HEALTH AND COMMUNITY CARE COMMITTEE

Wednesday 24 October 2001
(*Morning*)

Session 1

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HEALTH AND COMMUNITY CARE COMMITTEE
23rd 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:

Dr Sylvia Jackson (Stirling) (Lab)

WITNESSES

Isobel Allan (Carers Scotland)
Jess Barrow (Age Concern Scotland)
David Brownlee (Age Concern Scotland)
Helen Chambers (Carers Scotland)
Pat Dawson (Royal College of Nursing)
Dr George Dyker (Royal College of General Practitioners)
Dr Iona Heath (Royal College of General Practitioners)
Dr Bill Reith (Royal College of General Practitioners)
Anne Thomson (Royal College of Nursing)
John Wilkes (Carers Scotland)

CLERK TO THE COMMITTEE

Jennifer Smart

SENIOR ASSISTANT CLERK

Peter McGrath

ASSISTANT CLERK

Joanna Hardy

LOCATION

The Chamber

Scottish Parliament

Health and Community Care Committee

Wednesday 24 October 2001

(*Morning*)

[THE CONVENER *opened the meeting at 09:34*]

Item in Private

The Convener (Mrs Margaret Smith): I welcome members to this meeting of the Health and Community Care Committee.

The first agenda item is to ask members whether they are happy to discuss item 3—on the reporter's draft report on organ donation for transplantation—in private this morning and at any subsequent meetings until we are happy to publish the report.

Members *indicated agreement*.

Community Care and Health (Scotland) Bill: Stage 1

The Convener: We move on to agenda item 2, which is the continuation of stage 1 evidence on the Community Care and Health (Scotland) Bill.

Pat Dawson and Anne Thomson from the Royal College of Nursing are present. Good morning ladies—or girls, if you prefer. It is good to see you again, Pat. I see that you are running neck and neck with the Deputy Minister for Health and Community Care with your appearances before the committee.

We have received your written submission, but do you wish to make a statement before my colleagues and I ask questions?

Pat Dawson (Royal College of Nursing): Thank you for your warm welcome, convener. It is nice—[*Interruption.*]

The Convener: There is a problem with the sound equipment, but we can just shout at one another. [*Interruption.*] We do not have to adjourn, because the problem has been sorted out.

Pat Dawson: I will start again.

The Royal—I am sorry that I hesitated, but sometimes I lapse into my previous jobs. I bring thanks from the Scottish board of the Royal College of Nursing, which is pleased that we have been asked to give evidence to the committee.

By way of introduction, I have with me Anne Thomson, who is a senior officer with the RCN in Glasgow and who has many years of experience of some of the issues that are pertinent to today's discussion.

We have presented some brief notes on the contents of our submission. I confirm that we have no difficulties with parts 3 or 4 of the bill, but we would like to give more detailed comments on part 2, which deals with joint working. We have made some brief written comments about part 1.

We recognise that the bill when enacted will be enabling legislation. We also recognise the commitment that has been given by the committee and the Parliament to the provision of free nursing and personal care. The RCN in Scotland strongly supports those measures. Although we support many of the bill's provisions, we would like to make a couple of general points on the bill.

Given our experience in the NHS, we know that joint working, partnership arrangements and other work have been moving forward apace. We also know that the committee and the Parliament set great store by consultation with the public and staff. We suggest that it would have been important to have included more robust consultation provisions in the bill—indeed, such provisions could still be considered—including consultation with the public, external service users and staff groups and their representatives.

We recognise that consultation is taking place on changes to employment legislation, such as the Transfer of Undertakings (Protection of Employment) Regulations. In order to encourage joint working, team working and partnership working to deliver high-quality integrated care to patients and clients, we also recognise that a stable work force is important. Everyone should enjoy harmonised terms and conditions of employment, so that we do not start off with one staff group feeling aggrieved because their rights or contractual obligations are inferior to those of other groups. We hope that the committee will make use of Anne Thomson as an expert witness because we are involved in the integrated human resources group—led by Peter Bates, who is the chair of NHS Tayside—that is exploring some of the detailed provisions in the bill. We acknowledge that the bill will enable ministers and the Government to make other provisions around those issues, which are of primary importance to us.

For example, partnership working is very advanced in the NHS, but there is no collective agreement between the RCN and local authorities. Indeed, local authorities have no history of employing nurses. Local authorities currently employ about 980 members of staff whose main qualification is in nursing, but who are not employed as nurses.

I hope that later the committee will want to tease out the issue of the NHS move to a tripartite governance arrangement in which financial governance, clinical governance and new requirements on staff governance are being developed and consulted upon. Those issues are clearly important for nurses, the work force and our members.

Broadly speaking, those are the key areas that I think that the committee will want to concentrate on, given that our purpose in being here is to represent members of the RCN in Scotland.

The Convener: I will kick off with a question about general principles. Colleagues will ask about some of the specific points that you made about consultation, joint working and staff arrangements.

In its inquiry into the delivery of community care in Scotland, to which representatives of the RCN gave evidence, the committee highlighted its concern that the principles of fairness and equity should underpin community care policy in Scotland. Do you believe that in general the bill as introduced upholds those principles?

Pat Dawson: Yes, in terms of service provision. The key elements are carers and access to integrated services. The policy is set out well in the policy memorandum. Few issues in Scottish policy and legislation have been addressed more than has the care of older people, care of people who have learning disabilities and care of people who have continuous care needs. In general, the bill supports fairness and equity in service provision. From our perspective, we hope that the bill applies equally to staff and that the ambition of achieving fairness and equity is supported by the structures and the requirements in legislation that are connected to staff rights.

Nicola Sturgeon (Glasgow) (SNP): Some witnesses who have spoken to the committee said that the bill will be, by and large, enabling legislation. A lot of the meat that will go on the bones of the legislation will come from regulation by ministers. One of the powers that will be given to ministers is the power to define social care by legislation, which is a means by which to separate personal care from the living costs of residential care. Does the RCN believe that it would be better to have more detail in the bill, in particular a definition of personal care, to make it more difficult for future Administrations to change the policy?

Pat Dawson: That is a live question. South of the border the definition of nursing care is contained in an act of Parliament, which is causing severe difficulties over whether care is supervised, directed or provided by nurses or by others in a support capacity. We know that the care development group has done detailed work on personal care. I suspect that it would be sensible to have better refined definitions in the bill, which were agreed and sensible. The bill could then stand up in terms of future provision and encompass the convener's comments about fairness and equity.

That is equally true of staff rights. A position in which detailed provisions for transfer arrangements, pensions and so on were not progressing fairly and equitably would reduce the impetus of the bill. Those provisions are absolutely essential to make the system flow and to ensure that services are good and that patients and clients are cared for.

Mr John McAllion (Dundee East) (Lab): The section of your written submission entitled "Charging for Social Care" states:

> "There is little here that gives the NHS an involvement in what care should be counted as social care."

What specific provisions do you want to be included in the bill to guarantee NHS involvement in the procedures?

Pat Dawson: That goes back to my answer to Nicola Sturgeon's question. We feel strongly that consultation must be strengthened to ensure that involvement with the NHS and other people from different professional groupings who have different perspectives and experiences can contribute to the definitions of care provision.

Mr McAllion: Should the bill include a provision to ensure such NHS involvement?

Pat Dawson: It might help if the bill contained a definition of personal care. If there were powers to consult, evidence from those key groups would be heard in the debate.

09:45

Mr McAllion: So the bill should contain some kind of requirement for consultation with the NHS.

Pat Dawson: Yes, because the reverse seems to be true. The NHS must consult local authorities on certain provisions, but the reverse is not the case. We are seeking a balance of fairness.

Mr McAllion: The Minister for Finance and Local Government recently announced that £200 million—£100 million next year and £100 million the following year—has been set aside to implement free personal care for older people. Is that sufficient provision for such care, or do you think that it will cost more?

Pat Dawson: To be truthful, I am not sure that the RCN has any evidence that either supports or refutes the calculations of the care development group, the Sutherland commission and others in this complicated matter. I am afraid that, on behalf of the RCN, I have no comment to make on whether there is sufficient money in the pot.

Mr McAllion: You sat on the fence beautifully there.

Pat Dawson: Thank you.

Dr Richard Simpson (Ochil) (Lab): I should first refer to my declaration of interests. I am a director of a nursing home company, albeit that—as I constantly remind people—it operates only in England and is therefore not affected by the bill.

On funding—specifically for staff—are you satisfied that payments to nursing staff within the local authority sector, the not-for-profit sector and the Scottish care homes-type profit sector are being paid appropriate wages and given correct terms and conditions? For example, are nurses in the non-public sector pensioned? I believe that that is an aspect of costing, because at the moment there is significant underfunding that has not yet been fully addressed.

Pat Dawson: First, I should point out that people whose primary qualification is nursing are not employed by local authorities as nurses. However, your second point is very valid.

Dr Simpson: I realise that what you say is technically and legally the case because local authorities cannot currently employ nurses. However, in practice we know that nurses have been assigned to local authorities on joint-working arrangements in various areas, particularly learning disabilities. Although I am not concerned so much about the public sector, are you satisfied that, even without the legal requirement, the levels of remuneration and the terms and conditions are adequate?

Pat Dawson: I will ask Anne Thomson to answer the question about the current practicalities.

Some voluntary organisations have approached the RCN in Scotland and some have made preliminary requests for information about pay and terms and conditions so that we can support them and make advances in future.

Anne Thomson (Royal College of Nursing): The staff who work with local authorities are mainly on secondment, which means that all their employment rights are protected. Although that arrangement is quite complex and is not without problems, it is certainly working at the moment in small areas, particularly in learning disabilities where we use secondments extensively.

Did you also ask about terms and conditions and pay of staff in areas of the non-public sector, such as private nursing homes?

Dr Simpson: That is a matter for the employer—there is no national agreement. However, if we are really going to value the work force as a strategic entity—providing community care no matter what the technical source of employment—we need to have some sort of national agreement. It will all be funded by the public now, so why should not we insist that those workers are paid an appropriate rate for the job, wherever they are employed?

Anne Thomson: That is a massive problem. There are considerable gaps between NHS nursing staff and private sector nursing staff. That is causing nursing staff recruitment and retention problems in the private sector. Many nursing homes struggle to recruit and retain staff because of the pay and terms and conditions that they are able to offer. They do not have the opportunity to be part of NHS pension schemes; they must use private pensions. More than a third of our membership is employed by the independent sector.

Dr Simpson: Thank you. That confirms my feeling.

Mary Scanlon (Highlands and Islands) (Con): On the definition, the submission from Disability Agenda Scotland says that it is concerned that younger disabled people, aged 16 to 59, appear to have fallen off the agenda. That is despite the Sutherland commission's proposal that all of its recommendations for older people could equally apply to other age groups. If we consider the care development group report, it is called "Fair Care for Older People". Is the Royal College of Nursing concerned that the definition of personal care might apply exclusively to older people and that the younger disabled have fallen off the agenda?

Pat Dawson: There is something in what you say. It is not an issue that we have debated internally, so my comments probably reflect the principles of fairness and equity that the convener set out right at the start. You are right—as we identified earlier, much of the concentration of the policy work has been on older people. People who have mental health problems or learning disabilities could well be seen as the forgotten young of Scotland. I understand that the provisions of the bill take some account of that in terms of direct payments and other issues to do with—

Mary Scanlon: Would a clearer definition of personal care ensure that the younger disabled—aged 16 to 59—would not fall off the agenda?

Pat Dawson: I hear what you are saying; however, I do not know enough—I am not sure whether Anne Thomson would either—about the other rights, services and financial payments for that age group. I am therefore unable to comment.

Mary Scanlon: On joint working, you say in your submission—you mentioned it in your statement—that

"Para 10(1) requires consultation by the NHS",

but it is unclear whether local authorities require to consult.

You also mention that, in England and Wales, there is the establishment of care trusts to facilitate joint working. There is a different policy direction in Scotland, where the lead is given to local authorities. Why are you concerned about that?

The next paragraph in your submission says that the human resource practicalities of joint working are considerable. I would like to hear today that they are not insurmountable. However, I am concerned when you say that nurses might

"be very reluctant to enter into a contract with an employer with no history in employing their profession".

Pat Dawson: I will take your second point. I am sorry, but I have forgotten what your first point was.

Mary Scanlon: That is not surprising. The first point was that it is unclear whether local authorities are required to consult the NHS.

Pat Dawson: I have made that point two or three times. A reciprocal arrangement needs to be made. Not only that, but consultation powers need to be extended externally—to communities and the public at large—and internally, to staff representatives within those organisations.

You made a point before your final point.

Mary Scanlon: I have made so many points.

Pat Dawson: Anne Thomson will come in on the integrated human resource management issues because she has detailed knowledge of them from being on the working group. At the moment, we have new NHS organisations. Those organisations do not have a nurse executive on their boards. Provision has been made for joint working in areas of responsibility of local authorities where they have not been able to employ nurses. They have no history of delivering nursing services and we do not know whether they will have a professional or leadership structure that will support the requirements of the regulatory body and meet the requirements of clinical governance in respect of standards of provision. It might be the case that employers who know their business will be more attractive to nurses in choosing where they wish to work.

Mary Scanlon: Given that policy direction and the lead in community care in Scotland is given to local authorities, whereas they are given to NHS trusts in England, are you saying that community care would be local authority, social worker-led rather than medically led? Do you fear that nurses or the medical profession might not have the necessary input?

Pat Dawson: I hope that policy direction will not be medically led but nursing-led. I understand the point that you are trying to tease out. I mentioned England because, in a sense, organisational change there supported a direction in which the NHS would lead. The provisions in Scotland do not say explicitly that local authorities will lead. However, the guidance from the community care and joint future group is that local authorities should be given most of the resources to facilitate joint working. The patterns of joint arrangements are based on mutuality and partnership so the two must come together. In a sense, it might be that there is no lead agency, but in England there is. On the other hand, local authorities and the NHS have sought to work together on the matter.

Local authorities are a new player on the block in nursing. We need to ensure that they are best supported so that issues relating to the transfer of staff and resources, for example, do not become insurmountable. Perhaps Anne Thomson will comment on practicalities.

Mary Scanlon: It does not give me much faith that nurses are reluctant to enter into contracts with local authorities. You spoke about partnership and participation. If nurses are reluctant, how can there be partnership and participation?

Pat Dawson: We have said that nurses might be reluctant until the practicalities—

Mary Scanlon: They might be very reluctant.

Pat Dawson: They might be reluctant until their terms and conditions, their professional accountability and their supervisory capacity are known. There are issues relating to accountability and regulatory frameworks. For example, we still do not know whether nurses will be singly registered with the new nursing and midwifery council or dually registered.

Mary Scanlon: Are you working with the Convention of Scottish Local Authorities to overcome such problems? Are you negotiating with local authorities?

Pat Dawson: That is a fair question. To my knowledge, we are not.

Mary Scanlon: Should that be happening?

Pat Dawson: The question is a fair one and I will take it back to my chairman and the organisation's chief executive.

Mary Scanlon: I thought that you had responsibility for making negotiations happen.

The Convener: John McAllion wants to make another point. Anne Thomson can then say something.

Mr McAllion: Problems with local authorities as employers of nurses and with nurses employed in the independent sector have been identified. Should not the integrated human resources group—led by Peter Bates—address those issues? Should that group make recommendations to deal with such major problems?

Anne Thomson: I am fortunate to be a member of the group. I am a coalface, full-time trade union official so I have direct experience of staff difficulties. It is not correct that nursing staff are not willing to work in local authorities—in fact, there is great willingness. Many who have been transferred, through secondment arrangements for example, have found an enjoyable working environment in which to improve patient care. However, that cannot take away from the fact that the difficulties are significant—there is no other way to put it.

My organisation and its members feel strongly that if we do not get this as right as possible beforehand, it will be much more complicated to do so in the long run. The human resources working group has been set up in the past four months. I have found the group helpful, but the work load is overwhelming. I have been shocked by what we have to tackle. The group is teasing out some of the difficult issues, but it is a hard job. We must consult the staff as much as possible beforehand on what will work, because if it does not work for the staff, integration and the seamless service will not happen. The group is working, but it is very difficult. We have an awful lot of work to do and we cannot ignore that.

10:00

Mr McAllion: Will the group publish a report or will it report privately to the Minister for Health and Community Care?

Anne Thomson: It will report to the minister, but I understand that the report will be published.

Mary Scanlon: Do you think that it would help to make things work if you talked to COSLA rather than talking to your own members all the time? Through joint working you could enter into negotiations and start now to tease out the problems.

Anne Thomson: You are right. There are practical difficulties, which I will highlight if members will give me a second or two. For example, as Pat Dawson said, the RCN has not been recognised by local authorities as a trade union professional organisation, so we do not have direct, easy links. That must be built upon. We are already doing work in our local areas, in particular with the unified boards and so on, but it must be strengthened. Big gaps are widening, which must be examined. Partnership working in the national health service is far more advanced than it is in local authorities. Employers and employees in the NHS currently work within a partnership model, which has been embedded for several years. We do not yet have that relationship with local authorities.

Staff governance will arrive shortly in the NHS and will be another responsibility along with financial and clinical governance. Local authorities do not have those responsibilities. Staff governance is about the NHS being an exemplary employer. The unified health boards are accountable in their areas. There are big gaps that must be addressed. Mary Scanlon is right that we must have links and start talking, but it has been difficult, because we have not previously had a history with local authorities, because they have not employed our members. Local authorities and COSLA must be informed about us. We are aware that more work needs to be done between our organisation and local authorities.

Dorothy-Grace Elder (Glasgow) (SNP): As you will know, it is a matter of pride for the Parliament that it passes legislation quickly compared with Westminster. Do you think that the Executive has provided adequate opportunity to consult all interested parties on the Community Care and Health (Scotland) Bill? I remind members of the timetable: the care development group's final report "Fair Care for Older People" was published on 14 September and the bill was introduced on 25 September. Would you like to comment on the consultation, or the lack of it?

Pat Dawson: This area of policy has had a head of steam for a good while now, arising from this auspicious arena and, externally, from voluntary organisations and our organisation, which has made policies for older people's care an important piece of work. We know that many of the consultation exercises were done in public and in partnership with voluntary organisations and our organisation, so I would be reluctant to criticise the amount of consultation from the RCN's viewpoint.

I accept the point about the proximity of the publication of the care development group's report to the introduction of the legislation. I would not like to comment on whether that has stifled the consultative process. We will take on board some of the views of the Health and Community Care Committee on priority working, partnership and consultation policies. I am not sure that I would say that the period between the publication of the report and of the bill was too short.

Dorothy-Grace Elder: I am thinking about the future and continuing consultation. You emphasise in your evidence the importance of consultation prior to voluntary joint working and ministerial intervention. Bearing in mind—which we try to do all along—the fact that the bill is enabling legislation and that a great deal will be left to ministers to regulate, do you have any suggestions on providing a means of continuing consultation, for example a forum?

Pat Dawson: There will be arenas in which to address the regulation of care; for example there will be the Scottish social services council in which to address our membership's ambitions for terms and conditions. There may be value in the establishment of forums, but we already have networks of community care forums, which could be central to the consultative process, the dissemination of information and understanding how the act will work in practice.

Dorothy-Grace Elder: Would you like that to be a statutory requirement?

Pat Dawson: We have commented strongly on the fact that consultation is a core issue for any health and social care legislation.

The Convener: I will sweep up. Can you describe any additional proposals that you wish to be included in the bill?

Pat Dawson: Yes. We have made it clear that consultation has to be reciprocal and must be extended. We have alerted the committee to issues about staff governance. We have taken the message about partnership working with local authorities and their umbrella organisations. The consultation networks may have to be extended to address that. We have alerted the committee to the detailed work that has to be done on making joint working attractive and achievable and on encouraging staff to work in different ways to deliver good-quality care to patients and the Scottish public.

The Convener: I thank Pat Dawson and Anne Thomson for their contributions.

10:07

Meeting adjourned.

10:11

On resuming—

The Convener: I welcome to the committee Helen Chambers, John Wilkes and Isobel Allan from the Carers National Association.

We have received your written submission. After you make a short opening statement, we will ask you some questions.

Helen Chambers (Carers Scotland): To keep the committee up to date, I should point out that we rebranded a couple of weeks ago and are now called Carers Scotland instead of the Carers National Association. I hope that our new name makes it clearer what we do.

I thank the committee for inviting us to give evidence today. As the convener said, I will make an opening statement and John Wilkes and Isobel Allan will supply any expertise that is necessary to answer members' questions. Both John and Isobel sat on the carers legislation working group and Isobel has much personal experience, having cared for her daughter for more than 20 years.

We welcome the bill and the provisions in it that impact on and support carers. The principles of the bill offer the opportunity to revolutionise the experience of carers in Scotland and to change fundamentally their status and position, from being perceived as needy and a drain on resources to being seen as partners in the provision of care.

The bill's major provision is a right for carers to receive a community care services assessment, independent of the needs of the person for whom they care. Although we welcome that substantial step forward, it will be of use to carers only if they are aware of the right and feel able to use it; if the assessment is focused on carers' needs instead of on providing a package that a local authority already has; and if the services identified in the assessment can be—and are—provided. Carers assessments need to be much more robust and result in service provision instead of being a technical exercise in establishing further unmet need. Also, although the bill's explanatory notes state that the assessment is available to all carers, we are concerned that the bill should state that carers under 16 also have a statutory right to independent assessments.

That brings us to one of our major points. Many items that are specific to carers are to be left to guidance. That is not satisfactory. Although an endless number of documents in Scotland without statutory power have many fine and laudable intentions regarding carers, thousands of carers in Scotland end up with a very raw deal, compromising their health and ending up in poverty to support those who would otherwise be supported by the state. That situation must change. If the Scottish Parliament really wants to change the experience of carers, it must be robust and overt in its intentions.

It was recently acknowledged that

> "Ministers support strongly the … overall vision that carers should be recognised as partners in providing care, not treated by other caring agencies as clients with needs for services."

That is a profound realignment for carers in Scotland. If that statement on behalf of Scottish Executive ministers is to mean something, members must dig out from guidance and include in the bill the recommendations for the NHS in Scotland and local authorities to identify carers and offer support. How can carers be regarded as partners in care provision if the other partners are not aware of their existence? The statement becomes illogical and meaningless.

10:15

No doubt, the rebuttal of that request will be that guidance will be enough and will be robustly implemented. To be honest, we do not believe that. Recent research funded by the Scottish Executive and carried out by Carers Scotland and the Coalition of Carers shows that, irrespective of all recent Government and regional carers strategies, both NHS Scotland and local authorities can be absolutely useless in engaging with carers both systematically and individually. Consequently, we have no confidence in leaving such an important and significant intention to guidance. We are aware that our suggestion will result in a request for new burdens moneys, but it is probably time for people to put their money where their mouth is and to support carers properly.

As well as an amendment to that effect, we would like members to pursue an idea suggested at the previous evidence session, which involved Professors Petch and Bell, that the principles behind the bill should be spelt out in it. We ask that the principle of carers as partners in care be included in such a statement of principles.

There is a great deal of good intent to support carers behind the bill, but carers need more than intent; they need services and formal recognition. The bill can be a vehicle for that, but only if it contains up-front, systematic provision for carers. I reiterate that as well as the provisions for independent carers assessments, we would like the bill to contain: a statement that assessments are also a right for under-16s; a statutory duty on the NHS to identify carers, to offer them information and to refer them on as appropriate; a statutory duty on local authorities to provide information to carers about their rights and the support available; an outline of the principles behind the bill; and the principle of carers as partners in providing care in the statement of principles.

The Convener: I will begin with a question about the general principles of the bill, which we are meant to consider at stage 1. The committee is concerned to ensure that the principles of fairness and equity underpin all community care policy in Scotland. I understand that, generally speaking, you support the bill. Do you think that its provisions uphold the principles of fairness and equity in service provision for service users, as well as for carers?

Helen Chambers: We strongly support the principles of the bill. As I said, we want them to be more overtly stated and think that that would be quite symbolic. The bill can provide equity for carers if its provisions are carried out systematically. One of our major fears is that carers, despite having rights under the bill, may be unaware of those rights and might not claim their right to an assessment. If assessments are not delivered in a meaningful way and if services are not delivered following assessment, the whole thing is pointless.

The bones are there; the follow-through and the implementation will be important. I believe that there was discussion during your previous evidence session about implementation, with suggestions about bodies to see through and review implementation. We would support that. The bill's provisions need to be implemented systematically. There also needs to be accountability and sanctions if its provisions are not carried through.

The Convener: You touched on the great deal of unmet need that exists, which I think we are all aware of from anecdotal evidence.

I know that you will find this a difficult question to answer but, from what you have heard so far from the Executive and from the care development group, has the Executive made sufficient financial provision for the bill?

John Wilkes (Carers Scotland): Over the past year or so, there have been a number of measures to improve the resources that are available for carers. Local authorities received extra provision linked to the carers strategy. Free personal care will designate further resources that will be of benefit to carers as well. It is hard to calculate the full impact of those changes and balance them against the fact that there are about 600,000 carers in Scotland, of whom about 90,000 to 100,000 provide intensive care. Whether the resources match up remains to be seen, but we think that a positive step has been taken.

Mary Scanlon: My question concerns your emphasis on fairness and equity. You mentioned under-16s. Disability Agenda Scotland is concerned that disabled people between the ages of 16 and 59 appear to have fallen off the agenda. Concern has been expressed that the emphasis for care development is on older people. Do the bill and the memorandums give younger disabled people the attention that they deserve?

Helen Chambers: Our focus is on carers of all ages. The bill states that its provisions relate to carers of all ages and we are happy with that. Whether the needs of those who are cared for have been met overtly is a different debate. We are perhaps not in a position to comment on that.

Mr McAllion: In your opening remarks, you mentioned that thousands of carers throughout Scotland get a raw deal. The bill will give them a new independent right to assessment. Assessing their needs will in itself cost the local authorities money. Meeting the needs that have been assessed will be another huge cost on top of that.

To meet the increased needs, the Executive has set aside an additional £15 million for the next three years, which is £5 million each year. Is that anywhere near enough money to meet the kind of demand that is likely to be unleashed by independent needs assessments?

Helen Chambers: It is difficult to tell. Estimates of what it would cost to replace informal care with formal care vary widely. At the committee's previous meeting, Professor Bell talked about £200 million. The Institute of Actuaries has given us a calculation, which is being reviewed upwards, of more than £3.4 billion.

Mr McAllion: Did you say billion or million?

Helen Chambers: I said more than £3.4 billion.

The Convener: That is half the health budget.

Mr McAllion: A sum of £5 million a year would not come anywhere near the required figure in that case.

Helen Chambers: The figures are difficult to tease out because we are only at the start of considering the health economics and we are only beginning to project the percentages of care that will be substituted. One must bear in mind the fact that there will also be a cost benefit, because the more effectively carers and the cared-for are supported, the less they will be run into the ground, and the less they will require expensive and intensive interventions. Obviously, there will be a lag between people being properly supported and our experiencing the health and economic outcomes of that, such as people returning to work and not needing health or other local authority services.

We should not consider people only as a drain on resources. The whole argument needs to be reframed so that we regard people's human rights and support them within the community. That will have economic and health benefits, which will result in savings in what we spend on health. The figures are difficult to work out, but we would not make the usual demands for more cash. The situation needs to be examined and monitored.

Dorothy-Grace Elder: Before I ask about consultation, let me say that John McAllion and I did not hear clearly the statistic that John Wilkes gave about the number of people who are cared for. Could you please give me that statistic again?

Helen Chambers: We do not have a statistic for the number of people who are cared for. There are 626,000 carers in Scotland. That figure is from the Scottish household survey; it is a Scottish Executive figure.

Dorothy-Grace Elder: Could you give a rough idea of the number of those cared for, to add on to that?

Helen Chambers: I do not have that figure to hand. NHS Scotland would be able to provide it.

Dorothy-Grace Elder: If you add 626,000 to those who are cared for, that would be about a million, which means that about a fifth of the population of Scotland are involved in this matter in one way or another.

Helen Chambers: Projections from recent research show that by 2037 the number of carers in Scotland will be almost a million—almost one in five of our population.

Dorothy-Grace Elder: In view of that and the great importance of carers, which everyone acknowledges, do you think that the Executive has provided adequate opportunity for carers organisations to take part in the consultation on the bill?

Isobel Allan (Carers Scotland): I am a carer and I have been listening with great interest to what has been said. I believe that there were 200 replies to the consultation. I do not know who sent the forms back, whether they were people from statutory services, carers organisations or groups. People might give their recommendations a slightly different slant depending on where they are coming from. There probably was enough consultation. I am interested in how the Executive decided what to include in the bill. Was it based on the response to the consultation? I am not aware of the contents of that.

John Wilkes: The period of consultation for the carers was between April and July. Our experience was that carers organisations and carers throughout Scotland engaged with that process. From that perspective, people felt that there was an adequate period of consultation. Isobel Allan's point, which I support, is that the feedback to the responses of the consultation has not yet been received. We are not sure what the overall responses have been.

Dorothy-Grace Elder: You think that there was adequate opportunity to respond, but you would like to have known by now what the feedback was and what the response was from the Executive.

Are you concerned about the brevity of time between the publication of the care development group's final report, "Fair Care for Older People", on 14 September and the introduction of the bill to Parliament on 25 September?

Helen Chambers: As both Isobel Allan and John Wilkes have said, there was a substantial amount of consultation on carers aspects of the bill. Although parts of the care development group report relate to carers, that is not its specific focus. The focus on carers lay elsewhere.

It was a considerable journey to produce the consultation. People participated in that process for more than a year. We know clearly what we want. That is outlined in the report of the carers legislation working group. We have identified seven measures that we want to be in the bill and we would like approximately another 20 to be in guidance.

The turnaround between 14 September and 25 September was rapid. I think that the short time scale was down to circumstance and timings more than intention. We do not have a complaint about that.

Dr Simpson: You have covered a lot of the issues that I was going to ask about. Do you think that the requirement to provide any carer who wants it with an independent assessment goes far enough? We will leave aside young carers for the moment, but is the balance right for adult carers? Should there be a requirement on a local authority to provide an assessment for a carer unless the carer does not want it? Should the onus be on the local authority, rather than on the carer, or are you happy that there should be a requirement on the local authority, if asked by the carer, to carry out an assessment and to provide information to carers about the assessment?

10:30

Isobel Allan: I am pleased that you have asked that question. Carers need to have an assessment in their own right, independently of the cared-for person. However, I feel extremely strongly that there should be a duty on the local authorities and the national health service to inform carers of that right to an assessment.

Please bear in mind the fact that carers do not get out all that much. We are in the house. How can we ask for something that we do not know exists? Last time I appeared before the committee, I said that, if we are talking about community care, we need to put the care back into the community. If the local authorities had a duty to inform carers, that would make a big difference. Do not give us any more work to do by having to chase an assessment. It is right that we can ask to have one if we wish, but the system that exists to serve the community has to take some responsibility in the matter.

Dr Simpson: Thank you. That is clear indeed. I have the same question on young carers, although you have really already made the point. Should there be a duty on the local authority to undertake an assessment of young carers or should the assessment be made only if the young carer asks for it?

Helen Chambers: Again, the assessment should be a requirement. It is time to nail such matters down, say what we want to be done and have the powers and sanction for that to happen.

John Wilkes: In the working group, we recognise that, under the Carers (Recognition and Services) Act 1995, carers have a right to an assessment that is linked to the person for whom they care. The number of assessments that carers have received in Scotland has been far lower than we would have wished, because carers do not know that they have the right. That is why the group recommended strongly that a duty be placed on the local authorities to inform carers of their rights. Clearly, carers do not have to have an assessment if they do not want one. As Isobel Allan said, it is difficult for carers to know that they have the right to one. The onus must be on the authorities to seek out carers and inform them of their rights.

Isobel Allan: The guidance to the Carers (Recognition and Services) Act 1995 stated that local authorities should publish information about community care and tell carers about their rights under the act. As John Wilkes indicated, that is not happening.

I have a terrible fear that there will be no duty and that the requirement will be left to guidance again. I feel that we are going over the same ground. I am getting older by the minute. I would like to know that I will still be around to care in five years' time.

John McAllion mentioned the huge cost of caring. The committee should consider the issue the other way round: you should consider not what it will cost to support carers, but what it will cost if you do not. People such as me will end up being users of services, not carers. Please remember that we are not service users; we are service providers. Unless you resource us for the service that we provide—just as you need to be resourced for what you do—we will not be around in five or 10 years' time. I will not be around in five years to sit here and say, "Please can you make that a duty and not put it in the guidance."

I am not being flippant. I cannot state this enough. Please do not put the requirement to inform carers of their rights in the guidance. That happened five years ago and it is not working. I had to type out the guidance and give it to my local authority so that it would know what it is supposed to do for me. I do not want to have to do that again.

Shona Robison (North-East Scotland) (SNP): From my background in the local authority sector, I can confirm what you are saying. Although the power already exists for local authorities to ensure that carers have the information, that is not happening. I share your concern that we need to progress from the current situation. I am not sure that the bill does that.

Is part of the reluctance to change from using guidance to imposing a duty the fear that that would raise expectations among carers that services would be provided? Does that lie behind the reluctance to put a duty on local authorities or health boards?

Isobel Allan: I am always concerned about raising expectations. We are talking about basic rights to a life. The intention is not to raise expectations but to meet the expectation of the basic right to a life of one's own.

There is fear among local authorities. To some extent, I feel for them. It is wonderful that, as I am a carer, no one can fire me for saying that there must be much more give and take between local and central Government, so that local authorities do not think that they will be penalised if they do not get something right. They should be supported if they do not get something right.

I do not know where the black hole is, but something happens after guidelines are drawn up. The guidelines are brilliant. I have read everything—the guidance is my daily reading, and it is great stuff.

The Convener: You say that because you do not get out much.

Isobel Allan: The respite care guidance and community care guidance is wonderful, so where is the hole? Something happens between here and the local authorities. The guidance disappears. We should not go into the blame game, but we need to find more effective mechanisms for making guidelines work without punishing people. We must have accountability. The fear factor is involved and that must be considered when we try to establish a mechanism for making guidelines work.

Helen Chambers: Shona Robison talked about raising expectations and whether local authorities might not meet them. We should set out to raise carers' expectations of the national health service. The NHS has not yet taken on board the carer issue. Good practice exists, but systematic consideration shows that local authorities, which are often one step away from the cared-for and carers, have much better relationships with them than the NHS has.

Care will often include medical provision, so the NHS is in touch with a high percentage of carers, but it does not take that on board when working out how it can effectively deliver services. If done appropriately, that could often produce a cost saving, rather than a cost drain, especially in delayed discharge, which has been at the forefront of our minds for a long time. We could move away from revolving-door discharges and admissions if carers were involved, so carers could be a useful resource for the NHS, if they expected to have proper and dignified engagement with NHS Scotland.

The Convener: Sylvia Jackson is at the meeting as the Local Government Committee's reporter on the bill.

Dr Sylvia Jackson (Stirling) (Lab): One of your main points concerns a duty on local authorities to provide support through assessments and other matters. Do you agree that monitoring the process is important to ensure that that happens? I am thinking of the Regulation of Care (Scotland) Act 2001. Do you have ideas about ways in which all aspects of the process could be monitored to make it effective?

Helen Chambers: I agree that implementation needs to be monitored. The bill is little more than fresh air unless its implementation is monitored and sanctions follow monitoring, even initially at a crude level that just involves counting. We know how many carers there are in Scotland and how many assessments are being done. If the number of assessments does not rise after the bill is passed, questions will have to be asked. I cannot say what that level needs to rise to for us to consider it a satisfactory outcome, but I am sure that that could be backed up with research.

Further depth to that monitoring is needed, because counting is a relatively unsophisticated technique for finding out whether we are meeting need appropriately or whether we are just conducting accounting audits of further unmet need. Best practice on that probably exists and could be rolled out. If it does not, it must be created, because we need to be able to say in three years' time that the bill is working as intended. The intention is to treat carers as partners in care and to support them. We must focus on whether all the mechanisms achieve that, or whether there is a different way of doing it.

Dr Jackson: Are you saying that it would be useful at some point to conduct research into how effective the process has been?

John Wilkes: It is vital. Carers organisations are concerned about how the resources that went with the carers strategy are being monitored. We are already into the second year of those plans and we are still waiting for the evaluation of the first year. There is no point in putting such plans in place if progress is not monitored and if those organisations that are not following the spirit of the plans very well are not told that they need to improve. If the message goes out that it does not matter how an organisation responds to such initiatives, they will not be implemented. Monitoring is an essential part of all those processes. We need to know what is going on, and we must tell those organisations that are not following the rules that are laid down that they need to do so.

Isobel Allan: That also reflects the difficulty with guidelines that I mentioned. They exist but they are not being implemented. There has to be a way of finding out whether the things that we hope are happening are being implemented. We must find mechanisms to do that.

Dr Simpson: There are clearly problems in identifying all the shortfalls that undoubtedly exist. Do you agree that the two areas that we really need to monitor in the assessments are the provision of emergency arrangements and the provision of respite care? My medical experience of working with carers tells me that those two guarantees—about what happens if a carer falls ill or has a major problem, or if someone needs respite care—should be part of any monitoring arrangements.

Isobel Allan: I whole-heartedly agree. That is crucial. The committee will be glad to hear that, as a carer, I am here to tell you that I do not want any services, because I do not need them. I am a provider. It is my daughter, not me, who needs the services. If she has the services that she needs, that in itself supports me as a carer.

Forgive me for personalising the issue—I cannot speak for the 600,000 other carers—but, as a carer, I need what you need. I need the right to have a normal life. I am not looking for anything special or anything extra. I just want the chance to sleep, to eat, to go out, to finish a meal and to have some kind of ordinariness in my life. The only way that I can get that is by getting a break. That is crucial; it is paramount.

However, we have to do more than look at the surface. We cannot just say, "Right, we will legislate that people need a break." We then have to look at what resources there are to give them a break. There is no point in saying, "Yes, Isobel, you can have so many nights a year," if there is nothing out there for me.

We have to look at the bigger picture and ensure that there is a joined-up system. Emergency cover is crucial, but it does not exist in a way that allows carers to tap in at a minute's notice. The bureaucracy is absolutely appalling in such situations. That is one of my greatest fears. I am fortunate because I have a husband, so there are two of us. I would be in a state of great concern if I were on my own. I would probably try to have a friend as a step-in, but we cannot just get through to someone on the phone. We need to cut the bureaucracy and trust people to get things right. If we are going to give somebody a position, let them have the resources and authority to get ahead and get something done to help people. We should not tie them up with bureaucracy. Taking a break is absolutely essential for carers. It is their lifeline.

Shona Robison: Thank you for that, Isobel. That was pretty powerful stuff. Earlier, Helen Chambers said that the principles of the bill should be outlined in the bill. Do the other witnesses agree that the definition of personal care should also be required to appear in the bill?

John Wilkes: That would be very helpful.

Shona Robison: The concern is that personal care will be defined by regulation and that the definition will not be the same for future Administrations. The definition of personal care could best be secured by including it in the bill. Do you agree that that would be helpful?

10:45

Helen Chambers: There is much to support that. However, this is a new experience for

Scotland. We need to weigh the advantages of including the definition of personal care in the bill against the possibility that we may not have got it right. Further down the line, when we are confident that we have got the definition of personal care right and that it is helping us to achieve the outcome that we want, it might be helpful. What matters is the outcome, rather than the mechanism that enables us to achieve that outcome. We may want to test the definition of personal care before including it in legislation. If today we are absolutely sure that that definition will serve us well, we should have the confidence to include it in the bill. It is for others to comment on whether we have reached that point.

Mary Scanlon: I am glad that Isobel Allan has had a break today. She was a star performer the last time that she appeared before the committee. I thank her for telling it to us as it is.

I want to ask about joint working between the NHS and local authorities and, in particular, the mechanisms that you feel may be required to recognise carers as part of joint-working arrangements. I refer you to your submission, in which you say:

> "Carers cannot be treated as key partners if the statutory bodies that are supposed to be engaging with them are unaware of their existence."

If you want to be major players in this partnership gang, is it helpful for you to say that

> "The NHS is remote, inaccessible and intimidating"

and that it

> "resists carer involvement"?

Those words concern me.

Helen Chambers: They should concern everyone. The statements that you quote were taken directly from research that I mentioned in my opening remarks. That research was funded by the Scottish Executive and carried out by Carers Scotland and the Coalition of Carers in Scotland. The statements appear in the first four sentences of the document, which has not yet been published. They are part of the headline research.

Mary Scanlon: Did your carers say that the NHS is remote, inaccessible and intimidating, and that it resists carer involvement?

John Wilkes: The research is as yet unpublished, but because we are one of the partners that carried it out we have permission to outline some of its key themes to the committee. Those support the evidence that we are giving today. Local carers organisations and carers on the ground have been asked about the barriers that they face when engaging with local authority community care planning processes and NHS planning processes. There is a feeling that—because of its different structures, we suspect—the NHS actually is as it is described in the statements that Mary Scanlon quoted.

Carers organisations feel that it is much harder to deal with the NHS than with local authorities. The NHS is a long way behind local authorities in recognising and understanding the need to involve carers as partners in its processes. It should be much better at getting carers and carers organisations involved in trying to change things. That is what the research is revealing. That is why we feel so strongly that a statutory duty on the NHS to identify carers, to provide them with information and to refer them on as appropriate would increase recognition in the NHS, which is patient-focused, of the need to involve carers.

Mary Scanlon: Isobel Allan said that many of the guidelines that are issued are very positive. They are part of her daily reading and give her great hope. However, it does not give me great hope when you fire broadsides against the NHS. It makes me fear that there is a huge gulf between you and the NHS. I worry about how that can be overcome. What will you do to ensure that people such as Isobel Allan and other carers are involved in joint working in future?

John Wilkes: Carers organisations do all that they can to engage the NHS at all levels in the process of thinking about carers. That will be a long job. We would not want to say that the whole NHS is bad. There are isolated examples in which the NHS has shown awareness in dealing with carers, but that approach is not systematic and consistent.

Mary Scanlon: If you want to be in their gang, is it not better to say nice things about them and to try to work together?

Helen Chambers: We have to tell it how it is. We will not change something if we do not define what the problem is—we cannot address the problem if we think that everything is okay. Research shows how carers perceive the NHS. It is our job to reflect that perception to you. I am sorry that the research does not say that everything is fine, but it does not say that because everything is not fine. However, we are solutions-driven and one of the solutions that we are offering the Parliament is to put more pressure on the NHS through a statutory duty to address these issues.

Mary Scanlon: Is there something that the committee could do to help to overcome the gulf?

Isobel Allan: The problem is bigger than the NHS and local authorities—it is about the power base. What we are doing today is radical. We are changing structures and the way in which things are happening. We are being more inclusive. We are talking about issues and trying to act on that. However, people who have done things in a taskoriented way are naturally resistant to move into another realm. We have to support them.

I have been at many meetings with the local authority and with the NHS and I am beginning to think that they are allergic to each other, because I cannot get them in the room at the same time. We are trying to change structures. We have to get local authorities, the NHS, carers, the voluntary sector and the private sector together to change the way in which things are done. That is not easy, but it can happen. The problem is partly historical.

Helen Chambers: Mary Scanlon asked whether there was anything that the committee could do. If the committee overtly supports the overall vision that carers should be recognised as partners in providing care and not be treated by other caring agencies as clients with needs, that would be a strong and useful statement of intent, which would help to effect change.

The Convener: We have significantly overrun on this section, so I ask that the final questions and answers be kept brief.

Nicola Sturgeon: I suspect that the answer to my question might take some time, so I will understand if you cannot go into detail. We appreciate the frankness of your evidence. Sadly, some of the comments that you have made about the NHS are familiar to us and should cause us all concern. There is no disagreement about the fact that, if joint working and co-operation are to work properly, there has to be good will and determination on the part of all the partners in the process. We have talked about statutory duties and the NHS's view of carers as partners in the delivery of services rather than as users of services. Are there other examples of practices in the NHS that lead carers to see it as inaccessible and intimidating and that could be altered through the bill or other changes to working practices?

The Convener: Before you answer that, I would like Dorothy-Grace Elder to ask her question, so that you can answer them both together.

Dorothy-Grace Elder: I would like to thank Isobel Allan for some of the most profound and moving testimony that we have heard in the committee. Could I clarify the point about the NHS being remote and intimidating? Would you include local authorities or some of their departments in that? At my surgeries I hear about appalling bureaucracy. I do not think that your overall implication is that the NHS is alone in that—you seem to encounter that at local authority level as well.

Helen Chambers: We need to tease out two aspects of that: the service provision to the individual and the systematic approach within the planning systems. We do not want to walk away today having said that each individual carer's experience of the NHS is that bad—that would be misleading. Those comments were about trying to engage with planning systems and to effect change.

You ask whether there was anything else that would make a difference. Some research that we did this year—I can supply a copy to the committee—examined hospital discharge and hospital discharge planning, which can be tremendously poor. There is some hideous anecdotal evidence about people being delivered home in their pyjamas with no one to meet them. Many things could be addressed. Much of the time, that is a matter of tweaking things; it is not about huge resources. It is about involving people in planning processes and being big enough to listen and to make changes.

Dorothy-Grace Elder asked whether we would include local authorities in those statements. That is not what came out from that research. The research on local authorities, which is in the submission, focuses more on consultation being done badly, structures and attitudes intimidating carers and carers' voices being lost as a result of a lack of support and resources. The points are not dissimilar, but they are not the same.

The Convener: I thank the witnesses for participating this morning and for the submissions that they provided for us. The committee sees carers as partners in the provision of care and you have made some powerful statements to us. Isobel Allan may not get out much but, when she does, she comes out fighting.

10:56

Meeting adjourned.

11:00

On resuming—

The Convener: We will restart the meeting. The next witnesses are Dr Bill Reith, Dr Iona Heath and Dr George Dyker from the Royal College of General Practitioners. I welcome the witnesses and ask for a short statement before we move on to questions.

Dr Bill Reith (Royal College of General Practitioners): As committee members might remember, the Royal College of General Practitioners has worked consistently in support of the proposals to implement free care for the elderly that were outlined by the royal commission that was chaired by Sir Stewart Sutherland. We welcome the bill and the intention to implement the Sutherland proposals to provide free care for the elderly.

The Convener: Thank you. Dr Heath gave evidence to the Health and Community Care Committee inquiry, in which we highlighted our concern that the principles of fairness and equity should underpin all community care policy in Scotland. Do the provisions of the bill uphold those principles?

Dr Reith: In general, they do. In drafting legislation that was based on a report, changes will inevitably be made. However, the broad thrust of the bill and the proposals that it contains will meet the principles.

Mary Scanlon: The care development group report was entitled "Fair Care for Older People". Disability Agenda Scotland is concerned that younger disabled people aged 16 to 59 appear to have fallen off the agenda. Are you concerned about that?

Dr Reith: I must say that we are not concerned specifically about that. Although we have not considered that question fully, there is always a danger that a particular group or groups that are small in number might be overlooked. I am sure that it is not intended, but we must be mindful that it happens sometimes.

I have highlighted how much we welcome the current bill. We support equally the care development group report, which seems to be a sensible and laudable document. From our written submission, members will see various points that pick up on themes from the report.

Mary Scanlon: Does the care development group report, which is the basis for the bill, address adequately the needs of younger disabled people, given that its emphasis is on older people?

Dr Iona Heath (Royal College of General Practitioners): Sutherland asked us to concentrate on older people. We felt, however, that if we could get it right for older people, advantages would follow for others because discrepancies would become immediately obvious. The overwhelming need was to get the situation right for older people, because it has been wrong. However, we expect to see a knock-on improvement of service for all those who, for whatever reason and at whatever age, need help with personal care.

Mary Scanlon: Are you saying that older people are at issue and that some influence will be felt by younger disabled people, although they might not be the principal target group?

Dr Heath: One could say that there is a parallel between what is going on in Scotland and what is going on in England. If free personal care can be shown to work well in Scotland, I hope that a comparison will be made that will ensure that improvements are made throughout the United Kingdom. Similarly, if provision can be got right for a vulnerable part of the population that is not being got right for a smaller but equally vulnerable sector, an irresistible momentum for reform will be generated.

The Convener: I presume that if partnership working can successfully be put in place, a change in attitudes will permeate into other parts of the NHS and local authority systems.

Dr Heath: Exactly.

Shona Robison: The bill will give ministers powers to define social care by regulation for the purposes of separating out the personal care element from the housing and living costs of care packages. Would it be beneficial to include in the bill a definition of personal care?

Dr Reith: It would be helpful to have the principles outlined, perhaps in the introduction to the bill. Some people might argue that definitions will change over time, but we must start somewhere. The definitions that have been set out are a pretty good first step.

Mr McAllion: If the definition were included in the bill, it would be possible to give powers to the ministers to change the definition if necessary. Would that defeat the purpose of including the definition in the bill?

Dr Reith: It would not be beyond the wit of everyone concerned to ensure that the definition could be adapted if necessary. It is always helpful to set out underlying principles and to make them open and transparent. In this case, it seems that the best place to do that would be in the introduction to the bill.

Mr McAllion: To what extent do you support the provisions in the bill that deal with the promotion of choice, which are the sections that deal with deferred payment schemes, the opportunity to top up residential accommodation costs and the arrangement of residential care outwith Scotland?

Dr Reith: We want to ensure that there is equity of access. When people are getting used to the provisions of the bill, there will be a period of time during which it might be appropriate to make that sort of provision.

Dr George Dyker (Royal College of General Practitioners): It is imperative that patients have choice. That is the crux of the matter for general practitioners. If a patient wanted to receive care at home or near relatives—wherever they might be in the UK—we would support that. There are problems with direct payments, but they have been identified and the situation will evolve as the regulations are produced. I am sure that any difficulties with direct payments will be sorted out.

Mr McAllion: What problems have you identified with regard to direct payments?

Dr Dyker: There are some concerns about the fact that the local authorities that make the direct payments will also provide the services.

Mr McAllion: Is there also a question about resources?

Dr Dyker: There is always a question about resources.

Mr McAllion: What will be the resource implications of extending direct payments?

Dr Dyker: There will be a requirement for increased resources, for which money has been set aside, although it is perhaps a little short of what is necessary. There will have to be increased resources. We are aware that, at present, local authorities have poor resources and that they cannot fund the places that are required, for example, in nursing homes. We hear every day about patients who are in hospital, but cannot get into nursing homes. Something must be done to equalise that before the proposals are implemented so that there can be sharing. We talked about money moving from the NHS to local authorities and vice versa; those organisations must start on an equal footing and with equal access to funding.

Mr McAllion: If the Royal College of General Practitioners believes that the money that is set aside is not enough, does it have a view on what would be enough?

Dr Dyker: I am merely quoting the document that we have before us.

Mr McAllion: So the RCGP does not have a view on the resource implications of the bill.

Dr Dyker: No.

The Convener: I want to broaden the issue. On the basis of what you have heard from the Executive in statements by Angus MacKay, the First Minister and others, do you feel that the finance behind the proposals in the bill will be adequate to meet the need?

Dr Dyker: A start must be made somewhere and we welcome the resources. I do not think that anyone knows the total resource implications of the proposals—they will have to be implemented in steps.

The Convener: It is a significant amount of investment, but there is a big need.

Dr Dyker: Yes.

The Convener: So the RCGP has no view on whether the funding level is adequate for the provisions of the bill.

Dr Heath: The wonderful report by the care development group, entitled “Fair Care for Older People”, seems to suggest that £125 million is required. I believe that the committee is working with the figure of £100 million.

The Convener: Yes, that is the sort of figure.

Dr Heath: We are concerned about that apparent shortfall because if the proposals are to win hearts and minds, it is important that they are successful from the beginning. If they were impeded in their early stages because of lack of finance, we would be concerned. The reasoning in the report seems to be pretty robust—having gone through the elaborate reasoning that was behind the Sutherland report, I attach much credibility to the figures that the care development group came up with. A significant shortfall is cause for concern, but any start is better than no start.

Dr Simpson: I declare that I am a member of the Royal College of General Practitioners, although I am not a practising general practitioner.

Further resources are to be transferred into local authorities and there is a suggestion that 100 per cent should be transferred from now on. Are you concerned about the adequacy of provision of medical services—for example, will there be further closures of long-stay NHS institutions? Do you feel that the joint-working arrangements in the bill make adequate provision for services?

Dr Reith: We must start somewhere. We support much closer working and we support the moves towards greater integration between health and social services. It was disconcerting to hear some of the evidence earlier this morning, because there seem to be tensions about and criticisms of the proposals. Those problems need to be brought to light but, at the end of the day, we are all trying to work together for the benefit of patients or—depending on what we choose to call them—clients.

Our organisation does not have a ballpark figure for the amount of resource that should be available. Dr Heath highlighted the fact that the figure in the care development group’s report has not quite been met. We take the general view, which is shared by many, that the health service is probably insufficiently resourced. However, resourcing of social services and other aspects of local authority work are probably equally inadequate.

In many cases, it makes sense to bring the health service and local authorities together and to allow virement from one to the other where there is agreement.

Some of the percentages of so-called blocked beds that I have heard recently are quite staggering. It seems that health service care, particularly in the acute sector, is relatively expensive. It makes sense for the health service to be able to vire to social services those patients to whom social services can provide more appropriate care than the health service if that is cheaper for what is, at the end of the day, a single public purse. If social services can better meet the needs of those patients, that is fine.

However, the reverse is also true. It seems at times that some social services departments might not feel quite the appropriate sense of urgency about making opportunities available within the community so that people are not left in hospital when that is not the best place for them to be.

11:15

Dr Heath: I detected another strand in Dr Simpson's question.

Dr Simpson: That is correct.

Dr Heath: One of the key issues for us is the possibility that treatable illness and disability in frail older people might be missed.

Dr Simpson: You have picked up my exact concern. There is a lot of concern that the current provision of medical services in the nursing-home sector is not adequate in terms of preventive medicine, nutrition and diagnosis of illness. We see that in the higher numbers of admissions and repeated admissions from nursing homes—and increasingly from residential accommodation—to hospitals on a swing-door basis.

Dr Heath: Absolutely. Key casualties of the shift to community care were older people who were distanced from specialist medical and nursing care. GPs were left to pick up a huge amount of work and they felt unsupported in that role. The key need is to build tiers of support back in.

I am particularly concerned about building in tiers of support for local authority care staff or personal care staff who have huge responsibility for early diagnosis. They are the first people to see problems, but they do not have much training. The bill gives us the potential to create supportive relationships between district nursing teams and personal care staff so that referrals can be rapid. That is not just about sharing funding; we must make integrated teams and build trusting relationships between those two groups.

We need much more ready access to geriatric specialists and specialists in the care of the elderly mentally ill. Such specialists are sometimes difficult to access and are particularly difficult for people who are in residential care to access.

Dr Simpson: I have referred on other occasions to the renationalisation of care for the elderly, but that is not a popular term these days. The term that should be used is, perhaps, reintegration of care, because care is too fragmented. A single care-home system is coming, which will eliminate the false discrimination or separation between nursing and residential homes. Local authorities will have powers to employ nurses. That will lead to a process of greater integration. There is a need to manage the sector as a totality, rather than as a series of fragmented parts. The focus should be on the individual.

Dr Dyker: The resource issue is not just about money. The resource issue is about flexibility within our systems. We have lost flexibility over the past 20 years or so. Our secondary care sector does not have the flexibility to cope with patients, so it is difficult to get admissions. The social care system does not have flexibility. I heard someone else give evidence this morning to the effect that there is no emergency response when there is a real problem. That must also be taken into consideration.

The fact that there is less flexibility leads to patients being batted backwards and forwards, as was said. Patients in nursing homes are not welcomed by hospitals because it is felt that they are already in a caring situation. The whole point of diagnosis is therefore missed. They are admitted, kept overnight and sent back again, frequently without diagnosis. That is partly because we do not have enough hospital beds and probably not enough community care places.

Mary Scanlon: I would like to emphasise joint working again. Your evidence mentions that you support joint working as a mechanism for delivering high quality and seamless care. I draw your attention to a comment in the submission about

> "the cultural gap that exists between health and social services".

The bill's emphasis is on the elderly. There is no doubt that GPs have built trusting relationships with their patients throughout their lives and, as you say,

> "the GP can often play a pivotal role in guiding the patient through their health and community care journey."

Do you feel that you are part of that community care journey?

I crave your indulgence for a second. This morning, I got an e-mail from a GP in the Highlands and it sums up many of the problems that you have already mentioned. The e-mail reads:

> "In a recent conversation with our local social work office I was informed that they have NO budget left for day care, respite and long term care for the foreseeable future. In fact emergency respite admissions will only be accepted if approved by the Head of Client Services."

The stress is not only on the patients, but on GPs. They are the people to whom patients go for help. In recognising that problem, what should the committee do to ensure that GPs have a pivotal role throughout the community care journey?

Dr Dyker: There has been a gulf between medical services and social work services for many years. We have completely different concepts about how to tackle patients. Back in the late 1970s and early 1980s we used to have a closer relationship with attached social workers and that worked extremely well. Thereafter, money was cut off—the usual story—and social workers had to be withdrawn.

I work in Lanarkshire, which is an area of high deprivation and not a wonderful place as far as medical health is concerned. However, I am lucky; I work in East Kilbride and we are working there with social workers again—two social workers are attached specifically for the care of the elderly. We therefore have a uniform joint approach to each of our elderly patients who requires assessment. That is the concept that is embodied in the bill.

Mary Scanlon: I have another quote from your submission to the committee. It says:

> "This may include integrating care staff and district nurses into a unified and effective community team, or placing social workers in the primary care context."

Do you feel that you should be taking a greater lead in progressing community care or do you feel like the distant partner in that relationship and that the local authority has the lead? Do you feel that you are an equal partner or do you have a greater role to play?

Dr Dyker: We have a pivotal role—we are closest to the patient. We are all concerned about the patient and we want to expand our primary health care teams and make them inclusive. We do not wish to lead and be superior to others, but to bring together the people who are involved in delivery of community care. Our task is to deliver a medical service to the community. That will involve everything that we are talking about today.

Dr Reith: The Scottish Executive commissioned a report on access to primary care. One of the things that came out of that report was that the public view general practitioners as people who are readily identifiable and—fortunately, from our point of view—people in whom they trust and with whom they are happy to discuss matters. For many people, the GP and the general practice is the portal to all sorts of care, including aspects of social care and social support.

Because general practitioner services are available 24 hours a day, at times of crisis the general practitioner or the on-call service is inevitably the first emergency port of call. However, we are keen to work with others. Like Dr Dyker, I have experience of a social work team being based in the health centre and working closely with us, which was of enormous benefit to the patients who came through the system. We worked much more closely together.

Mary Scanlon: I appreciate what you have said and that there have been moves towards rapid-response teams and joint working. However, what would you say to one of your fellow members—who e-mailed me—who must face patients to say that there is

> "NO budget left for Day Care, Respite and Long Term Care"—

and that

> "emergency respite admissions will only be accepted if approved by Head of Client Services"?

Why is it that we have all those teams in joint working, partnership and so on, but halfway through the financial year that general practitioner is faced with having nothing? What is going wrong in the Highlands—and generally—to cause that?

The Convener: We can broaden that question to how we cope generally with a great deal of unmet need. Section 3.1.1 of your submission talks about the need to integrate staff and it gives two examples of how that might work. I acknowledge what Dr Reith said about his positive experiences of having social workers in the primary care setting. I have a great deal of sympathy with that because of the particular place that primary care has in the provision of a health service to people and the view that they have of the service. Do you think that the bill as drafted is flexible enough to deliver joint working in the way that you think is necessary, given the backdrop of potential unmet need and resourcing difficulties that Mary Scanlon talked about and which we are all aware of?

Dr Heath: That brings us back to what the Royal College of Nursing said about the local authorities being the de facto leaders—leadership is unspecified—within the partnership. That situation brings advantages, but it also brings the risk of missing treatable medical conditions if the task is considered to be simply to provide care. The robustness of the diagnostic process is significant at the beginning and throughout the process. There is anxiety about whether the network of collaboration and consultation at the levels of primary care organisations and local authorities and between individual nurses, doctors and social workers will be sufficiently robust. We must ensure that everybody is signed up to the correct balance and is constantly prepared to revisit the balance.

A person gets his or her assessment, gets his or her care package and then there is somehow a sense that that is the end of the story; however, the whole situation can change the following day. There is a need to be vigilant, which brings me back to care staff's key role in a changing or destabilising situation. That also brings us back to our pivotal role of signposting people to early interventions. It is clear that our colleague in the Highlands has great trouble in doing that if services do not exist to back him up.

Mary Scanlon: They do not exist.

Dr Dyker: The problem of unmet need poses the question whether the funding is appropriate for the Highlands and whether management of that funding is appropriate.

Mary Scanlon: That is a good point.

Mr McAllion: It strikes me that, ideally, the general practitioner should signpost the elderly patient, or whomever, towards the care package that is most appropriate to their needs.

I have spoken to social workers in Tayside who have attended meetings between the NHS and local authority staff—social workers, GPs, health visitors and district nurses—and say that they all agree. However, at those meetings, there is never anybody who controls the budgets. The people who control the budgets remain inside the NHS and the local authorities and protect their budgets; the money does not flow both ways or follow the patient. Is that not the real problem?

Dr Dyker: That is a problem. It is an area in which the new local health care co-operatives could become involved if it is highlighted as a priority. There could be some way of addressing it.

11:30

Mr McAllion: Somebody with control over the budgets must be part of the teams that are undertaking joint working, as budgetary decisions will determine what money is available.

Dr Reith: I echo what George Dyker has said about the role of the LHCCs. I also hope that the new unified boards will help the process, especially as they are meant to link up more with local authorities. Both levels of involvement are required: the individuals from the professions must work much more closely at the front line and they must be supported at the higher, strategic and funding level. There is no point in local authorities and the NHS making statements about what they would like to see if they do not facilitate those things.

Nicola Sturgeon: I agree that the LHCCs have the potential to improve on the arrangements that are in place now. However, given how LHCCs currently operate, we could still be left with the problem that John McAllion has highlighted, whereby the professionals in the organisations agree but the funding decisions are made elsewhere and the divisions perhaps remain as stark as ever. If what you have suggested is to work, do you agree that we must consider empowering LHCCs and giving them more control of resources, through commissioning powers or whatever? Is that a necessary step towards making them the successful vehicle that you suggest they might be?

Dr Reith: Probably, yes. Over the past few months, there has already been a degree of empowerment regarding the additional funding, which is intended to continue for the next couple of years. However, in the scheme of things, annually that is a relatively small sum of money.

A source of concern for general practitioners is the fact that we have little scope for influencing the sorts of decisions that you have mentioned. Some people baulk at the word "commissioning", which is why I prefer to use the word "influencing". Nonetheless, it would be to everyone's benefit—to that of the service and, ultimately, to that of the patients and the public—if there were some primary care influence over the way in which services are organised and run.

Dr Jackson: I represent the Local Government Committee, so I am especially interested in the local authority aspect of the debate. You have made some useful comments on the importance of joint working and the way in which it could be implemented.

First, paragraph 3.1.4 of your submission mentions that there is

> "an urgent need for the simplification of planning and monitoring systems so that organisations are only required to produce documents of proven utility."

Will you please expand on that? Where are the difficulties and how could the systems be simplified?

Secondly, you said that some social work services do not have the sense of urgency regarding bedblocking that they might have. What evidence do you have to support that statement?

Dr Reith: I shall address the latter point first. There are different interpretations of words. If I receive a call that I think is an emergency, I drop everything and go immediately. Other people in other professions choose a different interpretation; for example, an emergency might be something that has to be dealt with in the next 24 hours.

The Convener: Have you ever thought of joining the Foreign and Commonwealth Office? That was a very diplomatic answer.

Dr Dyker: That is why he is here.

Dr Reith: I do not know whether that would be a plus or a minus.

The Convener: Maybe it would not be a plus at present.

Dr Reith: I will respond to Dr Jackson's point about whether there is evidence of a lack of urgency among social work services. That is an enormously difficult question. Mary Scanlon mentioned the problem of running out of budget halfway through the year. It is a real issue, but having spoken to colleagues, particularly those working in secondary care, I think that there seems to be an enormous number of people who are cared for in the secondary sector but who could be more appropriately cared for in the community. I guess that figures on that will be available.

You might then return to the question of definitions—I see that you are smiling, Dr Jackson, I think because you suspect that I am building an elephant trap for myself. I will let you think about that later. I have forgotten your other point? Was it about monitoring?

Dr Jackson: Yes, it was about planning and monitoring.

Dr Heath: I am sure that you are all aware that general practice considers itself beleaguered by governance and audit requirements around every initiative. Those requirements are taking a huge amount of time away from the day job. Although we are signed up to the importance of both audit and governance, there has to be some rationalisation of the reporting requirements that are put both on general practices and on health authority and local authority staff. We have the feeling that we are spending hours of time producing reports that nobody has time to read. That is deeply demotivating and demoralising. We are cruising for a crisis.

That situation has been the flavour of the past five years and has developed an unsustainable, exponential momentum. We have to reconsider more sensibly what we are embarked on and how to improve the service through such mechanisms as reports. They are undoubtedly extremely powerful and useful, but doing one or two of them a year properly is much better than trying to do 50 of them terribly badly—which is in effect just going through the motions.

Dr Jackson: In the joint working arrangements that are already beginning to be established, including the close working with social work, have you come across ways to get over such difficulties, or are the arrangements so imposed that you still have to work under the old regimes?

Dr Reith: There are many examples of good practice. The development of rapid-response teams was mentioned earlier this morning.

Dr Jackson: I suppose that that comes under planning, but I was really thinking about monitoring and what you have said about producing reports.

Dr Heath: The joint working arrangements help enormously in the day job; I do not think that they have had an impact on the requirements for what we are expected to audit and to report on.

Dr Dyker: With more face-to-face contact, the need to carry out work on paper decreases.

Dr Heath: It should do.

Dr Dyker: Meeting people is a better form of communication than having a constant paper exchange. As has been said, documents frequently go unread and often do not meet the requirements of the people who send them out in the first place.

The Convener: We will now move on to health board lists.

Dr Simpson: I want to put something on record before turning to that. George Dyker was referring to better social work in the late 1970s. The Mitchell report, which came out then, strongly recommended some form of attachment of social work to every primary care team, although not necessarily full placements. It is a pity that that report was never implemented—we might not be struggling with the situation today if it had been.

Your report is clear and short on the question of health board lists. Do you foresee any problems with them? You seem to be very much in favour of them; I ask the question simply to give you an opportunity to comment.

Dr Dyker: In the west, we have a slight anxiety about the registration process. Each non-principal—I am talking mainly about locums—will register with one health board. The relevant document makes it appear that they will need to register again if they work for a separate health board. Under the bill, most of the locums whom I employ in Lanarkshire will be registered in Glasgow because they live there and do most of their work there. I get the feeling that the process will be automatic, but I want reassurance that once locums are registered in Glasgow, they will be registered nationally and there will be no bureaucracy to go through if I need to employ someone who is registered with a different health board.

Dr Simpson: We will ask the officials and the minister that question.

Dr Reith: I will add that it is quite clear to us that the thrust of the bill is about the implementation of free personal care for the elderly, but I guess that the opportunity has been taken to add on one or two other issues. We support the idea of a supplementary list. However, once that list has been created, making people aware that they cannot work as a locum unless they are on a supplementary list will become a big issue. Our experience of previous regulatory change suggests that such change takes considerable time to implement. I presume that, as this is a proactive piece of legislation, people will be given due notice as to when the changes will happen. Although the regulations are not contained in the bill, they are not as clear as they might be about the distinction between personal medical services and general medical services and whether both groups of doctors will have the opportunity to employ locums. Dare I suggest that the regulations—but not the bill, per se—may require tidying up?

Dr Simpson: It is good to have those comments on the record.

The Convener: We have other questions for you, particularly in relation to direct payments, but as time is moving on, we will pass those questions on to you in writing, if you are happy to reply to them. We also have a question about the consultation that took place between the publication of the care development group report and the publication of the bill.

I thank Iona Heath, Bill Reith and George Dyker for their contribution to the discussion and for their written submission. In what has been a long process in the movement towards free personal care for the elderly in Scotland, I have often paraphrased—probably terribly—something that Iona said: it is not the job of the health service to distribute wealth, as it is the job of a taxation system to do that. That seems to be the nub of the issue. I hope that we are on our way towards bringing about diagnostic equity and equality in Scotland. Who knows where that might end?

Dr Heath: We wish you the best of luck in pioneering that important task for the rest of us in the UK.

The Convener: We will have another short adjournment before we move on to our next set of victims.

11:42

Meeting adjourned.

11:46

On resuming—

The Convener: I welcome Jess Barrow and David Brownlee from Age Concern Scotland to our final evidence session of the morning. If you would like to make a short statement, please do so. We will then move on to questions.

Jess Barrow (Age Concern Scotland): We welcome both the bill and, in particular, the report of the care development group, which contained many sensible and pragmatic suggestions about how to go ahead with the implementation of free personal care. As members know, Age Concern Scotland has been working hard to get free personal care in Scotland and we are delighted that we are on the way to achieving that.

However, some key issues are not fully addressed in the bill. The first and most fundamental point is that we are deeply disappointed that the right to free personal care is not stated in the bill. We believe that that must be included in the statute as a fundamental principle. We also believe that the bill should include the definition of free personal care that was put forward by the care development group. That definition was pragmatic and sensible and we believe that it is wide enough to encompass all the aspects of care that should be covered. It would be enormously helpful if that definition were included in the bill, as it would be clearly laid out for everyone to see.

There is a great deal in the bill that will require regulation. Although I understand the intentions behind that, we would prefer the bill to be more explicit. As well as attempting to have equality and equity throughout Scotland, the bill should address charging. There should at least be a baseline below which no local authority is allowed to go, so that there is a clear understanding of what charging systems and procedures are in place. That would allow people to know precisely how they are expected to pay for elements of their care and the level below which they should not go. A standard system and clear policies and procedures are tremendously important.

Another issue that we come across a great deal in our work is notional capital. I am talking about the extent to which people’s capital assets are taken into account when they are required to pay for their care. Too often, people are assessed as having capital although they have disposed of that 10 or even 20 years previously. That causes great hardship and difficulty. Local authorities’ interpretations of notional capital vary enormously. We are very concerned about that. People do not know where they stand or what their responsibilities are. They may be denied care that they ought to receive. The bill is an opportunity to solve some of those problems and to introduce a system that is clear and readily understood. That will enable people to know their responsibilities, obligations and rights.

We also feel that the bill should impose on local authorities a duty to meet assessed need without unreasonable delay. That is particularly important for people who have assets. I will quote from a letter that we have received, as the situation that it describes is not uncommon. In the letter, a woman writes about her 86-year-old mother, who needed care and who had been diagnosed with the onset of dementia. The woman contacted the local social work office and was asked by an employee whether her mother had capital. In the letter, she writes:

> "When I informed her that my mother had some savings then I was hastily told that we would have to seek private care for her. I was posted a list of private care homes in the area and advised that my mother would have to finance this for herself."

That is not a reasonable way of dealing with someone who is desperately seeking help, support and advice. The woman concerned understands that she needs to support her mother and to provide some kind of financial help, but she did not want to be abandoned entirely by the social work department. We feel that that is deplorable and that local authorities should have a duty to provide more than simply a list of local care homes.

A case that I came across recently provides another example of what happens to people in the position that I have described. Somebody living in a private nursing home had spent all their capital because no one had told them that once their capital had been reduced to a certain level, they were entitled to care. That is not acceptable. Social work departments need to be involved from the start, so that people are made aware of their responsibilities and rights.

Another fundamental element of the bill is the extension of choice. We welcome enormously certain aspects, particularly the provision for direct payments, which will help people to exercise much greater choice in how and where they meet their care needs, which is important. It is important that we provide people with the help and support that will enable them to use their direct payments properly. Research into direct payment schemes has shown that there is a role for advocacy and support in that area. However, direct payments are a welcome step forward.

Another issue relating to choice is deferred payment. The fact that the bill contains mechanisms that will enable deferred payments to be made is a welcome step forward. However, we would like deferred payments to be offered as of right to anyone who wants them. It should not be for local authorities to choose whether they should offer a deferred payments scheme.

We do not think that the issue of choice has been properly addressed in the part of the bill that is concerned with top-up payments. That must happen if that part of the bill is to work. We welcome the extension of the ability to make top-up payments to individuals, so that it is no longer limited to a third party. However, the facility should be available only when someone has been given a real choice as to where their care needs are met. People must be able to choose whether they want to go into a local authority home in which all their care needs will be paid for or whether they want to spend their limited resources on more expensive care that is of a higher quality or provides something that is lacking elsewhere.

We would be really concerned if top-up payments were used as a matter of routine simply because the only available care in the area was more expensive than what the local authority would normally pay for. I know that that touches on the dispute between COSLA and Scottish Care over payment for places in more expensive homes that has been much in the press recently. However, the issue is fundamental. Top-up payments should be available only where people have real choice about where their care needs are met. We have to ensure that local authorities are prepared to pay the cost of providing decent care and do not end up relying on older people to top up with their own resources.

Finally, we feel that the bill relies heavily on regulation and we would like more measures enshrined in statute. It is particularly important that the bill should contain a fundamental statement of principles to ensure that the legislation is much clearer and is much easier for the courts, individuals and local authorities to interpret. I am happy to answer any questions.

The Convener: On the basis of your written submission and oral statement, am I right in thinking that you welcome the bill and that you think it upholds the principles of fairness and equity in community care services that we have been discussing?

Jess Barrow: Yes.

The Convener: You have also made it clear that you feel that bill relies too heavily on regulation and that there should be a fundamental statement of principles in the bill, so I think that that covers some of the questions that Shona Robison and I intended to ask.

Dorothy-Grace Elder: Has the Executive provided adequate opportunity to consult all organisations—particularly your own—and service users and their representatives on the bill's proposals?

Jess Barrow: The time scale is tight. The bill and the care development group report were published a fairly short time ago. We would always welcome more time to consult widely on the issue.

Dorothy-Grace Elder: Might you have made any omissions because of the tightness of the time scale?

Jess Barrow: The bill might rely heavily on regulation because of the length of time between publication of the "Fair Care for Older People" report and publication of the bill itself. If there had been more time between those two publications, the bill might well have contained more concrete proposals. It feels as though the bill has been drafted in anticipation of responses rather than in response to the report.

Dorothy-Grace Elder: Is that why there are fewer statutory recommendations and why so much is being left for ministers to decide afterwards?

Jess Barrow: It appears so.

Dorothy-Grace Elder: Given that there was just over a week between publication of the report and publication of the bill.

Jess Barrow: Yes. The time scale was short.

Dr Simpson: In pages 3 and 4 of your submission, you say that it is appropriate to leave the definition of accommodation to the ministers' discretion, partly because

"it will enable Attendance Allowance to continue to be paid to residents".

Will you elaborate on that interesting observation?

Jess Barrow: It is based partly on guesswork. One of the key issues in the care development group report was attendance allowance; funding of the whole package was very much dependent on the continuation of attendance allowance.

After the report had been published, we spent a long time scrutinising the Social Work (Scotland) Act 1968 and the National Assistance Act 1948. We felt that one of the key stumbling blocks was the definition of accommodation in those acts, which contained elements of care—because of that definition, the Department for Work and Pensions would be perfectly within its rights not to pay attendance allowance to people who were receiving funding for personal care, as that would count as funding for accommodation. I should point out that that is our interpretation, and might well be completely wrong.

Dr Simpson: Have you made a submission to anyone about that?

Jess Barrow: No, not yet. The time scale has been tight, but we will make submissions.

12:00

Dr Simpson: I am sure that somebody at the centre would welcome that, if there continues to be a problem with the issue.

I would like to clarify something about notional capital. There is not a set time by which one can go back; it is almost a question of intent, is it not? If there has been intent to move capital away from the individual, and if that intent can be determined, no matter how far back it happened, the capital will be liable to be re-included. Do you have specific proposals that the capital situation should match the revenue situation, in which a gift is no longer taxed after seven years, for example? That would remove the intent clause, but it would make the situation absolutely clear using existing legislation.

David Brownlee (Age Concern Scotland): The current situation is left very much to the interpretation of statute law and case law by individual authorities. We have found that there are differences in the treatment of similar cases. In line with the proposals on equity throughout Scotland, we would certainly welcome more clarity in guidance or, failing that, in the bill itself about a specific cut-off period. Intent is an issue, but, to a certain extent, one cannot tell how much people have been looking at that. I think that seven years is the relevant period for inheritance tax, but it is unlikely that people could see that far ahead what their personal care needs would be.

Jess Barrow: It is important to have a time limit of some kind. Seven years seems to be a reasonable limit beyond which no consideration of notional capital could be made, but up to which the issue of intent could be considered. There should not simply be a blanket rule that, for a period of up to seven years, notional capital will be taken into account. However, greater clarity is needed, because it is utterly unreasonable to pursue people for capital that may have been disposed of a decade or even two decades previously. That is not reasonable and consumes a great deal of court time, which is unacceptable.

Dr Simpson: Tying the time limit to something, such as inheritance tax, that may be changed by a subsequent act may not be appropriate. I am not sure whether, under the bill as drafted, ministers have powers to specify, in regulations or guidance, how notional capital is dealt with. Are you satisfied that the bill gives ministers such powers?

Jess Barrow: No, we are not satisfied that that is covered in the bill, and it ought to be. We would like the time limit to be specified in the bill, not simply in regulations.

Dr Simpson: Will you come back to us in writing on that?

Jess Barrow: Yes.

Dr Simpson: Thank you.

Nicola Sturgeon: What you said in your written submission and in your comments about the Department for Work and Pensions being able to continue paying attendance allowance is interesting and worthy of further consideration. However, let us put that to one side for the moment. For the record, it would be helpful to have Age Concern Scotland's view on the policy issue. Do you agree with the care development group that attendance allowance should continue to be paid and that free personal care should, if you like, be a top-up to existing provision rather than a replacement for attendance allowance, as the Department for Work and Pensions is trying to see it?

Jess Barrow: We agree with the care development group report—attendance allowance should continue to be paid. Attendance allowance should not be instead of the personal care element. There are additional disability costs that must be met and are not met through the proposals in the care development group report. Under the current regulations, attendance allowance will continue to be paid to people who receive free personal care in the community. It seems ludicrous to discriminate against people who receive their care in a residential establishment. We feel strongly that attendance allowance should continue to be paid.

Mr McAllion: You mentioned that, of right, individuals should have access to a system of deferred payment for accommodation costs and that such a system should not be left for local authorities to choose. Do you want the bill to include an explicit statutory duty on local authorities? If so, should the system be nationally agreed and uniform throughout the country? Alternatively, should there be a minimal system upon which local authorities could build if they wish, although they would not be able to fall below a certain system of deferred costs? What should be included in the bill?

Jess Barrow: In some ways, the idea is new, and it is therefore hard to know what system would be best and how best to implement it. Many things will be learned in practice, so it might be more appropriate for a system to be laid down in regulations rather than in statute. However, there should be a national system that is clearly understood and of which people are clearly aware. People should know that they have a right of access to the system. The system should be clear, simple, national, agreed and understood so that people can apply if they wish. The system could sit within regulations. The details do not necessarily have to be in included the bill, but the fact that local authorities have a duty to provide such a system should be in the bill.

Mr McAllion: So the principle should be in the bill and the detail of the system should be left to regulation.

Jess Barrow: Yes.

Mr McAllion: You said that top-up fees should apply only where real choice is available. What about clients who rely totally on local authority funding and cannot have top-up fees? Are such clients disadvantaged in some way because of the freedom of choice for others who have money for better accommodation?

Jess Barrow: I referred to people who would be entirely reliant upon local authority funding because the top-up part applies to them. They can choose to top up their fees from their capital or personal allowances—that is not a great deal of money.

When free personal care hit the headlines, I received a telephone call from a man whose wife was in a residential home and was funded by a local authority. She did not have the resources to be self-funding. The man topped up her fees from his pension. He was desperate because she was in a home that was too expensive for the local authority to pay for. The proposal would allow her to top up her fees and not be dependent on somebody else to top them up for her.

We want a system in which, of right, everybody has access to care that is fully funded by the local authority and in which top-up fees are not necessary. Too often, unfortunately, such fees are necessary at the moment, whether they are paid by a family member or a partner. The proposal would make it simpler for top-up fees to be available when there may be no other choice.

I had a feeling that there was no other choice for the gentleman who rang me. I explained to him that the proposals for free personal care would have no effect on him whatever, but I could not get more details from him because he was extremely distressed and put the telephone down. The call haunted me. We need to do something for people who are in that position. Too many people who receive funding from local authorities have to top up their fees because local authority funding is insufficient to cover the cost of their care. We want to be able to ensure that no one is forced into that position and that everyone who is not dependent on top-up funding has the option of a decent quality care.

Mr McAllion: In my local authority area, one elderly woman—she was 88 or 89 years old—was in a Catholic home because that suited her. However, that home shut down and the nearest one was in another local authority area and charged more expensive rates. Dundee City Council will not pay the higher rates and the woman has no relatives. Top-up fees will eventually result in her being moved out of that home. How do we deal with such cases?

Jess Barrow: There has to be more of an obligation on local authorities to pay the full cost of care. It is concerning that local authorities are prepared to pay much more to provide care in a local authority home than they would pay for care in a private home. There are all sorts of reasons for that—

Mr McAllion: Wages, conditions and pensions for the staff, for a start.

Jess Barrow: Yes. However, there should not be a ceiling for what the local authority will pay to place someone in a private home, because that makes it much more difficult for a private home to improve its standards and pay its staff properly. We must ensure that, when local authorities purchase care in the private sector, they pay enough to be able to purchase decent quality care.

Mary Scanlon: Section 4 deals with

“Accommodation more expensive than usually provided”.

Are you satisfied that such accommodation will be superior to that which is not more expensive than that which is usually provided and will it address better the needs of individuals? In other words, will such accommodation be worth paying for?

Section 4(2) talks about additional payments being made

“for the purpose of meeting all or part of the difference between the actual cost of the accommodation and the amount that the local authority providing it would usually expect to pay in order to provide accommodation suitable for a person with the assessed needs of the resident”.

However, section 30 of the policy memorandum says:

> “We envisage that regulations will be made to restrict self top-ups to residents with sufficient resources to ensure that the arrangement can be sustained and that the person is not likely to be impoverished as a consequence.”

I am a little confused by those two statements. What is your interpretation of them?

Jess Barrow: I am not surprised that you are confused. I do not always find such things terribly easy to understand either.

It is essential to ensure that enough money is made available by a local authority to meet a person’s assessed care needs. That will not be achieved by having an arbitrary ceiling on the amount that a local authority is prepared to pay to purchase a place in the private sector.

The issue of choice is relevant in relation to the issue of standards. If there is a choice between a local authority home that offers a perfectly good standard of accommodation that is in accordance with the requirements of the Scottish commission for the regulation of care and a smarter, more up-market home nearby that offers care of a slightly higher standard, people should be free to make a choice. However, we fear that that element of choice is missing and that people are pushed into paying for more expensive accommodation than the local authority is prepared to pay for without that accommodation necessarily being of a higher standard.

Mary Scanlon: My concern is that we seem to be developing a two-tier system. We are all for accommodation that is of a slightly higher standard. Am I right in saying that anyone in receipt of local authority funding who could not afford the top-ups or who had limited savings would be ineligible for the four-star homes?

Secondly, to return to my earlier question, how are you satisfied that homes that charge more provide a better service? Where does the two-tier system with more expensive accommodation come from?

12:15

Jess Barrow: My real concern is that we must have a one-tier system.

At the moment, the system provides a level of care that we hope will improve with the establishment of the Scottish commission for the regulation of care. There are basic standards of care, but people are not offered a choice. They are forced into accommodation in which they have to contribute top-ups just for the basic level of care. Top-ups are a red herring. We must ensure that decent-quality care is available at a price that the local authority is prepared to pay.

Ultimately, we live in a society in which we are free to do with our money what we choose. Some choose to live in a small house, some in a big house. We have different approaches to how we spend our money. The top-up system should be about allowing additional choice. However, first we must establish a one-tier system that works. Our concern is that we do not have that the moment.

Mary Scanlon: Are you saying that local authorities should not be allowed to charge more for their residential homes unless they have superior accommodation?

Jess Barrow: No. That is not what I am saying. I am sorry if I am not making myself clear. The fundamental issue is that, whether a home is run by the local authority or privately, the local authority should pay what it costs to provide care of a decent quality. Everybody who is assessed as needing that care should have access to that care without having to pay top-ups.

Top-ups should not be necessary, but unfortunately, too often, they are. We want a situation in which top-ups are unnecessary, but if they are to be continued, they should be continued purely to allow additional choice.

Mary Scanlon: Paragraph 30 of the policy memorandum says that top-ups will be restricted

“to residents with sufficient resources”.

Jess Barrow: I would like to know the definition of “sufficient resources”.

The Convener: We might want to investigate some points further with you in writing. For example, you talked about individuals. To what extent is that evidence anecdotal and to what extent do you have facts and figures behind it? How many people might be involved? What would the notional cost be if we were to say that we had to pay all the costs to which you have referred?

I will ask the remaining questions so that they are asked as quickly as possible. I have two questions, to which I would like quick responses. Do the provisions in the bill legislate adequately for carers and their needs? Do the provisions go far enough to address the need for greater integration of NHS and local authority services through joint working?

Jess Barrow: We are happy with the provisions for carers. We have not given them a great deal of consideration, because we know that other bodies represent carers and are more than capable of making their representations heard. We have focused on the parts on the bill that concern the implementation of free personal care.

Integration is particularly important. The proof of the pudding is in the eating. We will have to wait and see how the provisions work. It is important that people receive properly integrated care.

The system that is finally agreed upon must do something about delayed discharge and remove the financial disincentives. The GPs commented in their evidence that the cost of care in hospital is much greater than the cost of care in the community, yet far too many people still receive care in hospital when they should be elsewhere. We need to remove the financial barriers if we can. That is a matter of systems.

The important issue is the end result. We must have a system that meets the needs of those who receive the care.

The Convener: I thank the witnesses for their contribution.

We now move into private session for consideration of our reporter's report on organ donation.

12:19

Meeting continued in private until 12:30.

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