HEALTH AND COMMUNITY CARE COMMITTEE

Wednesday 12 December 2001
(*Morning*)

Session 1

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HEALTH AND COMMUNITY CARE COMMITTEE
31st Meeting 2001, Session 1

CONVENER

*Mrs Margaret Smith (Edinburgh West) (LD)

DEPUTY CONVENER

*Margaret Jamieson (Kilmarnock and Loudoun) (Lab)

COMMITTEE MEMBERS

*Bill Butler (Glasgow Anniesland) (Lab)
*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)
*Nicola Sturgeon (Glasgow) (SNP)

*attended

THE FOLLOWING ALSO ATTENDED:

Hugh Henry (Deputy Minister for Health and Community Care)
Mrs Mary Mulligan (Deputy Minister for Health and Community Care)

CLERK TO THE COMMITTEE

Jennifer Smart

SENIOR ASSISTANT CLERK

Peter McGrath

ASSISTANT CLERK

Graeme Elliott

LOCATION

The Chamber

Scottish Parliament

Health and Community Care Committee

Wednesday 12 December 2001

(*Morning*)

[THE CONVENER *opened the meeting at 09:36*]

Interests

The Convener (Mrs Margaret Smith): Good morning. Welcome to this morning's Health and Community Care Committee meeting.

I welcome Bill Butler, who is our new committee member. I hope that he enjoys his time on the committee and is able to make a useful contribution to our work. Does he have any interests to declare?

Bill Butler (Glasgow Anniesland) (Lab): I have no such declaration to make.

Items in Private

The Convener: The committee is asked to discuss in private items 5, 6 and 7 for the following reasons. Item 5 is on external research and we may name individuals in our discussions. Item 6 concerns our hepatitis C report. It is a new agenda item, which was added yesterday to deal with the fact that we have received the Executive's response to the report. It is likely that members will want to deliberate on it in private at this stage. We may issue our decision in public after the meeting or take it forward to a future meeting. Item 7 is a draft report and those are usually considered by the committee in private. Is that agreed?

Members *indicated agreement*.

Subordinate Legislation

Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No 14) (Scotland) Order 2001 (SSI 2001/451)

The Convener: Agenda item 2 concerns the time limit on debate. Members have been asked to indicate in advance whether they want to debate the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No 14) (Scotland) Order 2001 (SSI 2001/451). No comments have been received from members, so it is suggested that the committee agrees not to debate the instrument. Are we agreed?

Members *indicated agreement*.

The Convener: Under agenda item 3, we must deal with the emergency instrument, which is subject to the affirmative procedure. I welcome Mary Mulligan, who is with us in her capacity as the Deputy Minister for Health and Community Care. I think that we all share her ideas about ensuring that the committee works well with her and with Hugh Henry, who will join us later for our discussions on the Community Care and Health (Scotland) Bill. This is Mary Mulligan's first attempt at dealing with an emergency instrument on shellfish. We are well versed in doing so.

The Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No 14) (Scotland) Order 2001 (SSI 2001/451) is before the committee. The Subordinate Legislation Committee has nothing to report and no comments have been received from members. I ask the minister to move the motion.

The Deputy Minister for Health and Community Care (Mrs Mary Mulligan): Good morning. I look forward to working with the committee.

Today's discussion concerns the emergency order banning the catching of king scallops in waters off the west coast of Scotland. The order prohibits the harvesting of king scallops and has been triggered due to the finding of amnesic shellfish poison above the levels set by Europe. This is a consumer safety measure, as scallops that contain high levels of toxins can cause illness in humans—ranging from nausea, vomiting, headaches and, in extreme circumstances, short-term memory loss—and even death, when a large amount of toxin is ingested.

I move,

That the Parliament's Health and Community Care Committee recommends that the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No.14) (Scotland) Order 2001, (SSI 2001/451) be approved.

Motion agreed to.

Community Care and Health (Scotland) Bill: Stage 2

The Convener: Today, we start stage 2 consideration of the Community Care and Health (Scotland) Bill. Mary Mulligan and Hugh Henry will deal with separate parts of the bill.

Members should have before them a copy of the bill, the revised marshalled list of amendments, which was published yesterday, and the grouping of the amendments. The amendments have been grouped to facilitate debate. The order in which they will be called is dictated by the marshalled list. There will be one debate on each group of amendments and members may speak to their amendment if it is in that group.

After we have debated the amendments to each section, the committee must decide whether to agree to that section. Before I put the question on any section, I am happy to allow a short general debate, which may be useful in allowing discussion of matters not raised in amendments. We do not have to have a debate on each section.

If any member wants to oppose the question that a section or schedule be agreed to, he or she has the option of proposing a manuscript amendment to leave that section or schedule out. If that happens, it is my decision whether to allow the amendment to be taken.

I will not delay any division on an amendment to enable members who are not present in the room to return. Committee members who choose to go out for whatever reason must do so on the understanding that they might miss a division.

We do not intend to go beyond the end of section 13 of the bill today.

Before Section 8

The Convener: Amendment 1 is grouped with amendments 4, 5 and 9.

Mrs Mulligan: I am happy to be here to begin stage 2 discussion of the Community Care and Health (Scotland) Bill. I intend to focus on the provisions that are designed to improve support for carers. They might not form the largest part of the bill but they are as crucial to the sustainability and future of community care in Scotland as are any of the other elements of the bill.

It is worth reminding ourselves—I include the Executive in that—that, although we spend a lot of time and resources developing public services, those services are not an end in themselves, nor are they the biggest part of the equation. The simple truth is that carers provide the bulk of support to people who are cared for in the community—sensitively, without expectation of reward and often in the home setting.

I know that members of the committee share our view that the contribution that carers make to the care of people in the community is crucial. The support that carers provide is not an optional extra at the margins, but is at the core of all support and care. The Executive is already committed to doing more than ever to support carers, which is why we have included in the bill provisions to extend the rights of carers to access support through assessments—a recommendation that was made by the independent carers legislation working group.

I want to pay tribute to the thorough and objective work that was carried out by the members of that group over a sustained period last year. They produced a report that will help us to move the carers agenda further forward on a range of fronts.

At the heart of the group's report was the vision that carers should be recognised by Government and other care providers as partners in providing care to the person in need. The Executive fully supports that principle. For too long, carers have been undervalued, not involved in areas where they have a vital input to make and treated by other care providers as consumers of services. Therefore, we were not surprised by the support for the principle of carers as partners at stage 1, nor by the Health and Community Care Committee's call in its stage 1 report for the Executive to embody that principle in the bill. We agreed to consider how that could be done, because we recognise the powerful effect that doing that could have on other care providers.

09:45

We have examined closely how to include that principle in the bill and appreciate that a bold general principle might seem attractive. However, the committee will appreciate that it is attractive and of use only if we can be confident that it will have the intended effect.

It is important to appreciate the difference between trying to work out a principle to underpin a new regime, which is being created, and trying to superimpose a principle on an existing regime. The regime in Scotland is set out in legislation enacted in 1968 and a substantial body of case law has developed. Any new provision must take due account of that—to do otherwise would be dangerous.

We note the difficulties that have arisen from superimposing human rights principles on existing legislation. We have concluded that we cannot simply include a general principle about carers as partners in the bill, with which we aim to try to help

people in need and those who care for them. It is vital to examine the existing legislation and to find out where their rights can be improved.

That is what we have done. We have tried to work out what further rights those who support a carers principle have in mind and to establish what new rights might help those in need and their carers. Amendments 1 and 4 do that, by requiring local authorities to do two important things when deciding what services to provide to a person in need. First, the amendments require a local authority, once it has assessed the care needs of a person, to take account of the care contribution of the carer, if there is one. Local authorities will continue to assess the overall care needs of a person but, before they decide what services to provide, they will be obliged to identify and take note of the care being given by the carer. That is designed to ensure that local authorities recognise what the carer is doing and take full account of the carer's role in deciding what services to provide.

Secondly, amendments 1 and 4 introduce a new requirement for local authorities to consider the views of the person in need and of any carer before deciding on the services to provide. That will give people in need and their carers a clear voice in the process and will ensure that local authorities are required to take due account of any views that they express in reaching decisions on the services that are called for.

I recognise that amendments 1 and 4 would express in statutory terms what already happens in many areas as good practice. Nonetheless, I believe that it is right for us to demonstrate our commitment to the principle of carers as partners by incorporating the requirements into law. We will thereby ensure that best practice is spread to every area.

Taken together with amendments 3 and 7, which would place local authorities under a legal obligation to inform all carers of whom they are aware—and who provide a substantial amount of care on a regular basis—of their right to an assessment, we believe that amendments 1 and 4 embody in a practical and real way the principle of carers as partners in care. We believe that they significantly enhance the support given to carers and I ask the committee to support amendments 1 and 4.

Amendments 5 and 9 are technical. Together, they would allow references in the bill to the Children (Scotland) Act 1995 to refer to "the 1995 Act". Such references are made in section 9 and in the new section to be inserted by amendment 4.

I move amendment 1.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): I want to ask the minister about the wording of amendment 1. There is difficulty in interpreting that amendment. We will require definitions of "substantial" as well as "reasonable and practicable". Those are the points that will be contested. Why has the Executive chosen those words?

Mrs Mulligan: The concept of regular and substantial care is part of the definition of a carer that is used in the Social Work (Scotland) Act 1968, which the bill builds upon. On the phrase "reasonable and practicable", we recognise that there are concerns that the wording could be seen to give local authorities discretion about whom to take note of. As it is worded, amendment 1 means that local authorities can justify not taking views into account only if they can demonstrate that it is unreasonable and impractical for them to do so. The onus is put back on the local authority. I hope that the committee agrees that we should not impose a duty on local authorities that could be said to be unreasonable or impractical.

We have been careful in amendment 1 to provide local authorities with the flexibility to provide care for someone in need without seeking the views of carers. That is particularly important if there is an emergency situation or the carer cannot be contacted.

Finally, it is important that the authorities are not bound by the views of carers in the few cases where those views conflict with the wishes of the cared-for person. In an even smaller number of cases, the cared-for person may not be able to express a view on their care and the views of the carer may not necessarily be the most satisfactory for the cared-for person at that time. The amendment allows a certain amount of flexibility, but the onus is on the local authority to prove that something is impractical or unreasonable.

The Convener: If the onus is on the local authority to say that it is unreasonable or impractical, to whom will they be answerable?

Mrs Mulligan: It will be quite clear in the guidance that is issued that local authorities will be answerable under the legislation if it is shown that they are acting unreasonably.

The Convener: So the authorities would be answerable to Scottish ministers?

Mrs Mulligan: Yes.

Mr John McAllion (Dundee East) (Lab): In your letter to the committee, you said that the concept of carers as partners could not be included in the bill because it had "uncertain legal meaning". I want to explore the legal meaning of amendment 1.

You said that amendment 1 would give a voice to carers. In a sense, carers already have a voice. I have a constituent who has a severely disabled son and she is very unhappy with the level of

services, particularly respite care, that is provided by the local authority. She is able to voice that unhappiness through talking to me as her MSP and through direct access to the director of social work. Would she be able to use the provision to challenge the level of care in the courts? Would she be able to say that the social work department was not providing a reasonable and practical level of care, particularly respite care, for her and her son and take the local authority to court on that basis?

Mrs Mulligan: The local authorities would be answerable to the individual involved. The final recourse would be judicial review.

Mary Scanlon (Highlands and Islands) (Con): Strangely enough, most of the responses to the bill and most of the concerns that I have heard have come from carers. There is a strong feeling that their needs and wants are not being adequately addressed.

I wonder whether the minister would clarify something. In the letter that you sent to the committee on 7 December you say that your

"amendments express the spirit of what is meant in the vision of 'carers as partners in providing care' in practical terms that will stand up to legal scrutiny".

That seems vague. I am concerned that it is too flexible and vague to meet the concerns of people who have contacted the committee on the issue.

The letter continues:

"We also believe that these are realistic proposals that local authorities will be able to implement in the context of their existing obligations".

There seems to be an element of choice there. I am not sure that what you have said today goes far enough to meet the major concerns of the carers and carers organisations that have contacted us.

Mrs Mulligan: We are fully behind the principle of carers as partners. Their role has to be recognised and we believe that the bill will do that. As I said to Margaret Jamieson, the intention behind the wording of the amendment is to allow for flexibility but not to allow local authorities to opt out of providing support or of working with the carer. As it stands, the wording of the principle of partnership in care is open to legal interpretation; it was therefore considered unsuitable. The amendment gives meaning to the principle of partnership in care. It should ensure that Mrs Scanlon's constituent is able to receive the support and services that are needed and to be treated as a partner in that care.

The Convener: Margaret Jamieson asked about the definition of a substantial amount of care and you said that it was based on a definition in a 1968 act. Can you give us more information on that?

Mrs Mulligan: I am told that it is in section 3A of the Social Work (Scotland) Act 1968.

The Convener: Can you tell us off the top of your head whether it means X hours a week?

Mrs Mulligan: No, it is not prescriptive in that way. That kind of definition is not given.

Amendment 1 agreed to.

Section 8—Amendment of 1968 Act: assessment of ability to provide care

The Convener: Amendment 2 is grouped with amendment 6.

Mrs Mulligan: As drafted, section 8 of the bill provides carers of adults in need, for the first time ever, with the independent right to an assessment of their ability to provide care. Section 9 provides the same right to carers of disabled children. It has always been our intention to ensure that all carers, irrespective of age, have that right and I have been pleased by the overwhelming support for that.

When the bill was drafted, it was not clear that young carers—aged under 16—were entitled to request a carers assessment. The legal position had to be explored further. We wanted to ensure that any amendment to the 1968 act took account of all relevant factors. The legal advice was that, in order for carers who are under 16 to be able to exercise the right to an assessment, that right must be expressly extended to them. Amendment 2 does that for young people who care for adults in need; and amendment 6 does it for young people who care for disabled children.

I move amendment 2.

The Convener: The committee welcomes what you have said.

Amendment 2 agreed to.

10:00

The Convener: Amendment 3 is grouped with amendment 7.

Mrs Mulligan: We recognise the concern, which the committee shares, about the need to ensure that carers are made aware of their right to an assessment. Therefore we have lodged an amendment to build further on the new right to assessment, as Malcolm Chisholm indicated we would do during the stage 1 debate.

Amendments 3 and 7 would place a legal obligation on local authorities to inform all carers of whom they are aware of the right of carers who provide a substantial amount of care on a regular basis to request an independent assessment of their ability to provide or continue to provide that care. As I have said in other contexts, amendment

3 simply expresses in legal terms what is already good practice in many local authorities. However, by embodying in legislation the requirement to ensure that carers know of their entitlement to an assessment, we will send a clear message about our commitment to carers. Local authorities will be obliged to comply with the duty immediately in respect of new carers. We would expect them to comply as soon as reasonably possible in respect of all other carers known to them. I again invite the committee to agree to the amendments as a further enhancement of carers' rights.

I move amendment 3.

Margaret Jamieson: Why is the onus only on local authorities and not on other providers of care, particularly general practitioners?

Mrs Mulligan: Local authorities already have a role in identifying carers and ensuring that they are aware. For many authorities, that is presently good practice. We want to build on that good practice and ensure that it continues. We feel that it is easier to ensure that local authorities continue to play that role by enshrining it in legislation. To add that burden to those already borne by general practitioners would place on GPs a burden that they do not have at present and would duplicate a service that local authorities must already ensure is offered.

Margaret Jamieson: I accept your comment about building on good practice in local authorities, but there is a lot of good practice among GPs, who have set up registers, for example diabetic registers and various site registers, from their patient base. My GP practice recently undertook a survey of patients to find out whether they were carers. If one practice in Kilmarnock and Loudoun can do that, why cannot others throughout Scotland adopt that good practice? Many individuals interface with health services long before they interface with local authorities. In some instances, they are loth to contact the social work department and push themselves to the absolute limit. There will always be individuals out there who do not access the services that exist to assist them.

Mrs Mulligan: I recognise what the member is saying with regard to her own GP practice. As I said, that can be built on, too. In fact, members may be aware of the Princess Royal Trust for Carers. Its focus on carers initiatives might introduce similar practices. As that is still a pilot, we want to review its outcome.

At the moment, we must develop good practice for everybody as quickly as we can. Given that local authorities already have the responsibility, it is more practical—and quicker and more efficient—to build on that than it is to introduce a practice that other GPs may not necessarily follow.

As members are aware, the Executive is keen for there to be joint working between local authorities and the NHS. When GPs or other members of the NHS are aware of carers, they should work with their partners in the local authority to ensure that they are identified and given information about the services that are available.

Margaret Jamieson: When will the pilot be reviewed? If that happens before stage 3 is completed, I hope that we can make some alterations to enshrine the partnership approach that you talked about. That is welcome, but it needs to be formalised. If you cannot give the timetable for the pilot or if it does not coincide with stage 3, could you do something in the contract negotiations with GPs or with GPs who have opted for personal medical services?

Mrs Mulligan: I understand that the pilot will not be complete until next year and will probably not be reported on until the summer, which will be after stage 3 of the bill. We are keen to build on the joint working that has developed. Although that aim is not encompassed in amendment 3, clear guidance will be issued that says that we want to build on the practice of joint working by the NHS, GPs and other members of the NHS, and the local authority.

The Convener: Do you want to wind up or are you happy with what you have said?

Mrs Mulligan: I am happy with what I have said.

Amendment 3 agreed to.

Section 8, as amended, agreed to.

After section 8

Amendment 4 moved—[Mrs Mary Mulligan]—and agreed to.

Section 9—Amendment of Children (Scotland) Act 1995: assessment of ability to provide care for disabled child

Amendments 5 to 7 moved—[Mrs Mary Mulligan]—and agreed to.

Section 9, as amended, agreed to.

After section 9

The Convener: Amendment 19 is in the name of Janis Hughes, in a group on its own—I think that the amendment is in a group on its own, not Janis Hughes.

Janis Hughes (Glasgow Rutherglen) (Lab): We have had a fair debate on the spirit of amendment 19, as it addresses an issue that the committee discussed at great length at stage 1. The local authority aspect of the issue was dealt

with by amendment 3.

We heard much evidence that strategies for identifying carers are greatly needed. Carers themselves argued powerfully for strategies. They said that, previously, rules on such registers were contained in guidelines and were not legally enforceable. That is unsuitable. The consensus in the committee is that we need robust identification strategies that are enshrined in legislation. Amendment 3 placed a duty on local authorities but not on the NHS. Amendment 19 would require NHS bodies to prepare strategies.

In the minister's opening statements, she said that the bill looks at the need to provide support for carers. We agree with that whole-heartedly. Joint working—the current buzz phrase—started with the Regulation of Care (Scotland) Act 2001 and it moves on in the bill. It is right and proper for that to happen. However, we cannot demonstrate joint working when we have one rule for a local authority and another for the NHS. In the spirit of joint working, we need to consider how we protect carers across all agencies.

Best practice has been talked about. We would all support best-practice guidelines, but they are just that—guidelines. There is a groundswell of opinion that says that, unless we enshrine the strategies in the legislation, carers will once again feel let down by agencies such as the NHS. That is because the NHS will not have a duty to provide strategies to identify carers and so provide them with information.

I move amendment 19.

Nicola Sturgeon (Glasgow) (SNP): We heard evidence throughout stage 1 that backed powerfully an amendment such as amendment 19. I welcome the amendments to section 9 that we agreed, as they will improve things for carers. However, as Janis Hughes said, if those amendments are passed without complementary provisions to cover the NHS, we are in danger of perpetuating the divide between local authorities and the health service, down which so many carers and those who use the services fall. Does the minister accept that that is a danger?

One of the objectives of the bill should be to ensure that we bring together services. Amendment 19 would provide a useful mechanism to ensure that health boards would be obliged, in the same way as local authorities will be, to cater properly for the needs of carers.

Mrs Mulligan: We recognise carers' real concerns about how they are treated by local authorities and the NHS. As has been said, carers are also concerned about how well they work in partnership with the local authorities and the NHS. Some carers' concerns have arisen from bitter experience.

The Executive has given careful consideration to the views of carers and the Health and Community Care Committee. That is why we lodged the amendments that have been considered so far this morning. Those amendments will improve the ways in which local authorities, which are the lead statutory agencies in social care provision, recognise, support and work with carers.

It appears that amendment 19 intends to achieve a similar objective for the NHS. Amendment 19 would provide for ministers to require NHS boards to develop strategies for identifying carers and to inform carers of their rights. Although I recognise the intention behind the amendment, I cannot agree that we should seek to impose a duty on the NHS, similar to that which we have placed on local authorities to give carers information. We should not legislate for two different bodies to be responsible for the same activity.

I believe firmly that we should make the position clear—local authorities have the lead responsibility for social care and for providing carers with information and support. I believe that amendment 19 might undermine that responsibility. I have a more fundamental objection, which is that the amendment is not the right way to improve NHS support for carers. We agree that the NHS can play a vital role in supporting carers, but amendment 19 is not the most effective way of encouraging the NHS to engage more fully with carers.

We intend to proceed through partnership, dialogue and accountability. I am confident that there is the will and enthusiasm in the health service to do more for carers and to do it better. The Executive is working with the NHS on a range of initiatives to build care awareness into the main stream of the health service.

Through generic and specific clinical standards—set and monitored by the Clinical Standards Board for Scotland—NHS bodies are already required to involve carers in a wide range of aspects of clinical care. The standards are not just empty promises but are developed and monitored. It is important to note that they are monitored in consultation with the public, including patients and carers. The NHS bodies are formally required by the Executive to comply with the standards. Through local visits and consultations across Scotland, the Clinical Standards Board checks closely that the standards are being translated into practice.

The development of clinical standards is an evolving process and I accept fully that we are still near the beginning. However, I am confident that clinical standards are a powerful way—and the most efficient way—to build carers issues more firmly into the main stream of the NHS. There is

evidence that they are already making a difference. For example, following a recent Clinical Standards Board visit in Fife, the health board has invited the local carers centre to help to train staff in two hospitals on carers' needs and involvement.

10:15

Clinical standards are not the only way of advancing the carers agenda. As has been said, the carers agenda is relevant across the full range of NHS activity. I will give a couple of examples to illustrate that. First, the development by the Scottish Consumer Council, on behalf of the Executive, of a successor to the patients charter is an important route through which we will highlight the importance of carers and engage them more effectively with the NHS. Secondly, through the development of our learning together strategy for NHS staff, we plan to build carer awareness and information about the needs of carers into new induction procedures for all NHS staff.

As I have tried to make clear to the committee, and as the amendments to the bill that we have lodged show, the Executive is serious about supporting carers. We are equally serious about ensuring that the NHS plays its part as a partner. However, as I have explained, that can be achieved other than by legislation—by working with the health service to build the standards into its core way of working. That is the right way—the most flexible and effective way—of ensuring that carers get a better deal from the NHS in Scotland.

I hope that I have left no doubt that the Executive is serious about helping carers and is going further than ever before. However, I suggest that amendment 19 is not the way to progress with that.

The Convener: I reiterate the point that Margaret Jamieson made. When I talk to constituents and others about caring, I often find that many people who are carers do not identify themselves as such but simply say that they are husbands, wives, sons, daughters, mothers and so on. Although those people do not identify themselves to social services as carers who require services, they attend their GP's surgery and—as 90 per cent of us do—access NHS services through that route.

While the local authorities might be given the primary job of providing information to carers, there should be some investigation of the linkage and partnership that might be available through the NHS, particularly through GPs, as gate-keepers to a large proportion of that service. That would not have to be too onerous, nor would it be expected to happen overnight.

You say that you do not wish to impose a duty that makes two different bodies responsible for the provision of a particular service. However, later in stage 2, we will examine joint working. Within the bill, the Executive is allowing each partner to act on the other's remits in certain circumstances, so to an extent we must start to change the boundaries that we work within. Have you spoken to GPs about whether that proposition is doable in general terms and specifically in the context of discussions on their new contract?

You have outlined the importance of standards of clinical care. Will they form part of the performance assessment framework that will be undertaken by the new unified boards?

Mrs Mulligan: I shall answer your questions in reverse order. The clear answer to your last question is yes.

On discussions with GPs, there is an on-going review of GP contracts but I am not aware that the issue that you raised has been discussed. As far as I am aware, the GPs did not comment on that issue in their stage 1 written evidence, but I may be corrected on that.

On working together, asking the local authorities to take on the duty of providing carers assessments does not negate the possibility of the local authorities and NHS services working together to identify carers. I recognise that some carers may have immediate contact only with their GP and may feel reluctant to contact their local authority but, ultimately, the support will be provided by the local authority.

It is better that local authorities should have the duty and responsibility of identifying carers, assessing their needs and delivering on those needs. Although NHS practitioners and local authorities should work together closely, the responsibility for identifying carers should be made clear. At this stage, that responsibility should remain with the local authority.

The Convener: Can you tell us categorically whether that issue has been discussed in the on-going discussions on GP contracts?

Mrs Mulligan: I suspect that the issue has not been discussed, but I cannot say at this stage.

The Convener: Despite the fact that you intend not to accept amendment 19, it is obvious from what you have said and from your other comments this morning that you have some sympathy with the amendment and with the committee's general view on carers. Will you at least keep an open mind and approach GPs to find out their view—if the issue has not been discussed in those contract negotiations?

Mrs Mulligan: I am sorry that I am not able to give that information at this stage, but we will seek that information for the committee if it wishes us to.

Mr McAllion: I am grateful for the minister's assurance. It would be quite useful if we could get that information before stage 3, as a further amendment may need to be introduced at stage 3 if we are not satisfied with the situation.

If the duty to support carers applies only to local authorities, many carers could fall through the gap. Although in Fife clinical standards may be improving and carers may be being improved, that is not necessarily happening across the country. The successor to the patients charters and the learning together strategies are marvellous, but such things do not guarantee that people will get the information that they require.

We seek a guarantee that carers will not be allowed to slip through gaps in the provision. There must be an iron-clad approach to ensure that the people who come into contact with the NHS are identified and made aware of their rights.

Mary Scanlon: I am a bit concerned about the minister's comments about the Clinical Standards Board, which has an enormous remit throughout Scotland and is far removed from the day-to-day worries of carers that the committee has heard about. I can understand why the minister should latch on to that organisation, but I doubt that it can carry out the remit that she proposed.

I was also slightly concerned at the minister's response that amendment 19 could undermine local authorities. We should judge the amendment on the way in which it would benefit patients and carers, rather than on whether it would undermine local authorities. First and foremost, our concern is for the patients and carers. If joint working means anything, surely we can get our act together in relation to such a provision.

Mrs Mulligan: I meant to say that under the terms of the monitoring of clinical standards, we hope that the practice in Fife to which I referred will be shared throughout the country and that there will be a knock-on effect. We want to ensure that that is delivered everywhere and not just in one place. I acknowledge what Mr McAllion is saying about the discrepancy between the delivery in different areas. That needs to be addressed.

The point that I made about the amendment undermining the local authorities was that it might lead to doubt as to who has the ultimate responsibility. My concern is that in having a joint approach, we might lose the clear assurance that the local authority will take on the responsibility. I take Mary Scanlon's point and I am happy to take on board the committee's comments on the matter.

The Convener: I ask Janis Hughes to wind up and indicate whether she wishes to press amendment 19.

Janis Hughes: I hear the minister's comments, but I have some remaining concerns. The minister mentioned clinical standards, but those are simply guidelines. I accept that they are monitored, but putting a tick in a tick box is not what carers are looking for when they are in desperate need of identification and information. I do not think that that is particularly helpful.

Margaret Smith made a fair comment about GPs. People are often identified to local authorities by their GPs, so the GPs play a crucial role. I accept your comments about your willingness to consider the GP contract situation, minister. It is very important that we address that. None of the evidence that we took from the Royal College of General Practitioners identified any significant objection to moving in that direction. We need to ensure that we take on board such information before stage 3. In light of those points, I am prepared to withdraw amendment 19, although I reserve the right to lodge a similar amendment at stage 3, depending on the information that is provided by the Executive.

Amendment 19, by agreement, withdrawn.

Sections 10 and 11 agreed to.

Section 12—Delegation etc. between local authorities and NHS bodies

The Convener: Amendment 20, in the name of Mary Scanlon, is grouped with amendments 8 and 10.

Mrs Mulligan: Excuse me, convener, but this is when I must leave the committee.

The Convener: Thank you, minister.

I welcome Hugh Henry to the hot seat—he thought that he had escaped the Health and Community Care Committee.

Mary Scanlon: I would like to draw the minister's attention to recommendation 71 of the committee's report on the delivery of community care in Scotland. We recommended that

"A single body should be given the role of budget holding, planning and commissioning of community care services. The requirements are clear accountability and transparency of decision-making. The Executive should investigate options that will achieve these objectives and ensure a single point of entry for services."

We do not have a single point of entry and we do not have a single budget. I also draw the committee's attention to paragraph 66 of the policy memorandum. It states that ministers can intervene

"only in cases of failure where the expected service outcomes are not being delivered. … Scottish Ministers will be able to use this power to require that local authorities and NHS bodies adopt certain key principles, such as a single management structure, with a single budget and the

delegation of functions."

We have heard much information and received many submissions from various bodies that show that joint working is not working; the NHS and local authorities do not work well together. There is a culture of blame and of passing the buck. When the Parliament was set up, there were 1,600 blocked beds: there are now 3,000 blocked beds.

For those reasons, and because of the information that has been given to the committee, I want to move amendment 20. There is enough recognised failure within the NHS. If we can recommend that there be a single management structure when there is more failure, why cannot we have a single body now, rather than wait until more problems arise?

I move amendment 20.

10:30

The Convener: I ask the minister to speak to amendments 8 and 10 and to the other amendment in the group.

The Deputy Minister for Health and Community Care (Hugh Henry): Can I say how delighted I am to be back at the Health and Community Care Committee?

The Convener: You can say it, but we will not believe you.

Hugh Henry: After my short time away, I had forgotten how interesting it was to discuss amnesic shellfish poisoning on a Wednesday morning. It is a bracing way to start the day.

In moving amendment 20, Mary Scanlon spoke about recommendation 71 of the committee's report on the delivery of community care, which is that there should be a single body for budget holding in order to introduce clear accountability. The convener can correct me if I am wrong, but when that recommendation was made I do not think that it specified what that single body should be or where authority should lie. Mary Scanlon's amendment is a pre-emptive strike to try to determine where authority should lie. Mary Scanlon says rightly that joint working is not working. The bill and the amendments that have been lodged reflect that, and our proposals attempt to address that matter.

I make it clear to Mary Scanlon that amendment 20 would require a local authority to enter into a pooling arrangement, even when functions have not been delegated and the fund would not be used. That is like taking a sledgehammer to crack a walnut. The amendment would try to force something, even when there was no need for it. The pool, irrespective of its components, would always be managed by an NHS body. Amendment 20 would remove the potential for flexibility. The amendment does not try to determine where the best arrangement would lie; rather, it says that in every single case authority would best be vested in an NHS body.

I acknowledge that there are problems within local authorities, but the problems with delivery of care are not always within local authorities and the solutions are not always within the NHS. I hope that we can retain a degree of flexibility. I am disappointed that amendment 20 has been lodged, given the committee's broad acceptance of the Executive's approach to dealing with this matter jointly. There are complex matters involved and amendment 20 fails to take into account the purpose of the existing provisions, which enable resources to move on the back of delegated functions, and provide discretion to delegate, subject to directions from ministers. The provisions are driven by delegation. Amendment 20 contrasts with the discretionary provision in the bill on whether agencies should have aligned or pooled budgets, and on which body should be the host in a pooling situation. Amendment 20 would therefore undermine the fundamental principles of joint working and fairness in the bill.

Experience of the use of similar powers in England shows that agencies value flexibility such as that which the bill proposes. Good examples exist of local authorities hosting one budget and the NHS holding others. Amendment 20 would remove that flexibility and dilute the momentum of the joint approach and it could result in what should be joint activity being badged as NHS provision.

We want to set out the framework in the bill and leave local agencies to decide within that what is operationally best for them. Apart from the reduced flexibility that amendment 20 would create, it does not work in legal terms. Because it sets out a particular model of working, it cuts across the provisions in section 14 that enable ministers to determine how joint working should be addressed if there are failures. Furthermore, the amendment would require the establishment of a pooled budget even although the local authority or NHS body might not want to use it.

I believe that amendment 20 would undermine some of the fundamental principles in the bill, and I propose that it be rejected.

Amendment 8 would amend section 12(2) of the bill. Section 12(2) allows for regulations to define which functions can be the subject of delegation and other joint working arrangements under section 12. Amendment 8 would not alter that effect, but it would make it clear, in light of the amendments to section 14 that have been lodged, that the functions that are referred to are as prescribed under section 12.

On amendment 10, I will say first what it is not about: it is not about what we put into regulations and what conditions should apply to staff transfers. Amendment 10 is about being clear as to what powers we should use. Amendment 10 would ensure that there was no conflict between regulation-making powers under section 12 of the bill and existing powers in the National Health Service (Scotland) Act 1978. It is a technical amendment, which clarifies the relationship between existing powers and the new powers that are included in the bill.

Section 12 provides, among other things, for regulations that deal with staff transfers when powers are delegated from one body to another. Those regulations are specific to the circumstances of the bill and to the joint working proposals. Regulation-making powers in the National Health Service (Scotland) Act 1978 already allow for regulation of some aspects of staff transfers in relation to the provision of community care services, but they are not considered appropriate to deal with the specific circumstances of joint working. Amendment 10 would ensure that there is no doubt about which power to regulate applies when we want to set out what arrangements for staff transfer should apply for joint working. The amendment makes it clear that the section 12 powers apply, rather than those in the 1978 act. Therefore, the amendment would not have a direct effect on the position of staff.

I recommend that amendment 20 be rejected and that amendments 8 and 10 be agreed to.

Margaret Jamieson: Did the minister examine other options before he came to the conclusion that Mary Scanlon's amendment 20 was unacceptable?

If we accept amendment 20, we will negate any democratic accountability, because no one involved would be directly elected by the people whom they serve. Wearing my other hat, as a member of the Audit Committee, I am concerned that we would be creating another organisation that would require another audit trail. Would we be getting best value? The minister might want to comment on that.

I am sure that Hugh Henry is expecting me to raise staffing issues, so I will ask about the input of the Peter Bates working group on integrated human resources, regarding those who provide community care. A difficulty exists when someone who is employed by the health service works alongside someone from a local authority. All sorts of hares have been set running in respect of what terms and conditions will be applied. When will the Peter Bates group report its findings? Might the minister be in a position today, or later, to indicate what sort of road that report will be going down?

Hugh Henry: I will take the second point first. I cannot say what the outcome of the integrated human resources working group's deliberations will be. The group should report by April, but it would be wrong of me to pre-empt its deliberations. I will meet the group and some other people who have a direct interest in the outcome of the group's work, and I would not want to pre-empt that. I will inform the committee as soon as I can of the conclusions that are reached.

Margaret Jamieson outlined clearly one of the options, which would be to set up yet another body. Other options, including that proposal, have been considered carefully. The proposals are an attempt to improve situations in which joint working is not working—as Mary Scanlon said. We want to address that problem and our amendments would place a requirement on both bodies to work together and allow some flexibility for us to determine from where that might best be managed; however, it would also allow us to intervene if we see that joint working is not effective.

In terms of the various options that are on the table, the provision to allow flexibility with the potential for Executive intervention is the best route to go down.

Mr McAllion: I accept the point that if the objective is to increase accountability and transparency, the presumption would be in favour of an elected body, rather than an appointed one. I accept the point about flexibility—the arrangements should vary in accordance with local circumstances. Can I clarify the Executive's position, which is that it does not believe that there should be a single body, however constituted, with a unified budget for which it is accountable?

Hugh Henry: At this stage, we see no reason to set up yet another body, given that there are bodies that are already well established. We believe that the NHS and local authorities have a contribution to make. They have individual areas of responsibility, but we think that they could work more effectively together. We see no advantage in setting up yet another bureaucratic structure.

I hope that the proposals in the bill will be major steps forward. Some of the experience elsewhere in the United Kingdom gives us cause to be confident.

Mr McAllion: I want to be clear on this point. Would the funding streams from the NHS and local authorities remain separate under joint working?

Hugh Henry: Yes. The funding streams and elements of accountability would still exist, but they would come together for specific issues. If we find that the budgets are not being brought together for joint working, we will take steps to

intervene.

I am pleased that the committee supported the Executive's approach to joint working in the stage 1 report. Amendments 8 and 10 support that approach by refining the bill to make its effect clearer. We do not think that amendment 20 would develop matters. I ask the committee to agree to amendments 8 and 10 and to reject amendment 20.

Mary Scanlon: I do not intend to withdraw amendment 20.

I am pleased that the minister has acknowledged that joint working is not working. The recommendation by the Health and Community Care Committee was a strong recommendation that has cross-party support. That recommendation was a response to many submissions that were made to the committee and to members' experience of visiting different parts of Scotland and seeing how so-called joint working was not working.

I have one problem. Paragraph 66 of the policy memorandum recommends that the single management structure and budget can be delivered in a crisis where outcomes are not being achieved. Why is it that amendment 20, which proposes a single budget and management structure, would be illegal? Why are there so many problems with amendment 20 when it simply echoes the recommendation in the policy memorandum, which can be implemented only in cases of failure? If my amendment is so wrong, what about paragraph 66 of the policy memorandum?

The Convener: I am afraid that that will have to be a rhetorical question because we are winding up on the amendment and the minister cannot make further comments at this stage.

Mary Scanlon: Perhaps I can ask the minister for a written answer on that point.

The Convener: We are winding up the debate in preparation for the vote.

Mary Scanlon: The minister has an army of civil servants and I am simply seeking clarification.

It is an important point and if such provision can be implemented where there is crisis and failure, why is it so unacceptable—legally and from other points of view—in amendment 20?

The Convener: I hope that the minister will be happy to answer that in writing.

Hugh Henry *indicated agreement*.

The Convener: The question is that amendment 20 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR

Elder, Dorothy-Grace (Glasgow) (SNP)
Robison, Shona (North-East Scotland) (SNP)
Scanlon, Mary (Highlands and Islands) (Con)

AGAINST

Butler, Bill (Glasgow Anniesland) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Jamieson, Margaret (Kilmarnock and Loudoun) (Lab)
McAllion, Mr John (Dundee East) (Lab)
Smith, Mrs Margaret (Edinburgh West) (LD)

The Convener: The result of the division is: For 3, Against 5, Abstentions 0.

Amendment 20 disagreed to.

Amendment 8 moved—[Hugh Henry]—and agreed to.

Section 12, as amended, agreed to.

Section 13 agreed to.

The Convener: That is far as we will take the bill today. I thank the minister for his participation this morning.

10:47

Meeting continued in private until 11:25.

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