HEALTH COMMITTEE

Tuesday 7 February 2006

Session 2

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HEALTH COMMITTEE
4th Meeting 2006, Session 2

CONVENER

*Roseanna Cunningham (Perth) (SNP)

DEPUTY CONVENER

*Janis Hughes (Glasgow Rutherglen) (Lab)

COMMITTEE MEMBERS

*Helen Eadie (Dunfermline East) (Lab)
*Kate Maclean (Dundee West) (Lab)
*Mr Duncan McNeil (Greenock and Inverclyde) (Lab)
*Mrs Nanette Milne (North East Scotland) (Con)
*Shona Robison (Dundee East) (SNP)
*Mike Rumbles (West Aberdeenshire and Kincardine) (LD)
*Dr Jean Turner (Strathkelvin and Bearsden) (Ind)

COMMITTEE SUBSTITUTES

Mr Kenneth Macintosh (Eastwood) (Lab)
Mr Stewart Maxwell (West of Scotland) (SNP)
Mary Scanlon (Highlands and Islands) (Con)

*attended

THE FOLLOWING GAVE EVIDENCE

Professor David Bell (University of Stirling)
Fiona Collie (Carers Scotland)
Alex Davidson (Association of Directors of Social Work)
Ewan Findlay (Scottish Care)
Paul Gray (Scottish Executive Health Department)
Kate Higgins (Capability Scotland)
Jim Jackson (Alzheimer Scotland)
Alan McKeown (Convention of Scottish Local Authorities)
Stephen Moore (Fife Council)
Dr Willie Primrose (British Geriatrics Society)
Andrew Sim (Age Concern Scotland)
Pat Wells (Royal College of General Practitioners Scotland)

CLERK TO THE COMMITTEE

Lynn Tullis
Simon Watkins

SENIOR ASSISTANT CLERK

Tracey White

ASSISTANT CLERK

David Simpson

LOCATION

Committee Room 1

Scottish Parliament

Health Committee

Tuesday 7 February 2006

[THE CONVENER *opened the meeting at 14:00*]

Item in Private

The Convener (Roseanna Cunningham): Good afternoon. I ask everybody to take their seats. No apologies have been received, so we move immediately to item 1 on our agenda, which is to ask the committee to agree to take in private agenda item 5. That will allow us to review today's evidence—which will assist the clerks in drafting a report—and to consider the need for follow-up action. Our discussion will not be for the purpose of taking decisions but to allow an immediate review of the evidence. Members are also asked to agree to take in private similar discussions following future evidence-taking sessions in our care inquiry.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): We have had discussions before about whether to take items in private, and the committee has tended to feel that we should. You have just confirmed that we will not be taking any decisions during today's private session. Will you confirm that no decisions will be made during future private sessions?

The Convener: That is confirmed. The purpose is to review the evidence, to comment on it, and to consider whether it gives rise to anything that we have to follow up on.

Do members agree to take in private item 5 on today's agenda and future items of the same nature?

Members *indicated agreement*.

Care Inquiry

14:02

The Convener: Item 2 on our agenda is our inquiry into free personal care for the elderly. Members of the committee have done three separate case studies: we will hear brief feedback on their visits. A written report on the case studies will be pulled together into a committee paper, which will be circulated.

The three reporters are Janis Hughes, Shona Robison and Helen Eadie. Janis has just arrived, so she may want some breathing space.

Janis Hughes (Glasgow Rutherglen) (Lab): I apologise for my late arrival, convener.

The Convener: That is okay. I will allow you some breathing space and ask Shona Robison to report back from the group that went to East Lothian.

Shona Robison (Dundee East) (SNP): An issue that came across strongly was the difficulty that East Lothian Council has in meeting the demand for free personal care. A gap exists between what is provided by the Executive and what is required because of increased demand for services. The council has developed an eligibility criterion so that some cases are given priority. We had a long discussion about what that means for people who receive services.

That difficulty is compounded by others. For example, East Lothian is a rural area that has poor transport links and availability of staff is also a problem. The council has real recruitment difficulties and we learned that homes have difficulty in recruiting and retaining staff. Those were the key issues—our written report has more details.

The Convener: Helen Eadie was going to report back from Greenock and Inverclyde but she is not here, so I ask Kate Maclean to do it.

Kate Maclean (Dundee West) (Lab): Some of the issues that arose were not directly relevant to our inquiry, but were similar to those that arose at our forum in Perth.

Concerns were expressed about the weekly residential care allowance of £18.80. Some people who had put relatives into care homes had signed away the right to that money without realising that they had done so. It was suggested that there should be a cooling-off period after forms are signed to ensure that people are aware of what they have done.

It was also suggested that there should be more unannounced visits by the Scottish Commission for the Regulation of Care—I think that has arisen

previously—and that volunteer visitors could make unannounced visits to residential homes. It was thought that such visitors would examine different things to those that the care commission's inspectors would look at.

Concern was also expressed about the difficulty of accessing the direct payments system and the lack of information about it. The low take-up of care assessments and people not knowing about their entitlement to them were raised, as was updating them. Obviously, people's needs change over time.

Because of the make-up of the groups that we met, we discussed in depth the role of carers organisations and support for carers, which are often left out of discussions. It was thought that on-going training for carers to address health and safety issues should be organised and that there should be more information for carers about the level of support that is available. All the carers groups that we spoke to thought that by the time they accessed information or support groups, it was too late. They felt that if they had had access to such information in previous years, their lives and the lives of the people for whom they cared would have been made much easier. Those were the main issues that arose.

Janis Hughes: The visit to Inverness and Aviemore with Duncan McNeil and Jean Turner was good. All the members who were involved in it represent urban constituencies, so we were struck by the issues that affect remote rural areas.

One of the main issues that was brought to our attention was that the options in such areas are different to those that people would expect in the areas that we represent. There was a fair bit of discussion about that to aid our understanding.

Perhaps one reason why uptake of direct payments in the Highland Council area is the third highest in Scotland is the area's rural nature. People often prefer direct payments to be arranged for their care rather than using other facilities when, for example, there is some distance to travel to access those facilities. As I said, we were struck by the differences in what happens in rural areas.

In general, the care commission's work is welcomed and care standards are well thought of, although people said that perhaps there is duplication in some areas of local authority and care commission work, and comments were made about a lack of consistency in some inspections, in that one inspector may think that something is a problem when another does not.

On general provision, we visited a day centre in Aviemore and were struck by the service that was provided and by the enthusiastic comments of the people who were cared for. They were complimentary about everything that we asked them about.

I thank the clerks for their comprehensive report.

The Convener: Thank you.

Agenda item 3 is a round-table evidence session on free personal care for the elderly. The round-table format means that people do not have to wait for members to ask questions and you can also question one another. A variety of interests is represented around the table, so if somebody says something that you wish to contest, let me know that you want to speak and you can ask your question directly of that person. It is not the case that everything must be mediated through the politicians. For round-table sessions, politicians are asked—if not completely to take a back seat—to facilitate the discussion rather than take it over. Please keep that in mind.

I will ask participants to state which bodies they represent. I regret that there will—given the number of people who are involved—be no opportunity for opening statements. The only person who will make a brief opening statement is David Bell from the University of Stirling. He, with his colleague Alison Bowes, undertook a study of the funding of long-term care in Scotland that would be a useful starting point.

Ewan Findlay (Scottish Care): I am from Scottish Care.

The Convener: We will miss out the MSPs; they are probably well known.

Stephen Moore (Fife Council): I am head of social work for Fife Council.

Dr Willie Primrose (British Geriatrics Society): I am from the Scottish branch of the British Geriatrics Society.

Kate Higgins (Capability Scotland): I am from Capability Scotland.

Paul Gray (Scottish Executive Health Department): I am from the Scottish Executive Health Department.

Pat Wells (Royal College of General Practitioners Scotland): I am from the patient partnership in practice group at the Royal College of General Practitioners Scotland.

Professor David Bell (University of Stirling): I am from the University of Stirling.

Jim Jackson (Alzheimer Scotland): I am from Alzheimer Scotland.

Alex Davidson (Association of Directors of Social Work): I am the head of adult services in South Lanarkshire and I represent the Association of Directors of Social Work.

Andrew Sim (Age Concern Scotland): I am from Age Concern Scotland.

Alan McKeown (Convention of Scottish Local Authorities): I am from the Convention of Scottish Local Authorities.

Fiona Collie (Carers Scotland): I am from Carers Scotland.

The Convener: Thank you. I want to ask David Bell to outline the findings of his recent study. Some of us might have seen it reported in the press, but it will be interesting to hear directly from Professor Bell.

Professor Bell: I will take five or six minutes to explain the research that was published last week—"Financial care models in Scotland and the UK"—which was commissioned by the Joseph Rowntree Foundation. The foundation is extremely interested in the funding of long-term care in the United Kingdom as a whole. Its reason for commissioning our work was to see whether the rest of the UK could learn something from Scotland.

Other parts of the research—and work in which we are involved—include the extension of free domiciliary care in Wales, on which there will be a ministerial statement on 15 February, and the Scottish Executive's evaluation of free personal care, in which we are also involved.

The objective of our study was to examine the Scottish experience of free personal care and to consider its wider applicability to the rest of the UK. I looked at the financial side and at the costing of free personal care and my colleague, Alison Bowes, from the university's department of applied social science, interviewed clients and social workers and collected evidence on the ground.

I would like to summarise the key findings under four headings: costs, carers, experience and outcomes. In relation to costs, there is still to some extent—this may come up in discussion—an issue about definition. What exactly do we mean by the costs of free personal care? The meaning of costs is fairly clear as far as care homes are concerned, but the meaning of costs for care in the community is not so clear. However, assuming that the costs are what they have been suggested to be, they amount to 0.2 per cent of Scotland's gross domestic product, or 0.6 per cent of the Scottish Executive's budget. I am often quoted as being critical of the size of the public sector in Scotland, but I do not consider those amounts to be huge in relation to the overall budget.

14:15

Scotland is often held up to be much more expensive than the rest of the United Kingdom when it comes to the provision of care. The findings from our report are that the differences in costs have been somewhat exaggerated and that nursing care is, on average, funded at higher levels in Ireland, Wales and England. The top rate for nursing care in England is about £128, whereas it is £65 in Scotland. That is a big difference. Attendance allowance is payable in England and Wales to those who receive nursing care, but it is not payable in Scotland once personal care is being provided in a care home. That narrows the gap in the costs across the border. The difference in costs has therefore been exaggerated somewhat.

The free personal care policy has been associated with, but is not entirely the cause of, a large switch in the provision of care and a shift towards care at home. The size of the budgets for what local authorities are providing to residential homes on the one hand, and of the budgets for care in the community on the other hand, have switched over during the past three years. In other words, much more is spent on care in the community now than was spent on it four years ago. The growth in spending on residential care has been much more modest. The switch to care in the community has cost implications. On average, the costs are lower for care in the community, although—I am sure that this will be discussed around the table today—there are cases in which the costs of provision at home are higher than residential or care-home costs, and there is an issue around how local authorities should deal with that.

On demographic change, we expect that if things do not change in relation to costs over the next 20 or 30 years, the cost of free personal care will approximately triple, rising from 0.2 per cent of gross domestic product to about 0.6 per cent of GDP. That is all I want to say about costs at the moment, although there are many other issues.

I turn briefly to carers. We found no evidence of a reduction in the amount of informal care that is being provided. I refer both to the evidence from large-scale surveys, which I have looked at, and to evidence from individual interviews that Alison Bowes conducted. It might be—this is on the agenda for future research—that informal carers are now doing different things, but there has not been a wholesale reduction in informal caring, which is something that lay at the back of the minority report to the Royal Commission on Long Term Care for the Elderly. We have no experience of such a reduction happening although, admittedly, we are in only the first two or three years of implementation of the policy.

As far as the experience of individuals is concerned—this has been Alison Bowes's work—clients view care in a holistic fashion, and find it difficult to understand the financial boundaries and

packaging that we use. There is still confusion and there is a belief among a significant proportion of the population that all aspects of care are free.

The average care home fee is about £427 a week. People who receive nursing care and personal care will receive £210 a week, which leaves them to find another £210-odd from their own resources. Clients are a bit confused about the fact that hotel and accommodation charges are payable. Clients emphasised the crucial role of informal carers—that was central to their wishes—and their desire to have as much choice as possible, but we did not observe a great deal of dissatisfaction with the provision. Our conclusion is that people who have chronic conditions such as dementia and people of modest means have perhaps gained most from the policy.

On outcomes, about 8,000 people in care homes are receiving free personal care and about 40,000 are receiving care at home. There has been a significant increase in overnight provision and weekend provision—up by about 30 per cent since 2001-02—of care in people's homes. That partly explains the shift in the balance of expenditure towards care in the community as opposed to care homes. That is a broad summary of the key findings. There are other findings, which will perhaps come out in the discussion.

The Convener: Thank you. Does what you say mean that the public criticisms that we have all heard and read about are not the tip of some vast iceberg that you have discovered out there? Is it fair to say that the public criticisms—the ones that we know about—do not mask an even greater problem?

Professor Bell: Yes. We did not discover skeletons in the cupboard.

The Convener: That is a useful platform from which to start. I shall open up the cross-questioning. I see that Mike Rumbles is twitching—I was rather hoping that the first question or comment would come from a witness. If no one wishes to put their hand up, I shall come back to you, Mike.

Alan McKeown: I would like clarification from David Bell. I presume that the threefold rise in the cost of free personal care is for a static level of service provision.

Professor Bell: That is right. The further out we go in time, the more uncertainty is associated with projections and the more weight we must give to assumptions about how the costs of care will evolve. We make the standard assumption, which has been made throughout the United Kingdom, that the real cost of care rises at 2 per cent a year. In addition, there is no change in healthy life expectancy among older people. That is crucial, but it is something that we do not know much about. Do people spend longer in poor health, although their lifetimes are expanding? The evidence on that is not clear. As far as provision is concerned, we are just replicating the past. We are not introducing new technology or smarter ways of dealing with older people.

The Convener: Do any of the other witnesses want to come in at this point?

Dr Primrose: Did your research look into the nature of the assessment of the individual, particularly with regard to health status and what could be done to improve or remedy problems? We have concerns that there might be people going through the system who are receiving care but who have not had opportunities for rehabilitation and reversal of health problems.

Professor Bell: The simple answer is that we have not looked at that, although it may come up in some of the Executive's research later on. At the moment, that is not something that we look directly into.

Stephen Moore: Did your research consider the management of risk for older people living in the community?

Professor Bell: No. We were asked by the Joseph Rowntree Foundation to provide clear evidence about how the policy had worked in Scotland in broad terms, but not in the kind of detail that the Executive evaluation may go into, and to see how far that could be transcribed to the rest of the UK.

The Convener: Are there any other questions of clarification for David Bell before we move to the wider discussion?

Ewan Findlay: I have a question about 2 per cent being the rise in the real cost of care. When you arrived at the figures, did you have a breakdown of the costs of salaries and food—of what is actually included in the cost of care?

Professor Bell: Yes. Some issues that we have touched on and discussed with the committee are not discussed much in the report. One of the key issues on which more work needs to be done is staffing and its costs. We heard earlier about the costs of staffing and the difficulties of staffing in rural areas, where the demography looks worse because people are aging and young people are leaving the community. There are hidden assumptions in the report; we are aware of them, but we have not spelled them out. We have looked at different projections, based on other scenarios, about the increasing costs, which go in the way that you would expect them to.

Ewan Findlay: Given that so much of the cost of care is down to staffing, and given that Government legislation will put the minimum wage up—it has often gone up by 7 per cent—the figure

of 2 per cent seems extremely low. Increased training is required as well. Those costs are going to rise more than inflation.

Professor Bell: The figure is 2 per cent above the rate of inflation—it is 2 per cent real that we are talking about. Today, that would be about 4.5 per cent in nominal terms.

Ewan Findlay: The increase is 2 per cent above the rate of inflation.

Professor Bell: Yes. This is an interesting point. We talk about a smart, successful Scotland, but the occupation that has grown most rapidly in the Scottish economy over the past four years has been care work. It is mainly carried out by female workers. Not only has the number of care workers grown dramatically, but the average number of hours of care that they provide has grown, although their average wage has hardly increased at all over that period. I did not put that in the report, but it was part of the work that I did in association with the Joseph Rowntree Foundation.

Kate Higgins: Another element of the free personal care package is the provision of free nursing care to people who are resident in care homes but who are under 65. Do you have any statistics on how many people under 65 are receiving free nursing care and how much that is costing the Executive?

Professor Bell: The direct answer to your question is that I do not have such statistics. However, the work that I am doing on Wales is looking at the costs of personal care for the under-65s in relation to the costs of personal care for the over-65s. I cannot say any more about that because there will be a ministerial statement in Wales on 15 February on that controversial matter. I will be happy to share that information with you after 15 February.

14:30

Mike Rumbles: This will show my ignorance, but you said that the highest rate that is currently payable for nursing care in England is £129. Obviously, there is a set figure of £65 a week in Scotland for everyone who qualifies. Does it vary in England by trust or health board area?

Professor Bell: There are three rates, of something like £129, £105 and £80. People are assessed on the level of nursing care that they might require. I have forgotten the distribution between the three levels, but that is how it works. That in itself creates controversy, because additional boundaries are being added. Therefore somebody can argue about the level of nursing care that they will need.

Mike Rumbles: That is just what we discovered in East Lothian with the criteria that were applied there.

It is a given that the £210 a week—£65 a week for nursing care and £145 for personal care—is fixed. It is fossilising at that level because it is not linked to inflation and the Executive has no intention of increasing it. I am therefore surprised that you say that the cost of free personal care could triple, when the actual amount of money available to individuals is not moving. Will you explain why you said that?

Professor Bell: We possibly made the wrong assumption that the Executive will eventually have to increase the payment. The cost is going up in line with the 2 per cent increase.

Mike Rumbles: Do you have any information that the Executive is thinking about that? It is news to me if it is.

Professor Bell: I have no information on that point.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): We all seem to get stuck on cost. Eight thousand people have a residential place at an average cost of £427 per place. The £210 allowance leaves a gap of about £200, which people have to pick up. How important is the benefits system in plugging that gap? How much medical benefit do those 8,000 people get? How much medical benefit do the 40,000 people in the community get? Is that money being used effectively to buy services?

Professor Bell: A general point is that the benefits system and what social work and the health service provide are not joined up.

In relation to care at home—care in the community—130,000 people in Scotland receive attendance allowance and 40,000 receive care from a social work department. There is quite a big gap between those numbers that the Department for Work and Pensions has not easily been able to explain. The criteria for attendance allowance look quite similar to issues relating to personal care. I am not saying that they are identical, but there is a broad similarity, so it is puzzling that there is such a big gap.

In relation to benefits in care homes, most local authorities are clearly trying to ensure that clients maximise their benefit income. People will not necessarily make up the whole of that £210, so the local authority will have to make some kind of contribution. It will make up a significant proportion of that total. Of course, other people will not be in the circumstances in which they can claim those benefits because, by and large, the other benefits that we are talking about are means tested. However, the old age pension is not means tested, and all the people that we are talking about will be eligible for that. The size of the gap will vary depending on the individual's circumstances.

Mr McNeil: Convener—

The Convener: Hold on. I have people on a list already. Shona Robison is next, then Alan McKeown.

Shona Robison: Can I—

The Convener: Will your question be directed to David Bell again?

Shona Robison: Yes.

The Convener: Can you hold on just a second?

Alan McKeown: I would like to add a point of clarification on the care fee level. In the coming year, it will be £470.

The Convener: Kate Higgins, are you indicating that you want to put a question to David Bell?

Kate Higgins: No, I want to clarify a point that David Bell made about attendance allowance—

The Convener: I am keen to remind people that this is not supposed a be a two-hour interrogation of David Bell, who will be here for the entire afternoon. He is here to take part in the discussion, which we hope will range just a little more widely.

We will take points from Shona Robison, Alan McKeown and Kate Higgins. I hope that we can widen the discussion.

Shona Robison: David Bell, have costings been done in relation to the attendance allowance that is being taken out of the care system in Scotland due to the decision to implement free personal care? What impact has that had? Has any assessment been made of that? If you cannot provide that information today, it would be helpful if you could provide it as a follow-up to the meeting.

In your opening statement, you said that the costs of providing care at home were higher than the costs of residential care. In East Lothian, we found that, where the costs of remaining at home reached the costs of residential care, the council automatically decided that residential care was the choice to make because it was felt that, at that stage, the person's needs would be so great that they could not remain at home. We had a bit of a debate about that and I would be interested to know if you came across that in your research.

Professor Bell: The care development group knew that the cost of those in care homes not receiving the attendance allowance would be about £21 million. The number of people in care homes has risen slightly and the value of the attendance allowance has increased, which means that we are now talking about a figure of about £25 million to £30 million, compared to the figure that we had in 2001.

In relation to care in the community, there is a slightly strange situation. If you go into a care home and are receiving personal care, you get a fixed amount that does not vary, but if you are receiving care in the community, the legislation says that you should not have to pay for the care that you are receiving. However, you can receive care at widely differing ends of a spectrum.

According to the Scottish Executive's figures, the average cost of care at home is £3,000 a year, compared to £7,000—£140 multiplied by 50—for personal care in a care home. People can receive personal care in their own homes relatively cheaply. However, you are talking about those at the top end of the spectrum, where the costs are competitive with the costs of residential care. We came across issues about what happens to those people, but we did not find a large enough sample to enable us to come to any conclusions. The situation arises because, in one setting, the amount for personal care is fixed and, in the other, it varies as the person's needs vary.

Alan McKeown: On a point of clarification, convener, I should point out that in 2006-07 the average care fee for a nursing home will increase quite significantly to £470—or a few pennies above that.

Kate Higgins: I am sure that Andrew Sim and Jim Jackson can talk more accurately about the link that David Bell made between the number of people claiming attendance allowance and the number receiving free personal care, but it appears to be similar to the relationship between disability living allowance and free personal care. It is a mistake to think that people receive attendance allowance or DLA to pay for care services; instead, they receive the money as an acknowledgement of their care needs. How they use it is up to them. There is no unwritten contract that requires the allowances that the Government pays over to be used to pay for a care service.

Over the piece, councils have seen the payment of such allowances as an opportunity to introduce charging policies, because it means that people have the funds to pay for services. However, the fact is that many people who receive attendance allowance have partners or spouses who provide a lot of unpaid care. As I have said, other people are better placed than I am to speak on this matter, but I am aware of many elderly couples and families with younger disabled adults who do not buy or claim entitlement to care services—and to personal care services, in particular—or use externally provided services because there is a dignity issue at stake and a strong feeling that the family should provide such care. We need to get away from the idea that the Government pays out these allowances on the understanding that they will be used to pay for care service provision.

Professor Bell: I agree with that. Attendance allowance is described as a contribution towards acknowledging a person's disability. I was just puzzled about why the gap between those two groups of people is so large.

I should also point out that we know very little about how informal carers—or the private care at home market—operate in Scotland and whether the people in question are really receiving the provision that best suits them. I certainly did not expect 130,000 people to come knocking on the door of social services—although, interestingly, the Welsh intended to use that criterion as the route into free domiciliary care.

The Convener: We need to broaden things out and move the focus away from David Bell's research, because he will be feeling a little bushwhacked by now.

Although we will discuss how free personal care has improved conditions, I wonder whether we can jump to the ways in which it has evidently not worked. I know that witnesses around the table will have a variety of views on the matter.

Jim Jackson: I would like to raise the issue of food preparation.

The Convener: We managed to get to 2.43pm before that was mentioned.

Jim Jackson: Page 35 of the care development group's "Fair Care for Older People" report clearly states that the definition of personal care should include

"Assistance with preparation of food."

Moreover, it was included in the definition of personal care set out in the Scottish Executive's guidance and in a letter from Jinny Hutchinson to local authority chief executives, directors of social work and so on. The fact that the issue is rumbling on is of great concern and, indeed, Alzheimer Scotland has found that there is immense variation in practice among individual local authorities.

I want to ask the local government and COSLA representatives around the table about the steps that are being taken to overcome the confusion over food preparation. I feel that the guidance is immensely clear on the point, but certain local authorities obviously do not feel the same.

The Convener: In asking Alan McKeown to respond to that question, I realise that he might find it difficult to do so. After all, in representing COSLA, he will represent a number of different interpretations of the guidance. Indeed, I am not sure how Fife Council stands on the matter.

14:45

Alan McKeown: Paul Gray might want to do a double act with me, because we are in discussion on the issue. Jim Jackson summarised a situation that is familiar to us all: there is a great deal of confusion about what is and is not involved in

"Assistance with preparation of food."

There is confusion about whether the assistance is for the preparation or the eating of food. I do not have the answer to that now, but we are in discussions with Paul Gray and his team to work out exactly what the intention is and what should and should not be included so that we can get clarity. We are working with our lawyers and the Executive lawyers to sort out the matter. The intention is to sort it out sooner rather than later. To make a bold statement about timing, we will try to sort out the issue as far as possible by the end of this month so that we can produce fresh guidance and bring clarity. The issue is causing confusion and a fair amount of distress in some quarters.

The Convener: From a political perspective, it seems that there is not much ambiguity about what the Scottish Executive has produced—the intention seems crystal clear to me. I am not entirely clear why there is an ambiguity. What is Fife Council's position?

Stephen Moore: We do not charge.

The Convener: So you think that there is no ambiguity.

Stephen Moore: We look forward to the clarity that COSLA and other colleagues will bring to the debate. The issue is bigger than individual councils. As Jim Jackson said, we want clarity throughout Scotland so that the ruling is applied fairly and equitably.

The Convener: Does anybody from any aspect of care provision want to argue that the published advice and guidance is ambiguous on that matter?

Alan McKeown: Is that apart from me? I am feeling rather lonely.

The Convener: You have to represent a variety of views.

Ewan Findlay: What is the ambiguity and can we help to sort it out?

Alan McKeown: The ambiguity arises from the definition in the legislation and from the fact that the letter to which Jim Jackson referred is not the original guidance, but a letter that was issued with secondary guidance, although the secondary guidance did not differ from the original guidance. At the beginning of the policy, every council charged for assistance with the preparation of food but, as a result of the letter, councils took a policy decision on that. Some councils decided that they would not charge and some have continued to charge. We are in a halfway house and we need to sort out the situation. We are not saying that we

do not want to resolve the matter; we are saying that we want to resolve it and we are in active discussions with our members and with the Scottish Executive on how we go about resolving it quickly.

The Convener: That still does not answer the question about what is ambiguous. Alex Davidson may want to comment.

Alex Davidson: South Lanarkshire Council does not charge either. The bottom line is that we try to meet people's needs. Whenever we are faced with such issues, we find practical ways to deal with them. The issue cuts across a number of policies; for example, the supporting people regulations are different, but they impact on the same area. There is a huge debate about how we package our provision to allow staff to prepare a meal and feed it to someone, if that is required. It is almost the health bath-social bath divide again. We need clarity throughout Scotland.

The Convener: I find it difficult to understand how the wording could be any less unambiguous. Without getting into the same argument, does anybody's view differ from mine? I do not want to misrepresent people's views, but the matter seems pretty unambiguous to me.

Alan McKeown: There is a difference between the preparation of food and assistance with eating food. If we aggregate the preparation, it becomes a volume of work that has cost implications. We have been told by members of the care development group that the preparation of food was never meant to be free, although assistance with eating food and with specialist diets was to be included in the policy. That is where the ambiguity lies.

Mike Rumbles: It is difficult to accept that interpretation. I have a copy of the leaflet from the Scottish Executive that goes to every individual in Scotland who makes an inquiry about free personal care for the elderly. Under the heading "Food and Diet", it states:

"Assistance with eating and assistance with special diets. Assistance to manage different types of meal services. Assistance with preparation of food."

It is as simple as that, although Alan McKeown seemed to suggest that there is some confusion. Actually, the only confusion seems to be in some councils doing something different from what the legislation says—what the legislators and the Executive wanted to happen—and what the information leaflet that goes to each individual says. I hope that you understand the annoyance or anger of individuals who receive this information from the Executive that says that the preparation of food is free when they find that certain councils are charging them illegally for it.

Alan McKeown: I accept that, and we know why that is happening. On page 9 of his report, "Financial care models in Scotland and the UK", David Bell cites the Regulation of Care (Scotland) Act 2001, which says

"but without prejudice to that generality, to eating and washing".

The 2001 act does not say "assistance with the preparation of food"; it says "eating". That is where the confusion lies. There is a difference between the 2001 definition and the definition in the Community Care and Health (Scotland) Act 2002.

Mike Rumbles: The definitions are the same. I do not have the legislation in front of me, but I have looked into this.

Alan McKeown: The definition in the 2001 act is not the same as the definition in the 2002 act.

Mike Rumbles: I beg to differ on that point. The Executive says that the definition is the same. When we passed the bill we knew what we were legislating for, and the Executive has produced a leaflet that tells every person who applies that the preparation of food is free; nevertheless, councils are charging people for it.

Alan McKeown: It is schedule 1 of the 2002 act that differs from the definition in the 2001 act.

Shona Robison: I would like to hear what the Executive's representative thinks.

The Convener: I was about to go there as well.

Shona Robison: I presume that the Executive has a view about any ambiguity.

Paul Gray: I should not have worn this pink shirt—it makes me too visible.

There are different approaches among local authorities, and it is not in anyone's interest that it should be so. As Alan McKeown has said, we are working with COSLA to bring out a clarification that will be understood and accepted by all and that is within both the terms and the spirit of the original legislation. The preparation of food lies beneath a heading that talks about a person's eating requirements. I suspect that it is not for me to comment on the fact that different local authorities have taken their own, different legal advice about the interpretation of the schedule. I believe that that leads us to where we are at the moment.

Our ambition is to get to a point where there will be no disparity of view between the Executive and the various local authorities that COSLA represents. That is what we are working towards. Alan McKeown is right to say that we are trying to achieve that by the end of February.

The Convener: I am bound to say that I am still none the wiser as to how the ambiguity arose in the first place, but I do not want to labour the point. Jim Jackson has raised it reasonably and we have

had a discussion about it. Our incomprehension of the apparent ambiguity is clear.

Are there other areas where we think that free personal care is not working well?

Mike Rumbles: I am sorry to go back to this, convener, but you talk about ambiguity and I have still not discovered the ambiguity. Alan McKeown read the quote from part 1 of the 2001 act. Professor Bell's report, which I have in front of me, is absolutely clear. On page 9, the report states:

"While nursing care was defined as interventions requiring a registered nurse,"—

that is fair enough—

"the definition of personal care used in the 2002 Act was derived from the Regulation of Care (Scotland) Act (2001)."

The same wording was used, and the wording was this:

"'personal care' means care which relates to the day to day physical tasks and needs of the person cared for (as for example, but without prejudice to that generality, to eating and washing) and to mental processes"—

not just physical processes, but even the mental processes—"related to those tasks".

The legislation is comprehensive and clear; the Parliament passed what we, the legislators, intended. The Executive understands what the legislators intended; I am at a loss to understand how individual councils—not COSLA, but individual councils—can interpret the legislation differently. I do not understand the different interpretation.

Alan McKeown: I do not want to prolong the discussion. The fact that we are discussing the issue and are not getting any further forward is because the ambiguity exists.

The Convener: Not necessarily. There is considerable doubt around the table that there is an ambiguity. We will have to move past that because we are not going to resolve it just now. I thank Jim Jackson for raising the point; it has been a clear area of concern for several months.

Are there other areas of specific concern?

Fiona Collie: Shona Robison mentioned the ceilings on care at home. There has definitely been anecdotal evidence that individuals are not being offered the package that they want; they are being offered a care home. That means that carers have to pick up the slack.

There also seems to be a tightening of eligibility for other services to support older people and individuals might not get a home help, domestic help or small aids and adaptations. All those things support individuals, and help them to maintain their independence and stay at home.

Those are a couple of areas that we have been concerned about.

The Convener: Are you saying that an element of compulsion is beginning to enter the system at the point at which the cost—

Fiona Collie: I do not think that it is necessarily compulsion, but it takes away an individual's clear choice to stay at home. I do not think that an older person should be put in the position of having to choose between their home or going to a care home.

The Convener: Okay. Does anyone else want to come in on that particular point? We are talking about the point at which the cost has risen to where local authorities begin to want to say that someone should be in a home.

Ewan Findlay: I am not sure what we can do about that. Looking to the future, can the Executive afford to keep everyone at home if they wish to stay there, regardless of their care needs?

Fiona Collie: That is probably a reasonable point; such care needs to be properly costed. There is also a cost to the physical and mental well-being of the individuals and carers who will have to pick up the slack. It will affect their opportunity to save a pension and to work. We are talking about making people unwell or leaving them in poverty in their old age because they have not been able to work. We have to see exactly what it would cost to enable people to stay at home.

Ewan Findlay: Do you see any way forward?

Fiona Collie: I do not know—I do not have a costing. We have to find evidence that it is not unaffordable.

Professor Bell: We do not know the full costs. We know the average costs, but we do not know how widely they will be distributed. It is important that we start to gather those data accurately. It is therefore important that local authority information systems are reasonably comparable so that we can do the costing that Fiona Collie is talking about.

Kate Higgins: I want to add to the points that were made. I agree with Fiona Collie that it would be a helpful debate to have, because society is going to have to face up to the issue. That is not just because more people are living longer. More disabled people are living longer and they have more complex support needs. People with learning disabilities such as Down's syndrome live much later into middle age and have increasingly complex support needs. Increasing numbers of pre-term babies are surviving not only birth and infancy but are reaching adolescence and adulthood. That is all part of the demographic time bomb.

Although the inquiry is about how free personal care is working for older people, an examination of

whether the policy will be successful in the long term—other groups who might qualify for free personal care are going to have to be considered—will have to take into account the demographic time bomb at both ends of the scale, as well as people's rights to stay at home. At the moment we are encouraging younger disabled adults to live independently in the community, in their own home, but how sustainable is that in the long term?

15:00

Dr Primrose: It is an equity issue. As was indicated, those with a learning disability, or younger disabled people, get care packages that can cost £20,000, £30,000, £40,000, £50,000 or £60,000 a year, whereas the cost of maintaining an elderly person in their own home probably does not approach a sixth of that. We give a lot of support to members of the population who have physical and mental frailties, but we are not willing to give the same level of support to a much larger, expanding population: the elderly.

Alex Davidson: I want to follow that up. Frankly, Willie's figures are far from the case. The cost of enabling an individual with a learning disability to live in his own tenancy as part of the hospital discharge programme would be around £70,000 a year. If any complexity is added to that, the cost will rise to £100,000. From work that I have done across Scotland with NHS Quality Improvement Scotland on the hospital discharge programme, I know that costs for people with autism and other severe needs are in the £250,000 bracket. There are affordability issues around that. The impact of such demands means that we must consider rationing and must make decisions about where the cut-offs for care might be.

I will share some figures with the committee to give members a sense of where the social care and home care market has moved in a colleague authority. In 1998, that authority provided services to 9,800 people. In July 2005, that figure had dropped to 8,900, which I suggest is because we are targeting what we are doing. From 1998 to 2005, the weekly hours involved have gone from 37,500 to 80,000, which is a huge increase. The average weekly hours were 3.7 in 1998, but they are now 8.98 per person. The non-core-hours figure for evenings and weekends is particularly interesting. It has gone from 8 per cent to 43 per cent, within a budget that has gone from £17.5 million in 1998 to a projected £44.1 million. That suggests to me that the pressures in and around our systems are from the non-core hours at evenings and weekends.

We are radically altering the pattern of care against a background of hospital closure programmes in which the number of continuing care beds is diminishing, which is putting real pressure on our systems. We must also meet demands in the community for other care groups, such as the disabled. In a sense, that is no surprise. For me, the holistic bit is to move the debate about free personal care for the elderly into a debate about the whole care system. We need to look at the interface with community equipment. We are still waiting for the Executive to respond to the adapting for care report—"Adapting to the future: Management of community equipment and adaptations"—which is now two or three years out of date. We need direction.

My council has made a huge spend of £9 million on equipment to get people home fast, along with the four weeks' free care that goes with it, whether that is needed or not, frankly. Many people refuse that because they do not need it. We have a difficulty reducing that number after the four-week period. The holistic bit is important and Professor Bell's paper rightly makes that point. The whole care market must be considered, including the recruitment and retention of staff, which is a huge issue, and not just in the poorer rural areas. In Edinburgh and, as I heard from Stephen Moore, in Fife, there are difficulties in recruiting social care staff because the employment market is so buoyant. It is the same in Grampian. The real challenge is how we provide a social care market in, for example, the Western Isles and Grampian.

We must hold on to that holistic bit. There are bigger issues than free personal care for the elderly. That and the supporting people programme certainly freed up the money, but they are only a part of the whole care market.

Stephen Moore: I want to pick up on the issue from a local authority perspective. We must manage risk, but we are sometimes in danger of concentrating on the financial aspects of managing only one policy. However, managing risk is the core of what we do in local authorities, along with our health service and voluntary sector colleagues. We must not forget that.

The elderly population is increasing. In my council area, the over-85 population will increase by 22 per cent in the next five years. In the same period, there will be a 16 per cent drop in the number of children of school age, so there will be a big variance in our population. The big challenges for families, particularly for those who are elderly themselves and perhaps also have great needs, will be in looking after elderly relatives in their 70s, 80s and 90s.

In my council, we are admitting elderly people to live, by their own choice, in an old people's home setting. The average age of admission is 84 and they live on average for a further three years in the home. Our figures for those receiving free personal care at home reflect what Professor

Bell's report shows. The figure has gone from 20,000 people in 2002 to 40,000 in 2004. We manage the risk and the support to people in their homes.

My area of Fife is no different to many others. In some parts of Fife we cannot recruit home helps—forget social workers. The care staff who work 24/7 make all the difference in caring for people safely in their own homes. Feeding, clothing, caring for and medicating people and ensuring that they get social contact are real challenges for us in a society where we are going to lose school-age and working-age population at the same time as the number of people who need care increases.

Figures from Capability Scotland show that in 1957, parents of boys born with Down's syndrome would have been told that their child's average life expectancy was 16 years. There are now people with Down's syndrome well into their 40s, 50s and 60s, living way beyond what our society expected even a generation ago. We need to care for them and recognise that there is a growing issue with the number of people with significant disability living much longer, beyond the time when their family can care for them. Long-term hospital closure will impact on that. We have to plan for that so that we can deal with it five, 10 or 15 years from now, rather than considering only the elderly population that we have today.

The Convener: Is it not wonderful that we have increased life expectancies across the board? I do not think that we should see that as a problem. It is a challenge, but it is not a problem, because it benefits us all.

I have a question for David Bell. You might not know the answer, so perhaps some of the council representatives might contribute. When we talk about free personal care for the elderly in particular, as well as other aspects of care—Kate Higgins reminded us that this is not just about care for the elderly—we tend to mean permanent, on-going care that people will have for the rest of their lives. Nevertheless, a significant part of the provision of free personal care is temporary; it might be locked into place for a period of time until the need for it disappears. That can happen even with quite elderly people. I certainly have experience of it in my constituency. Someone might break a collar bone and need help with washing, dressing and getting ready for bed until they heal. Has any attempt been made to quantify the proportion of the costings for that aspect of care, as opposed to permanent care?

Professor Bell: Last night, I was looking at figures from West Lothian on yet another project that we are doing on this issue and local authority records on individuals. The typical pattern is of a build up of services—people start with one service and carry on adding others. However, it is true that services are provided for a relatively short period of time in a significant number of cases. They then stop and no other services are provided for a long time before the need for them kicks in again.

The Convener: Can the council representatives back that up? Can you give any quantification—even off the top of your head—of how much is spent on that as a percentage of the total?

Alex Davidson: Our delayed discharge figures might give us an idea of what is happening. There is anecdotal evidence of the delayed discharge process pushing people home without appropriate support—I am scared to say, "too quickly", because that undermines the argument. I am thinking in particular of rehabilitation and the provision of physiotherapists for people who have had a stroke. With all the lifelong limiting illnesses, the earlier the intervention the better the chance of a full recovery.

I am not wholly convinced that we have got that right yet. We have seen a struggle to provide the services that will prevent people from going into hospital. We all know that if someone spends a week in a hospital bed it takes them six months to recover. We have to consider getting people home or preventing them from even entering hospital. The Kerr report assists in that regard. We need social care money to assist us in that. Health provision is also a factor; allied health professionals need to be involved to make sense of what is happening.

The Convener: Does Fife Council have a figure for what is spent on short-term intermittent care as opposed to permanent care?

Stephen Moore: I do not have that figure. Weekend and overnight support has increased by 30 per cent in two years. The average age of a patient is 84. We have to prioritise our resources to sustain people.

Dusting, ironing and cleaning are now a minority of the tasks that our staff do; for the most part, they perform personal care tasks. I will reopen the controversy by saying that such care is about helping people to eat wisely, well and regularly and about helping to ensure that they are medicated and toileted and that they are safe getting in and out of bed. Supporting people at home is an increasing part of care tasks. Without that support, people would be in residential care; they could not be sustained in the community.

The Convener: There still appears to be no quantification of how much of that provision is short-term as opposed to long-term, permanent care. We always talk about such care as if it is long term and permanent, but that is not always the case.

Stephen Moore: You are quite right. Well over 90 per cent of older people—I do not know the

exact figure, so I do not want to venture the wrong one—live, and will continue to live, and die in their own homes. They do not need residential care. The support tasks that we provide maintain them safely in their own homes and communities.

The Convener: The support might not always be permanent; it might be intermittent.

Stephen Moore: Increasingly, a fixed amount of care is needed; without it, the person could not be sustained at home.

Professor Bell: I might be able to get some figures to the committee, once we have done the project in West Lothian.

The Convener: That would be very useful.

Alex Davidson: Perhaps the material that arises from the single shared assessment as it beds in properly and as more electronic systems are developed might be able to capture some of the necessary information. Our system talks to the health service; it counts people's needs and compares and contrasts timescales and so on. Accurate evidence might come from the single shared assessment in the near future.

Dr Primrose: Short-term support is essential to maintain in the community those people who do not need to go to hospital; it is also useful for accelerating discharge from hospital. However, we have to have an accurate health assessment that underpins what is going on. That is what concerns me. Often, when someone in the community begins to fail, we put them in care but we do not get to the bottom of the diagnostic problem that has caused the person to start failing. We need to improve on that. I do not have much confidence in how the single shared assessment is running and how the health service input contributes to it. It is not doing very well.

The general practitioner contract does not have many points in it that allow for involvement in that area of care. We need to look at the GP contract and how it will target frail older people and improve the quality of what is being done for them. We also need to look at outreach services from specialist services for the elderly and try to involve people who know about the psychiatry of old age so that we can raise the standard of the short-term problem—although we still have not talked about the long-term problem.

Later, I would like to spend a few minutes on the assessment of need for those who move into care homes. That move is hugely important and it could be done better.

The Convener: Shona Robison wants to raise a new subject, which might be perceived as a criticism of how the existing system works.

Shona Robison: If someone has been assessed as requiring a residential or nursing home place and is therefore entitled to free personal or nursing care, is it within the legislation for a council to say, "We recognise that need—that is the assessment and that is what the person requires—but our funding is insufficient to meet demand and therefore we will operate a waiting list?" Does Fife Council do that?

Stephen Moore: We have to operate a waiting list, because we have to ensure that those who are in greatest need get the service first. We are talking about extremely vulnerable children, adults or older people. Fife Council funds 40 admissions into residential care per month: 25 are from hospital and 15 are from the community. There is a great deal of talk—although not as yet in today's discussion—about the pressure of delayed discharge, but we should bear in mind the fact that hospital is only part of the care of older people, albeit a hugely important part. Admission and discharge arrangements are crucial to giving people quality of life in their own home and community in the long term.

Fife Council manages risk in the home and in the hospital. We do not have a particular problem with waiting lists, as we have a very big private sector. We provide 200 beds of our own in 11 local authority old people's homes, and we purchase 1,800 beds every day of the week in the private and voluntary sector. Doing that is a challenge, particularly as the elderly population increases and risk increases alongside it.

15:15

Shona Robison: The existence of waiting lists is not about the lack of a bed; it is about the lack of council funding. You mentioned delayed discharge; my understanding was that money was available to help to move people out of hospital beds, but I have two live cases about that subject. One is in the community awaiting admission and the other is in a hospital bed at Ninewells. That surely means that that person is in an inappropriate bed but cannot move because the council does not have the funding. Is the money in the wrong place? Is that the problem?

Stephen Moore: The Executive awarded each local authority additional moneys to facilitate the patient's medical journey into hospital and back out again to ensure that we avoided bed blockages. I referred to our 40 admissions—25 from hospitals and 15 from the community—to make the point that local authorities have to manage risk in the hospital environment as well as in the community.

I do not want to comment on any other councils, but Fife Council has just about sufficient money to deal with today's and last year's admission rates, but the pressure is growing dramatically, as is

demonstrated by the figures that I cited earlier—an average admission age of 84 and a 22 per cent increase in the over-85 population. That is a big challenge throughout Scotland. We certainly face it in Fife and we have to take the money from somewhere else. We have one budget for social work and we have to make decisions about whether money goes on older people, child protection or drugs and alcohol services. That is the choice that we face.

Shona Robison: There seems to be a growing mismatch between the number of people who have been assessed as requiring a certain level of care and the money that councils say that they have in their budgets to meet that demand. The worry is that waiting lists will grow because of that. Will the Scottish Executive address that?

Paul Gray: That is genuinely a difficult question to answer. I will try not to dodge it, but forgive me if I do not comment on the individual decisions that councils have made about the allocation of their money. The legislation does not contain the concept of a waiting list, but there is a general concept of councils having to prioritise the services that they provide. I hope that the work that we are doing on costings, to which David Bell and others are contributing helpfully, will give us a better insight into those issues. We are certainly anxious that the provision of free personal care should be in line with the legislation and according to assessed need.

Shona Robison: Are you aware of the waiting list numbers for each council at the moment?

Paul Gray: Not personally, but if the committee is asking me a question, I will do my best to answer it.

The Convener: I remind committee members that we will have the minister before us to answer those questions, some of which might be more properly directed at him.

Mike Rumbles: I raised waiting lists at First Minister's question time a long time ago. According to the First Minister, the waiting time is the assessment time. He made it clear in his response that, once an individual has been assessed as being in need of free personal care, they are entitled to receive it. That is the law, so it is basically a legal entitlement. I am therefore surprised to find that waiting lists seem to be appearing in certain council areas and that councils allocate the amount of money that they have based on the list. That is surely not correct and therefore we need to know which councils are operating such a policy.

The Convener: Jean Turner has indicated that she wants to speak; is it on a different issue?

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): It is interrelated. It is to do with—

The Convener: I am not inviting you to speak at the moment. I am just asking whether it is on the same topic or on something slightly different.

Dr Turner: It is to do with the workforce, quality of care and discharges.

The Convener: It is on something slightly different, so we will explore waiting lists a bit more before we move off the subject.

Dr Primrose: I will follow on from Mike Rumbles. There are issues of capacity in some areas, where, no matter how much we would like to put somebody in a nursing home, there are no places available. In other places, there is access for people who are self-funding but no access for those who require the full level of support from the council. There can therefore be two queues, in a sense, if there is capacity. In other situations, there might be no places in care homes within a radius of 50 miles. That contributes to delayed discharge, and it will not be an easy problem to sort out.

Alan McKeown: There are capacity issues in some parts of Scotland. In other areas, however, there are no capacity issues. Working with the improvement service, we are considering how to close that strategic planning gap, to develop the long-term, high-quality provision of care homes in Scotland and to establish what that model might look like. The answers might be different in different areas.

As I understand it, Mike Rumbles is right to say that once people have been assessed they are legally entitled to receive a service. However, I think that that applies only in cases in which the resources are available to provide the service. Stephen Moore referred to the funding of 40 admissions per month to residential care. The basis is one in, one out: someone has to leave the system, either by no longer requiring the care or by dying, for someone else to enter it. The number of those who receive free personal care should be static. If the number is increasing, that is probably because councils are spending over and above their budget

Ewan Findlay: That is not happening. In Dundee, there is an overspend and referrals have dwindled almost to a stop. I have been told that the current waiting list is at least 30. There is now capacity in Dundee where there was not capacity before. Everyone to whom I have spoken about it, including members of Scottish Care, has welcomed free personal care. They think that it is a fantastic idea. It has gone down very well. The only time that the policy does not work is when it stops flowing.

We need a 12-month spread of the money that is available. If councils approach the end of their budgets with no money left to place people, the

policy on free personal care is not working. The councils have spent all the money. The situation in Dundee is crazy; there are people who need our care and we can provide it, but because the council has run out of money, people are not getting the care that they need. The Council has to manage a £2 million budget overspend and they do so at the cost of the elderly people concerned.

Mike Rumbles: I will follow on from what Ewan Findlay said and direct the question back to Alan McKeown. When a council tells an individual that they have been assessed as being in need of free personal care, which is their legal entitlement, that is one kettle of fish; it is quite a different kettle of fish for the council to tell them that it has no capacity at the moment to fund that care, although it is working to ensure that that capacity is made available. The scenario that Ewan Findlay has just painted—of a council saying that it has run out of money and that it cannot provide the service—is different. There are two different scenarios, one of which is more understandable than the other. Surely it cannot be a defence in law for the council to tell someone, "We're sorry but we can't provide you with your legal entitlement because we've run out of money." That is not a defence, is it?

Alan McKeown: A range of pressures act on authorities at any one time. Willie Primrose highlighted the fact that, because of the specific care market in some areas—including Edinburgh—and given the high number of older homes and smaller homes that are situated in tenement buildings, often with older home owners, increasingly people are considering property prices and their levels of equity and deciding that it is better for them to get out of the market. That leaves Edinburgh with a shortage of care beds. The City of Edinburgh Council has to work hard to source beds outwith its boundary. There has to be a reprovisioning of the type of home that is available in Edinburgh. The council has to source homes, which takes time.

We know that some of our members are net importers of elderly people, because people retire in certain areas. Unless there is an exodus of people who are already being funded, that means that there is a backlog. The council would love to pick up all the services—councils do not want to say no to people—but with the best will in the world, the budgetary reality is that that cannot be done unless an active decision is taken to cut budgets for other priorities. That is the financial reality that councils are faced with.

Mike Rumbles: Are you saying that if councils have capacity, those individuals who come into the area and are assessed as needing care are entitled to it and that the council is legally obliged to provide it? If the council can provide the care but chooses not to do so because it has other financial commitments, surely the answer is to go back to the Scottish Executive and to say, "The amount of money that you have allocated us for free personal care for the elderly is not sufficient and you should therefore allocate us the correct amount of money." Looking at the situation from the individual's point of view, it strikes me that a council that says to an individual, "Yes, we have the capacity here but we choose not to fund you because we are underfunded ourselves" is not in a legally sound position. That is basically the scenario that you are setting out.

Alan McKeown: I cannot comment on the legality of it because I am not a lawyer, but if the council is using its full allocation of resource and its needs are greater than that, the guidance allows it to say to an individual, "You've been assessed as needing care but we don't have the resource to provide it." I think I might be right in saying that—I am looking at Alex Davidson for support here.

On your point about whether we should go back to the Scottish Executive and ask for more money, we have done that and we received a bang on the ear.

Kate Higgins: I do not wish to get into the funding issues because we, as a voluntary sector provider, have our own steer on what happens to money and the level of fees that are paid—that is a bunfight that continues in other forums. However, it is important to see assessment as not just a care home issue. Assessment and the identification of need and support levels also happens to people who are waiting at home to receive care services. What I have heard being played out round the table fills me with horror. It raises issues about what is going on elsewhere in the care system. As Alex Davidson pointed out, we need to start joining up our thinking on how we respond throughout our care services. The same issues arise all the time in relation to equipment and aids and adaptations, in that assessments take one level of time then identifying the funding takes another. That was one of the issues behind the demise of the record of needs system. Assessments were being done and then there seemed to be no money to provide the support that was needed. Assessments started taking longer; waiting lists suddenly started appearing and people began eking out the assessment process to make the problem of the waiting lists go away.

The last thing that we would want for the policy of free personal care would be for the same issues and the same ways of dealing with the challenges to start happening, because we would reach the stage at which we would have to rip up the policy and start again. That would be a shame, because there is still a lot of mileage in it.

Once we start scratching the surface, we find that the issue is in the processes that are taking place. Fiona Collie made the point in the Carers Scotland submission that there are lots of powers in the Community Care and Health (Scotland) Act 2002 that the Scottish Executive has not found an appropriate time to start utilising. One of those powers is the legal duty on local authorities and health authorities to start joint working, processing and budgeting, in practice as well as on paper. If we scratched the surface of what is going on in local authorities, we would find that there are far too many people with a stake in the process and that there are blockages along the way between different departments and between health authorities and local authorities.

Kate Maclean: I think that Ewan Findlay said that 30 people in Dundee who had been assessed as needing residential or nursing care are on a waiting list because the funding is not available for them to access those places. Since Dundee has been specifically mentioned, I wondered whether, before we question the minister, we could ask Dundee City Council what the position is; it would be useful to have that understanding. My understanding is that, although there are people who are waiting for funding, there are also people who are waiting for a specific facility—they could be given a place somewhere else, but they are waiting for a specific care home. That might be adding to the waiting list.

We should ask COSLA how many people who have been fully assessed in each of the council areas are on a waiting list and, of those people, how many are on the list because they are waiting for a specific facility and how many are on the list because the funding is not available. It would be useful to have that information when we question the minister.

15:30

The Convener: I will bring in Ewan Findlay, and then Jean Turner, who wants to raise a different issue.

Ewan Findlay: Alan McKeown mentioned the Edinburgh problem, whereby people are selling homes because of the high price of residential properties. I want to dispel that myth. Many nursing home owners in Edinburgh have sold older properties that have gone back into the residential sector because they do not meet the new care standards. The writing has always been on the wall with regard to the old Victorian and Georgian buildings. They will not last into the future as care homes because they cannot hold enough people and will not be able to compete with new builds. It is a myth to say that a lot of people came out of the care home sector because the properties were worth more as residential properties than they were as nursing homes.

There are technical reasons for the situation. The bricks-and-mortar value will always be there. If a business is attached to a bricks-and-mortar value, the value is enhanced. That bricks-and-mortar value will never go away. It would be wrong to let the myth go into the ether and have people believe that that is why Edinburgh is lacking in nursing home beds. Most of the problem comes from underfunding. The figures with regard to building and opening a care home never made any sense, because nursing homes and care homes have been starved of funds for years.

The Convener: I thought that you were making a different point, Alan.

Alan McKeown: Scotland is a growth market for care homes, with £43 million of additional investment in the area this year. That figure is quite stark. Corporate providers are saying to us that Scotland is the most attractive place to do business in the United Kingdom; some of them are looking to switch their attention from the European market to the Scottish market because of the significant investment that has been put into the area.

Ewan Findlay: Yes, but that significant investment has been made only recently. I agree that the corporate providers are moving into Scotland.

The Convener: We should bring our discussion of that subject to an end. Before Jean Turner raises a different issue, I should say that, while we are all airing grievances, it would be useful if we could get some specific ideas about the improvements that could be made to the system to make it work better.

Dr Turner: David Bell mentioned that the numbers of care workers are growing but that their wages are not. Who provides the care for people? Obviously, people provide that care. If there is no incentive for people to work in an area, there might be a high turnover of staff, which will mean that an old person does not see the same person each time.

Quality of care needs to be measured not only by the care commission, but by the councils. When they set up their discharge polices and processes, to what extent are they checked? I get the impression that not a lot of research is done in that regard. Willie Primrose mentioned the fact that, when people go into a care home, their state of health seems to stay the same or to deteriorate. It is the same in the home. I wonder what research is being done in that area. We are where we are because of the great need to put people out of a hospital bed and into the community. On the whole, that is cheaper, apart from when those people need more and more care. It has emerged in the evidence that, when that happens, things

can get so costly that councils want to push people back in to hospital.

Kate Maclean talked about people with special needs and people living longer; we might need to reinvent the institutions that we have closed, because those people's parents will not be there to look after them.

What knowledge is there of the processes that have been set up? How good are they? Some good discharge systems are in place, but sometimes we are so keen to get people out of hospital beds that they fall outside those systems. Sometimes, when people go home, they have umpteen people coming to their house, they are confused and the situation deteriorates.

The Convener: Perhaps the people who are here from local authorities can help with that, but I noticed that you were looking at David Bell. Does he have any comments to make on that point?

Professor Bell: Not a lot, but I will mention two figures. The average weekly cost of a geriatric bed in Scotland is £1,100 and the average weekly care home fee is £420, so a geriatric bed costs more than twice as much as a place in a care home. I think that those figures are from last year; as Alan McKeown said, care home fees have increased since then.

Stephen Moore: We face a number of challenges. In many ways, they are wonderful challenges because one of the greatest privileges that any of us can have is to be given the responsibility to care for someone and to be entrusted to deliver that care. That means that we must maximise choice for individual recipients.

The average admission age of 84 years, which I mentioned, is significant. It came as a surprise to Fife Council and my staff when we realised how good we are at sustaining people, by their choice, in the community. However, we cannot do that without effective GP services. We must be clear that the journey of care into hospital often occurs at a point of crisis. What happens if we do not manage the crisis? The person will remain in hospital or will be unable to return to their home unless we put in place a lot of other services. Often, the patient's confidence has dropped, the family members' confidence has dropped and the community is raising all sorts of issues. We need to manage the journey into and out of hospital carefully and with sensitivity. Many old people will be able to return to their own homes. The figures in David Bell's research show that clearly and the increase in the number of people who receive free personal care—from 20,000 to 40,000 within two years—is an indication of that.

We have a different challenge in relation to people with special needs or learning disabilities. It is right to close our long-term hospitals. Those individuals have a right to the same quality of care and quality of life that all of us have, but there is a challenge for our society and for all of us in Scotland. How do we care and sustain that support—and enjoy that support—with people with disabilities in our communities? They have something that can enrich all our lives. We are failing them if we say that all we have is a five-year window and a 10-year window. The last long-term hospital closes in Scotland this year. We must begin to prepare ourselves with good-quality staff who are well trained and able to deliver the quality of care that we need to offer in the future.

A further challenge lies in the fact that the drop in the school-age population will lead to a drop in the working population. For example, in north-east Fife we cannot attract home help staff. We have 70 vacancies at any one time and we bus in staff from other parts of Fife. The continuity and consistency of care has gone. Carers and the recipients of care are confused about who is coming into their homes. That is not good enough. That is a challenge that Fife Council and all rural councils face and they will continue to face it unless carers' wage structures and career prospects change. Carers are often women, they are often low paid and they are often in part-time work. We must recognise that we have a responsibility to them. The new training agenda and registration of the workforce will enhance the quality of staff, but we will face a challenge five or 10 years down the line and we need to start planning for it now.

Alan McKeown: Stephen Moore encapsulates the complexity of the problems that local authorities face. The problem is not that we are not striving to deliver services or that we do not want to do that. The problem is that we operate in a complex world, some aspects of which are outwith our control. We do not have the flexible models of care that we require. We need to create a world in which we can help to develop those models of care, but that will require some capital assistance. With the best will in the world, local authorities will not develop those models; that work is likely to be done by housing associations or by our partners in the independent sector. We are in discussions with the independent sector about how we can encourage the debate, but we know that some seedcorn funding might be required. We must be concerned about future needs as well as meeting current needs. There is a host of problems. It is tempting to seek rapid answers, but sometimes those answers cannot be found and there will be a lead-in time of three to five years.

Helen Eadie (Dunfermline East) (Lab): I want to ask about innovative ways of caring, or those that represent best practice. The question is for David Bell, although others may want to respond,

too. Are new models around that have not received the exposure that they ought to have received?

Secondly, you said that you do not have much data on the private care sector. I am concerned about that, because I am conscious that the quality of care standards in the private sector may not be what we would want them to be. That issue has appeared on my radar screen in my work as a constituency member. What is being done to improve matters? There is anecdotal evidence that would concern us all.

Professor Bell: I will be brief. I have experience of what has happened in West Lothian, where we are considering the new, innovative form of care—I always forget what it is called; it is care with something else. A technology package is involved. People come from all over the world to see it and we are currently evaluating it.

Helen Eadie: Perhaps we could go there to see what is happening, as we are just down the road.

Professor Bell: Yes. We know little about the private home care sector because many private arrangements are involved. People decide to buy in their home help from somebody whom they know. Our knowledge of how that sector works and its importance, not only in Scotland, but throughout the United Kingdom, is virtually zero. Work needs to be done on it.

The Convener: It would be useful to have more information about the West Lothian model.

Mr McNeil: Can we throw direct payments into the mix at this point? I do not know how much time we have.

The Convener: Quite a few folk want to speak.

Mr McNeil: I want to ask about flexible responses. We received strong evidence in Inverness and—

The Convener: Do not jump the queue, Duncan.

Mr McNeil: I thought that discussing direct payments would be relevant at this point.

The Convener: A couple of people are waiting to come in on the subject that we are discussing.

I ask people to think about improvements that could be made. There is only around half an hour left for the discussion and we must try to get through as much as possible.

Alex Davidson: Members might want to consider work that is being undertaken in the Executive on workforce issues, on which there are important papers.

Secondly, I want to mention better drivers. The hospital closure programme for people with learning disabilities is a good example of how to join up working around set targets and achieve things. The programme has dramatically improved the quality of life for people who were resident in hospitals and has developed a range of new models of how care can be provided and houses can be commissioned through housing activity, which Kate Maclean mentioned. We must consider the whole cluster, be holistic and ask questions such as, "What do we need to make Kirklands hospital in Bothwell close by the year 2005?" The number of houses and staff need to be added up, training must be done, and there must be good assessment. Such drivers and such thinking about what we are trying to achieve will bring us a helpful direction of travel.

There are other models. Duncan McNeil touched on direct payments, which I hope that we will come to in a minute. A number of us have considered such matters on working groups for the Executive.

Pat Wells: I support what Stephen Moore said about taking a holistic approach and trying to get a better deal for carers. There are tremendous shortages of carers and there is very low staff morale in some areas. Some carers simply say that they can earn more in Tesco with much less responsibility. We will reach a crisis point if we do not address the problem quickly. There is a serious problem with continuity of care in some areas and standards leave a lot to be desired, as has been said.

The Convener: I invite Nanette Milne and then Duncan McNeil to ask questions.

Mrs Nanette Milne (North East Scotland) (Con): I want to ask about a different issue, convener. I want to say something about the regulation of care. I do not know whether you want—

15:45

The Convener: On my list, I have Willie Primrose, Jim Jackson and Duncan McNeil. I see that they have something to say that follows on from this specific area.

Dr Primrose: My point follows on from Jean Turner's and is about what evidence there is that we can do things better. A study has been completed recently, the findings of which I want to highlight because they are relevant. In a randomised trial of older people moving into care homes, some were assessed by a geriatrician and some were not. Those who were assessed by a geriatrician spent fewer days in a nursing home, had fewer attendances at casualty, experienced less decline in physical function and caused less carer distress in the following six months. Those are a lot of pluses from doing the job of assessment properly.

The Convener: I remind everybody that there will be a separate session on the regulation of care. Although it is difficult to separate issues out precisely, we must remember that some aspects of this will be explored in more detail.

Jim Jackson: I will quickly run through a list of some interesting developments.

Technology has been mentioned, and a number of local authorities are pioneering its use across Scotland. That has some merit and should be pursued.

Secondly, there is supported housing. Supporting people money is being used on some quite creative ideas that are models of supported housing between a care home and people's own homes.

Flexible care is at the heart of a lot of the delayed discharge schemes and rapid-response teams. I am talking about the principle of breaking out of simple models in which people assume that care will be provided by either the home help or the district nurse—holistic is the word that has been used today—and breaking down professional boundaries so that the care goes in a flexible way to the person.

We need to keep an eye on better design of care homes. There will be a need for care homes in the long term, and some of the new ones, because of financial considerations, risk being warehouses for older people. It is possible to design creatively care homes that have sub-units on a domestic scale. There must be a lot of encouragement to keep that work going.

One report that you might want to look at is "Better Outcomes for Older People", which the Scottish Executive and COSLA produced last year under the joint futures heading. That contains a large number of interesting examples of better services for older people and the leadership that we need to encourage. Having seen the report and contributed to it, I have not heard anything since its publication—it seems to have died a death, yet it contains a lot of examples of good practice.

My final point is on leadership. Leadership in free personal care is to stop making it a tug of war or piggy in the middle between COSLA and the Executive. I have brought my press cuttings, and in one of them someone from a local council is saying, "We're not talking about a few swimming lessons; we're talking free personal care." It is very upsetting for older people who think that it is an excellent policy and who have benefited from it to see it as part of a battleground between COSLA and the Scottish Executive. There needs to be a robust debate—I am sure that one is taking place—between the two, but it needs to take place behind closed doors. To resolve matters, we need to try to work towards a consensus on the real costs of long-term care for older people. It is not only about free personal care. There needs to be a consensus so that the public arguments can be dispelled and our energies can be put into developing the better services and training programmes that we all know are needed, given the growing number of older people in the next few years.

Mrs Milne: My point is about the regulation of care.

The Convener: Bear in mind the fact that we will have a separate session on the regulation of care.

Mrs Milne: Yes, sure. It is just that in Perth and in East Lothian people raised with us the duplication that sometimes happens in the work of the care commission and some local authorities that are setting their own standards. That impacts on the owners of care homes—especially the smaller care homes—who are a bit confused and bogged down with paperwork. I wonder whether COSLA or the local authorities could comment on that.

The Convener: I do not want to get into that in depth today. We still have issues directly to do with personal care to discuss. We will have a bigger session in which we can explore the issues that you raise.

We move on to direct payments.

Mr McNeil: We picked up evidence previously, including in Inverness, that the direct payments system has been a positive and empowering experience for some people and that it has dealt with some of the continuity of care issues that Jean Turner raised. The reality is that in some old-age pensioners' homes, people are looked after by five different people in one day. I am not saying that that happens seven days a week, but it happens. When people get used to a home help or a carer, they are spun round when a home help organiser comes up with a new plan to cover their area. If someone who a person trusts and has got used to is suddenly taken away, that can cause great distress. That happens every week in Scotland.

Direct payments are not yet readily available to people who do not have the confidence to get through the barriers. Although the scheme exists as a tool that can and will be used, quality and continuity issues are not being addressed. There seems to be a growth in uptake of the scheme among people who are articulate enough to get into it.

What are the barriers? Why does the Highland region have the highest number of direct payments? What are the figures throughout

Scotland? Why are some councils encouraging the scheme and raising awareness of it while others do not make the option widely available to the people who currently complain about the services that they receive in the community?

The Convener: I remind the committee that we have commissioned separate research on direct payments that will cover the obstacles to uptake of the scheme.

Janis Hughes wants to ask about direct payments, and will be followed by Mike Rumbles. Does Pat Wells want to say something?

Pat Wells: I live in the Highland region and one of the reasons why Highland is successful comes down to personalities to some extent. The person who deals with direct payments in Highland is very effective and efficient and works very hard to promote the scheme as well as to explain the difficulties—there are endless difficulties with it. As has been said, people do not have the confidence or ability to deal with the budgets, but if that problem is overcome, I agree that direct payments will make a huge improvement.

Janis Hughes: I agree with Duncan McNeil's points. As Pat Wells said, we understood from our discussion with Highland Council that one of the reasons why it had the third highest figures for uptake of the scheme in Scotland was partly to do with rurality. If a care home is many miles away, it is much more attractive to take the direct payments option. It may also be because more members of the extended family live in such communities than is perhaps the case in more urban areas.

I will be interested to hear any comments on Duncan McNeil's point that the scheme is being accessed only by certain people and that others are less attracted to applying. We heard from some people about the bureaucracy involved and about how the length of time required to fill in the forms is off-putting.

Jim Jackson spoke earlier about flexible care and holistic care, which are important considerations. We were told that one of the obstacles put in people's way was that they had to provide care plans a year in advance. If so, people will find it difficult to do that. We talk about flexible care, but we do not always know a year in advance exactly what the care needs of the person being cared for will be.

Another suggestion is that local authorities should consider having a bank of staff who can be employed by direct payment recipients if they do not have relatives who are willing to care for them. Do any of the local authority representatives want to comment on that and the other issues?

Alex Davidson: I am happy to respond. A number of us have been involved with the Executive in looking at direct payments. The previous group looked at older people and how we might improve the uptake of the scheme. The current group is looking at mental health service users and how we might make an impact for them.

Work is going on in the area but major issues are involved. Some of them are to do with resources and some are to do with attitudes. In some cases, people simply do not want the service. We are auditing uptake in South Lanarkshire to see why people do not want the service. It is easy to say that we do not sell it well enough, but, just as in Marks and Spencer, people have a choice of either taking or leaving a product. The majority of people, particularly older people, are not interested. On entering the scheme, one becomes an employer with all that goes with that—tax returns and the rest of it. That seems to some of us like taking a sledgehammer to crack a nut.

The English white paper, which was published last week, offers a range of alternatives that free up money for people to get access to services in a self-directed, self-managed way. That much softer and more flexible process encourages people to do what Janis Hughes was suggesting—to manage their own home help. That approach does not go beyond how we want to free things up in local government social work departments.

There are other issues to do with staff attitudes, for example, that we hear about from people across Scotland. People who are involved in assessment—never mind people who are offered the service—do not understand the scheme well enough. We need to crack that problem. There is an issue about advocacy and ensuring that people are well supported in making these choices. There are issues concerning capacity that are related to the Adults with Incapacity (Scotland) Act 2000. Do people have the capacity to take on what we are asking them to take on? If not, we need to find alternative and more complex ways of arranging things, but many people back off from that approach.

The idea of a bank of staff already exists in the direct payments scheme. People can organise that for themselves. For example, there has been some talk of several direct payment recipients coming together to have a group of staff so that they might have their own care suppliers, in effect, while, at the same time, being able to contract with other providers. Several of the providers present can already provide that. The choice is more individual than local authority-led. It can be done in different ways, even through buying local authority services, and it seems to me that the consistency that members are seeking may come from that option.

We are in the early stages. An interesting point, about which Stephen Moore may say more, is that his colleagues in Fife have driven the direct payments model from 1997 onwards. I know that from working with them and, in their view, the scheme peaked at about 200 service users in Fife—the number may have gone up or down a bit. When I was on the previous direct payments working group, it was felt that that was the limit. It was becoming harder to impact on the market and to take the scheme further. Direct payment is an option for some but not for all. The danger is that we run around trying to assist everyone to go down the direct payments road. It will be interesting to watch the English white paper develop.

The Convener: That is useful. I will bring Mike Rumbles in on the discussion of the direct payments working group. Does Stephen Moore also want to comment on it?

Stephen Moore: Briefly.

Mike Rumbles: I agree with Duncan McNeil and Alex Davidson that, for some people, direct payments for free personal care is a very positive and empowering experience.

My question is for Paul Gray from the Scottish Executive. Can the Executive give us good news on the uprating of the level at which free personal care is available for individuals, considering that it was set four years ago? I am not aware of any plans to do so, but is the Executive working behind the scenes for an uprating of the scheme, or will it wither on the vine?

Paul Gray: I do not know whether you regard no news as good news—I suspect not. That is a matter that I will leave to the minister to answer. I have noted your question and will ensure that the minister is made aware of it.

The Convener: Stephen Moore wanted to come in briefly, and then Kate Higgins. For the last 15 minutes I want to move on to a different aspect of the discussion.

Stephen Moore: Direct payments are an important aspect of encouraging and promoting personal choice. The take-up figures in Fife, which are the highest in Scotland, are still not good enough. Primarily, our success and the inroads made have been in the area of learning disabilities. From now on, the challenge will be for parents of children with disabilities. That is a new challenge for us and for carers, and it will affect the cost and availability of services in Fife and beyond.

16:00

Kate Higgins: On the direct payment model, I echo much of what Alex Davidson said, particularly the idea that it has been like taking a sledgehammer to crack a nut in relation to empowering disabled people and others who receive care services to have choice in their lives.

We have service users who took up direct payments and who still use them and love the scheme; we have service users who want direct payments but who cannot get them for love nor money—there is anecdotal evidence that, even in this day and age, their every effort is thwarted by their local authority—and we have people who have tried the system and given it up because they found the employer obligations, the risk and everything that goes with that particularly onerous. Those obligations have been one of the major blockages to personal empowerment. We expect disabled people to do an awful lot more than we expect of ourselves to become fully paid-up members of society. Not everybody particularly wants to be an employer—otherwise, we would all be employers. The individualised budget model that is being tried in England has merit and seems to offer a halfway house.

I am not sure whether the committee is aware that the support for direct payments is being changed. Direct Payments Scotland is being wound up, as its funding will stop this year. As I understand it, most of the funding for the provision of support to people in taking up direct payments will go to local authorities. The expectation is that it will be passed on to local support groups to encourage people to take up and keep going with direct payments. While some absolutely excellent councils, such as Fife Council and Highland Council, have done an awful lot to promote the take-up of direct payments, other local authorities have, for whatever reason, been particularly bad at that. The big question that needs to be asked of the Scottish Executive is why, at this stage in the process of direct payments take-up, some of those who create blockages in the system are deemed to be part of the solution. We have not achieved a solution yet.

The Convener: If you have specific examples of the kind of obstruction or dissuasion that you talked about, it would be helpful if you could let the committee have information on them.

We have only about 13 minutes left, so I want to move on to a follow-on question, which is whether free personal care should be extended and, if so, to whom and why. At our public event in Perth, we heard a strong message from younger individuals who deal with multiple disabilities that they find it offensive that their care is circumscribed. They feel that free personal care is a right that should be extended to everybody. I am interested in our witnesses' views on the possible extension of the scheme. I recall that, when the legislation was introduced, the minister at the time said that that

would be considered but, so far, that does not appear to have happened.

Jim Jackson: Our organisation finds it difficult when younger people with dementia are not eligible for free personal care while others are. We have made submissions to the Executive to the effect that we would like the scheme to be extended in principle, although it is necessary to consider carefully the interaction between the available benefits for people who are under 65 and the available benefits for those who are over 65. If such a policy were introduced, we would have to ensure that it did not inadvertently lead to younger people with disabilities being worse off. We all know what happened to the attendance allowance and how the original plans were changed.

Stephen Moore: Professionally and personally, I believe that it is not sustainable, in terms of social justice, to deny people, because of their age, a service that would sustain their quality of life and their ability to stay in their home and make choices. Society must consider whether to pay for that care. You as politicians have to make the decision, thank goodness, but, as a public servant, I believe that it is neither desirable nor acceptable to deny someone access to care that would sustain them in their community and provide them with the quality of life that I would want.

Ewan Findlay: In the spirit of agreement, I do not think that free personal care should be denied to anyone. Anyone who needs it should receive it.

Fiona Collie: Our position is that care services should not be charged for, no matter how old the person is. Charging only contributes to carer poverty. We should also look again at whether free personal care for older people should be directed as much at their health and well-being as at their care needs.

Kate Higgins: Capability Scotland supported the extension of free personal care to the under-65s right from the start, and we welcomed the commitment that the minister made on that way back in 2002. We are extremely disappointed that, although we are now in 2006, things have not really moved forward. We always acknowledged that we had to let the system for the over-65s bed in, to find out how it worked and what its implications would be, and we absolutely accepted the Executive's wish to carry out more research on the whole system of care services and needs. Indeed, that is what we called for.

As far as we are aware, none of that has happened to date. It was promised that a research group would be set up in 2002-03; it was set up in January 2004, but was disbanded in April 2004 amid promises that a scoping study of care services would be carried out. Interestingly enough, by that time, the research group's remit no longer covered free personal care. As I have said, as far as we are aware, the Executive has conducted no research into the whole package of care support, services and needs. The fact is that the issue touches not only on care services but on questions such as how to support young disabled people to get into work and to lead—for want of a better phrase—the ordinary lives that the rest of us take for granted.

However, we are now four years on and none of that has happened. We are extremely disappointed to find ourselves not an inch further on from the commitment that was made in 2002 and would welcome the committee's involvement in getting to the bottom of why that should be the case. After all, no one expected these things to happen overnight. We knew that this was a long-term game. We would simply like to see some movement.

People around the table have said again and again that we must examine the whole system of care services. Others might be better placed than I am to answer this question, but whatever happened to the joint futures agenda? It, too, appears to have fallen off the overall agenda. As all these matters are linked, examining such questions would be helpful.

The Convener: Given that Willie Primrose and Andrew Sim represent the elderly end of the spectrum—in other words, those who are currently eligible for free personal care—I wonder whether they are worried that extending its provisions would impact adversely on what their client group is entitled to claim.

Dr Primrose: In fairness, the provisions should be extended. Any such measure should be budgeted and applied fairly, but it would be a good idea.

Andrew Sim: I agree absolutely. After all, the policy is clearly agist. Our only hesitation is that such a step might open up a can of worms. Jim Jackson has already highlighted the other funding streams that are available to younger people, and we have discussed the disparity in care packages for older and younger people. I guess that we would need to debate the matter in the context of such equality issues.

The Convener: Are there any further comments on extending free personal care?

Mr McNeil: I wonder whether David Bell has any figures on that.

Professor Bell: Yes. The bottom line is that it is going to cost.

The Convener: That is always the bottom line.

Professor Bell: The Welsh figures, which will be released in less than two weeks' time, will give

the committee an idea of the relative costs of extending the policy to the under-65s. In my research, I asked all Welsh local authorities for the costs of providing care for people under and over 65. I cannot give you the exact figure, but the bottom line is that although many fewer people under 65 receive such care, the average cost is higher because their needs are more complex.

Kate Maclean: Duncan McNeil makes a good point—"free personal care" is a misnomer. It obviously is not free, even if people are not paying for it out of their own pockets—although it would not come directly out of their own pockets anyway. It would be useful to know the cost of meeting the unmet needs—including the needs of people under 65. Obviously, we will not be able to get the exact figures, but it would be interesting to know the approximate figures. Once we know what the figures are, we can discuss how to fund services. We would all want people of any age to receive free personal care, but it would be useful to know the costs. We do not know how such care can be funded.

When the policy came in, the cost was clearly underestimated, because there is unmet need among the over 65s, never mind the under 65s.

The Convener: We have five minutes left. Are there any areas where we think that everything is working effectively? Let us end on a positive note.

Ewan Findlay: Things are working very effectively. When it works, it works, but when there are waiting lists and things do not flow, it does not work. However, everyone I have spoken to is very happy with free personal care.

The Convener: David Bell's research suggested that things were going well.

Professor Bell: Yes, we did not find much dissatisfaction with what was being provided.

I will make one point about waiting lists. Money from the Executive comes to local authorities through grant-aided expenditure, and the question arises whether each local authority gets just enough to pay for personal care needs over the year to come. That amount is very difficult for local authorities to predict. The money is not ring fenced so, if a local authority receives more than it needs, it can put the money towards other services.

The Convener: Do you think that there are many such local authorities?

Professor Bell: If a local authority receives less than it needs, there will be problems and perhaps a waiting list. It is very important to know more about how such situations come about.

The Convener: I ask Alan McKeown whether there are any local authorities complaining that they receive more than they need—he should not answer that.

Does anyone else want to make any positive points?

Mr McNeil: Interesting points are being raised and we should ask how we can get the figures. There will be ups and downs so I presume that, in some years, local authorities will have had surpluses. I hear in my ear that money has been spent on hanging baskets.

The Convener: That is what everybody says.

Alan McKeown: Britain in bloom is very important to a number of local authorities.

Since the policy's inception, COSLA has conducted at least three soft investigations into the operation of free personal care, in order to keep the policy on track. Local authorities have been asked how it is going. A couple of years ago, four authorities received extra resources because the number of clients that they were having to pay for was not as great as had been expected. We balanced things up by giving them extra resources.

There are pressures in parts of Scotland but, overall, we think that the policy is fully funded. David Bell's research suggests that that may not be the case in future, but, at present, everyone seems to have concluded that the policy is good and is operating properly. If it were to be more fully funded, we would be happy to extend it. On balance, we think that things are all right just now.

The Convener: Right, it is time to end this evidence session, because we have other items on our agenda. I will suspend the meeting for a couple of minutes to allow people to leave the room and to allow committee members to resume the places that they would occupy at a normal meeting. That is not an invitation to all committee members to disappear out the door. We have more work to do.

I thank all the witnesses for coming. If anything occurs to you that you would like to raise, please get in touch with us.

16:14

Meeting suspended.

16:16

On resuming—

Subordinate Legislation

Food Hygiene (Scotland) Regulations 2006 (SSI 2006/3)

Mental Health (Recall or Variation of Removal Order) (Scotland) Regulations 2006 (SSI 2006/11)

Mental Health (Form of Documents) (Scotland) Regulations 2006 (SSI 2006/12)

Feeding Stuffs (Scotland) Amendment and the Feeding Stuffs (Sampling and Analysis) Amendment (Scotland) Regulations 2006 (SSI 2006/16)

The Convener: Item 4 is subordinate legislation. The committee is asked to consider four negative Scottish statutory instruments, as shown on the agenda. The Subordinate Legislation Committee had no comments to make on SSI 2006/11, SSI 2006/12 and SSI 2006/16. That committee's comments on SSI 2006/3 are reproduced in the abridged report in members' papers. No comments have been received from Health Committee members and no motions to annul have been lodged. Are we agreed that the committee does not want to make any recommendation in relation to the four sets of regulations?

Members *indicated agreement*.

The Convener: Thank you. That ends our public business. We will move into private session, so anyone who is not required may leave.

16:17

Meeting continued in private until 16.40.

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