That £50 million will go into the community over the next few years, but we argue that at first the switch from informal to formal care and the take-up of unmet need will be slow. In the first year, we have set aside only £8 million for the cost of the switch-over from informal to formal care and the cost of existing unmet need.

The last table in my report includes that £8 million in year 1. However, we budgeted for a total of £50 million, leaving £37 million under the heading, “non-recurring investment in community care services”. We intend to put that money into the community to improve its capacity to provide services. We expect those costs to taper off over three years. In other words, at the end of year 3, we expect the unmet need to be met and the switch-over from informal to formal care to have taken place. That gives a three-year window during which there will be extra funding to put in place the capacity to improve care in the community. That will be directed through local authority budgets.

The experiment in the States related to people who were already carers. They were given new services that were provided by the state. Those people already had the experience of being carers and had to decide whether they would continue with informal caring or allow the state to provide the care formally. That might be an appropriate way for us to gauge how much substitution there will be over the next few years.

However, in 10 years’ time people will be confronted for the first time with caring for their parents. They will have had no experience of caring and it is not clear to me that they are the same kind of people as the people with whom the experiment in the USA was conducted. We might find that the substitution effects are even greater than envisaged and that potential increase in costs worries me slightly.

To sum up, I do not attach great risks to the issue of demography. However, there is considerable uncertainly about the real increase in unit costs over the longer term. Substitution between informal and formal care is also an area of uncertainty. Another important issue is the question of unmet need—demands that might appear because people know that a service has become available.

Dr Simpson: The last table in your paper illustrates the tapering effect on non-recurring investment, balanced against the increasing costs of the switch-over from informal to formal care and of unmet need. In what way will the non-recurring investment of £37 million and £19 million occur? What will it be?

Professor Bell: It will be moneys that will be distributed by the Executive to local authorities, through grant-aided expenditure. It will be incumbent on the Executive to suggest ways in which local authorities might use that money to increase their capacity to provide informal care. Clearly, some authorities will have less to do than others and, as far as I know, it has not yet been decided precisely what kinds of direction or advice ought to be given to local authorities on this important issue.

Mary Scanlon: You have covered the main issues relating to finance. Could you explain what, in the section headed "Other issues", is meant by "diagnostic equity", as opposed to

"the more traditional understanding of equity"?

Alison Petch made a point about the supply of workers. You ask in your paper:

"Will smart technology reduce the requirement for such labour?"

Will you explain what you mean?

Professor Bell: I had a hand in framing the paragraphs on equity in the care development group's report, so I am reasonably familiar with what is said there. There are two forms of equity that one ought to consider. Normally one would expect that handouts from the state would be directed towards the poorest in the population. I call that income equity. Policies that are progressive provide more resources to the poorer members of society. Policies that are regressive shift the balance towards those who already have high incomes. With diagnostic equity, one would expect people who receive different forms of care to be treated in a roughly equivalent fashion.

Mary Scanlon: Would that be irrespective of income?

Professor Bell: Yes. Take the examples of cancer and dementia. Should somebody who has dementia be expected to pay for care while somebody on whom many thousands of pounds are spent to treat their cancer is not expected to contribute at all? We must consider balancing diagnostic equity and income equity. The group has moved towards the conclusion that diagnostic equity is the key issue highlighted by Sutherland.

The new policy will not, in fact, particularly benefit the poorer members of society, because the care of poorer people in care homes is already provided free. As far as care homes are concerned, the policy will benefit mainly those who would be self-funders, and who have more than £18,500 of capital.

I hope that members will permit me to be deflected slightly for a few seconds. As an increasing proportion of the Scottish population become homeowners, and as they age, we expect that an increasing proportion of those who go into care will be self-funders. We might expect that, over the years, the cost of caring for the elderly will decline, because the private contribution will increase relative to the public contribution.

Income equity is a difficult issue to grapple with. I did some rough calculations and mainly the top three deciles of pensioners will, in terms of income, benefit from the provision of £90 a week for people in care homes. The care group was keen to ensure that a significant amount of the money that was being promised would go towards care in the community. Apart from the view that the balance of care ought to be moved towards care in the community, it is also true that the money will be spent in a more income-equitable way. Everybody in the community who requires care—irrespective of income and not only if they have more than £18,500 of capital—will benefit.

Mary Scanlon: Are you satisfied that people are given equity in care provision, regardless of their income?

Professor Bell: In the sense of diagnostic equity, yes. It is also true that people, regardless of income, will now be treated the same. Whether you think that that is equitable in the income sense is a different matter. If you think—leaving aside diagnostic equity—that people ought to contribute more when they have higher levels of income, then we have moved a little towards inequity in that sense.

The Convener: But we have moved towards diagnostic equity.

Professor Bell: Yes.

The Convener: That is fundamental.

Mr McAllion: When answering Richard Simpson's question about whether there was enough money in the budget, you seemed to say that that depends on a number of factors.

Professor Bell: Yes.

Mr McAllion: You described predictions of such factors as either carrying quite a lot of uncertainty or being uncertain.

Professor Bell: Yes.

Mr McAllion: Your predictions, as an economist, are your guesses. How do we know that they are your best guesses, as opposed to your most convenient ones, which just happen to fit with the money that is available in the budget? [*Laughter.*]

11:30

Professor Bell: That is, in fact, quite a reasonable question. We looked into all the assumptions in considerable detail. We were anxious to make it clear that there is a big funnel of doubt over costs. I reiterate what Lord Sutherland and Alison Petch said. The policy has to be revisited to ensure not just that it is working and delivering care, but that the costs are under control.

We did not make the policy fit the money that was available. For the first few years, we have tried to take up what might otherwise be seen as the slack—that is, £37 million, followed by £19 million in the next years—to enhance provision in the community. Despite the fact that the group felt that that money might not be required immediately, we were keen to ensure that we spent the entire budget on the aim of improving the quality of care in the community.

Mr McAllion: If your assumption about 2 per cent growth a year is wrong and growth turns out to be 3 per cent a year, what would the cost be?

Professor Bell: The cost would be hundreds of millions of pounds by the end of the 20-year period. However, that is not a cost of the policy.

Mr McAllion: Are you saying that, if your assumption is wrong, the additional cost to the budget will be hundreds of millions of pounds?

Professor Bell: That is true, but one must keep on revisiting the policy to ensure that it is delivering value for money and still attracting the level of Executive priority that members want it to have.

Mr McAllion: A lot of people will be praying that you got it right.

Professor Bell: I think that I did.

Margaret Jamieson: There has been a lot of speculation that the Department for Work and Pensions will not continue to fund payments for people who receive attendance allowance. What consideration did the care development group give to potential consequential changes in funding due to the altering of previously UK-wide social security benefits?

Professor Bell: We knew that the issue of the attendance allowance was under consideration. If we had had a longer period in which to produce our report, we might have had more of an outcome as far as the attendance allowance is concerned. In a way, it is a little unsatisfactory that there has been no outcome yet.

I understand that the DWP is keen to ensure that the rules for the benefits system are applied across the UK. That knocks us into a real difficulty over the payment of £90, which we saw as a top-up to the £55 attendance allowance that the DWP would provide. I realise that that is a constitutional issue, but it is also an issue for the policy on care for the elderly. One could argue that it does not matter where the money comes from and that it just so happens that it comes from Westminster. However, one would not wish to take a twin-track approach to the budget, because one would want to start with a single pot or joined-up budget and to have the freedom to allocate that budget as one would wish to allocate it.

I understand that the negotiations have yet to yield an outcome. It is clear that oddities exist in the way in which the attendance allowance is dealt with; the allowance will be withdrawn from people who receive personal care and who live in care homes, but it will not be withdrawn from those who live in the community. In the documentation that is associated with the provision of free nursing care in England, it is also made clear that there will be no effect on the attendance allowance as a result of that policy. We have wrestled with the problem of whether we can really distinguish between those two areas of provision, and whether we would want to do so. The DWP may want to continue with one set of rules, but there are clearly oddities within those rules that can be pointed out to it. In my view, it would be sensible to have one pot from which services to the elderly were delivered.

Margaret Jamieson: Did the care development group consider any other costing model that did not include social security benefits?

Professor Bell: Our approach was based largely on the approach that was taken by the Sutherland commission. In Wales, where this issue is also being examined, the Sutherland approach to allocating total care costs may not be taken. I refer members to the first table under point 6 of my handout. We allocated costs in the way that Sutherland did, based on what we believed to be weekly charges in nursing and residential homes. The method that we used was simple. We worked out nursing costs as the difference between the cost of a nursing home place and the cost of a residential home place. Living and

housing costs are based on what the DWP thinks they ought to be. Personal care costs are the difference between those two figures. That methodology is not very sophisticated, but it reflects exactly the approach that Sutherland took.

The sum of £145 per week consists of £90 that is contributed by the Executive and £55 from attendance allowance. We did not consider other costing models. We did not have information that we could use directly to assess nursing costs. I notice that in England three bands have been created, of £35, £85 and £110. Those figures are based on direct estimates of the cost of nursing care.

There is no complete alternative to the costing model that we used. We are pointing out that, if attendance allowance is not forthcoming, the Executive will have to find an additional £55 a week to meet the full costs of care for everyone in care homes.

Margaret Jamieson: Is that a serious obstacle to the implementation of free personal care in Scotland?

Professor Bell: That depends on what the Executive has in reserve and on its priorities. When there is a fixed budget, any amount spent on one thing cannot be spent on another. It is as simple as that.

Nicola Sturgeon: I want to ask about a couple of points of detail, but for the moment I will stick with the general issue. As you were speaking, it struck me that, had the Scottish Parliament decided to widen the definition of nursing care to include personal care, the attendance allowance problem would not have arisen. Do you agree that removing attendance allowance from Scottish pensioners would break up the UK system?

I am aware that the details that I want to ask about may not add up to a huge amount of money, but they are important. My points are based on the assumption that the attendance allowance problem will be sorted out and that Scottish pensioners will retain attendance allowance. In arriving at the figure of £145 for free personal care, however, you have added £90 to the existing £55 per week. Although £55 a week is the higher rate of attendance allowance, an unspecified number of people receive the lower rate of £37. In their case, £37, not £55, will be added to their £90. Did the group consider how many people would be affected by that and what the additional bill would be? If the attendance allowance continues to be paid, that situation will give rise to an additional bill, which will have to be met by the Scottish Executive.

I also want to ask about the position of partial self-funders—those who do not currently qualify for attendance allowance. They will get the £90 from the Scottish Executive, but I am not sure where the extra £55 for them will come from. If personal care is no longer means-tested, it arguably no longer comes from the local authority in the way that it does now. I have some doubt about the robustness of the figures. Both those points of detail will remain, even if Westminster agrees to continue to pay the attendance allowance.

The Convener: I think that Nicola Sturgeon made three points there.

Professor Bell: Yes—I am trying to juggle them around. To start with the lower rate of attendance allowance, I understand—although I do not have figures with me—that not a huge number of people are covered by the £37-a-week provision in care homes. I think that that rate applies only to those who require daytime care, as opposed to day-and-night care.

The partial self-funders who have their attendance allowance withdrawn are from the group whose capital lies between about £11,500 and £18,500 per year. I do not think that they form a large group of people. A total of about 8,000 people are concerned, the vast majority of whom are paying for the entirety of their care.

It is true that, as people's capital diminishes, they will fall into the category of being partial self-funders. My honest answer is that the group did not look into that matter in any great detail. I do not have a huge worry about the prospect of an additional bill such as Nicola Sturgeon described—I think that the costing will be increased by a relatively small amount. I do not think that there are many people in that intermediate category. However, it was fair to raise that point.

Nicola Sturgeon's first question was whether the removal of attendance allowance from Scottish pensioners will be the straw that breaks the camel's back as far as the UK-wide social security system is concerned. That is a difficult one to call. There have been movements between budgets in the past, so the social security system does not have a fixed set of responsibilities that have never changed. New benefits arise and some benefits are transferred. It would seem odd if the whole system collapsed on the basis of about £20 million, given that the total budget is about £80 billion. It will be very interesting to see what happens; it will also be interesting to see what happens in Wales and Northern Ireland, where the same problem is being investigated.

Mary Scanlon: Would anyone who was assessed as eligible for personal care also be eligible for the full attendance allowance?

Professor Bell: I do not think so. The calculation of the attendance allowance assesses

the extent of the time over which care is being provided, whereas the allowance for personal care depends on several aspects of care. The two do not necessarily exactly coincide.

Dr Simpson: May I ask a brief supplementary question?

The Convener: We are running out of time.

Dr Simpson: All right—I will leave it.

Mary Scanlon: The care development group reported on joint working and joint arrangements. Given the group's acceptance that local authorities remain the best vehicle through which to allocate funding, what alternatives to GAE might operate? Have enough resources been provided to ensure that joint working will address the concerns about bedblocking and appropriate care that were mentioned earlier?

11:45

Professor Bell: The funding of community care was an issue that considerably exercised the minds of those who sat on the group. Direct payments were discussed, and the group listened to evidence from other countries. We were aware that the take-up of such schemes in Scotland had been limited. As an economist, I generally favoured direct payments, but I was also involved in the evaluation of the nursery voucher scheme when it was implemented back in the early 90s and I am aware of the problems and the plus points that are associated with direct payment schemes.

It seems obvious to me that if one is to deliver policy in a joined-up way, one must have a joined-up budget. For example, attendance allowance, irrespective of where it comes from, will impede joined-up working. The group also discussed the issue of ring fencing—which was also raised this morning—and whether it is an appropriate mechanism for ensuring that local authorities are delivering the services that the Executive wants them to deliver. As Lord Sutherland said, ring fencing does not always deliver what those at the centre believe it will deliver. What about those local authorities that already spend above the amount implied by the ring fence?

An associated point is that the Executive is moving towards outcome budgeting. That seems to offer a more appropriate method, as local authorities will provide indicators of how much provision exists across the spectrum for the services that they are expected to provide. Outcome budgeting will be less of a straitjacket for local authorities and may make them feel as if they are developing more independent policies.

GAE is the specific mechanism through which the money will be allocated. I had some doubts about that, but those doubts have been allayed. I am aware that GAE in the area that I come from—the far north of the Highlands—has not led to a good outcome as far as teachers' pay and the McCrone settlement are concerned. I was concerned that GAE might not provide outcomes that are appropriate to the policy that we are trying to put in place. Let me try to put that simply: if the GAE approach is going to work, it must allocate money to the areas in which there are many self-funders, because that is where much of the money will be spent. I am assured that, in the short term, nothing can be done about that issue. However, I urge the committee to consider it as the policy develops, because certain parts of the country in which there are many self-funders, such as the Borders, might find themselves in difficulty if their moneys are allocated through GAE alone.

Mr McAllion: To what extent do you think that the provisions in the bill adequately dovetail with the recommendations of the care development group? Are any of the group's recommendations missing from the bill?

Professor Bell: I am not a legal expert. My feeling is that the bill has broadly captured the main ideas that the care development group proposed. As a mere economist member of the group, I was struck less during the working of the group by the issue of free personal care and more by the commitment among the different agencies to work together to ensure that there is joined-up thinking between the NHS and the local authorities. In a way, such momentum is better than legislation if it can be kept going and if the Executive encourages it as much as it can.

Janis Hughes: Professor Petch mentioned the work force in her submission. We will take that subject on board in our deliberations about the bill. You mentioned smart technology in your paper and Mary Scanlon also mentioned it. How will modern smart technology have an impact on the bill, specifically with regard to the work force?

Professor Bell: A point about costs that I should have made earlier has a bearing on your question. The group talked a lot about whether changes in the balance of care, which is what we want to bring about, would change the cost profile. As people filter down from NHS long stay, through nursing care, residential care and down to care in the community, the cost of an average package, but not necessarily of each individual cost, might decline. That might be an offsetting factor that reduces the overall cost, in the same way that the overall 2 per cent increase that I talked about at the start is brought about. Changes in the balance of care might lead to more efficient, as well as better, working. That might partly solve the budgetary problems.

The next matter is the work force. I know,

because I have been involved to some extent, that the NHS executive is looking at work-force issues for NHS staff. I have produced a report on that issue, together with colleagues from Aberdeen. There are evident problems that might be localised, which is interesting. You could decide, as the care development group decided, that you should have a uniform rate of payment for care, but the market could say that it costs more to care in Edinburgh than it does, say, in Aberlour. Over the next 20 years, there might be an element of lots of people trying to fish from the same pool, particularly since, as table 1 in my report indicates, the size of the nought-to-44 age band will decline significantly over that period. We have rehearsed all the issues about training, recruitment, retention and so on. However, that issue needs to be given careful thought over the next few years. I suspect that it needs to be thought about throughout the health sector—the NHS as well as the care sector.

The Convener: Do you have anything specific to say about smart technology?

Professor Bell: Sorry—I forgot about smart technology.

The Convener: You have tried to evade the subject twice. [*Laughter.*] I am not sure what the problem is with it.

Professor Bell: We were told about various examples of smart technology being introduced. There is a famous house in West Lothian that many people have visited, in which smart technology has been implemented. I suppose that smart technology is being mentioned simply to flag up the fact that opportunities exist to give people better experiences at not too great a cost, which may reduce labour costs. Even if those opportunities do that in a small way, they should be explored and, I hope, progressed, because labour costs dominate the whole cost structure in care work.

The Convener: That takes us back to the comments that were made earlier by Alison Petch about the importance of housing and proper planning.

Professor Bell: Yes. Possible costs must be linked to housing.

The Convener: Thank you for your evidence and for your contribution as a member of the care development group.

I will pull together two or three points from this morning's evidence that we will follow up. We will write to the Executive and ask for an indication of councils' current spending on care for the elderly. If the Executive does not have that information, we will try the COSLA route. We will attempt over the next few weeks to get a picture of what is happening throughout Scotland.

Given that we have a tight time frame for taking evidence in committee meetings, it might also be useful—even if only for me as convener—to see the care development group's consultation responses. There were several hundred responses, which may contain points that we might want to develop, and we should request a copy of them.

We have also requested further written evidence from Alison Petch, on direct payments.

Are members happy to proceed on that basis?

Members *indicated agreement*.

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

11:56

Meeting continued in private until 12:30.

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