HEALTH COMMITTEE

Tuesday 21 February 2006

Session 2

£5.00

Produced and published in Scotland on behalf of the Scottish Parliamentary Corporate Body by Astron.

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HEALTH COMMITTEE
5th 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

David Bookbinder (Scottish Federation of Housing Associations)
Fiona Cherry (Royal College of Nursing Scotland)
Eric Drake (Scottish Public Services Ombudsman)
Jim Dickie (North Lanarkshire Council)
Ewan Findlay (Scottish Care)
Annie Gunner (Community Care Providers Scotland)
Will Mallinson (Edinburgh Advocacy and Representation Service)
Alan McKeown (Convention of Scottish Local Authorities)
Adam Rennie (Scottish Executive Health Department)
Lord Sutherland of Houndwood
Hilda Smith (Association of Directors of Social Work)
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 21 February 2006

[THE CONVENER *opened the meeting at 14:02*]

Care Inquiry

The Convener (Roseanna Cunningham): I welcome everyone to our first committee meeting after the February recess. I extend a particular welcome to Lord Sutherland, from whom we strongly wished to hear since we are reviewing personal care for the elderly, among other matters. Lord Sutherland has indicated that he wishes to make a statement at the start of today's meeting.

I have received apologies from Jean Turner, who is unable to be here today, and apologies in advance from one member of the committee who will be required to leave early.

Lord Sutherland, you have seen the briefing note from the Scottish Parliament information centre and will know some of the issues that are likely to be raised.

Lord Sutherland of Houndwood: Thank you very much for inviting me and for being helpful in accommodating my awkward diary. It is much appreciated that the committee made time for me.

I will refer to the report from the Royal Commission on Long Term Care for the Elderly, but also to some events that have happened since. If it is all right, I will end by asking the committee a question.

I stand by the original conclusions of the royal commission's report. We were not perfect, but we were broadly right and broadly going in the right direction. I will mention the report's main recommendations—I think that the committee has picked up on two of them. First, personal care should be free at the point of delivery, although it is important to remember that it is never free, in that somebody must pay for it. Secondly, a care commission should be set up, and significant steps have been taken towards that end.

The third and almost unnoticed recommendation—the one that caused most sucking of teeth among civil servants in Whitehall—is that there should be a single budget for care for the elderly. At the time of the report's publication, there were two budgets for two separate departments—health and social security. That was the source of a great deal of uncertainty and inefficiency in this area. The sucking of teeth implied: "You mean merge two Whitehall departments?" It was not quite, "How dare you," but as far as the civil servants were concerned it was like inventing a new theory to take over from Einstein's. That recommendation has not been dealt with.

I have been impressed by the co-operation in Scotland between the Health Department and local hospitals, general practitioners, the primary care trusts and the relevant local authority departments. Good things have happened, which will probably extend even further.

The grounds for our recommendations are worth recalling. The first is natural justice, which I can illustrate simply. If people suffer from lung cancer or cirrhosis of the liver, or go climbing mountains when they should not, fall off and do themselves terrible injury, they receive free care. However, people who suffer from the illnesses associated especially with old age do not receive free care. It is that injustice that we thought should be corrected, as a basic principle. There are two ways that we can go from there: we can either put the illnesses of old age on the same footing as all other illnesses, diseases and so on; or we can say that if the burden of covering those illnesses in the same way as other health service costs are covered is too great, we should perhaps introduce additional charges or taxation throughout the whole service. We could say that the whole package is more than we can afford and that therefore people should be means tested and, if they can afford it, should pay for their hotel costs when they go into nursing homes and care homes. That is an alternative direction in which we could go. If it is a matter of savings, the policy could apply throughout the health service. That would be a bold policy for a politician to follow, but it would accord with some degree of natural justice.

The second ground for our recommendations was that the quality of provision would rise. When we took evidence, we were told moving and painful stories in public session by people who literally broke down in front of us because of the difficulties that they had faced in arranging care for themselves or, often, for an elderly relative, neighbour or friend.

The third ground is efficiency. I will come back to that. I am sure that the committee has been given copies of the Joseph Rowntree Foundation study that was published two weeks ago. It is the first independent assessment of free personal care, and I regard it as vindicating the wisdom of the Scottish Parliament in moving in that direction. Basically, the report is positive. It deals with a number of the issues and indicates that there are things yet to be achieved and difficulties and details to be sorted out, but it is positive about

what Scotland is getting for what free personal care is costing.

There were variations in the results in relation to our expectations. One of the expressions that I learned when I was undertaking the report is one that economists apparently use all the time—the funnel of doubt. When one draws a graph with a maximum and a minimum, the funnel of doubt emerges on the graph. One treads down the middle.

We reported eight years ago—at least, most of the work was done eight years ago—which is quite a while ago, and things have moved on. Changes have happened in the community that have increased the costs in a way that the Joseph Rowntree Foundation pointed out. One is the cost of regulation. We need a regulatory system, so I am not complaining about that, but it can be expensive. The second is the fact that the minimum wage has risen beyond the rate of inflation. Again, that is a good thing. It has had an impact on care, as it has on any other form of public spending that involves individuals. This is a time of full employment; care providers therefore are not only looking for very talented people but having to compete for staff, sometimes in difficult situations.

Another factor, which I think was not anticipated by those in the Scottish Parliament who backed the policy, is that the attendance allowances that were saved by the policy represented a net saving to Westminster. In other words, there were certain allowances to which people were entitled and which they got until nursing and personal care became free. That entitlement was then withdrawn and there was a net cash saving. I have asked questions in the House of Lords that seek to identify how much was saved, but when we compute the total cost to the public purse—we are all taxpayers who contribute to that—it is lower than the headline figure because attendance allowances are not paid, which means a net saving to what is now the Department for Work and Pensions. That saving was not returned to the Scottish Parliament, although it was made from our expenditure. That is a very important point. If you are considering real costs, you have to deduct that saving, whether you are considering real costs in Scotland or what would be real costs in England.

The minority report considered the difficulties that our recommendations might cause. One difficulty might be in the area of costs. I am sure that we will come back to that during questioning. Secondly, both the people who signed the minority report were concerned—reasonably—that free personal care might downgrade the role and willingness of informal carers. The Rowntree report indicates that that is not so. Because allowances are being paid to people who remain at home, the quality of informal care has gone up rather than down.

There were, of course, worries about the phasing out of care at home because people might think that if care is free, why should they not go into the local nursing home? Again, as Rowntree demonstrates, that has not happened.

There were some doom-laden predictions that we would suffer a mass migration of grannies up to Scotland. I live down the A1 and I was out there, scanning the road for large container lorries with zimmer frames rattling against the sides, but it did not happen. We knew that it would not because Canada did the same thing and it did not happen there.

The question that I want to leave with the committee before we turn to the discussion is this: we need to have a policy, so what is the alternative? Westminster does not have a sustainable policy for people in England, and I will give two reasons for that.

The underlying reason is that there is an attempt to draw in law and in the distribution of money a distinction that we and all the professionals in the field believe to be impossible—a distinction between health care and social care. You will know the old joke: when is a bath a social bath and when is it a health bath? Drawing that distinction was the bane of the system that we used to operate in Scotland because there were great difficulties in deciding what should be paid for, who should do what and so on when there was no single budget.

The outcome is that the Westminster Government has had to issue to local authorities instructions—certainly guidance—about what can be paid for and what cannot. Not surprisingly, the guidance has turned out to be so vague that local authorities have interpreted it in different ways and the parliamentary and health service ombudsman is inundated with claims against the system. In the first claim, the ombudsman very bravely ruled in favour of the complainant. The next thing I heard was that there were 3,000 claims on her desk, with a total potential cost of between £180 million and £200 million. That was some time ago, and I am sure that the cost will have gone up. That is not a sustainable system. The ombudsman was saying to local authorities, "Whatever system you are operating is not working and is going to cost you more money." The systems were not working because authorities were trying to draw a distinction that cannot be drawn in law and worked with.

The Convener: Thank you. I suspect that the big question about when a bath is a social bath and when it is a health bath has been overtaken

by the question about when food is being prepared and when it is not being prepared.

Lord Sutherland: So I hear. I do not have a strong view on that, because I do not know the details.

The Convener: It is always interesting to see how things move on, although the basis for the debate might be very similar. Various questions will arise out of our briefing note. I will start with Kate Maclean, who has a question on definitions, on which you might want to comment.

14:15

Kate Maclean (Dundee West) (Lab): To a certain extent, Lord Sutherland, you covered that in what you said about experiences down in England.

To what extent is the way in which personal care has been implemented in Scotland in keeping with the royal commission's expectations? We have certainly heard some evidence that confusion exists in Scotland about the definition of personal care. There is confusion both on the part of members of the public, who often feel that all aspects of care will be free, and on the part of local authorities and service providers. The commission's report said that the definition should offer

"a logical, understandable, workable and above all just approach to the issue of funding."

From the evidence that we have received, that does not seem to be the case. How do you feel that the issue has been handled in Scotland?

Lord Sutherland: As a matter of fact, the commission spent a great deal of its time on definitions. I regard the chapter in our report that deals with the definition of personal care as being probably the most important one. Our definition of what should be provided free is laid out clearly in that chapter. One of the difficulties that many members of the public had was that when the press discussed the matter, they omitted the big issue of hotel costs. Our position on that was clear, but the press headlines managed not to convey the fact that hotel costs—those relating to food, light and heat, which one would normally pay for oneself—would be covered by the individual and that if separate sources of help, such as benefits, were appropriate, they would be provided through the relevant channel.

There is a real problem in that regard. A number of individuals have put it to me that they thought that we said that such costs would be met. There were two reasons for the approach that we adopted. First, we were conscious of costs. Secondly, without exception, all the older people whom we met said that they had paid for such things all their lives and wanted to continue to do so. They said that if adding in hotel costs would be problematic, whatever form of income they had should be devoted to meeting them. I am not sure why there is a difference of opinion between local authorities. Will you illustrate that?

Kate Maclean: I think that another member was going to deal with that, but I will pick up what the convener said about food. What element of the provision of food is personal care and what element is a hotel cost? Feeding someone with food obviously counts as personal care, but is the preparation of that food, or shopping for it, a hotel cost or personal care? Some elements of the provision of a meal might be personal care, but others might be hotel costs. The same is true of giving someone a bath—some elements of that could be personal care and others could be hotel costs. Heating up the water and fetching the bubble bath to put in it could be hotel costs, whereas helping a person in and out of the bath could be personal care. That is where the confusion arises. One component of the provision of care could involve both hotel costs and personal care. The fact that local authorities and care providers sometimes interpret the guidelines differently is creating confusion among members of the public. If someone knows that someone who lives in a different local authority area is getting certain things free, that can cause confusion and, in some cases, anger.

Lord Sutherland: The fundamental criterion for us was whether someone was prevented from doing what was essential because of a debility or a disability that had been brought about by the illnesses of old age. If someone was quite capable of doing their own shopping, for example, that would not be included in personal care. If they were quite capable of preparing their own food, that would not be included in personal care. It is likely that the same people who have to be helped to eat will have to be helped with the preparation of food as well. That is where I draw the line. Rather than categories of tasks, the starting point was assessment of the position of the individual who had the disability or debility in question.

Kate Maclean: The fact that such assessment can sometimes be quite subjective could lead to differences arising between local authorities.

Lord Sutherland: I hope that the differences would be not between local authorities, but between individual cases in relation to people's personal needs. Some local authorities are bound to have people who cannot feed themselves and who, ipso facto, cannot cook either. If people with severe dementia need help with feeding, they ain't going to be able to cook the meals themselves; equally, people in the same local authority area who do not need help with feeding may be able to

do some food preparation. That is where I think that the line should be drawn.

The Convener: In those circumstances, you would be concerned about any local authority having a blanket policy. You are effectively saying that no blanket decisions should be made and that the policy should always be individually led.

Lord Sutherland: It should be individually led. As a point of principle, local authorities should consider what a person is prevented from doing because of the disability that they have

The Convener: That is a useful way of looking at it. Thank you for that.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): You are saying that the important thing is the assessment that the local authority makes of the individual and that there should be no blanket approach outwith that. It is about the personal assessment.

Lord Sutherland: In this and any other scheme, the assessment is absolutely fundamental—you are right about that. It is about the quality of the assessment and the grounds on which the assessment is made.

Janis Hughes (Glasgow Rutherglen) (Lab): You said in your opening statement that the provision of free personal care is a matter of "natural justice". The commission's view was that any system that was eventually legislated for should be

"logical, understandable, workable and … just".

Given what you have just said about not wanting to see blanket policies across local authorities, do you think that the existing legislation meets those expectations?

Lord Sutherland: I do not see why the legislation should prevent local authorities from having proper assessments carried out. They need proper assessments, not a set of rules that say, "We pay for this; we don't pay for that."

Janis Hughes: Do you think that the definition of free personal care in the legislation is sufficiently clear?

Lord Sutherland: I believe that it is if you take the route of considering the need of the individual. That has to be the right route to go down.

Shona Robison (Dundee East) (SNP): I have a question on waiting lists, which different local authorities also handle differently. Some appear to operate a waiting list of people who have been assessed as requiring free personal care because they say that they do not have the resources to meet that need. It would be interesting to hear your comments on that. Was that envisaged? Do you think that it is right?

Lord Sutherland: Ideally, we do not want waiting lists. The system in Scotland should operate more efficiently with regard to waiting lists than does the system in England, where there is still a risk because although the cost of care in a hospital falls to the health authority, the cost of care in the community falls to a local authority service. One of the worst examples of what was happening previously all over the country was of people being passed from one service to the other and falling down the crack in between them. That is why we wanted a single budget. Although the system that is now in operation in Scotland ought to diminish that problem, there are two potential problems: first, that not enough money is going into the system and, secondly, that local authorities have other demands on their purses that lead them to ration what goes into the system. There may also be a question about efficiency.

I was surprised at how quickly the policy bedded down. There were problems in the Highland Council area for a while, but when I talked to one of the senior people in Glasgow shortly after the Regulation of Care (Scotland) Act 2001 was passed, I was surprised that I was not given a tirade. The reverse happened there; I was told that the authority could cope, although the new system required a bit of coaxing and adjusting at the edges. I hope that the current problem is temporary or, if it is not, that the committee will discover why.

Shona Robison: I also want to ask about the effect on service provision in general. One of the arguments against the policy—it was made in the dissenting report, I think—was that it could potentially transfer income and wealth to better-off people at the expense of improving services. We have heard about the pressures that local authorities—some more than others—are under in relation to funding services and it seems that there is a bit of a mismatch in terms of the resources that are required. Is that a concern that you share? You said that the committee should get to the bottom of the matter. We hope that we will. Was it envisaged that the demand on services would increase because of the policy's being well advertised and free?

Lord Sutherland: My answer to both questions is that we thought that the policy would increase demand and therefore force up public expenditure in unanticipated ways. The Rowntree report points out the success of the promotion of care at home, which is normally the cheaper option and so represents a considerable restraint on the rise of the total public cost.

On the transfer of wealth to better-off people, there is a question of justice. We asked why draw a line in the sand at the point at which someone's illnesses happen to be associated with old age.

Why say, "You have reached 60 or 65, so we'll start charging you for what would otherwise be free because you're more susceptible to Alzheimer's disease, dementia, certain forms of stroke and so on"? I confess that I have an interest because I will turn 65 on Saturday, but the situation strikes me as being unfair. The right approach would be to face up to the facts that we cannot afford to provide certain services free and that we should therefore distribute the charge equally across the population rather than target a particular group.

Shona Robison: One of the disputes seems to be about how the initial calculations were made about what each local authority would require. It seems to have been a snapshot of who required what at that moment in time, but it appears that no account was taken of future numbers of people coming forward for services. Also, the rate that was set has not been increased. Do you have any comments on that?

Lord Sutherland: There are two sides to the issue, one of which goes back to the attendance allowances that were withdrawn. I do not have the exact figure for the sum that was saved by that means. I have asked, but people are taking a bit of a time to find the answer. However, if the basic calculation took into account how much was saved in that way and how many people would now be receiving attendance allowances, I believe that any rise—the figures that are before the committee show a rise of about £18 million—would be mopped up in that sum.

We accepted that the costs would go up and we graphed them quite significantly, but we also made a point of saying that it is important to acknowledge that the cost of everything increases. The cost of every public service that is individualised and labour intensive is going up because we are quite properly trying to pay people decent living wages. The percentage of gross domestic product that is the total cost of the policy is the key figure because, on average—we used the exact Treasury assumptions in this regard—the economy grows by 2.25 per cent a year. Sometimes it is lower and sometimes it is higher but, over 100 years, that is the average growth. Our costs could be contained in that if that were the will of the people.

The Convener: So you do not have any concerns about long-term sustainability, as long as people keep their eyes wide open on the issue of the general good to society rather than simply focus on a figure at the bottom of a page of profit and loss calculations.

14:30

Lord Sutherland: Yes. It has to be decided how much of the total national wealth is to be spent on such care. Given Scotland's demography, I will be amazed if more is not spent—I would be amazed even if the policy were not being followed—because people are living longer and the cost of hospital treatment is much greater, although that is a separate item.

The Convener: If I recall correctly, the Joseph Rowntree Foundation's figure was 0.6 per cent of GDP.

Lord Sutherland: Yes.

The Convener: Mike Rumbles has questions on costs.

Mike Rumbles: I want to turn round the economic question. I just heard you say that if the will exists, you are not really worried about long-term sustainability.

Lord Sutherland: I did not say quite that. I said that it is important that the will exists because we could not have a society in which people do not want to spend money on care or education.

Mike Rumbles: Indeed. My question is focused on the amount of money that the Scottish Executive has allocated to free personal care and nursing care costs. When the policy came into effect in 2002, the amount was £145 per person a week for personal care and £65 per person a week for nursing care, which makes a total of £210 a week. That has been set in stone and there has been no suggestion that the Executive is considering increasing the amounts, even in line with inflation. When the legislation was introduced, we were all surprised that the amounts were not linked to inflation. The matter has been allowed to wither on the vine. Do you have any thoughts or comments on that?

Lord Sutherland: I do, and I hope that the committee does, too. If you work out the cost of something that Parliament wants to do and to which it has given priority, there has to be the will to provide the means. I know that that is about making hard choices, but the amount that has gone into the Scottish exchequer has gone up every year and will continue to do so in the near future, as far as we can see. All the signs are that the economy will continue to grow at the average rate, in which case the policy is affordable. However, some public sector cash has to be invested in the policy as a particular spend.

Mike Rumbles: Do you have comments on the level at which the funding was set? We know from evidence that the highest figure for nursing care south of the border is three times the £65 a week that we provide.

Lord Sutherland: In England, the amount of money that local authorities are willing to provide varies dramatically according to the need in the community. That has two sides to it. One is how

many people need care and the other is how many providers there are. A market operates—I have seen it. If the market is undersupplied with providers, whether of residential care or whatever, the local authority pays more. That is the reality.

Local authorities should have their own benchmarks. Most, although not all, run their own care homes. There ought to be parity among care homes, whether they are run by the local authority or privately, in terms of what they pay.

That reminds me that I should declare an interest—I spoke to the clerk about this. I have been, but am no longer, a non-executive director of a care-home business, so I have seen the inside of that side of things. I am president of Alzheimer Scotland and am just about to do some work for the futures forum on older people, which I just happen to be interested in.

Mike Rumbles: I have one final direct question. Do you think that £145 for personal care and £65 for nursing care is a sufficient level of payment to individuals in 2006?

Lord Sutherland: I point to the example of care homes going out of business. I point not to the example of private owners who are making or losing money—there are both—but to the example of the Church of Scotland, which is a charitable body that could not afford to continue in the business and pay its staff what it regarded as being reasonable wages. I regret that that was not possible, but I think that it provides a barometer of the real costs. As far as I know, that body was no less efficient than any other.

Mike Rumbles: Could you be more specific and tell us whether you think the level of payment is right?

Lord Sutherland: I suppose that I am implying that if people are being driven out of business the situation should be examined.

I would like to talk about the matter in relation to the Scottish Commission for the Regulation of Care, but I imagine that members will ask about that.

The Convener: Yes, we will.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): I have enjoyed your evidence on this point. However, is the Church of Scotland really the classic example? Are we suggesting that if everyone gets the same level of funding they will all be equally efficient and will provide the quality that we expect? Do modern care homes deliver more savings because they are heated differently? All kinds of questions are emerging, and we do not really know enough about the Church of Scotland's situation to pinpoint exactly why it has closed down homes.

Lord Sutherland: I have to say that I have discussed the matter in detail and have done the odd bit of charitable work for the appropriate committee in the Church of Scotland.

Mr McNeil: In that case, is the only issue the cost of running homes?

Lord Sutherland: I would need detailed figures in front of me. I think that you have made your point in that respect. [*Interruption.*]

The Convener: I am sorry about that, Lord Sutherland. I was indicating to Helen Eadie that I would come to her now because you appeared to throw out a lure with regard to the care commission, on which she has questions.

Helen Eadie (Dunfermline East) (Lab): Has the work of the care commission fallen short of the expectations that you and your colleagues on the Royal Commission on Long Term Care for the Elderly had for it? How might we expand the commission's role?

Lord Sutherland: I am not critical of the care commission's work because I am very much in favour of implementing rigorous standards to monitor the provision of care by various providers. That is immensely important, because the group of people about whom we are talking become less able to care for themselves.

That said, we recommended that the care commission should have a broader remit because we knew that the questions of costs and relative costs that the committee is now debating would arise. There is also a question of demography in that the number of people in the workforce will decline relative to the total population. As a result, it will be more difficult to find people who are able or willing, or who can be persuaded, to work in the care business. Most services, industries and businesses face that major problem.

We could not predict all that in detail, so we wanted a national care commission that would set standards not only for providers but for Government, and which would be able to advise the Government on how those factors were changing and on changes that could be made to allow sensible strategies and policies to be drawn up. Of course, the care commission does not have that role, but I am interested in how the Health Committee has partly taken it on. Clearly, there are many ways of finding the right structure and, given that you are the people's elected representatives, this way might be as good as any. However, as I have said, we felt that it was important that the care commission would not just impose standards but would, with the Government's agreement, monitor the situation and advise the Government on what was needed.

On Mr McNeil's point, I believe that the provision of care will change radically; for example, there will be more serviced homes in specially built communities. In that respect, I will be very interested to see what happens with the Joseph Rowntree Housing Trust care village, which I think will be spectacularly successful. I have seen similar projects in the United States; some have been very successful at eliding the distinction between being in a residence and being at home. I should perhaps point out that some housing associations in Edinburgh have gone partly down that route. The change that will take place—which, again, could not have been predicted by the Royal Commission on Long Term Care for the Elderly—will affect the cost and quality of care and how it is provided and offered. That change is not far down the road.

Helen Eadie: I agree with you to some extent, but the example that you mentioned is a one-off. The question that the committee faces is how we provide for the on-going scenario. In your documents, there is an implicit assumption that there is a wider role for the care commission. Are there specific recommendations that we should make on how the care commission's role could be expanded?

Lord Sutherland: I do not think that one can set up a body such as the care commission and just assume that it will run. That relates to Mr Rumbles's question about the sums of money that are devoted to it. Things change dramatically, including the cost of staff. In five, 10 or 15 years' time, the type of homes and the provision that is made will be different, so we need to ensure that those who make policy and fund it get the best possible advice. The care commission is the system that we thought would produce that. If there is another way of doing it, that is fine. We are not hung up on a particular structure, but we saw that there was a need for a care commission because without it the debates will return and we will have them every few years.

The Convener: I have two questions. First, what are your views on the expectation that the care commission will be self-financing? Secondly, I heard something on the radio this morning about the investigation of complaints by the care commission and its apparent lack of reporting—it is not passing issues up the line. I ask you to comment briefly on that. I will then bring in Nanette Milne.

Lord Sutherland: On the handling of complaints, I do not know the details, but I did wonder how such a commission would interact with, say, the Scottish Public Services Ombudsman, which also handles complaints and investigations. We do not want work to be done twice—we would rather have it done properly once.

On whether complaints are referred onwards, I think you are referring to the question of whether the care commission should alert the funders to what is happening in particular homes. Of course it should, and it should also alert homes that are the source of the problem as soon as it upholds a complaint.

The Convener: What about the expectation that the care commission will be self-financing?

Lord Sutherland: The commission's becoming self-financing is the natural way to go, as long as it does not give the commission a monopoly whereby it can raise costs as it sees fit and with no checks. I would want to know what the checks were. In principle, the cost of care includes the cost of regulation, but who is checking that and who sets the regulatory fees?

Mrs Nanette Milne (North East Scotland) (Con): My question is on the extension of the policy to people under the age of 65. Your commission suggested that its recommendations could apply to younger people who have disabilities and who require long-term care. The Scottish Executive has commissioned research on that. In the light of your experience of the policy for older people, do you still think that the policy should be extended?

Lord Sutherland: Our recommendations were phrased as they were because, at the last minute, our remit was suddenly extended to include, where relevant, other groups in the community. By that time, we had agreed to produce a report based on one year's work. Royal commissions have never been known to work at great speed, but we did not want to hold back because we thought that, if there was anything worth recommending, it was important to get it into the community quickly.

We met representatives of disability groups and thought that the best we could do was to highlight the issue. We did that because we believed that there was an issue, but we could not go into detail on the economics and provision of care across the country as we did for the group that we were initially commissioned to deal with. Although we had not done detailed work on that, we thought that there was an issue. We did not see why the principles should not be applied to other groups in the community. However, before I could answer the question fully, detailed work would have to be done and I would need to know its outcome.

14:45

Mrs Milne: So, do we need to look at the outcome of the work that the Executive has commissioned?

Lord Sutherland: Yes—absolutely. That is the right way to go. Before one can say whether the issues are the same, a thorough and proper analysis is needed. Our belief—it was more than a hunch—was that the two groups are very similar.

Mrs Milne: When last we discussed the issue, it occurred to me that our hand may be forced by European legislation that will come in later this year by way of the directive on age discrimination. Could the legislation make it illegal to deny such care to people under 65?

Lord Sutherland: That was always a possibility. As I said, we did the guts of our work in 1998. Although such legislation was not an issue then, we could foresee what might happen in terms of the European Union, the Human Rights Act 1998 and so on. The inefficiencies in the system in England will force the issue there. I refer to the legal evidence that is piling up through the work of the brave lady who is the parliamentary and health service ombudsman.

The Convener: You made a huge personal investment in the work that was done in advance of the policy's coming into force. Notwithstanding individual issues and problems, can we take it from what you have said today that you are satisfied with what has happened in Scotland as compared to what has happened in England?

Lord Sutherland: Yes. What the Scottish Parliament did was remarkable. Sir Humphrey would have said that it was brave or courageous, but I think that it was remarkable. In the eyes of many people, the delivery in Scotland of free personal care for the elderly is a flagship policy. It shows that the Scottish Parliament is prepared to think things through from scratch.

There will always be arguments about who makes a sandwich and who does not. However, such issues are small in financial terms when compared with the big arguments that the parliamentary and health service ombudsman is raising in England. The committee might want to look at the recent judgment in the important Grogan case in Kent, which shows the inadequacy of the philosophical basis—if I can call it that—of the system that the Government is trying to operate in England.

The Convener: Thank you for coming to committee, Lord Sutherland. We are about to move into our round-table evidence session. If you have time to do so, you are very welcome to sit and listen; if not, we will understand. Thank you again for coming to committee this afternoon.

Lord Sutherland: Thank you for inviting me, convener. I would love to stay, but I am afraid that other matters call me.

The Convener: I thought that might be the case.

Lord Sutherland: I will read the *Official Report* of the meeting.

The Convener: Thank you.

14:48

Meeting suspended.

14:54

On resuming—

The Convener: Under agenda item 2, on our care inquiry, committee members will report on recent care commission inspections in which they participated as observers. Mike Rumbles and Janis Hughes have participated in inspections; Nanette Milne and Shona Robison have yet to do so. I invite Mike and then Janis to give brief verbal reports on what they saw and remind them not to name the facility that they visited.

Mike Rumbles: I turned up for the inspection on 31 October, which is Hallowe'en. We were met by the manageress, who was in Hallowe'en garb, let us say, and who set the scene for a very good visit.

Two members of the inspection team performed the day-long inspection—I stayed for most of the day. It was conducted in a friendly, efficient and, above all, professional and constructive way, and I was impressed by the fact that it was evidence based.

The session started with a tour of the premises. We had a good look around the place in order to get our bearings before we went into questions such as what the residence was about and how many people were there. The two inspection team members then split and I accompanied the leader of the team—if I may call them that—who sat down with the manageress of the residence. The other member of the team went off and spent a great deal of time simply talking in detail to individual residents and members of staff.

The senior member of the team sat down with the manageress in the office and went through the checking process very effectively. When questions such as "Did you do this?" and "Did you do that?" were asked, the manageress would not simply say, "We do that. That's fine"; rather, the process involved the inspector saying, "Right. Where's the evidence for that?" It might be said that the process is paper based. While the paperwork has to exist, there has to be evidence that something has been done. If a fire drill has taken place, people must be able to show where it has been marked down and registered.

The inspection was done effectively. It did not simply involve chitchat and people being asked whether they were going through the motions—the

aim was to maintain the residence's efficiency and records. All sorts of questions about security and efficiency were asked. The session was very much evidence based.

I do not want to go into too much detail about the visit, but I want to get across that it was useful. I gained an education about what care inspections involve, and feel that the care home's management also got a lot out of the visit—it was an informal education process for them too.

Janis Hughes: Around two weeks ago I visited a home as an observer on an unannounced inspection. I fought to maintain unannounced inspections as a member of the Health and Community Care Committee when we considered the Regulation of Care (Scotland) Bill and I was pleased to observe such an inspection.

Like Mike Rumbles, I participated in an inspection from 9 o'clock until after 6 o'clock, although it did not end then. I understand that inspections often take place during the night or, to be more specific, at night shift to day shift changeover times so that the continuity of care can be looked at.

Like Mike Rumbles, I was impressed by the inspectors' thoroughness. Their work was very much evidence based. I was also impressed by their knowledge and experience. The inspectors whose work I observed had backgrounds in health and social care, and they had a great deal of knowledge and experience, which showed during the inspection. I was impressed by the amount of paperwork that was looked at—a copious amount was requested and closely inspected.

We did a thorough tour of the facility and talked to several members of staff, both publicly and privately. We also sat in on a residents meeting and talked to some individually. I was particularly impressed to find that the inspectors were keen to work with the staff. The unannounced inspection aimed to follow up on issues that arose out of the announced inspection some months before. I was glad that the inspectors were happy to work with staff in the home to address several issues that had been raised. What I saw was not the end of the inspection: the inspectors were to go back the following week to follow up and address other issues with the staff. All in all, it was an enjoyable experience. I hope that committee members will participate in such inspections.

15:00

The Convener: We now move on to the substantive item of the round table discussion on care inspections. I remind everyone that the committee will hold further sessions in respect of the care commission. Although we will discuss the work of the care commission today, it will not be the only day that we will discuss it, so I urge everyone not to feel that they have to get everything in today.

I have received apologies from Aileen Anderson of the Scottish Partnership for Palliative Care. Eric Drake, deputy Scottish public services ombudsman, is substituting for Alice Brown. I invite participants to identify themselves and indicate which groups and organisations they represent. Due to the numbers involved, there is no possibility of statements. I will start with Ewan Findlay, who is a repeat performer.

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

David Bookbinder (Scottish Federation of Housing Associations): I am representing the Scottish Federation of Housing Associations.

Hilda Smith (Association of Directors of Social Work): I am standing in for George Hunter, chairman of the community care standing committee of the Association of Directors of Social Work.

Adam Rennie (Scottish Executive Health Department): I am from the Scottish Executive Health Department.

Jim Dickie (North Lanarkshire Council): I am the director of social work at North Lanarkshire Council.

Annie Gunner (Community Care Providers Scotland): I am from Community Care Providers Scotland, which is the association for voluntary sector providers.

Fiona Cherry (Royal College of Nursing Scotland): I am representing the Royal College of Nursing Scotland.

Eric Drake (Scottish Public Services Ombudsman): I am deputy Scottish public services ombudsman.

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

Will Mallinson (Edinburgh Advocacy and Representation Service): I am from the advocacy service for older people covering Edinburgh and the Lothians.

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

The Convener: Pat Wells will have to leave at around 4.15 pm to get a train back north.

We need to discuss four key questions in today's session. I will begin by throwing in the first one. In general terms, is there unnecessary

duplication of care service inspection by the care commission and others, particularly local authorities? That was flagged up to the committee, and it would be useful to hear the witnesses' views on it. Will they also quantify the extent of duplication that they believe exists? Who would like to go first? Do not all rush at once, or I will designate speakers.

Annie Gunner: I will take the plunge. I feel I should go first because we have flagged this issue up to the committee on several occasions.

I was struck by the fact that the first word of our response to the committee was yes, and that the first word of the response from my colleague from North Lanarkshire Council was no. Initially, it looks as if we are entirely at odds on the question of unnecessary duplication. The reason is the word "unnecessary". My colleague's position, and that of local authorities more generally, is that they have to introduce service review and monitoring processes, which may risk duplicating the care commission's procedures. They feel that that is necessary, but from a provider's point of view we do not understand why.

To us, the logic of the Regulation of Care (Scotland) Act 2001 was that the care commission would register, inspect and regulate services and local authorities would take its word for it. We thought that local authorities would place a contractual requirement on providers that they register with the care commission, at which point local authority involvement would stop. In practice, that is not happening. Our submission gives anecdotal evidence from providers about the duplication that is taking place.

From my colleague Jim Dickie's submission and other evidence, the reason seems to be that local authorities have different duties and responsibilities in respect of care management and contract compliance. We accept that but, on the ground, local authorities and the care commission look in the same place and largely at the same evidence, although possibly for different reasons and with different motivations. We are not persuaded that that is necessary. Another issue, which is mentioned in Jim Dickie's submission, is that the care commission's processes may not be rigorous, thorough or timely enough to satisfy local authorities' requirements in respect of service review. If so, our concern would be about the implications for the care commission.

I re-emphasise that, whatever the motivation or reasons, the practical effect is that two sets of agencies look at largely the same evidence and documentation, which takes up an enormous amount of management time on the part of providers. The committee must consider the resource implications. The care commission costs £30 million a year, and local authorities, in duplicating some of the processes, are obviously committing resources. We can find resources to duplicate the processes while, at the same time, voluntary sector providers are being told that there are not enough resources to run services adequately. From the point of view of providers, there is unnecessary duplication. The solution must be more joint working, and perhaps even statutory requirements.

The Convener: In an average year, how many inspections would a single establishment be subjected to?

Annie Gunner: The care commission has minimum statutory requirements on that, as the committee will know. In addition, some authorities, although not all of them, carry out at least one annual inspection or quality assurance or contract compliance monitoring visit—or whatever the description is. On top of that, funders and purchasers often require quarterly reporting. When we talk about duplication, we are not necessarily talking about people turning up at the door of the service.

The Convener: Let us separate the two issues. In any one year, on how many days will the average provider have to deal with folk who turn up at the door? Is it two days?

Annie Gunner: As our submission states, one provider said that it took five days for one inspection and two days for the other in the same year.

The Convener: Does that vary from provider to provider?

Annie Gunner: Yes, it varies from service to service and from authority to authority. As I said, part of the issue is people physically turning up to inspect a service, but another part is the duplication of the information and reporting requirements.

The Convener: I want to separate out the two issues: one is about the inspections in which people turn up, and the other is to do with reporting. With the provider that you mentioned, were there five days of inspection by the care commission plus two days by the local authority?

Annie Gunner: I think that it was the other way round.

The Convener: That is interesting. Is five days of local authority inspection and two days of care commission inspection unusual? Were there particular reasons for that, or is it the average scenario?

Annie Gunner: It is hard or almost impossible to average out the figures, as we represent 60 providers that provide services for 50,000 people. However, we have anecdotal evidence that the

situation is a problem for a substantial number of our providers.

The Convener: With the greatest respect, I am having slight difficulty understanding why even seven days of inspection out of a year of 365 days is such a burden. I may be missing something—people might wish to comment on why that is such a burden.

Annie Gunner: We have to return to whether all the inspections are necessary. Our view is that they are not. As we have a national regulator, why would anybody repeat any of its processes for any length of time, whether for two days or for two hours?

The Convener: The point that I am trying to make is that, in global terms, that does not seem to be an enormous amount of time. Other witnesses might want to explain more clearly why it is onerous, or say that it is not onerous.

David Bookbinder: To back up what Annie Gunner said, the most onerous aspect is not visits. A lot of services that are provided to people in ordinary housing are not visitable services; people's houses are not establishments, so they do not get visited as such. The main issue for the 66 housing associations in Scotland that are registered support providers is returns. They have to do desk-based paperwork that the local authorities ask for, on policies that are similar to but different from those on which the care commission asks for paperwork, and they have to provide similar sets of returns—sometimes quarterly, sometimes monthly—on what their staff do hour by hour.

The fact that such returns are sought across the board is understandable, because there is equity for all services, but some services are sheltered housing schemes where people get £10 of support a week, while others are 24/7 services where people get £700 or £800 of care a week. All services get the same treatment and require the same returns. Some of our members are providers of one small service. For example, a housing association in the east end of Glasgow might have one sheltered housing scheme among its 1,500 properties. That one scheme makes it a registered support provider, which means that it has to fill in all the returns that the local authority asks for, as well as those that are subject to statutory regulation by the care commission. It is the desk-based paperwork, rather than the visits, that creates difficulties.

The Convener: Ewan, do you want to come in on that?

Ewan Findlay: No.

The Convener: You looked as though you were twitching, ready to come in.

Before we move on, I ask everyone to take their BlackBerries and mobile phones off the table and away from the microphones, because if they are on they interfere with the sound system.

Jim Dickie: I thank Annie Gunner for conducting a dialectic, which set out my position as well as hers. I am used to that in my dealings with Annie; no doubt she will get me back for that comment.

It is important to be clear about the subject matter. First, I see a clear distinction between the regulatory activities of the care commission and the activities about which I am primarily concerned, which relate to provision of care through a contractual arrangement with specific providers. That is much more about individuals' experience of the care that I have purchased on their behalf and on behalf of my authority. I see the job of the care commission as setting the scene, setting out the framework in which services are provided, setting national standards and ensuring that providers who are registered adhere to those standards. My concern is that I am paying for the care of large numbers of people—something like 50 per cent of my budget is taken up with buying care from a huge range of registered and other types of providers. That cuts across the home care sector into long-term care. It is a complex field but one in which the care commission has an important and overarching role.

The question about unnecessary duplication almost invites the response that duplication is, arguably, always unnecessary; it is rarely an efficient way of managing one's affairs. To that extent, I am interested in minimising duplication.

The other qualification that I have to introduce is that I am talking in large part about the authority in which I operate and the particular experience that we have in working with providers and engaging with the care commission. My comments reflect what goes on in my field.

Is there unnecessary duplication? No. Do we need greater collaboration or synchronisation? Yes. However, I do not think we can ever say that we can do away with one or t'other of the care commission and the local authority. As someone who works for an authority that probably spends tens of millions of pounds on care, I need to be able to reassure the people to whom I am accountable—the elected members of North Lanarkshire Council—that I am spending that money wisely. When issues arise about quality or the care of individuals, at the end of the day, it is me who is het for that. I must have systems that can deal with that.

15:15

I can also reassure you that I do not have an inspection team. I have a small team of staff

whose job is to commission services from the independent sector, to deal with tenders and, thereafter, to handle contractual issues. The people who do the more detailed work are the care managers. The care managers assess the needs of individuals, place them and thereafter oversee and review the delivery of care to them.

We work with a large number of providers—private and voluntary organisations—and that is not going to diminish; we will work with more as new organisations come into the field. Frankly, I have no interest in having a huge infrastructure in my department in order to police that sector in the way that might be being presented. We have a collaborative relationship with the care commission and, in large part, with the providers. When issues arise, we will deal with them clearly, robustly and, I hope, constructively. I hope that we can streamline some of the processes that are involved.

I have one other point of clarification. Annie Gunner referred to the perceived imbalance in inspections that are conducted by local authorities and the care commission. The first bullet point on page 4 of her written submission refers to the fact that two days are taken up by the supporting people review, which is a bit of the bit that I have responsibility for, and that five days are taken up by the care commission reviewing the same services. That is the other way round from what she said.

The Convener: However, do you accept that some of the information that is being sought by you and by the care commission is the same information?

Jim Dickie: Yes.

The Convener: Has there been any discussion with the care commission to establish a basic format for the stuff to be dealt with, to which local authorities could add rather than duplicate? I ask Alan McKeown to answer that question, as he is here to represent COSLA. I wonder whether, at a broader level, there has been discussion with the care commission of ways to reduce the duplication.

Alan McKeown: People accept the fact that there is some duplication. As Jim Dickie says, local authorities have a duty of care not only to the client, but to—

The Convener: That is not what I asked.

Alan McKeown: I know, but I am coming to an answer. We have a responsibility to ensure that we are doing the right things. We are held accountable for that—

The Convener: Fine, but I do not want a speech every time that a question is asked. Has COSLA discussed with the care commission the possibility of reducing the duplication?

Alan McKeown: Yes.

The Convener: Right. When did those discussions begin?

Alan McKeown: They began at the tail-end of last year, through our politicians raising the issue of duplication and asking that some action be taken.

The Convener: So the discussions are current.

Alan McKeown: Yes.

The Convener: It is useful for the committee to know that. Is there a timescale for the delivery of something fruitful from those discussions?

Alan McKeown: We do not have an end date, but we are moving swiftly on the discussions.

The Convener: That means that there is a possibility that the situation might be resolved before the care commission inquiry is finished.

Alan McKeown: When will the care commission inquiry finish?

The Convener: We will have reported fully by the beginning of the summer.

Alan McKeown: We will have made substantial progress by then.

The Convener: Right. I note the lack of commitment to a timescale. However, what you have told us is useful, as that will help to reduce some of the duplication.

Pat Wells: It is important that the local authorities remain involved. It was the local authority that picked up some of the day-to-day care problems in a case that I was involved with; the care commission did not pick them up at all. The paperwork looked fine and a line was drawn under the case for that reason. It was the local authority that got to grips with the problems.

The Convener: I ask Alan McKeown or Jim Dickie whether there has been an audit of the regular checks that local authorities carry out.

Jim Dickie: I am trying to recall whether there has been any such activity. We are subjected to internal audit in relation to the operation of the policies and processes to which the council has committed itself. From time to time, there is detailed scrutiny. We also have scrutiny panels to which I render account for the broad policies for which I have responsibility, including charging arrangements. I am acutely aware of being under the microscope on a routine basis.

The point that Pat Wells made illustrates the difference between the Care commission and local authorities. We have different responsibilities. That is not to say that if the care commission went into an establishment and became aware of difficulties

that individuals were facing, it would not raise those with me—it would. However, in general terms, we have overlapping but substantially different responsibilities.

The Convener: That comment is useful.

Hilda Smith: The ADSW is involved in work with the Scottish Executive supporting people duplication group, which is chaired by Pat Bagot and Chris Taylor. The group has been working for about 12 months on issues of duplication under the supporting people initiative, especially in respect of registered social landlords. It has been examining local authorities' accredited provider lists, which are sometimes called restricted standing lists. It is comparing the items that local authorities check through that process with those that the care commission checks. The group is made up of representatives of the ADSW and the Scottish Federation of Housing Associations. I believe that CCPS is also involved from time to time and that the care commission has made representations to the group. It has made considerable progress towards streamlining the accredited provider process for checking providers. Basically, it is removing duplication in so far as that is possible.

The Convener: I am hearing that work is being done to reduce duplication as much as possible. The clerks have taken note of that information and we will attempt to have some of it circulated to committee members.

Will Mallinson: I support what Pat Wells said earlier. The experience of advocacy in Edinburgh is that the local authority gives a voice to older people, through the visits that it carries out to homes.

The Convener: That is a useful comment.

Annie Gunner: I want to respond briefly to one or two things that have been said. The work that is being done by COSLA and the care commission relates primarily to the memorandum of understanding, which is very much about clarifying who asks for what and why. I am concerned that the regulated providers have no involvement in that process. I question how we can arrive at any effective memorandum of understanding if the people who are most directly affected are not part of the discussion.

The Convener: Perhaps Alan McKeown can explain why the care providers are not involved in the discussion.

Alan McKeown: They are not involved because it has just begun. We are scoping out the discussion with the care commission to establish its basis before we move forward. It is a question of timing.

The Convener: Is it intended that care providers should be involved?

Alan McKeown: Yes.

Annie Gunner: Alan McKeown and Will Mallinson have spoken about the need for local authorities to stay involved, because they pick up things that the care commission does not. The implication of that comment is that we require two teams of people, because one may have to pick up what the other misses. In that case, there may be no end in sight to the problem. Is it being suggested that it will exist in perpetuity? As my colleague Hilda Smith said, we are involved in processes that are aimed at tackling some of the issues. The difficulty from our point of view is that we will end up largely with voluntary agreements, which local authorities can choose to use or not to use. We wanted to bring that to the committee's attention because we wonder whether something slightly more stringent than a voluntary agreement might sort some of that out.

Kate Maclean: When I visited Greenock, carers groups there suggested to me that committees of lay volunteers should visit care establishments in the same way as lay volunteers visit other establishments. What do the witnesses feel about that?

Pat Wells: The patient partnership in practice group in the Royal College of General Practitioners Scotland—P3—suggested that as well. Provided that the lay people were informed and knew what they were looking for, it would be an extremely good thing because they would see much more of the day-to-day aspects of care establishments that have a major effect on residents' quality of life. There might not be any need for the local authorities to remain involved, provided that the care commission's remit was modified to include lay groups in its visits but, at the moment, there is not an awful lot of confidence that the care commission will pick up on the important day-to-day issues that many residents raise.

The Convener: The point is that, as long as local authorities pay the piper, they want to have at least some opportunity to call the tune. That is what it comes down to.

Jim Dickie: To reiterate that point, it is unrealistic to aspire to a situation in which only one body is involved, whether it is the care commission or local authorities. We have a shared interest, but we have different responsibilities and the point that the convener made emphasises that. It is fundamental that we grasp that point, because it helps us to understand how we would manage the process. I am aware that people want to come together and I support that.

When I had responsibility for inspection in North Lanarkshire prior to the care commission's establishment, I had a system of lay inspectors

who worked with our in-house inspectors to examine the quality of in-house and externally provided care in our area. It is gratifying that the care commission is considering developing that option.

The Convener: Kate, are you thinking of something analogous to prison visitors?

Kate Maclean: I hesitate to say that, because there is obviously no relationship between care homes and prisons, but it would be a similar set-up in that lay people with a certain amount of training would make visits. They might examine slightly different matters from those that the statutory bodies' inspections cover.

The Convener: How would the care providers who are present feel about such lay visitors?

Annie Gunner: My understanding is that the care commission is already developing that approach.

The Convener: I am not asking about the care commission; I am asking about your response to the idea.

Annie Gunner: Community Care Providers Scotland would welcome it.

Helen Eadie: Following the visit that Kate Maclean and I made to Greenock, the newspapers picked up on that point and I received a six-page letter from a social worker. The letter arrived only this week, so I will pass it on to the committee. The writer was anxious that the introduction of lay visitors would be a retrograde step and would dilute the care commission's work. They were very concerned that the commission's work should not be diluted.

The Convener: That is another view. If you pass the letter to the clerks, we will all be able to examine it.

We move on to money. Does anyone want to put their paw up and comment on the self-financing of the care commission, the impact that that has on the commission's operation and the escalation of fees? I remind everyone that the committee will have a further meeting in which we will take evidence from the care commission.

15:30

Ewan Findlay: The money seems to swing in a big circle around the Government and local authorities. The care commission receives money from, for example, care homes and the local authorities that pay the care homes' fees get their money from the Scottish Executive. Much of the funding for the care commission's fees comes from care home residents who are funded by social work departments and it seems crazy that there is so much invoicing and bureaucracy to move money around that comes from or ends up in the same place.

Jim Dickie: This is unusual, but I am in strong agreement with the witness from Scottish Care. It seems sensible to consider tidying up the matter. There is no great merit in recycling money through different organisations. There might be a slight difficulty in situations in which care is funded by the state to a lesser extent. This might be a little controversial, but it might be legitimate to call on individuals receiving care who can afford it to help to pay for care commission inspections—but that is at the margins. It would make more sense for the care commission to be funded directly.

The Convener: Does anyone else have a view or concerns on that?

Alan McKeown: COSLA shares the view that Jim Dickie expressed. We agree with Scottish Care that there is no point in recycling the money, which is inefficient. Notwithstanding that, when the fees go up, Scottish Care gives us a lot of grief and we have to deal with that thorny issue. The system should be streamlined.

Kate Maclean: If the care commission were funded directly, rather than through the fees that are paid for residential care, would people pay less for residential care? Would less money go in at that end of the system, because money would go directly to the care commission?

Ewan Findlay: Yes.

Mr McNeil: In a similar vein, are the witnesses saying that the care commission's costs should just pass to the Scottish Executive, or that its fees should somehow be deducted at source? I understand that it can be considerably inconvenient when people complain, but are the witnesses suggesting that we solve the problem simply by increasing the overall burden to the taxpayer?

Jim Dickie: The taxpayer pays anyway.

The Convener: Yes, sooner or later.

Jim Dickie: Rather than shuffle the money round the bureaucratic maze, it would make more sense to have a simpler system. It would not be impossible to adjust the grant aid that is provided or whatever fees are paid to achieve a sensible outcome. I am not sure that I remember what the rationale was for the current system, but people do not seem to regard it as a good thing.

The Convener: Bureaucratic mazes cost money.

Ewan Findlay: To answer Duncan McNeil's question, the Executive should fund the care commission entirely, which would make savings on shovelling money around and be more efficient.

The Convener: I presume that the argument that is being made is that we are talking about taxpayers' money anyway.

Mr McNeil: What is the problem, then?

The Convener: The bureaucratic maze creates an additional cost. That is the problem.

Mr McNeil: That is what I do not understand. It was suggested that every time the fees go up, care homes and others complain, but if the money all comes out of the same pot and we are just talking about a bureaucratic matter, why is there a problem?

Mike Rumbles: The care commission's costs might be the same, but if the Executive paid the full amount, someone would lose money. Surely the money that was available to pay for elderly residents' care would be reduced.

Alan McKeown: In the current system, the Scottish Executive gives money to local government, which then gives money to the care homes—the members of Annie Gunner's organisation, for example—through the care fees. The care homes then give money to the care commission. That is an unnecessary chain of expense—an inefficiency that could be stripped out of the system, perhaps reducing the overall cost.

Jim Dickie spoke about nuances in the system. We will have to get to grips with those, but we should explore the potential savings.

Mike Rumbles: The money has to come from somewhere, but if the Scottish Executive provides it, less will be available for care.

The Convener: The point is that the money has to come from somewhere anyway. Perhaps Adam Rennie can clarify the issue and tell us whether the costs in the bureaucratic maze are even remotely traceable.

Adam Rennie: It might be helpful to go back to the financial memorandum to the Regulation of Care (Scotland) Bill. The Executive's intention was that the care commission should normally be financed through fees charged to providers. That policy has been maintained, and I was interested to hear Lord Sutherland describe it as the natural way to go. It is a good and transparent policy to let the costs of regulation fall on the regulated. I understand that that is how the Scottish Environment Protection Agency is funded, for instance.

The policy has a sound intellectual justification, but practical arguments have arisen over what has been described as a money-go-round or a bureaucratic paper chase. The only point at which fees are identifiable as individual bags of money is when the care commission invoices the registered providers once a year for their continuation fees. Thereafter, the money does not have a discrete identity. It is not as if the providers then send a great collection of bills to local authorities, which then send bills to us. It is all just part of the cost of operating the care service.

The Executive has taken steps to simplify the procedure for minor fees that are charged by the care commission. As the minister announced just before Christmas, a fee will no longer be charged for things such as applications for a new certificate of registration or for a variation of conditions. Those fees were very small and a bit of a nuisance, so they will no longer be charged.

Helen Eadie: The submission from North Lanarkshire Council says:

> "It is worth noting that there have been precedents, such as the Food Standards Agency, where regulation was funded from the public purse."

The question for us is whether the policy should be consistent for every agency.

The Convener: I am going to bat this issue on to the clerks, because we would all benefit from having more detailed information on the traceability of the costs and on the different ways of financing regulation. SEPA and the Food Standards Agency have been mentioned; to allow us to make comparisons, it would be helpful to find out what happens across the board.

Ewan Findlay: The National Assembly for Wales has also abolished fees, so the committee may be able to find out the policy details in Wales.

The Convener: That is a useful suggestion.

Alan McKeown: Communities Scotland operates the same evidence-based assessment process for its regulation, and it does not charge.

The Convener: Okay.

Mrs Milne: Are there checks and balances within the care commission to ensure that the charges for regulation are justified?

The Convener: That is something that we will have to raise directly with the care commission next week.

Adam Rennie: I will respond to Mrs Milne's question. Every year, the care commission's budget has to be approved by Scottish ministers, and that is part of the process of setting the maximum fees that the commission can charge.

As you say, convener, the committee will hear from the care commission next week. I would be surprised if it tells you that the Executive is soft on it—although I may be wrong about that.

The Convener: I have just been told that the care commission is coming on 7 March, so it is not next week but next week but one.

Annie Gunner: In 2004, CCPS did some work to try to establish where the money went. We asked a question of principle: should we have a bureaucratic trail of money going through all these transactions? On a more practical level, we tried to find the money. We wrote to all the authorities in Scotland and asked them whether they could identify the money that the Scottish Executive had apparently provided for the purpose in question. We received replies from 26 authorities, all of which said that they could not trace the money—they did not know where it was. If we want to argue for transparency in one part of the system, there must be matching transparency in all parts of the system.

The Convener: Will you send the committee information about that?

Annie Gunner: Yes. I can let the committee have the documentation.

The Convener: That would be useful.

Annie Gunner: Another important aspect to consider is what providers pay for. Our submission says that our member who pays the highest fees pays the equivalent cost of five full-time inspectors per annum, but such fees do not reflect the level of service that is received. That issue arose during my previous appearance before the committee, when it was discussing a reduction in the minimum frequency of care commission inspections. A big issue was who should pay for what. If poorer-quality providers require much more attention from the care commission, they will, in effect, be subsidised by fees that higher-quality providers pay. That factor must be considered.

The Convener: It is useful to remind the committee about that.

David Bookbinder: I have a brief comment to make about proportionality. A housing association that is a member of the Scottish Federation of Housing Associations with one sheltered scheme could pay the commission a fee that represents a quarter or a fifth of the cost of the support that it provides. It can quickly be worked out that low-level support that costs each person in a 25-person scheme roughly £10 a week represents a relatively low annual service cost, but care commission inspection fees can be around 20 per cent or even 25 per cent of that. Most housing associations that provide support have a landlord role—that is their mainstream role—and if the local authority cannot cover care commission fees through the supporting people scheme, which is frequently impossible, the money will, in effect, come out of the association's reserves, which are usually designated for repairing the stock over a long period. Therefore, tenants across the whole housing association will pay the care commission's fees for the sheltered scheme. Perhaps that is another source of fees that we have not taken into account.

The Convener: It would be useful if you could forward concrete examples of such costs representing a huge percentage of the costs of provision. Such examples are useful to our deliberations.

I want to move on to the registration system, which is an issue that people have raised with us. There are concerns about the complexity of the system and the resulting reduction in the range of services and about new services being discouraged. In my constituency, there are indications that respite care on a day-care basis is beginning to drop out of the system because it is subject to a separate inspection regime. That takes us back to our previous discussion. A number of providers are beginning to come out of the day-care market simply because they think that it is not worth continuing to be in it. I invite comments on the registration system and on its impact on the provision of services and on the encouragement of new services.

15:45

Jim Dickie: I will make what is probably a neutral point. I do not get the sense that the registration system impacts on whether services continue to exist, except where something is profoundly wrong with them. Models of service change over time: we are currently seeing a significant move towards person-centred services, which are less reliant on the buildings in which people have traditionally congregated, such as residential settings and so on. Different approaches are being adopted. Therefore, we may be witnessing an evolutionary change and not the impact of the registration system.

Will Mallinson: I back up what the convener said. Wearing another hat, as the chair of the Edinburgh Voluntary Organisations Council's forum on services for older people, I can say that we too find the situation complex, confusing and frustrating. I can send some examples to the committee.

The Convener: Please do. Concrete examples are always extremely useful.

Adam Rennie: I agree entirely with Jim Dickie's perspective. The situation is evolving, which means that the kind of services that people provide will change over time. The various care service definitions that were set out in the Regulation of Care (Scotland) Act 2001 were necessarily a snapshot of the kind of services that were around at the time. There is provision in the act for the list of care services to be extended by way of ministers making an order. That can happen organically, over time.

The Convener: Is not there a need for a monitoring exercise to ensure that the services that are being delivered evolve not out of bureaucratic necessity but because they are needed?

Jim Dickie: Absolutely. The safeguard is to talk to the people who use the services and to the carers who support them. The more we talk to people, the more we hear that the models of care that people want are those that are focused on individual needs. People do not want to have to put up with services that are off the shelf, so to speak. The purpose of the National Health Service and Community Care Act 1990 was to move us into that kind of era. It has taken us a long time, but there is a lot of evidence that we are doing it now.

The Convener: I raised my concern about day care and respite care because I sense that an issue is beginning to develop in those areas.

Adam Rennie: The 2001 act must have hard-and-fast definitions, which can appear to be very bureaucratic. We are talking about a statutory system of regulation with criminal offences attached to it. Under the 2001 act, it is a criminal offence to provide a particular sort of service without being registered. The 2001 act also contains lots of powers for the care commission and so on. Therefore, it is important to understand exactly where the line is drawn.

The Convener: We could usefully ask the same question of other witnesses on other panels, as they may well have a different perspective from the one that is being expressed around the table today. I think that Will Mallinson was suggesting that that is the case. We need to ensure that we take that evidence.

I turn to the complaints system. Does it need to be changed? Is there a better way to do things? Can we protect complainers in a better way? In previous evidence-taking sessions, we have heard that people are afraid to complain because they are worried that some kind of retaliation or sanctions may be taken.

Members of the panel who listen to the radio may have heard the fairly lengthy phone-in programme this morning in which people were complaining about the complaints system.

Eric Drake represents what can be called the repository for some of the complaints that are made. Do you have a comment to make on the subject?

Eric Drake: The short answer is yes, there does need to be change. We do not have good evidence that people are being penalised for making complaints, but we have evidence that people are afraid that they will be penalised if they make complaints.

A related issue is that it is often difficult for people to understand whom they should complain to; the system can be extraordinarily complicated. If I may, I will illustrate that with a case that we are in the throes of investigating. The complaint was made by a lady about her elderly mother's care. The mother was first in a national health service facility; then in a privately run facility where her care was funded by the NHS; and then back in NHS care. Therefore, she had to pursue her case through the NHS, the private care provider and the care commission before she brought the case to our office. She is also pursuing a complaint about individual nurses with the Nursing and Midwifery Council, which is very difficult to do. It is unsatisfactory for the care provider to have all those people dabbling in what is essentially the same issue. I would argue for much greater simplicity.

The Convener: That is useful. Does anyone else want to comment?

Pat Wells: There is an urgent need to make readily available to every resident and every relative or appropriate carer a simple, clear complaints pathway. The complaints system is currently intimidatory and stressful. Whether or not there is evidence of residents or their relatives being adversely affected because of complaints having been made, the fear that that will happen exists. We must get away from that.

Mr McNeil: We all have anecdotal evidence from certain groups who tell us that they are afraid to complain or that they do not know anything about the complaints system but fear that there may be consequences if they complain. Although the issue is serious, it must be handled carefully—sensational headlines are not helpful. There is an issue about evidence. I do not know whether others agree that we should not bandy headlines about, because they can become self-fulfilling and make people afraid to complain.

How do we have a debate about the issue without frightening those who are not already frightened to complain? We must all be responsible. That includes campaigning organisations, which might get a headline on the issue but terrorise elderly people into believing that if they complain they could be put out or face other dire consequences.

I want advice on how to tackle the issue. I would appreciate any opinions on how we could simplify the process and whether we could red-flag things. MSPs find ourselves in the situation of asking whom we should complain to. Eric Drake's organisation would tell me that unless I have got over all the other hurdles, I should not go to it. You are locking me into a system that you criticise. How can we overcome the barriers?

The Convener: There is perhaps an argument for having some of the relevant journalists before us to give evidence on their role.

Mr McNeil: We could also examine press releases.

The Convener: You make a very good point.

Shona Robison: I would like Pat Wells to say a little more about an issue that she mentioned, which we could perhaps put to the Scottish Commission for the Regulation of Care when its representatives come before us.

Pat Wells said that the day-to-day care issues were not picked up through the formal inspection process. Why was that the case? Was it a failure of the complaints system? What lay behind it? The issue was very much the substance of what was discussed on the radio phone-in this morning. Is information being passed from one organisation to another as it should be? It strikes me as being a bit of a double whammy when carers and relatives have to run around to get their voice heard. The issue—that the care provision is not as good as it should be—should be picked up as a failure within the system, but in the situation that was alluded to, that did not seem to have been the case. It would be useful to hear more about that.

Pat Wells: I admit that I speak from some fairly bitter experience. The care commission report on the particular care home read brilliantly—it stated that there were no problems. However, as someone who went to the home every day, I have to say that that was far from the reality. The problems that arose related to the things that inspectors perhaps do not look at, such as people becoming cold because they have been left in a bath while the water is run out. Such things are difficult for inspectors to pick up, but they affect people's day-to-day lives.

Care homes' mission statements state that the dignity of residents is important, but dignity is a seriously overused word in speech and a seriously underachieved thing in practice. Dignity is not afforded to people even in simple ways. Dressing is a good example of that. Often, young males, sometimes from abroad, work as carers, dressing and dealing with elderly females. The care commission's inspection report said that people could choose who they had to dress them, but when I mentioned that to the care home, it said that that was not possible. Residents get upset about such things, which make them feel that life is not worth living.

I have many examples of things that the care commission is not picking up. I will not mention them all. The care commission's reports make things sound fine but, in reality, I know that they are not fine. There is a big gap, which I want closed.

I suggest that every care home should have a relatives group. Not everyone would be interested in participating in such a group, but it would enable relatives to come together to discuss problems. Often, the problems that occur are experienced by many residents. A relatives group would mean that problems or difficulties could be mentioned anonymously to managers—and possibly to the care commission—rather than being pinpointed as coming from individual residents.

A relatives group could also give support to relatives who have had a bad visit, perhaps because their loved one is not in a good state. Relatives might be elderly and not in good health themselves. Often, they have nobody to turn to or to support them, which is sad.

The Convener: You indicated that there are things that you do not want to say or to put before the committee but, with respect, we need that evidence. If you do not want to give it in an open evidence-taking session, will you at least give it in writing?

Pat Wells: I do not mind giving the evidence; I am just conscious of the committee's time.

The Convener: Will you provide some examples in writing?

Pat Wells: Yes.

The Convener: That will be useful because we will be able to put some of your points to the care commission when we see it. At a simple level, it is useful to know that elderly ladies are having to endure having their clothes changed by young males. Most people will be pretty unimpressed by that—I certainly am. That is an example of the kind of information that we need.

Fiona Cherry: My first point is about clarity of roles. I am concerned that inspections are carried out at different levels in different areas. There does not seem to be a level playing field. I am concerned about the educational input and the steep learning curve that inspectors have had to endure. People who run care homes are well aware that a percentage of their staff must have certificated training. I would like the same stringent rules to apply to the inspectors, so that they have the same training and are aware of the facts that we heard from Pat Wells, which are horrifying. It should not be a question of social workers going into a care home to pick up on a problem. The inspectors are there to inspect and to regulate the system and they must learn how to do that. They have to go into care homes and pick up on the nuances.

When I troubleshoot in nursing homes, I begin by setting up a relatives group. Such a move has been extremely beneficial because it provides an opportunity not only for the relatives to state their

concerns clearly but for the staff to learn. After all, the staff are terrified of complaints and worry that their jobs are on the line.

I believe that, for everyone in the sector, the issue comes down to learning. For example, mature women who might have no qualifications need to be trained properly in dealing with individuals and to know that they should not recoil from clients who are worried and want to complain. Instead, they need to listen to the complaint and take it on.

We need more emphasis on training. However, I understand that, because funding is to be reduced, such training is likely to be cut. If that happens, the whole thing will fall on its head, because we will not have people who are trained to provide adequate care.

16:00

Will Mallinson: I agree that we need more relatives groups in residential care homes. However, we also need independent representatives or advocates for older people, particularly those who do not have any relatives to support them or who have unsupportive relatives, to take forward their complaints and to give them the support that they need.

Mike Rumbles: I wonder whether Pat Wells can tell us why the inspection team did not pick up the problem that she highlighted.

Pat Wells: I do not think that the person concerned ever saw or spoke to anyone from the care commission. The commission does not seem to speak to many relatives or, indeed, residents.

Mike Rumbles: I accompanied only one inspection, but I was impressed by the fact that the team spoke to relatives and residents.

Pat Wells: Yes, you said that.

The Convener: Perhaps an MSP should accompany every community care inspection.

Hilda Smith: I understand from colleagues in the care commission that, despite the fact that the number of complaints is increasing, the commission is not picking up on problems partly because the inspection teams inspect against only two or three standards. I do not know the exact number off the top of my head, but I believe that 15 to 18 different standards apply to care homes. That is why local authorities monitor the services for the people for whom they are responsible.

The Convener: So the problem that Pat Wells highlighted would not have been picked up by the inspection team because it might not have been looking at that particular issue.

Hilda Smith: That is possible.

The Convener: Okay.

Ewan Findlay: With regard to Pat Wells's comments, my nursing home used to be inspected by the health board. I agree that when the care commission took over responsibility for inspection one noticeable difference was the emphasis on paperwork. The health board also seemed to have a feeling for what was happening; its teams seemed to know from experience whether things in a care home were right or wrong.

Mike Rumbles seemed to be impressed by the methodical approach to paperwork and the fact that everything was evidenced. However, it brings us back to the old nurse's complaint about spending more time with a pen in your hand than with the patient. I do not know how to change the situation, but I know that it needs to be changed. Instead of being bureaucrats, nurses must be hands-on.

To be fair, I think that the care commission does a good job but, as it progresses, things need to be tweaked. It is only to be expected that any new body will have teething problems. To touch on what Fiona Cherry said, perhaps it needs to have a mix of staff, so that more nursing staff do inspections. We must examine the qualifications and experience of some of the inspectors. Ultimately, getting that right can only benefit residents.

Mike Rumbles: I would not like anyone to go away with the wrong impression of the feedback from my visit. I was extremely impressed by the professionalism of the inspection team. One team member was entirely engaged in speaking to people while the senior one was engaged with the manager of the care home. However, it was not led by paperwork; the paperwork was the evidence. It was not just a cosy chat from which they got a feel for the issues. It was an in-depth discussion of all the issues with evidence taken.

The Convener: Adam Rennie wants to come in and then Ewan Findlay.

Adam Rennie: Thank you, convener. The committee will be able to speak to the care commission about the two points that have been raised. Care commission staff are being trained—on a phased basis—through the new regulation of care qualification from the Scottish Social Services Council. It is intended that all care commission inspecting officers will obtain that award.

On Hilda Smith's point, yes, the care commission is inspecting against the national care standards on a phased basis. As the committee will know, there is a great deal in each national care standard. Typically, there might be 15 standards, supported by a large number of more detailed statements. The work is done on a phased programme. A particular set of standards

is considered in one year's cycle and then another set in the next year. An eye is kept on obvious problems in relation to any of the standards that are not part of the detailed focus. The care commission will be able to tell the committee more about that.

The Convener: I want to ask Annie Gunner about this and then Ewan Findlay can add anything he wants to say.

Pat Wells gave a particular example of elderly ladies having to endure having their clothes changed by young males. Frankly I find it appalling that anybody is put in a situation in which they have no alternative but to endure what must be an appallingly embarrassing, if not humiliating, experience. I want to ask the providers—Annie Gunner, Ewan Findlay and Jim Dickie—about that aspect of provision. It is not about the larger care issues but about affording individuals a level of respect. The suggestion is that that is often swept aside because it does not happen to be convenient for the providers. Will the providers comment on that?

Annie Gunner: That was a very powerful example and I do not think that it is an isolated one. We need to ask ourselves whether any inspection process would pick up such an example, given that it is limited to one or two days. I remember having this discussion when the original legislation was going through the committee. Shona Robison will remember that too. The question arose whether we should inspect once or twice a year. My then colleagues from the providers' associations said that such an example was unlikely to be uncovered during inspections, however frequent they might be.

Such instances are picked up when a provider has a proper quality assurance management culture and system, which allows service users themselves—not inspectors or local authorities—to articulate what they think about the service. As my colleagues Fiona Cherry and Eric Drake stated, such a system will be receptive to rather than frightened of what they say. Several of the larger providers have made some headway in that area.

One difficulty is that inspectors and purchasers do not recognise that as being part of the whole process. When we were before the committee on the minimum frequency of inspections, we said that inspectors and local authorities ought to work with providers to validate a quality assurance monitoring system that would operate 24 hours a day, not just one day a year. It must also enable service users to articulate what they think of the service and be receptive to what they say. If that happened, we might start to crack some of the issues.

Ewan Findlay: What happened to that old lady is abhorrent. It should not have happened because the choice of who she wished to be toileted by should have been in her care plan, which outlines what should happen in practice. If that does not happen—I am not sure whether the incident happened in a nursing or care home—the nurse in charge should be held to account for it as well as the manager matron. It should not happen, but as it does happen, the question is how we stop it.

My last comment, and Alan McKeown might want to speak about this too, is that Scottish Care and COSLA are working towards a new quality agenda. Alan McKeown might want to touch on that.

The Convener: Okay. I want to bring in Jim Dickie, then I will ask Pat Wells to comment.

Jim Dickie: I share the feeling of abhorrence that committee members and others have expressed at Pat Wells's description. The reality is that the best safeguard against that kind of behaviour is good values and standards on the part of those who manage institutions, establishments or care units, so that they propagate those values and scrutinise the practice of their staff, as well as having external systems that keep an eye on practice. An inspection regime such as we have—or, indeed, the contract compliance system that we have—is unlikely to easily unearth such matters.

We heard about family support groups. They help to give folk the opportunity to articulate concerns—vague or otherwise—and those can then be followed through. The worst things happen in places where there is relatively little interaction with the outside world. Such interaction cannot be restricted to one simple conduit; there must be many different approaches, involving professionals and lay people.

Pat Wells: The quality assurance for that particular care home read really well and said that the residents could express preferences. When I brought the subject up with the staff, the bottom line was, "We haven't got the staff to do it—we would have to take somebody off another corridor." They were mainly people from eastern Europe anyway and communication was a dreadful problem. They do not know how to do basic things such as use a coat hanger—it was so demeaning. That was just one example and I will send you a list of the others.

The Convener: I know that you have to go now, Pat. Alan McKeown is waiting to speak.

Alan McKeown: In response to Ewan Findlay's point, the intention is to develop a different system, based on quality assurance models and on asking those who receive care or their

guardians about the standards that they expect and the standards that they get. That requires some work with the care commission on the current standards, a number of which are aspirational rather than standards against which performance can be measured easily.

We have some work to do to move the standards into a model that allows us to inspect objectively. We could also consider whether we could attach a fee level to some of the quality areas, such as whether institutions have staff who are able to do the job, turnover and training of staff, because our models for linking those things together are not very sophisticated. We have to move away from the current model to one that is much more sophisticated, but COSLA cannot do that; it must be done by a collective that involves the Scottish Executive, the care commission, those who use services and their advocates.

Mr McNeil: Even more shocking than the claim that that incident happened is Annie Gunner's comment that it was not an isolated incident. It is important for the committee to quantify whether that practice is widespread, where, why and how it happens and how we can put a stop to it. Clearly, everybody here says that it should not happen.

To come back to my original point, if it is a rare occurrence, it should be made clear that it is a rare occurrence. The incident makes for another headline that might terrify elderly people and their relatives in situations where such incidents might happen. How do we get to the stage of being able to quantify the type of incident that Pat Wells described?

16:15

The Convener: Pat Wells will give us some specific evidence, which may give us a way into some of the other cases. Our difficulty, as Pat Wells said, is that the headline inspection reports would have us believe that everything is fine, but going underneath them is difficult. The point about the potential for relatives or visitors groups is well made. The committee might need to return to that issue to address it. At present, there may be no way of quantifying the number of cases that we are talking about.

Mr McNeil: Are we talking about an isolated incident? I see people shaking their heads.

The Convener: There are people with their hands up, so I will give them a chance to speak.

Shona Robison: I ask Fiona Cherry to expand a little on her comment that funds for training are being reduced.

Fiona Cherry: I have concerns about the adult modern apprenticeship scheme. The funding for over-25s is being reduced for next year, but the over-25s are more suited to looking after people in the care setting than younger people are, as they have more experience of life.

Shona Robison: Will you send us written information about that?

Fiona Cherry: Certainly.

The Convener: I ask Annie Gunner to address Duncan McNeil's point.

Annie Gunner: I am slightly concerned that the discussion is focusing entirely on care homes. The majority of our association's members provide non-residential services. Those services are also what David Bookbinder of the SFHA has an interest in. The issue is not only about people turning up and inspecting premises. We are involved in the provision of care at home, housing support, supported living and daytime services. With such services, the possibility of uncovering the type of incident that we are talking about through inspection becomes progressively more remote. That is why it should be the providers' responsibility to have in place a system that enables them to evaluate their service and which is validated by purchasers, the care commission and other partners. The crucial point is that there should be a system that enables service providers to say what they think of their service.

Kate Maclean: A simple way of assessing whether the situation that Pat Wells mentioned is occurring would be for the care commission to ask various establishments what percentage of their residents are women. If 80 per cent of the residents are women and 70 per cent of the staff who are on the rota are men, there is obviously huge potential for the situation to arise. A preliminary check over a period of a week or even a day would give us a snapshot and tell us how likely the situation is. We could do exactly the same for non-residential care. If eight women are visited in a day and half the people who are visiting to provide personal care are men, it is obvious that the situation is arising. It would not be too difficult to get a snapshot of how widespread the problem is; I suspect that it might be fairly widespread.

The Convener: I am sure that it is. We need to put that point directly to the care commission.

Helen Eadie: I want to pick up Annie Gunner's point that it is a shame that we have not delved more into care that is provided in the home. We all know from anecdotal evidence about some of the issues that arise from that, so we need to think about how we can revisit that issue. We should consider the point that was made by Pat Wells about relatives groups having the possibility of whistleblowing. I would be interested in Eric Drake's thoughts on that. We have whistleblowers in other sectors of our society.

The Convener: I am trying to draw the discussion to a close, but three people are now indicating that they want to speak. If we have time, Eric Drake may come back on that; if not, perhaps he could send us written information.

Adam Rennie: I will pick up quickly on Annie Gunner's point. The questions that we have discussed about the care commission apply to all its activities and it is worth remembering that it has about 15,000 registered services, more than 10,000 of which are services of childminding and the day care of children. Understandably, the committee's interest is in health and social care services, but more than half the care commission's expenditure is on the group of services that I described.

The Convener: Our inquiry focuses on personal care for the elderly as well as on the care commission's operations, which is why the two issues are becoming tied up.

Will Mallinson: My response to Duncan McNeil is that the incident is not isolated. We have advocated for male and female residents who have made the same complaint and who wanted carers of the same gender.

The Convener: If you have quantification of that, please let us have it.

I ask Eric Drake to talk about whistleblowing in one minute.

Eric Drake: If I have only one minute, it would be best to provide written evidence.

The Convener: That would be useful, as it would allow us to go into more detail.

I thank everybody for coming along. I do not know whether anybody—I do not mean MSPs—wants to make a very brief final comment. Some people around the table have been involved quite a lot in the discussions, so I am not sure whether anything could be added. I take it that Annie Gunner's point about the variety of provision of care was a general comment. Does anyone else wish to make a very brief comment—I mean in 30 seconds—to flag up issues?

Will Mallinson: Advocacy is one of the national care standards that the commission should act on, but it is not doing that.

The Convener: That is useful to hear.

David Bookbinder: I will talk briefly about proportionality. The care commission is young and we must let it take things step by step. However, the fact that we have heard much evidence about care and nursing homes points to the view that, in time, a care or nursing home should be subject to a different approach to inspection and the weight of the inspection regime than is a small low-level service such as sheltered housing. On a risk assessment basis, the public's resources are better put into services in which the difficulties that we have heard about today are most likely to occur. In time, a proportionate approach should be taken.

The Convener: I thank all the witnesses for their attendance. Their evidence was extremely useful and informative. We will not take evidence for the care inquiry next week, but we will return to it at our meeting in Dundee on 7 March, when we will take evidence primarily on the care commission and related issues. Much of what has been raised today will be replicated in the discussion on 7 March, so you might be interested in keeping track of that on the internet or through whatever means is most convenient for you.

I ask the witnesses to leave and committee members to regroup in whatever way they think appropriate so that we can move to agenda item 4.

Subordinate Legislation

National Health Service (Variation of the Areas of Greater Glasgow and Highland Health Boards) (Scotland) Order 2006 (SSI 2006/33)

National Health Service (Constitution of Health Boards) (Scotland) Amendment Order 2006 (SS1 2006/32)

16:24

The Convener: The Subordinate Legislation Committee has considered two instruments that relate to the winding up of Argyll and Clyde NHS Board. The relevant instruments are described in the paper that has been circulated. The orders will effect a significant change in the area's health care provision, so we might want to take evidence from the Executive on the dissolution process before formal consideration of the orders. We could take evidence and undertake formal consideration at next Tuesday's meeting, if the committee wants to do that. I am advised that the Subordinate Legislation Committee has identified a significant issue, which I understand has something to do with having the capacity to set up a new body but not being able to dissolve the old one. I am conscious that one member of the committee might have a particular interest in the matter. Do members want to take evidence at next week's meeting?

Mike Rumbles: The clerk's briefing paper says that the order

"does not require to be formally considered by the Health Committee."

The Convener: That comment refers to one of the orders.

Mike Rumbles: Yes, it refers to the National Health Service (Constitution of Health Boards) (Scotland) Amendment Order 2006 (SSI 2006/32), which abolishes Argyll and Clyde NHS Board. Will the Subordinate Legislation Committee, which identified the issue to do with the order, take up that matter? I do not want the Health Committee to take it up if the Subordinate Legislation Committee is doing so.

The Convener: The Subordinate Legislation Committee will report to the Parliament on matters within its remit. It identified the issue and is flagging it up. The matter is more important to the Subordinate Legislation Committee, because it concerns the process. The Health Committee is the policy committee; if we were to take evidence on the order, we would consider policy issues rather than the process, which is more properly the remit of the Subordinate Legislation Committee.

Mike Rumbles: Is the Subordinate Legislation Committee taking the matter up?

The Convener: Yes. I presume that the issue will figure in the report on the orders that that committee gives us—I am advised by the clerk that the National Health Service (Constitution of Health Boards) (Scotland) Amendment Order 2006 (SSI 2006/32) will not be referred to us, because it does not raise issues that would come before this committee in the normal course of events. The Subordinate Legislation Committee will refer to us only the National Health Service (Variation of the Areas of Greater Glasgow and Highland Health Boards) (Scotland) Order 2006 (SSI 2006/33). Do members want to take evidence?

Mr McNeil: I regard the matter as a legal technicality.

The Convener: Yes, but you are talking about the National Health Service (Constitution of Health Boards) (Scotland) Amendment Order 2006 (SSI 2006/32), which will not be referred to this committee. Do you want to take evidence on the other order?

Mr McNeil: I do not know whether policy issues arise. The matter has long been debated and discussed in all sorts of committees. We are in the process of going forward and—from a selfish perspective—I think that the sooner that happens, the better.

The Convener: If there are no further comments, I take it that members do not want to hear from the minister.

Members *indicated agreement*.

16:28

Meeting continued in private until 16:42.

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