HEALTH COMMITTEE

Tuesday 7 March 2006

Session 2

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HEALTH COMMITTEE
6th 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:

Alan Baird (Dundee City Council)
Mary Hartnoll (Scottish Commission for the Regulation of Care)
Councillor Glennis Middleton (Angus Council)
Robert Peat (Angus Council)
Jacquie Roberts (Scottish Commission for the Regulation of Care)
Bailie Helen Wright (Dundee City Council)
David Wiseman (Scottish Commission for the Regulation of Care)

CLERKS TO THE COMMITTEE

Lynn Tullis
Simon Watkins

ASSISTANT CLERK

David Simpson

LOCATION

Discovery Point, Dundee

Scottish Parliament

Health Committee

Tuesday 7 March 2006

[THE CONVENER *opened the meeting at 13:30*]

Care Inquiry

The Convener (Roseanna Cunningham): I welcome everybody to this afternoon's meeting of the Parliament's Health Committee, at which we will continue with our care inquiry.

We meet in Dundee because the Scottish Commission for the Regulation of Care is based here and it seemed more sensible for us to come here rather than for everybody to come down to Edinburgh. We will hear later from the care commission, but we will first take evidence from representatives of Angus Council and Dundee City Council.

From my right to left, the first panel of witnesses is: Robert Peat, who is director of social work for Angus Council; Councillor Glennis Middleton, who is convener of social work for Angus Council; Bailie Helen Wright, who is the convener of social work for Dundee City Council; and Alan Baird, who is the director of social work at Dundee City Council. I welcome both the politicians and the officials to our meeting.

I know that the representatives of Dundee City Council want to make a short opening statement—I do not know whether the witnesses from Angus Council will do the same—but I ask that it be kept as short as possible. We have allocated roughly from 1.30 pm to 3.15 pm for the entire meeting, and we need to try to give equal time to both panels.

Bailie Helen Wright (Dundee City Council): On behalf of Dundee City Council, I thank the committee for giving the director of social work and me the opportunity to contribute to such an important inquiry.

Social work provides a complex and diverse range of services that take account of many pieces of legislation, but our most important function is to meet the needs of individuals and to change people's lives.

I am proud of the services that Dundee City Council provides every day to older people. We are committed to helping people to remain in their own homes for as long as they wish. That means supporting them every day throughout the year so that they can remain independent for as long as possible.

In Dundee, we have welcomed the introduction of free personal care for over-65s, and have followed that principle in the services that we provide for older people. Although the speed of implementation may not always be fast enough for everyone, our commitment is sincere. In future, increasing demands for resources will be placed on the Scottish Executive, given the trends that local councils face in implementing free personal care effectively in local communities.

In Dundee, 32.9 per cent of all households contain one or more pensioners and 42 per cent of the population is over 45 years of age. Some 22.2 per cent of the population is over 60 and 18 per cent of the population is over 65. As the committee will know, Dundee also has the highest levels of poverty in Scotland, as the poverty rate is 28.3 per cent. Poverty is usually accompanied by ill health and demands on our services.

Along with partners in NHS Tayside, the voluntary sector and the Scottish Executive, the city council will continue to do as much as possible to help to improve the lives of older people in Dundee.

Councillor Glennis Middleton (Angus Council): Care is a hugely complex issue that can be neither understood nor managed unless all aspects and impacts of decisions that are made are given careful consideration.

Local authorities are often accused of not striking the right balance between care at home and care in a residential setting. We are under enormous pressure from the Executive to expand care at home so that older people need not enter a residential setting. However, that pressure impinges on individuals' choices. We cannot offer choice if pressure is exerted in only one direction. Until social isolation is factored in as part of the assessment criteria, that problem will continue.

At the same time, the Executive is applying pressure to reduce the delayed discharge figures. The quickest way to reduce the figures is to transfer an individual to a nursing or residential setting, which increases the burden on such places and makes it unlikely that the individual will leave. However, if more time and resources were available a suitable care package could be put in place to allow the person to go home, where they would be likely to stay for a long period before they needed to move to a residential care setting. We must also deal with pressure from families who are concerned for the safety and well-being of their loved ones and who often would prefer them to be cared for in a residential setting.

Demographic trends tell us that during the next 10 years in Angus there will be a 30 per cent

increase in the number of people over 65 and a 20 per cent increase in the number of people over 80. Such increases call into question the sustainability of universal free personal care. Free personal care brings financial advantages to individuals; it does not mean that they receive more or better care. An individual who is assessed as requiring a package of care will receive care according to their need, regardless of whether it is free. Resources are finite, and as many more people require care in future, difficult choices will have to be made. Either we must change current policy so that free care is no longer universal, or we must change the assessment criteria so that people access services at a later stage. However, the latter approach is problematic, because an individual who accesses care at a later stage might need more care than they would otherwise have needed. In addition, free personal care is currently denied to people who are under 65, who might need a greater package of care than do some older people, which smacks of inequity.

Direct payments are also problematic. They are made on assessed need and do not mean that individuals will receive more or better care. People who require only one or two hours' service per week often feel that it is not worth the effort of entering the direct payments scheme. More vulnerable people who require significant levels of care find it hugely daunting to take on the role of employer or to seek out an appropriate organisation from which to purchase care.

We must also consider the impact of direct payments on a local authority's ability to provide services. If an authority's resources are reduced as a result of direct payments, the knock-on effect will be a corresponding reduction in the capacity of the local authority to fulfil its statutory duty to provide services and to safeguard the well-being of everyone, including people who are in receipt of direct payments. When things go wrong, such people's first port of call is the local authority that provides the direct payments.

We all want to deliver the best possible services, but until there has been full consideration of the practical impact of decisions that have been made, local authorities will continue to juggle competing demands and pressures.

I have tried to be as brief as possible—I can breathe now.

The Convener: Thank you. We will go straight to members' questions. I have allocated until about 2.15 pm for questions to this panel of witnesses.

Janis Hughes (Glasgow Rutherglen) (Lab): We asked witnesses to say in their written submissions whether free personal care has improved conditions for those who receive it and whether the legislation is operating effectively. In response, Dundee City Council said:

"The current construction of the legislation and supporting guidance can be interpreted to suggest that those entitled to free personal care and who have arranged it themselves, take priority over those who need care but cannot afford to arrange it for themselves. If this is unintentional then the legislation should be amended."

Will the witnesses from Dundee expand on that? I am not sure what it means.

Alan Baird (Dundee City Council): Some people who previously paid for private care feel that local authorities should take over the payments for it immediately, regardless of the level of need or risk. That could mean that they queue-jump others who are in greater need and are still waiting to be assessed or to receive a service. Some service users are encouraged to buy services privately and then send the bill to the local authority. That means that those who cannot afford to buy their care are at a disadvantage and that there is no equity in service provision.

Janis Hughes: My understanding of the legislation is that care will be provided if an assessment finds that it should be. Why do you think that the legislation needs to be amended? I understand your point that the perception might be different, but why do you think that the legislation is not clear?

Alan Baird: The legislation is based on whether and when need is assessed. We need to be clearer in the guidelines and the legislation about what exactly is being asked.

Janis Hughes: Has Angus Council had the same experience? I am interested to know because the matter has not been raised with us before.

Robert Peat (Angus Council): I understand Alan Baird's point, but we make provision on the basis of the assessment, and people are not able to queue-jump—care is provided on the basis of people's need. If people place themselves in a home and then seek free personal care allowance, we follow their assessment and they are treated as quickly as anyone else.

Janis Hughes: Do you think that the legislation is clear on that point?

Robert Peat: Interpreting and implementing the guidance has been relatively clear for us.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): Angus Council's submission states:

"making personal care free to everyone 65 and over, means that resources are not directed at those most in need."

In your presentation to us just now, you questioned the economic viability of free personal care, which accounts for less than 2 per cent of the health and community care budget. How can you say that resources are not directed at those who are most in need when resources should be directed at every individual who is assessed by the council to be in need of free personal care? Surely it is a case of whether someone needs the service or not.

Robert Peat: The service is provided on the basis of need, but some people can afford to pay. Our view is that although everyone is entitled to free personal care, people should be means tested. We have limited resources and we could direct the available resources at a wider range of people with needs.

Mike Rumbles: Should the same logic apply to the national health service? It is the same process—Parliament has decided that those who are assessed to be in need of care should have it.

Robert Peat: We would apply the logic of free personal care to people of any age, as our submission says. It is discriminatory to apply that logic to over-65s but not to under-65s. I agree with your health service scenario and your comment about services that are provided by the local authority, but we should be consistent in applying the logic.

Mike Rumbles: Just to confirm that I understand you correctly, you are saying that we should apply that logic consistently, without the discriminatory element of limiting care to those who are over 65, not that it should not be applied.

Robert Peat: Yes.

Shona Robison (Dundee East) (SNP): My question is directed to both councils, but perhaps to Dundee City Council in particular. The Executive says that you have had enough money for free personal care. From the lengthy correspondence that I have had with Alan Baird, I know that he takes a different view, because he says that that is not the case. You cannot both be right—someone is right and someone is wrong. Why do you feel that you are right? You are all facing a waiting list for free personal care. What is the extent of that list? What is the funding gap that stops you dealing with it? What are you doing to resolve the problem with the Executive? It is frustrating for us and for service users to be caught in the middle of an argument between the Executive and the council.

13:45

Alan Baird: One hundred people in Dundee are awaiting residential or nursing care. Thirty-five people are waiting for the free personal care allowance to be paid; five of them are currently in hospital. I have a responsibility to manage the social work budget and to bring it in on a yearly basis. At the moment, demand is outstripping supply. Our priorities, and how we move people out of the hospital system into the community and assess their needs, are reviewed on a weekly basis. Of the 100 people to whom I referred, a number are waiting for the home of their choice, whether it be a local authority home or a nursing or residential home, which accounts for some of the delay.

The social work department's spending is already 2.8 per cent above grant-aided expenditure. The plan is that over the next two months I will report to the social work committee on the services that we are able to provide.

Shona Robison: Bailie Wright, what are you doing to resolve your difference of opinion with the Executive about the funding allocation? What progress are you making on that?

Bailie Wright: We have indicated to the Executive that we are in need of extra funding. We have said that no one will wait for payment for more than three months post admission to their chosen residential, nursing or home care unit. However, to some extent we are victims of our own success. The introduction of a first contact centre reduced assessment times from six weeks to less than a week. The crisis teams have made a significant contribution to preventing hospital admissions and enabling early discharges. The wishes of older people to have their houses cleaned, their laundry done and minor household improvements attended to have been addressed by redesigning many of our services. We have created a laundry service and practical support and handyperson services. The Scottish Executive's policy on learning disability has been adopted enthusiastically and is being taken forward at quite a pace—although a pace that is affordable to Dundee. We can work only with the resources that are given to us.

Shona Robison: You indicated that none of the 100 people who are waiting for care will wait any longer than three months.

Bailie Wright: For free personal care.

Shona Robison: So none of the 35 people who are waiting for the allowance will wait any longer than three months.

Bailie Wright: Yes.

Shona Robison: I hope that that is the case.

Bailie Wright: Our statistics indicate that 14 people will be taken off our list right away.

The Convener: Mike Rumbles and Kate Maclean have questions about the issue. Would

the witnesses from Angus Council like to comment at this point?

Robert Peat: At the moment, no one whose assessment has been completed is waiting for free personal care in Angus.

Kate Maclean (Dundee West) (Lab): Approximately how long does your assessment process take?

Robert Peat: Ideally, a community care assessment takes 28 days. When dealing with some delayed discharge issues, we work on the basis of a six-week period.

Kate Maclean: Did Helen Wright say that assessment in Dundee can take a week?

Bailie Wright: Yes. Sometimes it takes less than a week. We are victims of our own success, because we try to get people into the system quickly, rather than make them wait for a longer assessment. The crisis team and the first contact centre have greatly helped us to produce the goods, so that the people who need a service do not have to wait for two or three months.

Kate Maclean: I will follow up on Shona Robison's question. Does your assessment process contribute to people's waiting for personal care?

Bailie Wright: Yes, certainly. If authorities take longer to assess people, people do not figure in the list. Because we assess much faster, we have a bigger list.

Kate Maclean: Are waiting lists for free personal care unique to Dundee, or do other local authorities have such lists?

Alan Baird: I will respond first to your previous question. The audit of best value and community planning that was carried out in Dundee last year used single shared assessment as a best-practice case study to highlight the fact that the first contact team, which is the first point of contact for people in the city, was able to reduce assessment times from 67.8 days to an average of less than 2.7 days. The speed of assessment in Dundee must have an impact on lists.

I understand that there are waiting times for free personal care in other local authorities.

Kate Maclean: Helen Wright referred to funding in response to Shona Robison's question. If Dundee City Council's social work department is spending 2.8 per cent above grant-aided expenditure, as Alan Baird said, the council is not receiving adequate funding to enable it to provide the services that it is expected to provide.

Alan Baird: That is right.

Councillor Middleton: The director of social work at Angus Council said that the community care assessment process might take 28 days, but the time taken depends on the complexity of each case. I stress that no individual is left without a service while a full assessment is undertaken.

I think we all agree that a lot of money in the current system is ring fenced. If we get no increase in our core funding, we will always struggle.

Mike Rumbles: It is interesting to hear from two councils that have different approaches. As far as I am concerned, the law is clear: an individual who is assessed as being in need of personal care is entitled to it. There should be no waiting lists; people should not be waiting three months for care, so it seems that the councils have a genuine dispute with the Executive about funding. I want the witnesses to respond to that point. The people who are affected by the dispute between the councils and the Executive are getting the care to which they are legally entitled if they are in Angus, but they do not seem to be getting that care if they are in Dundee. We are legislators—we know what the Regulation of Care (Scotland) Act 2001 says and we know what the First Minister said about the policy. When a person has been assessed, they are legally entitled to the care that they need. I am keen to hear responses, particularly from the witnesses from Dundee City Council.

Robert Peat: It is not helpful to compare authorities.

Mike Rumbles: I have just done so.

Robert Peat: I know, but it is not helpful. As Bailie Wright said, councils are responsible for providing a range of services to meet people's needs. Dundee City Council probably provides services that Angus Council does not provide because we do not have the resources to do so. Angus Council's budget currently enables us to make placements in residential nursing homes and to meet the demands of the policy on free personal care, but Dundee City Council might provide aspects of the home care service or other services that we do not provide—of course if we had additional resources we would like to provide such services.

Mike Rumbles: I understand why councils want to be helpful to each other.

Robert Peat: I am describing the reality—

Mike Rumbles: I understand that, but the committee is considering free personal care and the care commission. Two councils are giving evidence on how they respond to the policy on free personal care. As far as I read the situation, Angus Council, in this case, is responding to the situation within the law, while Dundee City Council

does not seem to be responding within the law. I would like a response to that, please.

Alan Baird: I am happy to try to respond to that, although I am not sure that I will satisfy you with my answer. As is well known, and as Bailie Wright said in her opening remarks, Dundee is one of the most deprived cities in Scotland. As director of social work, I cannot operate one part of my department differently from another, and there are budget pressures in many parts of my department. I know that there are similar problems throughout Scotland in social work areas that include residential secure care and the underfunding of learning disability services so that they cannot meet changing needs or the needs of older people who have learning disabilities. People are living longer.

I have a responsibility to bring the budget in. That is the responsibility that is given to me by the chief executive of the council and by its elected members. I came into social work 30 years ago, and I did so to make a difference to people's lives. We make huge differences to people's lives every day and that is something that I, as director of social work, am very proud of. In the end, however, I must balance the books, and that means bringing the budget in at the end of March, as required by the council.

Mike Rumbles: You also have to act within the law. If the law says that a person is entitled to free personal care after being assessed as needing it, that is what they are entitled to.

Alan Baird: I operate within the resources that are made available to me in the council.

Mike Rumbles: You should operate within the law, surely.

The Convener: We have heard the question and the response. Clearly, there are differences of opinion.

Kate Maclean: If the council was not operating within the law, your legal officers would presumably advise you that you were operating outwith the law. I take it that they have not done so.

Bailie Wright: That is correct. We have received legal advice, and it says that we are not doing anything illegal.

Mike Rumbles: I hope that you will re-examine that legal advice.

Shona Robison: I will try to be helpful. I think that the Executive has been using a get-out on this issue. There has been lengthy correspondence on the matter. The Executive's guidance states:

"Payments will take effect when the local authority is in a position to provide for or arrange the required services."

I think that that is a bit of a get-out that provides a bit of cover for the Executive on the matter. The issue can be resolved only with clarification about funding. Both councils cannot be right. If Dundee City Council does not have enough money, the Executive cannot be telling us the truth when it says the contrary. The committee must get to the bottom of this. Perhaps more detailed figures could be provided in relation to what the witnesses are saying and in relation to the sum of £2.8 million. That would be very helpful as we try to get to the bottom of the matter with the minister, particularly with respect to how the funding for free personal care was assessed when Dundee's allocation was originally made.

The Convener: We have already heard evidence from Robert Peat that Angus Council is managing to provide free personal care within budget only because it is choosing not to do other things that it might otherwise wish to do. I am not sure whether it is possible for Angus Council to let us know what things it is not doing in order for it to achieve the necessary budgetary constraint, which must be the case for the whole thing to balance out. It seems that one council is getting enough money while another is not, but the truth is that councils are making different decisions. It would be useful if Angus Council could provide us with information on that.

We will move on to a different subject now. Jean Turner wishes to ask about direct payments.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): Having taken evidence on the matter, we realise that the uptake of direct payments is different around the country for different reasons. Could you give me more information on what you think the difficulties are around delivering direct payments? How do those difficulties impact on your resource allocation for other services?

14:00

Councillor Middleton: In Angus, there has not been huge uptake of direct payments, although people have been made aware that direct payments exist. As I said in my opening statement, if a person has only one or two hours of care a week, they might simply choose not to bother. It seems to be a lot of bother for people to enter the employer market and have to pay someone. People who have significant care packages can be too vulnerable to go through the bother of doing that. If a significant care package is required in a rural area, there might be no alternative to the local authority package. In Angus, private companies are not mushrooming; there are not companies that are ready and willing to provide huge care packages. One or two companies have dipped their toes in the water, but that has not been widespread.

There can be an impact on local authorities' capacity to continue to provide services. For example, if 50 per cent of service users want a direct payment and 50 per cent do not, making the direct payment to the 50 per cent who want it will obviously impact on the economies of scale that can be managed by the local authority, which still has a duty to continue to provide services irrespective of whether people are receiving a direct payment. In one case, a parent requested a direct payment for her daughter, who had profound multiple disabilities; that payment came to nearly £60,000 per annum. You do not need to take £60,000 out of your pot too many times to completely skew the economies of scale and the services that the council can continue to provide for people who choose to have their services delivered by the local authority.

If things go wrong—sometimes direct payment schemes go wrong, when someone fails to turn up for work because the weather is bad and they do not want to drive, or for whatever reason—there is a reduction in the local authority's capacity to step in and ensure that the service is provided, because the money has gone in direct payments. There is a belief in some quarters that there is more to services that are paid for with direct payments than to services that are provided by the local authority. However, the payment is based on assessed need. It is not a case of saying, "There's £50,000—off you pop and spend it." It does not work like that.

There can be real difficulties when parents, quite rightly, seek what is best for their child and seek a significant amount of money because they believe that they can identify a better service, but the payment is made based on the assessment of need that has been done by the local authority. We cannot possibly have everybody coming along and chapping at the door saying, "Well, actually, my package will cost £75,000—I don't want your cheap £50,000 package." It happens and we have to be realistic. We have to deliver services to all those who need them, and we must have the capacity to do so. If individuals are independent enough and are willing to manage their direct payment, that is fine, but we must remain aware of the impact that taking resources out and skewing economies of scale can have on a local authority's capacity to deliver to other people.

Alan Baird: We are keen to promote direct payments; there has been a slow but consistent start over the past 18 months. We currently have 31 clients receiving direct payments—the bulk of those are for physical disabilities and learning disabilities. It is perhaps no surprise that older people are less inclined to go for direct payments because it entails the responsibility of becoming, in effect, an employer.

We have taken the route of working in partnership with the Princess Royal Trust Dundee carers centre. In other words, we are using a third party to help to move direct payments forward, which appears to be working well in the vast majority of situations, so we do not have any significant problems with direct payments and we will continue to support their incremental growth as demand occurs.

The Convener: Are you experiencing demand for higher cost packages around the £50,000 or £60,000 mark?

Alan Baird: I am not aware of any such demand. I am very clear that the assessed need is the assessed need and that the payment will follow. Obviously in the case of younger people who have considerable difficulties and complex needs, the packages are likely to cost more, although I cannot this afternoon give the committee specific examples of such packages.

The Convener: Okay.

Robert Peat: It is important to emphasise that Angus Council also supports direct payments: 33 people in Angus receive them. We also commission service provision from the Princess Royal Trust Dundee carers centre. In the past, we had a more local service, but we now contract into the service that that centre provides.

It is also important to say that a significant number of people value the services that are offered by the local authority. People are content with those services; they do not want direct payments.

The Convener: Okay. If huge numbers of people were to take up direct payments, would that be a concern? Could that lead to some of the issues that were referred to earlier?

Councillor Middleton: That would be a real problem.

Kate Maclean: I am interested in what has just been said. I had not thought about what might happen if more people were to take up direct payments. I can now see that that would have an effect on services for people who are not in receipt of those payments. Obviously, it is not really a problem in Dundee with our small geographic area, but I can see that the situation in Angus is different.

Councillor Middleton: The problem could be significant.

Kate Maclean: Could you reach the point at which it would be impossible for the local authority to deliver care services in an area because of the number of people in that area who took up direct payments? If so, would you have to ask the people who wanted to continue to receive the local

authority service to go down the direct payment route?

Robert Peat: That is our fear. It has not happened as yet, but we are afraid that that may happen in the future.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): We took evidence in the Highlands, where services have to be provided to people in remote and rural areas. We were told that direct payments provided the opportunity to deliver services in such areas without the hindrance of using neighbourhood schemes and so on. We also heard about efforts to raise client awareness of direct payments. As a consequence, more people in the Highlands are claiming direct payments than in any other local authority area. We heard from the Dundee City Council witnesses that the council has tried to raise awareness. Will the Angus Council witnesses tell us about efforts that it has made to raise awareness?

The evidence that we took in the Highlands also highlighted the importance of local authority services' being renewed based on the demand for flexibility. Direct payments appear to offer that possibility. People said that they did not necessarily expect that more money would be expended on them; what they were seeking was greater flexibility—for example, the flexibility not to have to go to bed at 7 pm in the evening or to eat their tea at 3 pm in the afternoon.

It would be useful if the Angus Council witnesses could pick up on some of those points. Do you have a more positive response to the challenges that direct payments bring?

Robert Peat: I said earlier that it was not helpful to make comparisons between authorities. The committee heard earlier that Dundee has 31 people who are in receipt of direct payments. As I said, Angus has 33, but we have a smaller population. I am not sure that I accept the point that Duncan McNeil makes, whose implication seems to be that we are not doing as much as Dundee is doing to tell people about direct payments. The evidence from the numbers suggests that we are doing just as much.

Mr McNeil: My impression from your statement is that you see the impact of the direct payment scheme on council services in a negative light.

Councillor Middleton: I am sorry if I gave that impression. We make a strenuous effort to ensure that all service users are aware of the availability of the direct payment scheme. We offer them a huge amount of support in making the decision whether to take up those payments. That work is supported not only by our social work and health committees but by the council itself. We have entered an agreement with the Princess Royal Trust for carers to ensure that outside advice is also made available to service users.

On rural services, we deliver services in rural areas; indeed, services in Angus are occasionally delivered by tractor when there is snow on the ground. We go to enormous lengths to deliver rural services.

What I said earlier was that we had not had an influx of companies that wish to provide alternative care services. I suspect that, because of their economies of scale, such companies do not regard Angus as being a place where they would wish to set up business. Many private sector and charitable organisations have set up residential care and nursing care services in Angus, but there has been no influx of companies that provide packages. We deliver services in the rural areas—private companies have not come in to offer alternatives. I am sorry, but I will not accept the blame for private companies not coming into Angus.

Robert Peat: It is also important to say that we are trying hard to ensure that our services are flexible. We do not, for example, put people to bed at 6 o'clock in the evening or whatever. We have significantly developed our home care services and we are trying to be as flexible as possible to meet the needs of individuals.

Mr McNeil: I am commenting on evidence that we received from people who receive care. It is recorded that some of those people say that the services that they get are not flexible enough for them and that there are problems in—

Councillor Middleton: I am sorry—is that in Angus?

The Convener: No. Some general issues have been raised with us and we are now trying to explore them with individual council representatives. It might be that, again, there is variation from local authority to local authority and that the flexibility issue is an aspect of that. We might need to investigate that further.

Mr McNeil: We seek confirmation that when the cost of the package is based on the assessment, there will be no situation in which any council would agree to pay more than it already pays. If someone got a package that cost £10,000, they should take out that figure in direct payments and not, for example, £15,000, £20,000, £60,000 or £75,000. The situation should be that the direct payment towards their package is what you already pay.

Councillor Middleton: Yes.

Robert Peat: The direct payment would be what we would pay to deliver the service.

Mr McNeil: The payment would be what the service actually costs you at this present time. People can take the money and go elsewhere with it, but are there any multipliers with it when they take it out?

Robert Peat: No.

Mr McNeil: Thanks.

Mrs Nanette Milne (North East Scotland) (Con): We have been picking up a variation across the country in actual or perceived duplication of care inspections. For example, perhaps the care commission does an inspection, then the local authority, among other organisations, comes in and does a similar inspection. I noticed that both councils commented on that in their written submissions. Will you elaborate?

Councillor Middleton: Angus Council has just agreed that we are keen to see integrated inspections in the future. Inspections are costly for the local authority, not just in monetary terms but in human terms because of the time officers spend on inspection. It would be enormously helpful if there were integrated inspections. We have just been SWIAed—

The Convener: Swiart?

Councillor Middleton: I mean that we have been inspected by the Social Work Inspection Agency.

The Convener: I wondered.

Councillor Middleton: We are happy because the SWIA inspection was a positive experience. However, an integrated inspection system would help all local authorities. Currently, we can have one inspection team in one week and another the next week, which is hugely disruptive to staff. We do not object to inspection, but integrated inspections would be better.

Mrs Milne: How do you envisage that working? Could the care commission do the inspections and share the information? Should it just be decided that a particular organisation will do the inspection one year and another will do it the next year?

14:15

Robert Peat: We were part of the SWIA pilot, as the convener said. The care commission provided information to SWIA and it is now refining its methodology. It would be helpful for future inspections if the care commission could be part of the inspection team, alongside the Social Work Inspection Agency. That would mean that there was not duplication whereby in one part of the year there is a SWIA inspection and in another part of the year a care commission inspection.

I know that the care commission has a range of responsibilities relating to the services that it inspects, but there could be a rationalisation of the regulatory bodies. I know that the different agencies are working together to consider how best to achieve that.

Another issue is our working with the care commission. We have workers who monitor the care that is provided for the individuals who are placed in establishments and we monitor the contract process. We work with the care commission to see how we can share information. We will be building on that work with the commission so that we can get the benefits of it, which will highlight issues in respect of practice and meeting standards. That will assist us in ensuring that we provide the best care for the individual.

The regulatory bodies need to work together, and we have to be clear that we and the care commission are getting the right information and sharing it with one another so that we can act on any difficulties that might arise.

The Convener: I ask the Dundee City Council representatives also to comment. Much of what we have heard has been about other inspecting authorities inspecting local authority set-ups. However, one of the complaints is that local authorities themselves are an inspection regime for care providers, who feel the burden of that in addition to the care commission inspections. Local authorities are on both sides of the argument. We will have to draw this panel's evidence to a close once the witnesses have commented on that.

Bailie Wright: Inspections can be quite costly to local authorities because they take up valuable time, which costs money. I am pleased to see from our most recent inspection that we provided quality services for older people.

The Convener: That was an inspection of you—I am asking about the inspection regime whereby you go out and inspect. I am saying that you are at both the receiving end and delivering end of inspections.

Robert Peat: I suppose that the difficulty is the term "inspection." We are not responsible for inspection units within our services. Our care managers are responsible for the care that an individual receives. We also have responsibilities to work with providers.

The Convener: The care home providers are basically flagging up the point that there is sometimes a double burden as a result of the multiplication of inspections.

Councillor Middleton: I am not convinced that there is a good basis for their saying that. There is a huge difference between the care commission

inspecting a home and a care manager visiting the person who is in their care to ensure that they are all right. I do not think that our care managers would be going through medicine cabinets or the kitchen; they are there to visit people for assurance that those people are being well cared for. They do not go to visit the home as a whole.

The Convener: Kate, did you want to come in?

Kate Maclean: Glennis Middleton has just answered my question.

The Convener: The last word will be from Dundee City Council.

Alan Baird: The inspection last August of our older people's services was one of the first that the care commission undertook. One of its strengths was the use of questionnaires that asked service users about the quality of care. We might not have been providing a service directly; it might have been provided through our approved providers. Given that we have ultimate responsibility for the quality and standard of care services at home, we were delighted not only to receive a good report but, more important, to know that service users were at the heart of the inspection. That is what we are all here for.

The Convener: I thank all the witnesses for coming along. I hope that they did not find giving evidence too difficult an experience.

I invite the second panel to come forward; we will proceed with evidence taking. I welcome the three witnesses from the Scottish Commission for the Regulation of Care: Mary Hartnoll, the convener of the commission; Jacquie Roberts, the chief executive; and David Wiseman, the deputy chief executive. I know that the care commission representatives want to make a short opening statement. I assume that Mary Hartnoll will make it. Please keep it brief—we have a lot to get through.

Mary Hartnoll (Scottish Commission for the Regulation of Care): I am delighted that the Health Committee is conducting such a high-profile examination of the quality of care services in Scotland. People deserve that. We know that the care received by some people in care services, particularly some older people, is of major national concern. The primary purpose of care regulation is to drive up standards.

The board of the care commission includes in its membership strong voices representing service users and carers, and the committee met two of them this morning. Many services in Scotland are good, but we want to ensure the same high standard for everyone. Raising standards requires that we work co-operatively with other bodies. For example, we work with the fire services to improve fire safety, and we work with the Scottish Social Services Council to achieve a properly trained workforce and to identify training needs.

However, people in Scotland need to be better informed about what they can expect when they, or somebody they know, are using a care service. The national care standards are excellent, but they must be better known. We want a much stronger consumer voice, and that requires consumers to have good information and support. People who are being regulated never love their regulator, but people who use services currently rely on an effective regulator to safeguard their interests.

We are committed to providing value for money. We have reduced the overall budget while taking on the regulation of more than 1,500 new and complex services. We will be pleased to provide further information on any of the work that we are currently doing, such as details of the lay assessors scheme—I am pleased that members managed to meet some of the lay assessors this morning—and our work to streamline our procedures and processes for regulation and inspection, following the extensive consultation that we carried out last year among service providers, service users and commissioners of services.

The Convener: Thank you. You mentioned discussions that took place this morning, so I should make it clear to everybody present that we have been in Dundee for a few hours and that this morning we met staff from the care commission, separately from their bosses, and lay assessors, again separately from the staff, to talk to them about what they are doing. We also met other board members. They were informal sessions, but we wanted the opportunity to speak to a wide range of people at the care commission, to establish their views, before we embarked on our formal committee meeting. When witnesses talk about the discussions that took place this morning, that is what they are referring to.

Mike Rumbles: One of the issues that is raised in the care commission's evidence is whether it is necessary to develop a complaints system to better protect those who make complaints against service providers. The written submission points out that there has been a 25 per cent rise in complaints. That is a good thing in that it shows that people are aware that they can complain and put things right, but I would like to ask about the perception—I do not know how widespread it is—that people, especially in care homes for the elderly, do not feel comfortable about lodging a complaint. The written submission says that

"where the service provider may be able to identify where a complaint has originated, the Care Commission has no legal power to prevent a service provider from exercising their rights under an agreed legal contract, for example in a care home setting."

It seems to me that you are almost saying that if someone is identified, the care home can legally act to withdraw their contract and that there is not much that can be done about that. Could you engage in a proactive system with care providers to ensure that that does not happen, so that people can be assured that they will not be penalised if they complain to you?

David Wiseman (Scottish Commission for the Regulation of Care): We acknowledge that there is a problem in that, for many people, there is an element of fear that if they make a complaint it will have an effect on the service that is provided to them. We are therefore working hard with people who provide services to ensure that they have a complaints process that is fair and does not penalise people.

We have had only one or two examples of action being taken against a person as a result of their complaint. The difficulty is that in those one or two cases the care provider said that they were no longer able to meet the increasing needs of the individual who complained, who needed a different service. It is difficult to take action against that. However, we examine each case to ensure that such a move is not used purely as a penalty against the person who makes the complaint. We are working on that and I think that work needs to be done elsewhere as well.

One of the things that would support people in the difficult process of ensuring that they get their say and are able to exercise their rights is an increase in the advocacy services available throughout Scotland. At present, provision is patchy. We want to tell service providers that people have to have access to advocacy services, but in some areas there is none.

Mike Rumbles: You are saying that the number of cases where the individual who has complained has been penalised is very small, so we are talking about a small element in the process.

David Wiseman: It might be a small element, but it has been brought to our attention.

Mike Rumbles: Should you be finding out whether it is happening?

David Wiseman: It would certainly be worth our while digging deeper into such situations. You said that there has been an increase in the number of complaints each year. It looks as though we are heading for a further increase this year. We need to look into some of those complaints and track what happened after them. That would be worth considering in the context of the resources available to us.

Mike Rumbles: Is there a real possibility that you will engage with that?

David Wiseman: We need to consider whether it is possible and whether we can resource it.

Jacquie Roberts (Scottish Commission for the Regulation of Care): All providers are required to make everyone aware of their complaints system and the fact that people are entitled to complain to the care commission.

Dr Turner: You said that there are difficulties with defining care at home and housing support services. Will you say more about direct payments and your concern about the most vulnerable people you mentioned?

Jacquie Roberts: We support the principle of direct payments. Our one concern is that the people who deliver services under direct payments do not come under our remit for regulation, so there could be concern about exploitation. However, we hope that the new protection of vulnerable adults bill, which will provide parents and service users with access to a list of people who are unsuitable to work with vulnerable adults or children, will address that. We want to ensure that there is such protection for people who use direct payments.

The difficulty of distinguishing, at times, between care at home and housing support services is that the definitions of care services in the Regulation of Care (Scotland) Act 2001 do not necessarily lend themselves to diverse, innovative services. Some of the most innovative, newly developing services are a mixture of care at home, housing support and other services that meet particular needs.

The Convener: The protection of vulnerable adults (Scotland) bill has not been introduced yet but, when it is, it is likely to come to the Health Committee.

Dr Turner: Do you have other difficulties when you are assessing the mixture of services that are provided to people at home? Services are provided by many different people, even in the same local authority area.

14:30

Jacquie Roberts: We use the national care standards, which must be taken into account. They can be used flexibly. When we are regulating and inspecting a service, we take into account its aims and objectives. Our director of adult services regulation has talked about a pick-and-mix approach to the standards. We have quite a flexible system to deal with different types of service.

David Wiseman: Each service must be registered separately, according to the type of care service it provides as defined by the 2001 act, but we have recognised that if a service provider provides a mix of services—sometimes

the same staff will be used to provide services and sometimes the services will be for the same people—we do not have to inspect it more than once. We therefore considered the reduction in our activity and introduced a discount so that there will be a fee reduction. We have attempted to find ways of minimising the burden while acting within the current legislation.

Shona Robison: I want to return to complaints. As things stand, if I were a care home resident, how would the findings on another person's complaint about that home that affect me be brought to my attention?

David Wiseman: That depends on the nature of the complaint. Different types of complaint can be made. If there is a serious complaint and we take enforcement action as a result of the investigation, we will publish the results in the next inspection report. That is a public document. Under the national care standards, care providers should make inspection reports available to residents. If we think that the outcome of an investigation will affect services more widely, we will pass the appropriate information to the local authority as the service purchaser or the health authority if it is the service purchaser. Therefore, we share information and complaints more widely than we need to under the legislation.

Shona Robison: That is all very well if people have access to where reports happen to be and if care home managers are decent sorts and decide that they will let everyone know about things, but is there room for improvement for the Scottish Commission for the Regulation of Care or another body? The issue is more about care homes because it involves people's places of residence. Even families are routinely advised about issues relating to complaints in homes. Obviously, personal issues and discrete information must be removed from the information that is provided, but surely every resident should have the right to know general information.

David Wiseman: We agree that every resident should have a right to know, but we think that it is important to ensure that the provider takes the responsibility in that respect. The provider has the main responsibility for the quality of the care whereas the regulator has to regulate to ensure that the provider meets quality standards. We must ensure that providers take on board their responsibilities.

The other factor is that inspection reports are required to be provided according to the national care standards. When we inspect, we consider the arrangements that have been put in place to ensure that an inspection report is made available to residents and carers, as well as to ensure the publication of such reports so that they are available more widely.

Perhaps other things could be done, but we must consider resource constraints. We regulate more than 15,000 care services and potentially between 400,000 and 500,000 people use those services. An obligation to provide an inspection report to every person would represent a huge resource issue. People may think that providing resources for doing that is worth while, but we do not have such resources at the moment.

The Convener: Will you give a quick indication of the balance of complaints that are submitted across the entire sector for which you are responsible? We are focusing on the residential sector, but you inspect much more widely and it might be useful to put that on the record.

Jacquie Roberts: The details are in our annual report—David Wiseman has a copy with him.

David Wiseman: Care home services, which include more than just older people's services, generated the most complaints.

The Convener: Does that category include residential establishments?

David Wiseman: Yes. The ratio of complaints about care homes for older people per service is greater than it is for any other service.

Janis Hughes: The care commission publishes inspection reports online and I assume that you give hard copies to the providers.

David Wiseman: Yes, we do.

Janis Hughes: If you highlight a serious issue in a report and you expect the provider to rectify the problem quickly and to take action before the next unannounced inspection, how do you document that? Is it clear to a person who reads the report online that the problem has been rectified?

David Wiseman: That depends on whether the action is a requirement under the legislation or simply a recommendation. If it is a legal requirement that will lead to enforcement action, notice will be given of the enforcement action. If the requirement is met, the enforcement action will be cancelled. We follow up problems in subsequent inspection reports and we follow up all the requirements on which we put a shorter timescale. We ask providers to produce an action plan that indicates how they will meet the requirement or recommendation and the timescale within which they will do so, unless we impose a timescale for action. Sometimes we impose short timescales because there is no reason why the requirement should not be met immediately, to protect people.

Janis Hughes: If I was looking at the inspection report for a home that I was interested in on behalf of a relative, how would I find out whether a matter had been dealt with?

David Wiseman: You could contact us or use our care services register, which is on our website. We are considering how we can provide information to people who do not use the website. We are developing the type of information that we include, because we think that more information is needed, including the type of information to which you refer. We are also considering how we include complaints information.

The Convener: Duncan McNeil wants to ask a question—I am sorry to have kept you waiting, Duncan.

Mr McNeil: I am doubly sorry, because Janis Hughes has asked a question that I was going to ask.

Janis Hughes: Sorry.

The Convener: Take that up with your colleague, Duncan.

Mr McNeil: When we took evidence from the residential care home sector, private home owners complained not only that they are subject to too much inspection from local authorities and the care commission but that information on the web is not always up to date and sometimes includes matters that they have addressed, which is unfair. If we want providers to respond to recommendations and improve best practice, we must acknowledge the efforts that they make to do so.

Who inspects the care commission's inspectors and monitors their reports? We heard complaints about an inconsistency of approach. This is a negative example, but people might think, "I can get away with something in the Highlands that I could not get away with in the west central belt."

We took evidence from the voluntary sector, which has traditionally had an innovative approach to the development and evolution of services. The voluntary sector complained that the system of regulation and registration is putting people off developing services. If that is the case, it is a crime. We would all worry if we thought that the regime was affecting the development and evolution of services that are run by people who have a culture of getting on with doing things. For example, people complain bitterly that the approaches to respite and residential care for children are being standardised. Are you aware of that? What are you doing to ensure that best practice can be developed and that innovation is not stifled?

Jacquie Roberts: You have asked us several questions, so we will share them.

David Wiseman: I will deal with the question about consistency in the inspection regime. There are a number of mechanisms for examining what the inspectors do. We have a process of internal quality assurance, which ensures that management takes a sample of the work that care commission officers have carried out. We also have internal audits that consider the processes that we use—we recently had an internal audit of the inspection process, which examined whether our procedures were being followed consistently throughout the different regions—and Audit Scotland audits the care commission's work.

We also have a published inspection process, which sets out what we expect to happen in an inspection by our staff. However, we need to acknowledge that we are talking about inspecting against national care standards, which are outcome-based standards. Therefore, inspection is not a simple process in which we can ask what the input—the provider's process—is and tick boxes for what the provider does, has and provides; it is a matter of making a professional judgment about how they achieve the outcome. The outcome might say, "People should feel safe and secure," and how provider X achieves that might be different from how provider Y does it, but both might be equally genuine ways of achieving it.

We also have to consider not only the type of the care service, but its specific aims and objectives. It might be that two services are of a similar care service type—such as two care homes that care for the same number of individuals—but have slightly different aims and objectives. Therefore, the judgment of how successful they are at achieving quality outcomes could be different.

When we consulted on our registration and inspection process, almost 16,000 providers responded on inspection. Of those, 95 per cent said that they were satisfied or very satisfied that inspection helped them to demonstrate the strength of their services as well as to highlight weaknesses, and 91 per cent said that they were satisfied with how inspection reports reflected the process. That is a good indicator, but we are not complacent; we want to deal with the other 5 per cent and 9 per cent.

Jacquie Roberts: Another important fact is that all our care commission officers must undertake the regulation of care training to train to be good regulators. Already, 50 people have been through that programme and another 50 are going through it this year. We are sure that that is ensuring even more improved and consistent practice throughout Scotland. Our officers have to undertake that training to be able to register as good regulators with the Scottish Social Services Council. That is another way of providing quality and consistency.

On the question about information being out of date, the good providers attach to their care inspection reports an action plan that responds to

any requirements that we have made. That enables them to demonstrate to the service users what they have done to improve the service.

On innovation, we are doing our utmost to promote new, small, innovative services. We have agreements with local authorities that enable us to get alongside them and health boards at the commissioning stage when services are being designed so that we can give advice about what would be a good way of achieving the standards for those services. Our written submission mentions the fact that, at the moment, the 2001 act requires that every type of service that a provider provides be registered in the category for that service. We are trying hard not to let that get in the way, because people need to know what sorts of services exist. However, I believe that we are being as flexible and innovative as we can to ensure that different types of services, particularly small services in rural areas, are adapting to the standards and the regulatory regime.

14:45

Mr McNeil: Does the act provide a barrier in that context that we should aim to remove?

Jacquie Roberts: As we say in our written submission, it would be helpful to develop a category of registration that allows people to provide wholly or mainly a particular type of service that can also be developed into different types of services.

Kate Maclean: My question is on inspections. I know that the commission's work involves much more than just inspecting residential establishments, but our questions are driven by the issues that people have raised, which predominantly relate to residential establishments, especially those that care for elderly people. The commission will not be surprised to know that we found a division between providers, who feel that they are overinspected, and users and their families, some of whom feel that not enough inspections take place.

I take on board what the local authority representatives said: it is obvious that the commission has a duty to carry out inspections and that local authorities, which are the purchasers of services, would not want to purchase services that do not meet the expected standard. In addition, care managers need to ensure that the needs of individuals are looked after. I therefore think that everyone accepts that all these interventions or contacts with care establishments are necessary. However, does the commission have any suggestions as to how inspections might be conducted so that care providers would not feel that they were overinspected?

One suggestion that was made to us by a group of carers in, I think, Greenock, in Duncan McNeil's constituency, was that informal visiting committees should be able to deal with issues that are of a less statutory nature but are nonetheless important to those who have vulnerable or elderly relatives in residential care. The suggestion was that a more informal set-up might be able not to inspect but to speak informally to residents and their families and to have a look at what is going on. How would that fit in to the current arrangements? Is it a useful idea?

Mary Hartnoll: I will deal with the last point first. As the committee will know, we are very keen on lay assessors and our first pilot scheme included people with a range of experience: previous users of services, carers and some who had a professional interest. From that pilot, we feel that previous users of services and carers make the best lay assessors. We want to expand on those groups because they bring an extra dimension. Some of those with a professional interest had a good impact, but the strength of those who had experience of using the services was their ability to communicate. We very much want to take that idea forward, but it will require a certain level of resources to train and support the lay assessors.

The idea of having independent visitors is more along the lines of something that involves people with professional experience. At this point, we are not as keen on developing that as on introducing lay assessors who have experience of services. We very much want to take that further.

Kate Maclean: I should say that the informal visiting committee that was suggested to us was not a committee of people with a professional interest, but of people who have a general interest in the issues faced by elderly people or, say, by people with learning disabilities.

Mary Hartnoll: I suppose that we could pilot the involvement of someone with an interest from the local community. That would take a certain amount of organising, but we would certainly be happy to consider it.

Jacquie Roberts: The national care standards support the idea that relatives associations and residents groups should be involved in the delivery of care. One way to promote that would be to promote the national care standards for care homes for older people and to show how important those are in ensuring that people receive the high level of person-centred care that they have a right to expect. That could get people more interested. I think that many providers wish that they had an informal relatives association, but they do not get the level of interest that they would like.

To return to the duplication of inspection, a significant step forward has been taken in the past

few months with the development of a national core contract by the Convention of Scottish Local Authorities, the care commission, some individual local authorities and providers. The core contract will refer to the information on quality that can be obtained from the care commission. It is significant that COSLA has acknowledged the absence of a consistent interest in providers among local authorities throughout Scotland. A few local authorities carry out what seem like duplicate inspections as their way of following contract compliance or the money that they provide.

Now that COSLA is working with us to deal with the issue, we will really make a difference on it, but we must accept that, as Mr Dickie from North Lanarkshire Council told the committee, local authorities spend a huge amount of money on the independent sector and therefore have a responsibility to follow up the contracts. However, we are now much clearer about what information can be had from the care commission when councils examine quality.

The Convener: I want to raise a different issue that is covered at length in your written submission—the impact of the current requirement for the care commission to be self-financing. You flag up concerns about the impact that that requirement might have on small-scale innovative development, for which the proportionate cost is much higher, and on rural developments, probably for the same reason. To back that up, you give evidence on the number of places in care homes and day care services for children. The figures show that there are fewer homes and services, but more places, which suggests that places are being delivered in bigger and bigger institutions. You raise the possibility that that relates directly to the fees for the inspection regime. Will you expand on the issues and on your point that, for some reason, the care commission has been singled out among regulatory bodies to be self-financing?

Jacquie Roberts: It is important to state categorically that the funding regime for the care commission is a matter for ministers and the Parliament and that it is current ministerial policy for us to become self-financing. We have regularly pointed out our concerns about the potential implications of that, particularly for small and innovative services. On the figures in our written submission, I should point out that the inspections of day care services are subsidised. However, we need to do further work on the possible impact on small and innovative housing support and care-at-home services. We continue to point out that other regulators, such as the Welsh care regulator, have had all fees abolished, although the English care regulator is considering a move to full cost recovery. The landscape is patchy.

Mary Hartnoll: The board's main concern in the past year has been about small and innovative services. Ministers took some action to mitigate the effect on such services, but it is undoubtedly more costly per head to regulate a small service relative to a large service.

The Convener: Do you mean more costly for the service?

Mary Hartnoll: Yes.

David Wiseman: In Scotland, we have a different perspective in that the care commission is moving towards self-funding through fees, whereas Her Majesty's Inspectorate of Education and the Social Work Inspection Agency have no fee regimes. The situation becomes even more complex when we work jointly with those agencies in inspections.

Jacquie Roberts: Yes, but we must point out that HMIE and SWIA are inspectorates and we are the regulator. We encourage providers to consider that the fee that they pay us is for a licence to operate and to be registered, not for inspection, although we have to follow up complaints and carry out enforcements and our other responsibilities.

The Convener: It would be interesting to monitor the extent to which you can adjust the perception of people who are still getting a bill for whatever it is that they think they are providing.

I have no indications of further questions from committee members, which perhaps reflects the extent of our discussions this morning. In the circumstances, I wonder whether there is anything that you as individuals want to say to us that has not already been covered in what we have asked you about.

Jacquie Roberts: One of the issues that the committee considered was whether the remit of the care commission should be extended—for example, to oversee the care home market. I wondered whether the committee wanted any information from us about that.

The Convener: Indeed.

Jacquie Roberts: This is taking into account what was included in the report by the Royal Commission on Long Term Care for the Elderly. The report recommended that a national care commission should be established that

"would have the tasks of looking at the whole care system in a strategic way, stewarding the interests of older people who receive services and reporting on spending on long-term care on a three yearly cycle to Government and Parliament."

That is different from the statutory remit that we were given, which is to provide information to the public about the availability and quality of care services. We do not have the statutory responsibility to consider managing the care

market. I know that amendments at the early stages of the 2001 act looked at whether the care commission should have responsibility for considering the way local authorities contract or provide money for services or for looking at the money that is given to the independent sector. However, we do not have that responsibility.

We do feel that we have a responsibility to influence the development of services for all age groups. In respect of older people, therefore, we have contributed a lot of work to a review called the range of capacity review. We think that we have information about the types of services that are delivered and whether they are of sufficient quality. We have contributed to the older people strategy and we have worked alongside it, looking at supporting people finance and supporting people reviews. We also contribute to policy initiatives in the child care strategy. We undertake some of what the royal commission expected, therefore, but we do only what has been asked of us from a statutory point of view.

Shona Robison: I understand what you have said about your role and the statutory limitations on it. One of the issues that I presume you are concerned about and that I and a number of other members are concerned about is staffing levels and issues associated with that within care services, particularly the care home sector. There are recruitment and retention problems because of the pay and conditions of staff. If we all want to lift the quality of care services, surely that is a fundamental issue. How does the care commission engage in discussions about such issues?

Jacquie Roberts: That is important. We work closely with our partner—the Scottish Social Services Council—on raising standards of qualifications, supervision and training of care staff. There are sections in the standards that are about the supervision, training and management of front-line staff, which is a vital area. We provide information annually to the workforce strategy group about the staffing in care homes and staff qualifications. It is part of our vision that we cannot deliver good care services without having good front-line staff who are well managed and supervised and feel free to speak up if they see any problems.

Is that what you were getting at?

Shona Robison: Yes. I suppose the question is how that is raised with the minister. I get the feeling that very general recommendations have been made about some of the staff ratios and that their general nature means that they are not always applicable to specific situations. For example, care homes will say that they meet the recommendations, but in fact the service on the ground needs a higher staffing level. I am sure that your officers find that that is the case.

15:00

The Convener: The issue is not just the higher staffing level, but also what might be seen as inappropriate staffing. We heard evidence about young eastern European males being involved in undressing and dressing very elderly ladies who, even if they were to complain, would be told that there was nobody else to do it. Most of us would regard that as a bit inappropriate, especially for very elderly people who do not expect that. Therefore, it is not about just staffing levels; it is also about the appropriateness of the staffing. If you could expand on that, that would be useful.

Jacquie Roberts: I will say just one more thing about staffing levels, then David Wiseman will talk about the appropriateness of care.

An important project, in partnership with the Executive, is currently considering staffing levels and whether it is possible to have a more defined formula to recommend to care homes. We are working hard on that. We make requirements for enforcement when we find that staffing levels do not meet the needs of people in the services. We do not want to get too formulaic about it, though, as it definitely depends on the needs of the people there present. Probably one of the most frequent requirements that we make concerns staffing levels.

We agree completely that there is an issue about appropriateness, and we have a quote from the national care standards about that.

David Wiseman: We agree with providers what staffing level they need in order to provide their service, and we make it clear that the level needs to be adjusted depending on whether they have a full complement of residents and on the dependency levels of the residents. When we inspect, we consider staffing levels and will take action if we think that people's needs are not being met, perhaps because of staffing issues.

There is a reference in the national care standards to the issue that you have raised. Although it does not talk about same-sex support or that sort of measure, it states:

"Intimate physical care or treatment will be carried out sensitively and in private, in a way which maintains your dignity."

Our view is that providers will have to demonstrate how they are meeting that standard. If providers are unable to meet that standard because of the mix of staffing that they have, they are not maintaining the dignity of the individual.

In some cases, a person might choose that type of care, but it is likely that older women will be reluctant to make that choice. Older men have always been used to being nursed or looked after by female nurses. We need to look at that

standard again, specifically to follow up the point that has been made.

The Convener: If people feel that their personal standards are being compromised by the care that is being delivered, that will very much affect their experience of residential care.

Jacquie Roberts: We have just appointed a nurse consultant whose specific task is to consider such workforce issues in care homes for older people. That innovation is aimed at improving knowledge and awareness of the quality of care that should be delivered, especially in nursing homes, and it has been supported by the chief nursing officer.

Janis Hughes: I have a quick question regarding the inspection regime. Some of the evidence that we have taken has suggested that there should be more unannounced inspections. What is your view on the sustainability of that?

Mary Hartnoll: We are moving towards more unannounced inspections in some circumstances. For example, where a follow-up of something has been required because something has not been good enough, we are moving towards more unannounced inspections. There is often benefit in announced inspections, in terms of the width and scale of what we need to look at and the need to get some of that organised. However, in terms of people being able to talk to us during an unannounced inspection, that can be either very good or not such a useful exercise. It can work either way. In general, we plan to have more unannounced inspections.

Jacquie Roberts: The plan is that all children's day care services will receive unannounced inspections during 2006-07. As an aside, when I visited a care home last year, one older lady told me that she thought that we should inspect in disguise, as well as unannounced.

The Convener: That would be interesting.

David Wiseman: I will talk about capturing the views of people who use services and of carers. Our previous model, because outcome standards had not been set, was based on ticking a box and asking whether a provider did something. We have tried to move away from that to a model of asking about the quality of the care that is being provided from the perspectives of people who use a care service and of carers. To capture that, we must spend more of our time on talking to people who use the care service and to carers. We are certainly considering how to ensure that we give our staff the right support to enable them to do that in the most meaningful way. Some of that relates to communication issues, because a number of people who receive services have difficulty with communication, and some of that relates to the development of our lay assessor scheme. As the committee saw this morning, if a lay assessor has a learning disability, people with learning disabilities are likely to talk more to them about the issues.

One question in our consultation last year was what the key issues for inspection were for people who use care services. The committee may be interested to hear that people said that safety was a key issue. They were concerned that, in the environment in which a service was provided—whether it was a care home or their own home—they should feel safe and secure. Cleanliness was also mentioned over and over as a top priority.

People talked about staffing, which has been mentioned. They wanted to know that enough staff were available and they wanted staff to be well trained, to put people's needs first and to be friendly, considerate and helpful. They needed to know that food that was provided as part of a care service was of good quality, was prepared in hygienic conditions and was nutritious, and they wanted a choice of food. Choice was important. People said that they wanted choices not just of food, but of activities in which they might take part. Other issues were the overall standard of care, concerns about the administration of medication and good management of people's finances—many people's finances are managed for them. We will examine all those matters in considering how we focus our inspection regime.

Jacquie Roberts: My final comment is that raising awareness of the national care standards is vital. It is important for people who are about to use services—particularly people who are thinking about entering care homes for older people—to know that the national care standards set out what they, their families and carers have a right to expect. The more that staff in care homes live, breathe and act the national care standards, the more likely we are to have higher-quality care.

The Convener: I thank all three members of the panel for their evidence. I rather expect that we will hear evidence from you individually and collectively on many issues in the coming years.

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 (General Ophthalmic Services) (Scotland) Amendment Regulations 2006 (SSI 2006/42)

15:09

The Convener: We still have one small agenda item to deal with, so I counsel members not to rush away. We have two negative instruments to consider. The Subordinate Legislation Committee made no comment on the instruments, no Health Committee member has commented and no motion to annul has been lodged. Do we agree that the committee does not wish to make any recommendation on the instruments?

Members *indicated agreement*.

The Convener: That is the end of our business. I remind members that we have no meeting next week. Our next meeting is on 21 March, when we will continue to take evidence for the care inquiry and will discuss our work programme.

Meeting closed at 15:10.

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