The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 27 September 2011

Session 4

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HEALTH AND SPORT COMMITTEE
6th Meeting 2011, Session 4

CONVENER

*Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

*Jim Eadie (Edinburgh Southern) (SNP)
*Mary Fee (West Scotland) (Lab)
*Richard Lyle (Central Scotland) (SNP)
*Fiona McLeod (Strathkelvin and Bearsden) (SNP)
*Gil Paterson (Clydebank and Milngavie) (SNP)
*Mary Scanlon (Highlands and Islands) (Con)
Dr Richard Simpson (Mid Scotland and Fife) (Lab)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Monica Boyle (City of Edinburgh Council)
Malcolm Chisholm (Edinburgh Northern and Leith) (Lab)
Dr Denise Coia (Healthcare Improvement Scotland)
Ron Culley (Convention of Scottish Local Authorities)
Geraldine Doherty (Scottish Social Services Council)
Dr Frances Elliot (Healthcare Improvement Scotland)
Michael Matheson (Minister for Public Health)
Councillor Douglas Yates (Convention of Scottish Local Authorities)

CLERK TO THE COMMITTEE

Douglas Wands

LOCATION

Committee Room 4

Scottish Parliament

Health and Sport Committee

Tuesday 27 September 2011

[The Convener *opened the meeting at 10:00*]

London Olympic Games and Paralympic Games (Amendment) Bill

The Convener (Duncan McNeil): Good morning, and welcome to the sixth meeting of the Health and Sport Committee in the fourth session of the Scottish Parliament. I remind members and the public who are present to turn off all mobile phones and BlackBerrys.

The first item on our agenda is to take evidence on the legislative consent memorandum LCM(S4) 2.1 on the London Olympic Games and Paralympic Games (Amendment) Bill, which is United Kingdom Parliament legislation. As the bill makes provisions for purposes that lie within the competence of the Scottish Parliament or that will alter that legislative competence or the executive competence of the Scottish ministers, a legislative consent memorandum has been lodged by the Scottish Government as required by the standing orders.

I welcome Michael Matheson on his first appearance at the Health and Sport Committee in his role as Minister for Public Health. I also welcome Odette Burgess, senior policy officer in the games delivery team, and Greig Walker, solicitor in the economy and transport division of the Scottish Government. I invite the minister to make an opening statement.

The Minister for Public Health (Michael Matheson): Thank you, convener. It is nice to be back at the committee, albeit at the other end of the table.

The business before us is the proposal for a legislative consent motion on proposed changes to the London Olympic Games and Paralympic Games Act 2006 that are before the UK Parliament. The London Olympic Games and Paralympic Games (Amendment) Bill was introduced at Westminster on 16 March and is a relatively small and technical bill. As its title suggests, the bill seeks to amend the provisions of the 2006 act. The bill contains only limited provisions that concern powers in the 2006 act on advertising and street trading within the vicinity of the games' venues, ticket touting and traffic management.

The Scottish Parliament needs to take a view on these proposals as Hampden Park stadium in Glasgow will host eight men's and women's Olympic football matches. Issues of devolved competence come into play as a result. The traffic management provisions of the bill expand the powers to impose traffic restrictions quickly in response to sudden or unforeseen requirements, but they do not extend to Scotland. However, Glasgow City Council still has a range of powers that are available to local authorities under the usual traffic legislation. We understand that the Olympic Development Authority has worked with Glasgow City Council and has provided the council with an assessment of how it can deliver what is required within the current legislative framework and that the council has now developed a plan to manage traffic movement around the city during the games.

The proposed changes to the advertising and street trading provisions are concerned with parliamentary procedure for regulation and enforcement. Under the 2006 act, advertising and street trading regulations are subject to the affirmative procedure. A change is proposed to make only the first regulation subject to the affirmative procedure, which will allow for any unforeseen circumstances that may necessitate a last-minute change—for example, if an existing venue were to become unusable. That is consistent with the approach adopted by the Scottish Parliament for the Glasgow Commonwealth Games Act 2008.

For England and Wales, the bill reverses a requirement of the 2006 act that articles that infringe the advertising and street-trading provisions, if seized by enforcement officers, must be delivered to the police. Infringing articles in England and Wales will therefore always be dealt with by enforcement officers in accordance with the new statutory rules for the handling and return of infringing articles.

Under the Glasgow Commonwealth Games Act 2008, however, there is flexibility for police and enforcement officers to agree enforcement practice between themselves. There is no statutory requirement for one authority to hand over property to the other. After consulting the Scottish police and the Crown Office, the Scottish Government supported an amendment to the bill to reflect the 2014 games position for the 2012 games. The amendment was agreed by the United Kingdom Parliament on 8 September and is now part of the bill.

The bill also proposes an increase in fines for ticket touting offences from £5,000 to £20,000. The changes were proposed at the recommendation of the Metropolitan Police as a more effective deterrent in response to organised

ticket touting by criminal gangs. It is not normal practice for summary courts in Scotland to be able to impose such high penalties, but the power exists for them to impose maximum fines of up to £50,000 when the offence is serious enough to justify such a penalty. Given the evidence provided, we are satisfied that an exceptional summary maximum penalty of £20,000 can be justified for the offence in question.

The London Olympic Games and Paralympic Games (Amendment) Bill has now passed its report and third reading stages in the House of Commons and was formally introduced into the House of Lords on Monday 12 September. We are advised that the second reading in the Lords will take place on 3 October. I therefore recommend that the committee approves the motion.

The Convener: I thank the minister. Mary Scanlon has a question.

Mary Scanlon (Highlands and Islands) (Con): Will the measures outlined today remain in place for the Commonwealth games in Glasgow in 2014?

Michael Matheson: No, the separate legislation that I referred to in my comments—the Glasgow Commonwealth Games Act 2008—will apply to those games.

The Convener: As there are no other questions, I thank the minister and his officials for their evidence.

Subordinate Legislation

Public Services Reform (Scotland) Act 2010 (Consequential Modifications) (No 2) Order 2011 [Draft]

10:06

The Convener: The second item on our agenda is to take evidence from the Minister for Public Health on an affirmative instrument. Members have received a cover note that sets out the purposes of the instrument, and I note that the Subordinate Legislation Committee had no comments to make on the instrument.

The minister is now joined by Alessia Morris, head of the sponsorship and social services improvement team, and Nicholas Duffy, solicitor in the food health and community care division, both from the Scottish Government. I invite the minister to make brief opening remarks on the instrument.

Michael Matheson: Thank you for the chance to say a few words about the order, which is subject to affirmative procedure as it amends primary legislation.

Earlier this year, the Parliament passed the Public Services Reform (Scotland) Act 2010 (Consequential Modifications) Order 2011, which came into force on 1 April 2011. That order made consequential modifications to primary and secondary legislation in connection with the commencement of parts 5, 6 and 8 of the Public Services Reform (Scotland) Act 2010—the parts relating to the establishment of Social Care and Social Work Improvement Scotland, Health Improvement Scotland and the new regime of joint inspections.

The order before the committee today is a follow-up order to tidy up an omission from the original modification order. As soon as the omission was noticed, the Scottish Government took the first legislative opportunity to bring forward the order to carry out the required modifications, laying the instrument in draft on the first day of this parliamentary session.

The order requires that relevant parts of the Fire (Scotland) Act 2005 are updated in consequence of the changes brought in by the 2010 act. It is a short, technical order. It does not take forward any new policy; it simply updates the 2005 act to refer to the most up-to-date legislation. There was no effect to that reference having been missed from the original modification order, as the Interpretation and Legislative Reform (Scotland) Act 2010 applies to give it meaning. The order simply tidies up the statute book to take account of the passing of the Public Services Reform (Scotland) Act 2010.

I am happy to answer any questions that the committee has.

The Convener: As the minister reminds us, we have the opportunity to ask him and his officials to respond to questions or to clarify technical issues.

As members have no questions, we move to agenda item 3.

Motion moved,

That the Health and Sport Committee recommends that the Public Services Reform (Scotland) Act 2010 (Consequential Modifications) (No.2) Order 2011 [draft] be approved.—[*Michael Matheson*.]

Motion agreed to.

The Convener: I thank the minister and his officials for their attendance.

Plastic Kitchenware (Conditions on Imports from China) (Scotland) Regulations 2011 (SSI 2011/282)

Food Additives (Scotland) Amendment (No 2) Regulations 2011 (SSI 2011/305)

Extraction Solvents in Food Amendment (Scotland) Regulations 2011 (SSI 2011/306)

The Convener: Item 4 is consideration of three statutory instruments. Members have received a note that sets out the purpose of each instrument. The Subordinate Legislation Committee commented that each set of regulations did not comply with the rule that a Scottish statutory instrument that is subject to the negative procedure must be laid at least 28 days before it comes into force.

Members have received the Subordinate Legislation Committee's comments and related correspondence. Committee members have given no indication of any issues with the instruments. Do members agree that we wish to make no recommendation to the Parliament on the regulations?

Members *indicated agreement.*

Regulation of Care for Older People

10:11

The Convener: Item 5 is our third oral evidence session for our inquiry into the regulation of care for older people. I welcome our first panel, which comprises Monica Boyle, head of older people and disabilities at the City of Edinburgh Council; Geraldine Doherty, registrar at the Scottish Social Services Council; and from the Convention of Scottish Local Authorities, Councillor Douglas Yates, spokesperson for health and wellbeing, and Ron Culley, health and wellbeing team leader.

Mary Scanlon: I direct my first question to Geraldine Doherty. I was shocked to hear that care-at-home workers do not have to register until 2020, that workers in care homes for the elderly do not have to register until 2015 and that registration of care home supervisors will not be achieved until 2017. What we have heard recently shows that training is important to the quality of care. Have you researched how training staff to Scottish vocational qualification level 2 or other levels improves quality standards?

Geraldine Doherty (Scottish Social Services Council): Do you mind if I start with a clarification? For workers in care homes for older people, the arrangement is that we have required managers to register first, then supervisors, practitioners and workers. We start with managers because we think that they are responsible for the ethos and culture of the unit and because it is important that organisations have the infrastructure to offer SVQs—managers and supervisors can be workplace assessors and internal verifiers. The managers have to be registered by next March, supervisors by 2013, and then practitioners and support workers. Given the resources for training, it is a phased approach.

10:15

We have recently been doing research and surveys to try to get better data about whether qualifications make a difference. We have a question about that up on our website and we are getting extremely positive responses in relation to the difference that qualifications make to not just the quality of care but, in particular, the confidence of the workers.

SVQs in care started in the mid-1990s in Scotland. Some of our feedback has been from workers who perhaps had not had a very good educational experience and were concerned about taking on qualifications, but who, with proper support, achieved well and whose confidence in themselves as workers was much enhanced.

Equally, some employers say that, through training, some of the more established workers, who were considered most able, had learned new ways of doing things. Training therefore increased the confidence of the workers, and made them value more the care that they were offering and understand better the complexity of that work and the importance of doing it well.

Mary Scanlon: The information that I referred to came from a parliamentary research paper. The point is that the deadline for the registration of support workers for care at home, for example, is 2020. That is too long. Am I right that there are 198,000 social service staff in Scotland?

Geraldine Doherty: Yes.

Mary Scanlon: I understand that at the end of last year, only 36,000 were registered, leaving 162,000 staff who may be in the process of registering but may have few or no qualifications. Am I right?

Geraldine Doherty: That is the case. There are currently just under 50,000 registrants—your figures are right for last year.

There are 90,000 people in the scope of registration and 50,000 are registered, so there is a shortfall of 40,000. Of the 60,000 care-at-home and housing support workers, only the managers are required to be registered at present. The decision was made just last year to register the other workers. The timing of that was influenced by the timing of the registration of support workers in care homes, because they require to be registered by 2015. They are a large group of staff—around 26,000—so to allow employers to plan out the resources needed to qualify all those workers, we looked at phasing that before we started registering the care-at-home workers. The issue is that it does take time.

The only thing that I would say—and not at all complacently—is that Scotland is the only country in the UK and, as far as we know, in Europe, that is investing money in getting these workers trained.

Mary Scanlon: I do not think that the investment is happening quickly enough. When we passed the Regulation of Care (Scotland) Act 2001, no member of any party realised that workers who support elderly people in their own homes would not need to be registered for 19 years.

These are difficult financial times. Given what you said about quality, if a policy were introduced to bring forward the registration of supervisors by two years, care home workers by four years and care-at-home workers by three or four years, would it be possible for the Scottish Social Services Council, with some resource, to create those jobs, to incentivise that training and to support those who go into homes, giving them—you used the word confidence—the confidence to care? In other words, could you create the jobs, register people, raise the quality standards and enhance elderly people's experience of being cared for? Can you give us some idea of the cost of bringing forward registration by three, four or five years and whether the Scottish Social Services Council is up to increasing registration and raising the standards?

Geraldine Doherty: Absolutely. The Scottish Social Services Council is completely committed to having a registered, regulated and well-trained workforce. As we say in our written submission, that is what secures safe practice and safe care. Inspection looks in on care, but what will really make the difference is a confident, well-trained workforce. With some assistance with resources, we could extend our operation. The system for registration exists; the issue is about numbers and getting more resources. Employers would need to be asked whether they feel able to do that. The resourcing of the registration is one element; employers being able to resource people to achieve qualifications within shorter timescales is the other element. The SSSC absolutely wants to see people registered and qualified.

Mary Scanlon: I am suggesting that there should still be a three-year period, which would allow employers to do that. The cost of an SVQ2 is around £450, but the individual learning account that every person gets is £200 per year. If the cost were spread over two financial years, that would go quite a bit towards paying for the training. I understand, from not-for-profit employers of home carers to whom I have spoken, that their carers are desperate to get the support that can be provided to give them, as you say, the confidence to do the job and to raise the quality of the service.

The Convener: I might want to bring in the employers, but there are a couple of supplementary questions specifically on that issue.

Fiona McLeod (Strathkelvin and Bearsden) (SNP): Ms Doherty, you said that there are 198,000 social service staff throughout Scotland and that there are 60,000 care-at-home staff.

Geraldine Doherty: Correct.

Fiona McLeod: So, a third of the social service staff in Scotland provide care at home. Because of demographics and the way that policy is going, we know that we will want more care to be delivered at home; yet, only a third of the staff provide that care.

Geraldine Doherty: That is the combined figure for care at home and housing support. One of the issues relating to regulation and the resourcing of training is the need to look at that shift in the care

pattern and ensure that the training is relevant and focused on the right people to get the services that we want. The figure of 198,000 includes people who are not within the scope of regulation—currently, 150,000 are within the scope of regulation. There are other workers in care who are not yet within the scope of registration or regulation.

Fiona McLeod: What kind of people are they?

Geraldine Doherty: They are social work assistants, adult placement officers and workers in day care for adults. Managers in day care for adults are within the scope of regulation, but workers are not.

Gil Paterson (Clydebank and Milngavie) (SNP): Bringing forward all that training and qualification sounds expensive. Who would pick up the cost if that went ahead?

Councillor Douglas Yates (Convention of Scottish Local Authorities): That is an interesting question. There is no doubt that resourcing and capacity issues are involved. The cost of accelerating the training would be substantial. I understand Ms Scanlon's point about the need to bring it forward as speedily as we can, as it is in everyone's interests to get the best-qualified staff that we can get in the shortest time; however, there is no question but that there is a resource issue. How that can be supported is another question altogether, perhaps not for this place.

Ron Culley (Convention of Scottish Local Authorities): I will build on that and break down the question. We need to think about resources going to different components in the system. To be straightforward, the SSSC will need greater investment in order to meet the types of targets that have been suggested. If we compare the resources at its disposal with those of similar organisations—NHS Education for Scotland on the national health service side, for example—the differences are quite stark. Considerable investment in the SSSC will be needed to drive things forward. There is a more challenging agenda for employers in councils and the private and voluntary sectors.

That said, we in COSLA and local government have tried to push quite hard on that agenda. Indeed, we have, in the past, created a means through the national care home contract by which we incentivise higher levels of training and qualification in the workforce, and we will probably want to push forward on that over the next few years. It is important that, if we are to take such steps and implement such measures, we plot a careful path towards the overall objective. In other words, we should not simply say that there will be a totally registered and qualified workforce by 2015; rather, we should make incremental gains towards that.

We certainly have contractual means that we can use to drive that improvement, but Councillor Yates alighted on the stark reality. There are increasing financial pressures on councils and private and voluntary sector providers, and it is more difficult to identify how to deliver additional investment into those environments, given how public finance works in Scotland with the local government settlement and the corresponding relationship between councils and private and voluntary sector providers through a commissioning process. The aspiration is great, and we are happy to work towards it, but we need to ensure that we do so in a way that does not disadvantage providers in the delivery of care.

The Convener: You alluded to the procurement process. We have heard that in some areas the procurement process is pushing wages down. We have also heard about a procurement process that has taken 60 per cent out of the training budgets. How do we get over that contradiction? How can we meet those costs and deliver the quality and continuity that we want?

Ron Culley: We recognise first and foremost that that is a challenge, but we must think about whether we are at a point at which a bigger political discussion is required about how social care is funded and supported in the future. Members have already touched on the demographics around social care. We must be alive to the fact that, in an environment in which we have increasing demand and diminishing public resources, real pressures relating to how those resources are used will be created. The reality is that the jam has had to be spread more thinly in order to meet the growing demand.

COSLA has argued that we should consider the development of the work by Andrew Dilnot that the United Kingdom Government commissioned. He reported on the future funding of social care in England. That work was done in an English context, but it raises fundamental questions about how sustainable the current system is and how we can attract finance into it. To put things simply, we do not have the resources to continue apace in line with demographic change.

The Convener: I assume you agree that the procurement process is an identifiable risk. Should the regulator include that in the risk register? Should they look at the procurement processes? We are considering the regulation of care, although we have gone wider than that. Does the regulator have a role in examining procurement procedures or contracts to establish whether risk comes from them? I see that Monica Boyle from the City of Edinburgh Council, which has argued

for a workforce development plan, wants to comment.

10:30

Monica Boyle (City of Edinburgh Council): As a local authority that commissions services, we specify requirements and set out our expectations on the training and support of staff. We are considering introducing minimum grades that we will accept when we procure services. Our recent commissioning strategy has indicated that we will commission new services only if they reach a minimum grade of 4, and that, with all existing services, we will work towards that standard.

Jim Eadie (Edinburgh Southern) (SNP): I have a question for Monica Boyle on day care provision. Last week, Dr Richard Simpson, Mary Scanlon and I visited the Caring in Craigmillar day care project to meet staff and clients to discuss their experience of regulation. Last Friday, as the constituency member, I visited the Prestonfield and district neighbourhood project, which has been serving the community of Prestonfield for more than 20 years. It provides excellent day care five days a week and has a range of activities for clients, a dementia day care service and an advice and information service for older people. Do you agree that that project is an exemplar of good practice, as evidenced by the ratings that it has received from the regulator, with two grade 6s for care and support and two grade 5s for staffing, which certainly meets the criteria that you just mentioned for the commissioning of services? What weight does the council give to the ratings from the regulator when it makes decisions about which projects to fund?

Monica Boyle: Prestonfield neighbourhood project provides very good day services for older people and is funded by the council. I am not sure whether there is a specific issue with the project, but if there is an issue that you want me to consider in more detail, I am happy to do so.

Jim Eadie: My understanding is that, despite the high ratings that the project has had from the regulator and the fact that it has been endorsed by the City of Edinburgh Council, there have been funding issues and funding has been withdrawn. I welcome your comments, and I would be grateful for an assurance that you will work with the centre to identify any funding issues and seek to resolve them.

Monica Boyle: Yes, I will. I am also happy to come back to you and give a wee bit more detail on the funding arrangements for that organisation, if that helps.

Jim Eadie: Thank you. Will you say a bit more about the weighting that the council gives to the ratings from the regulator when it makes decisions on the funding of projects?

Monica Boyle: The council tendered for day care services approximately two years ago. In the tendering process, quality accounts for 70 per cent of the contract evaluation, so the grading is taken into account.

Bob Doris (Glasgow) (SNP): One aspect of regulation that is being considered is the risk-based model. SCSWIS had revised that model, and the Cabinet Secretary for Health, Wellbeing and Cities Strategy gave a statement revising it further to involve more unannounced inspections in order to provide greater confidence in the system, which the committee certainly welcomes. We would like to think that our inquiry might have helped in that.

As well as considering how care homes are inspected, we have considered whether there should be a second tier of inspection that involves inspecting the care pathway of residents in care homes. That might mean selecting five or 10 residents and considering how they ended up in the care home, how they were referred to it, whether it is suitable for their needs and whether care at home was part of the pathway. The inspectorate would not just inspect how residents' needs are met in a care home; it would consider how they came to be in that home. I would like to hear the witnesses' views on how that could be inspected within the system and whether SCSWIS is best placed to do that multidimensional regulation.

Geraldine Doherty: One of SCSWIS's advantages is that it has brought together the care commission and the Social Work Inspection Agency, which enables it to examine in an integrated way the kind of assessment that gets people into care homes. It would be an advantage if the new organisation could examine the whole journey to ensure that people get the right care in the right place. For people who want to stay at home, the assessment of the support that they need should be examined alongside the care that is provided. An integrated approach in that respect would be very helpful and allow us to plan for the care that we want older people to have and which they themselves value and wish to have.

Ron Culley: I understand the motivation behind the question, but I am ambivalent on this issue. The policy direction is all about the better understanding of care pathways, which I implicitly agree with, but the challenge is how such an inspection is done and what it will tell us. Given the assumption that we cannot do it for the whole population, we will need a more targeted approach, but the question then is whether such an approach will allow us to draw general conclusions about the operation of the whole

system. Perhaps not; perhaps we need to identify best practice and potential weakness in the system and make observations on that basis. Although we are absolutely open to such a move, which certainly fits with the current policy environment, we need to carefully position the information that is used with regard to the agencies responsible for delivering that care.

Councillor Yates: Mr Doris makes a very good point. In our written submission, we comment on this issue because of certain concerns that we have. Unannounced inspections are fine up to a point and grading, too, is great in indicating how good a facility might be, but they are not the be-all and end-all. Other useful sources of information include professionals such as general practitioners and pharmacy assistants who regularly go into care homes, for example, to monitor medications and, of course, relatives who go in to visit. How can we capture all that information to ensure that we have the best and most rounded type of inspection and how do we feed it all back into the overall system to give everyone greater confidence that the routines in particular care facilities are robust and provide the quality of care that everyone wants? Gathering all that information will require a fair bit of co-ordination and I am aware of certain capacity issues at the moment—indeed, inspection services are losing personnel because of the economic climate. How can we gather all that information together in the most appropriate way to give the greatest confidence that there is quality and consistency of care in each care facility?

Bob Doris: You have all given the answer that I hoped you would give. I certainly think that this proposal provides a way forward and should be the direction of travel. I am particularly delighted that Mr Culley from COSLA sees it as such, although I agree with him that there would have to be a targeted and incremental approach to ensure that it is not overly burdensome on everyone involved. Nevertheless, I am delighted that all our witnesses are on board with this.

Ron Culley: Of course, you will need to think about how regulators come together to examine the issue. After all, pathways take individuals through not just the social care system but the NHS, so the question is how the two main regulators—SCSWIS and HIS—work together to deliver that analysis. I imagine that that will give rise to a number of organisational challenges.

Bob Doris: That is an excellent point. If we are asking local authorities and health boards to work together on service delivery, it is only reasonable to expect the inspectorates to do the same in a constructive manner. Although that is a challenge, it should not be insurmountable.

Mary Fee (West Scotland) (Lab): I would like to explore the panel's views on financial viability. I am interested in the extent to which they would like to see examination of the financial viability of a care provider. How far would you like that to go? Who would do it? Who would they report the findings of their scrutiny to? What enforcement, if any, should be put in place along with the ability to examine the financial viability of a service provider? If such a thing were in place, would it have any impact on smaller service providers?

Councillor Yates: Those are quite wide-ranging questions. There are two levels: care at home and care homes. COSLA was concerned about the situation that developed with Southern Cross, as you will be well aware. I wrote to Vince Cable to say that we were very concerned about the regulation of care and the regulation of finance, because we did not think that they were sufficiently co-ordinated. I have yet to receive an adequate response from Mr Cable on that issue.

Local authorities are very concerned about the providers of care at home and do their best to try to investigate the viability of those businesses. It is in no person's interests for the local authority to appoint a care provider to carry out care at home if it does not think that the service will be of consistent quality and the business is less than viable. Local authorities take all those things into consideration; they are very much at the forefront of their minds.

When the contracts are drawn up, local authorities look at the quality of care that businesses are able to provide. Such things are under continuous assessment. It is in the nature of the beast that we often get information from the service user or their relatives, which is a good indicator of the quality of the service that is being provided.

You asked how we guarantee that the company providing the service is financially viable. That is very difficult. Each local authority has to make a judgment call on it.

Ron Culley: It is absolutely a difficult issue. We are currently exploring it in depth with regulators and the Scottish Government. On process, we need to have a clearer understanding of the role and responsibilities, both at UK and devolved levels, of each agency that is involved. We need to take an analytical approach that allows us to understand what we can and cannot do, we need to look at the impact of any intervention, and we need to think through what contingency plans have to be put in place.

There are two elements to that. First, what preventative action can be taken to prevent a situation like the one with Southern Cross from happening again? Secondly, what information is

available to ensure that, in reacting to such circumstances, councils and others are as well prepared as they can be?

The issue is particularly difficult because the circumstances of failure in the sector over the past few years have been different in different cases. One of the big challenges with Southern Cross was that it looked to make money not necessarily out of the care business per se but out of private capital. We felt that there was work to be done on the regulation of private capital and private finance in respect of organisations that are involved in the provision of care. However, that is more in the domain of the UK Government and its management of the City of London than a devolved matter of the regulation of care.

10:45

We need to be careful that the Southern Cross issue does not blind us to the fact that there will be different pressures on different types of organisation throughout the system, all of which are very real. The difficulty that the Southern Cross analysis introduces is that, in responding to it, we treat all providers in the same way. For example, it might be difficult to envisage our asking for certain information from an organisation like Southern Cross but not from all organisations. Once we have navigated our way through the current situation with Southern Cross, I hope that there will be an opportunity for reflection so that we can put in place an arrangement that allows us to be more confident in the finances at the heart of providers. We expect that the voluntary and private sectors will become more rather than less important in the provision of care in the future, so it is even more important that we get this right.

Mary Fee: Do you envisage an expanding role for SCSWIS in examining financial viability?

Ron Culley: We need to consider that question, but I do not necessarily think that we are ready to answer it. We need to consider the issue over the next few months. It is probably right that SCSWIS's focus should remain on the regulation of care. We need to think about how the regulation of finance connects with that agenda and, where appropriate, co-ordinate that. That is why the process that I outlined is probably the right way forward.

The Convener: We discussed whether SCSWIS should have the capacity as a regulator to identify the kind of risks to people who use the services that were highlighted by the Southern Cross case or that of a voluntary organisation in Glasgow called One Plus, which crashed as well. The question is whether a regulator should have access to support through Audit Scotland, the Chartered Institute of Public Finance and Accountancy in Scotland or a commission so that it can identify weaknesses in organisations that supply care, because it is disruptive to people who depend on the care when organisations fail.

Ron Culley: There is also a prior question: for what purpose do we want to do that? Is it to prevent financial collapse, or is it to ensure that organisations with statutory responsibilities such as councils are better prepared to react to financial collapses? The latter is perhaps easier to achieve than the former.

Gil Paterson: I have a supplementary question. It is difficult to judge a private company's financial viability in any circumstance. I am sure that the committee is interested in what action should be taken when companies in the care sector collapse. Southern Cross was a fairly well-financed company when its contracts were awarded. What action should be taken when a company defaults or looks as if it is in financial difficulty? I am concerned about that question.

Councillor Yates: That is a very good question, and I wish that I had a straightforward answer to it. Outcomes for the residents of care establishments with problems are always at the forefront of our minds, and we must care for them first and foremost. In the case of Southern Cross, our number 1 priority was to protect the individual residents. As it happens, we have been close to the situation, which should come to a successful conclusion in the next five or six weeks. Nonetheless, it caused a lot of disquiet when it first emerged, not least among the residents of the care homes and their relatives.

Your question is a good one: what teeth are there to prevent that situation from happening again? The answer is none, which is the very reason why I wrote to Vince Cable to ask him to consider the regulation of finances to prevent such a calamitous situation from happening again.

The Convener: Mary Scanlon, did you want to come in on this?

Mary Scanlon: Not on this point.

The Convener: We will come back to you.

Fiona McLeod: I find the issue interesting. You said from the council's point of view that, when Southern Cross collapsed, your concern was for the residents whom you had placed there. Given that we cannot investigate or regulate the finances, how confident are you that the companies that are taking over the Southern Cross homes do not run on the same financial model as Southern Cross and that we will not end up in the same place again?

Councillor Yates: These are excellent questions.

The answer is that there is no guarantee. Until such time as the Westminster Government puts some regulation in place, we cannot guarantee that we will not end up in the same situation in future. Concerns have been expressed about other companies. We would love the worry to be taken away from us all, but we cannot have that assurance at this point. We are handling the situation as a one-off crisis, realising that we have to manage the risk across the whole sector.

Ron Culley: That is absolutely right. At the heart of the issue, we need to focus on the important relationships. We need to be in continual dialogue with the new organisations that are picking up the Southern Cross homes about their ability to ensure that care is provided in a suitable way. In building those relationships, we hope that those organisations would be able to identify any emerging concerns about their capacity to operate as a business and that, if any emerged, they would work with both SCSWIS and councils to ensure that we could move forward with a good understanding of the best way to ensure continuity of care. Essentially, that is what happened with Southern Cross.

The Convener: Does Malcolm Chisholm have a question at this point?

Malcolm Chisholm (Edinburgh Northern and Leith) (Lab): I have a question, but not on that particular topic.

The Convener: I think that all the members who wanted to ask a question on it have done so, so you can move us on.

Malcolm Chisholm: I am sorry that I came in late—I thought that this agenda item would be later. The two items before it did not last very long.

I was very interested in all the papers, but I would like to focus on the City of Edinburgh Council submission. Perhaps I am biased, but I found several interesting points in it. I will home in on the section under the heading "Inconsistency in grades/confidence in the system". The issue has come up with other witnesses, and there appears to be some disagreement. Some people have said that they have great confidence in the grades from SCSWIS and the nature of the inspections, but the Edinburgh submission seems to raise questions about it. I welcome the development in Edinburgh that you look at grades when you are commissioning care services, but I suppose that that begs the question whether you are entirely confident in the grades.

Monica Boyle: Our view is that there could be improvements in the grading system. We have experienced examples of services that are graded at 5 but have some recommendations and requirements while other services are graded at 4 but have no recommendations or requirements. There seems to be some inconsistency.

There are questions about the way in which SCSWIS inspects services. It might inspect only particular statements in one theme—for example, there may be six statements in one theme, but it inspects only two of them in any inspection. Therefore, we might find that, because it has inspected two particular statements, it gives a grading of 4 on one inspection and then, as it looks at other statements or themes in the next inspection, there is a variation in the grading. We believe that the grading system is important, but we think that some improvements to it are needed. We are working with SCSWIS and will talk to it about that.

Malcolm Chisholm: Is your concern about the fact that only one theme may be being looked at, or is it about the way in which that theme is being dealt with?

Monica Boyle: It is about the inconsistency. We have some examples of inconsistency in the grading.

Malcolm Chisholm: Do the other witnesses have any comments to make on how confident they are about the grading?

Councillor Yates: My counsel is to avoid an overreliance on the gradings. It is a bit like putting a car in for an MOT. The car may be good on the day on which it is inspected, but it might not be so good in three or four weeks' time. Gradings tend to vary. In some spectacular cases, the quality of a care home has diminished fairly rapidly in a few months. If a care home had a grading of 4 or 5, that would give confidence to someone who was looking to place a relative in that care facility, although that would be an indication only that it was good at the point of inspection. That is why there needs to be a more joined-up approach from local authorities and other people who go into the homes regularly. I talked about GP and pharmacy involvement and feedback from relatives and users of the service, which should all be important in giving people confidence about the quality and consistency of care in an establishment. Relying only on the gradings that are given at the time of inspection leads to overconfidence.

Ron Culley: The grading system, which was introduced by the care commission and has latterly come under the scope of SCSWIS, offers an overall assessment of the quality of the service, but we need to examine in more detail how it relates to individual outcomes. That is why I am attracted to Mr Doris's idea about care pathways and the experience of individuals.

A couple of months ago, when we were considering the bigger idea of public sector reform in COSLA, we argued strongly for a focus on

outcomes. We made the point that, although we have a fairly robust regulatory environment for assessing the quality of the education service, that often does not correlate with the educational outcomes for individuals, because there is a wider range of issues to consider. The grading system needs to move to an arrangement whereby regulators focus more on individual outcomes. Some of those themes were picked up in its development, but it is still focused on general service provision rather than on individual outcomes.

There are challenges in that. It can be resource intensive to capture information on an individual basis, and I am not sure how that sits in the public finance environment that we are in. However, if we can begin to connect service performance with delivery against outcomes, that will improve the overall performance of the regulator.

Geraldine Doherty: I support Councillor Yates's view that it is important that not everything is pinned on one aspect of regulation. We are working with SCSWIS on how we, as a workforce regulator that looks at the conduct of individual workers when there are concerns about their practice, work with the service regulator when there are concerns about the service itself. We share intelligence with employers and other workforce regulators, such as the Nursing and Midwifery Council, so that we have a broader picture. One aspect is how we bring together different strands of regulation so that we see a bigger picture and know where to focus our efforts.

11:00

The Convener: The evidence session has been helpful. I want to return to grading, on which the City of Edinburgh Council depends quite heavily.

Monica Boyle: I agree that the grading is the grading at a point in time and that services can deteriorate quickly. We have all experienced that. I agree that all agencies need to identify and highlight any weaknesses in the system. We all—the local authority, GPs and nurses—have a role to play. Concerns should be fed back to SCSWIS straight away.

SCSWIS needs to have the resource to respond quickly and to carry out more reviews when they are required, so that it can make recommendations if concerns arise. However, having a form of grading system is important for people who are making decisions about the care standards in care homes.

The Convener: The City of Edinburgh Council has moved to an approach of not procuring services when the grade is lower than 4—

Monica Boyle: That applies to new services.

The Convener: So you must have confidence in the grading system.

Monica Boyle: We want to have a grading system under which we can ensure the quality of care, but the grading system has inconsistencies. We are working with SCSWIS on care arrangements. We are about to enter into a four-month pilot with SCSWIS whereby we will consider how SCSWIS inspects care homes and how that fits in with our work to review care packages for individuals in homes. That pilot will bring together the timing of when we review people's care packages and when SCSWIS inspects a care home, and bring together the information. Once we have finished the pilot, we might be able to recommend how improvements could be made in the inspection systems.

The Convener: We have heard evidence about engagement with local pharmacists and GPs. Last week, the committee had sessions with service users and carers. Are the relationship, communication and feedback between those groups and the regulator sufficient? Are you concerned about that?

Councillor Yates: I do not think that those aspects are sufficient. As others have suggested, a far more joined-up approach needs to be taken, because that would allow people to be more confident about gradings. If the approach was more joined up and if we could be confident that information had been fed back to the centre, we could be more confident about the consistency of gradings. A question has been raised about consistency—something that is graded 4 here might be graded 3 there. The consistency of grading is important, so all the information must be fed into the centre.

Many changes or improvements will have to be made speedily. What powers will an inspection team have to ensure that that happens?

Ron Culley: I will talk about two themes and I will touch again on how we use the grades.

Most people would say that we always need to look at the extent of our engagement with people who use the services and to ask whether we are doing enough. In Campbell Christie's report, the view is that public bodies will need to put individuals and their views at the heart of public services, so we absolutely need to consider engagement.

I return momentarily to the grading system. We need to be careful not to expect that we can sort all the world's problems through regulation. I will explain what I mean by that.

As far as the grading system is concerned, some have called for the regulator to insist that all services be commissioned from providers that

have achieved grades of perhaps 4 and above. Such a step would be dangerous because it would begin to encroach on the role of the commissioning authority. Edinburgh's position is laudable but the fact is that it comes from a commissioning rather than a regulatory perspective. Similarly, in its national care home contract, COSLA has tried to put in place a penalty-and-reward system with regard to grading. As a result, homes that achieve a grade 5 or grade 6 get an additional payment, while those that achieve a grade 1 or grade 2 can be subject to penalties. That type of commissioning regime can be used to drive performance improvements instead of some regulatory instrument, which can be fairly blunt.

Finally, if we introduced such an arrangement, what would we be saying about those homes or providers that achieve a grade 1, grade 2 or grade 3? At the moment, according to the regulator, they are still fit to deliver a service. The regulator has the power to say that a service is not good enough and to stop it in its tracks but the 1, 2 and 3 grades are not designed to send out the message that a provider is failing in absolute terms with regard to care standards; instead, those grades merely suggest that there is clear need for improvement. We need to be awfully careful about trying to address all the challenges in social care through a regulatory tool. In fact, we will be able to sort things out largely through commissioning.

Mary Scanlon: Some of my points have been raised, but I note that in its written submission, the City of Edinburgh Council says, under the heading "Dealing with poor practice", that the role of SCSWIS, or what is now the care inspectorate,

"in dealing with poor practice should be strengthened",

particularly with regard to

"following up on improvement and enforcement."

As Councillor Yates has made clear,

"It is not consistent with councils' duty of care to have to wait until information appears on the public website."

It appears that people can find a bad report only by looking at the website and that there is no means for the care inspectorate to bring it to them.

I was also worried to read, under the heading "Roles and responsibilities":

"It would be more useful, consistent and safer if the regulatory body were to be more decisive regarding the impact of a negative report".

No matter what Ron Culley says about grades 1 and 2, the fact is that 1 is unsatisfactory and 2 is weak. Last year, 11 homes got a grade 1 or 2 and, according to a response that I have received to a written question, only two of those homes have been closed. You do not seem to know when a bad report comes out; you do not know what is done to follow up recommendations; you have said that the care inspectorate should be strengthened; and, finally, you have asked the inspectorate to be more decisive. That does not sound to me like an organisation that is fit for purpose.

Monica Boyle: Perhaps I should clarify a number of points. SCSWIS is involved in the bi-monthly multi-agency quality assurance meetings that we have on care homes and care at home, the purpose of which is to share information about any concerns that might have arisen. If certain information is not on the website, for example, SCSWIS will highlight that at one of those meetings.

That said, we are sometimes concerned about the speed at which an inspection report comes out following an inspection. Delays are not always SCSWIS's fault, but the fact is that it will not report until the action plan has been fully written up—and the person who has to do that might be the manager of the care home in question. That results in delays in putting reports on the system and allowing members of the public to see the information. However, as I have said, SCSWIS shares information with us at the bi-monthly multi-agency meetings.

As we suggest in our submission, though, the regulatory body could probably be

"more decisive regarding the impact of a negative report".

That relates to the point that Mary Scanlon raised about homes that are graded 1 or 2, which means unsatisfactory or weak, so the level of care is very poor. Often, SCSWIS falls short of recommending that we do not admit people to those care homes. Therefore, the local authority often has to decide not to put new clients into a home that has been graded 1 or 2. We might follow that up with an inspection.

If SCSWIS has concerns about an organisation and has to go to court to get agreement on the closure of a service, that can take a long time. We recommend that the committee consider the time that it takes under the legislation to make decisions through the courts about poorly performing homes.

Mary Scanlon: I understood that, under the legislation, a home can be closed in 30 days.

Monica Boyle: Yes, but people can appeal, and there can be a delay in that appeal process.

Mary Scanlon: Okay, so you want the inspectorate to be more decisive.

Councillor Yates: With underperforming homes, it is better to put in a system of improvement to try to raise the level, rather than to close the home, because the consequence of

closing a care home might be catastrophic in a local authority area. We know about the harm that displacing elderly people causes, so rather than close a facility, it is probably far better to try to put in place an improvement plan to bring it up to an acceptable standard.

The Convener: What happens if the home does not improve? How long does it get to improve?

Councillor Yates: If a local authority is involved, stepping stones would be laid down, setting out when the home would have to meet particular targets. Any local authority that had such a home would not place more clients in it and would do what it could to raise the standards in the facility. There might be a management issue or various other issues. I suspect that the closing of a home would be a last resort.

The Convener: I will raise a few issues that we have not covered. The committee is considering the current regulation of care, but we know from evidence that we have received that, in future, more care, and more complex care, will be delivered at home. What will be the regulator's role in that process?

Earlier, Mr Culley mentioned having an exercise similar to the Dilnot commission here in Scotland. I ask him to expand on that.

Also, we have received evidence from the Equality and Human Rights Commission in Scotland that refers to the new public sector equality duty. How will the human rights agenda drive the delivery and regulation of care in future?

Ron Culley: There were a few questions in there.

The Convener: It was three, I think.

Ron Culley: You will need to remind me of them as I go along.

On human rights, the view is emerging that we have to begin from a human rights perspective, which means starting with the individual and their basic entitlements and aspirations in a care setting. That is right, but challenges will still emerge, and the human rights agenda does not have a fix for all of them, particularly in relation to resources. For example, one tension in the delivery of social care is about how much we should invest in low-level preventive support and interventions and how much we should invest in reactive acute interventions. That is an awfully difficult question to answer in the abstract, and it is not necessarily illuminated by the human rights perspective, because human rights issues are at stake for those with low-level needs and for those with more intensive acute needs. The human rights agenda can take us only so far, as there are difficult questions that go beyond it.

Will you remind me what the other questions were?

The Convener: One was about the move to more care being provided at home. How will that be regulated?

11:15

Ron Culley: I refer back to a point that was made about care pathways. You are probably right. It is clear that the policy direction is to support more people in their own homes in a way that allows them to exercise choice and autonomy, and the regulation of that will probably mean that not only people's personal care needs but their medical needs will be supported. That points to the need for the two regulators to think about how to work together.

Your other question was about Dilnot. We need to urgently address the overall finances that are available not only in the social care system but in the health and social care system because we are, as members know, working towards a more integrated arrangement in that regard. There is a fairly stark challenge in dealing with demographic growth and diminishing finances. It is something of an irony that, in almost every other sphere of life, an arrangement in which demand for a product is growing and an increasingly wealthy population base is interested in buying that product is entirely satisfactory. However, such an arrangement in the provision of care presents something of a challenge, largely because of the role of state resources.

Dilnot raises questions about how the relationship between the citizen and the state should proceed, and how we can generate a sustainable financial base for health and social care services into the future. Irrespective of how well we integrate health and social care services, the reality is that there will be a point at which we will not have enough money to keep going. Even best-case analyses recognise that there will be a funding gap of billions of pounds in the future, irrespective of how well we optimise the provision of care. That is why dealing with what Dilnot has said is urgent. We need to begin to think through financial questions now so that, when the demographic changes really begin to kick in, we will have a response that is capable of dealing with them. We are not really close to that yet.

Geraldine Doherty: One of the challenges of the regulation of care at home is that somebody's home is involved, so sending in a team of inspectors will not work. The quality of the staff who are recruited and their management, supervision and training are even more essential than they are in any other aspect of care, because a lot of their practice will be unobserved—it will

take place in the homes of the most vulnerable people. Therefore, we need to have confidence about how those workers are supported and that their practice continues to be improved. How the provider of the care quality assures in an appropriate way, which recognises people's right to privacy in their own homes, will be a challenge but it is important that that is done. The initial assessment of the person's support needs if they are to stay in their own home and the question whether they are properly assessed at the right point to ensure proper care should also be regulated.

The Convener: How do we measure an outcome in that situation? You referred to that earlier. We know that people do not want 15 or 20 people in their homes over a week and that they want more than 15 minutes. How do we get the outcomes that we want without flushing them out? We cannot quantify what is happening, but we all know from our casework and our lives that it is happening. How can we get the regulator and others to recognise that? We were with carers last week who are very active in that area and have not had any contact with the regulator. People want to do more in their own homes and to be trained to do more. How do we open things up?

Councillor Yates: The direction of travel is quite clear; the Government has made quite clear the way that we should go. We know that the pathway is leading us towards a personalisation agenda, with more instances of self-directed support, where more and more older people are keen to manage and take responsibility for their own care and to choose what type of care they get and how often they get it. It is figured that, in that way, there will be greater consistency among carers.

That is a good way to go, but it is not without its challenges. I think that that is the right direction, but the challenge will be whether it is right for the state to interfere with a service user's choice about the type of carer or care that they choose, which might suit their particular circumstances. The whole idea of self-directed support is to tailor such support to the service user's specific circumstances, so that they get the care when they need it and at the level at which they need it. Should the state interfere in that? Should we regulate it, and, if so, how?

Fiona McLeod: I am slightly worried by your very last comment, Councillor Yates: should we regulate that? No matter how care is personalised or self-directed, surely we have to ensure that anybody who is being cared for in their home is being cared for by someone who is qualified and who has been assessed by a regulator to ensure that they are providing the right service.

Ms Doherty came close to answering one of my questions. We know that we have to look at regulation with regard to care at home. You have been talking a lot today about outcomes, individuals and the integration of many different regulatory bodies. With the increasing move to care at home, will we need two regulatory systems: one for care in a home and one for care at home? Alternatively, using the outcomes model, will we be able to have a system of regulation that covers care no matter where it is provided?

Geraldine Doherty: My preference would be the latter, because people move in and out of different care settings and we do not want to have one standard of care for someone when they are in a care home and another standard of care for when they are in their own home. You are absolutely right to say that we want to ensure that people are receiving good-quality care in the best circumstances for them. Those circumstances might change during their life and we might be able to re-enable them to go back into their homes. We should have one standard; splitting it would be really concerning.

Councillor Yates: I want to qualify what I said before by giving you an example to illustrate my point. In one case, a paraplegic was looking for a personal assistant and put forward a name to the social work department. That named person was vetoed by the chief social work officer. The rationale was that the person in question had a previous conviction for breach of the peace, which had happened several years previously. The social work officer disclosed that information to the individual who was going to employ that person and he was content with the system inquiry that had been carried out, because the breach of the peace had taken place when the person was a much younger man and he had moved on considerably since then. The case went to a social work tribunal and the service user asked, "Why should the social work officer veto my choice of personal assistant who I found quite caring and competent to deliver my care? Why should someone veto that individual because of a breach of the peace conviction?" The service user said that the social work officer did not know the individual as well as he did and asked why his choice should be vetoed. Such dilemmas will continue to crop up.

Fiona McLeod: But is it not the purpose of the system of regulation to ensure that, whatever the opinion of the person who is looking for a personal assistant or of the senior social worker, rules are followed according to the requirements of the Protection of Vulnerable Groups (Scotland) Act 2007, Disclosure Scotland and the regulation of social workers? There should be no dilemma if the regulation system encompasses all those aspects.

Councillor Yates: Absolutely, but the question arises what constitutes risk. It is about risk management. It is fine to think that we are risk averse, but what constitutes risk? The service user in my example did not feel that they were at risk from an individual who had disclosed in paperwork and in person at an interview that he had a breach of the peace conviction from several years before, when he was a young man. It is a question of objectivity and opinion.

Ron Culley: That is related to an earlier point, which was that some aspects must be addressed through commissioning and some must be addressed through regulation. The case in question is a good example of arriving at a satisfactory outcome through a commissioning model. If we have an arrangement whereby an individual and the council are satisfied about the level of risk relative to the outcomes that we want to achieve in the arrangement, that is a satisfactory outcome. Clearly, there must be an overall regulatory environment, but we do not want to create an arrangement in which individual choice and autonomy are stifled because of regulatory constraints, which can often be to the detriment of individual outcomes.

Geraldine Doherty: Just for clarification, during the passage of the Regulation of Care (Scotland) Bill, there was discussion about the issue of personalisation, which was not as well known at that time but was beginning to appear. There was a view, particularly from disability rights groups, that people should be free to choose the best package of care for them. The Regulation of Care (Scotland) Act 2001 sets down that the SSSC will not regulate personal assistants working in a one-to-one arrangement, but we do regulate care-at-home workers. Clearly, commissioning takes place within an overall regulatory framework.

It is interesting that the debate about personalisation and regulation happened back in 2001 and that the current arrangement is the outcome of that. That has been questioned along the way, because of concern that someone who is looking for care might not be in the best position to decide whether it would be safe for a particular person to care for them. That is the issue at the moment. There is a difference between regulatory amendments for care-at-home and housing support workers, and those for personal assistants.

The Convener: Thank you very much. We are coming to the close of this evidence session. We have asked a number of questions, but is there anything we have not raised that you wish to put on the record?

Councillor Yates: I just want to thank the committee for asking such direct, good and searching questions, which have given us all pause for thought.

The Convener: You can come back again, Councillor Yates. [*Laughter*.] We look forward to seeing you. Thank you all for your time and your evidence, which I am sure will be useful for our inquiry. I suspend the meeting for a couple of minutes to allow for the changeover of witnesses.

11:28

Meeting suspended.

11:34

On resuming—

The Convener: I welcome to our inquiry into the regulation of care for older people our second panel of witnesses: Dr Denise Coia, chair, and Dr Frances Elliot, chief executive, both from Healthcare Improvement Scotland. Bob Doris will open the questioning.

Bob Doris: In the previous session, I asked the witnesses about having a more integrated approach to inspection and regulation and mentioned care pathways. It might help us if, first of all, you could set the scene a bit and give the committee an idea of the areas where HIS would inspect or regulate.

Dr Denise Coia (Healthcare Improvement Scotland): Thank you very much for asking that question, because it leads nicely into issues that we were going to raise anyway.

We are a unique organisation in that we provide evidence through Scottish Medicines Consortium, the Scottish intercollegiate guidelines network and the Scottish health technologies group and also have an improvement and scrutiny function. With regard to health, the key issue for us is scrutiny of community health services and acute service care. My colleague Dr Elliot was going to try to pull together how our organisation might deliver that integrated function in the community.

Dr Frances Elliot (Healthcare Improvement Scotland): We are responsible for reviewing healthcare provision, which obviously goes across the spectrum from primary care to other community services and hospitals. The fact is that Scotland's ageing population is increasing the burden caused by chronic disease. Moreover, older people have much more complex needs that cross the areas of health and social care, and they are more vulnerable in all primary care and hospital settings.

In response to your question on care pathways, I point out that those do not differentiate between health and social care. The individual and his or her carers expect to have his or her needs met,

whatever those needs and whatever the setting might be. As a regulatory body, we will need to do much closer regulation with the care inspectorate to determine whether the quality of health and social care in the community as well as in hospitals is adequate.

Bob Doris: When the care inspectorate as a regulator goes in to inspect a residential home for the elderly or a nursing home—in other words, a place where nursing care is delivered in a residential setting—does HIS chat with the inspectorate in advance? Does it put in someone from its team? Does it provide advice? What is the interface between HIS and SCSWIS?

Dr Elliot: The only formal direct joint inspections that we have carried out were part of the multi-agency inspection of older people's services pilots that we ran 18 months to two years ago in Forth Valley and Tayside, the purpose of which was to look at much closer integration of health and social care scrutiny. The results of the exercise were quite interesting and were linked to the work on the integrated framework for delivering health and social care in the community.

At the moment, however, we go in only at the care inspectorate's invitation; after all, it has its own professional advisers who can give advice on pharmacy, nursing and general practice issues. We have started to discuss how we might collaborate much more in that respect but, given that it has its own set of advisers, the inspectorate might ask us for input to inspections only if it did not have certain expertise in an area.

Dr Coia: Since the establishment of the two new organisations, the chairs and chief executives have met every month. We both have a common vision about what inspection and regulation in the community should look like, and we are both concerned that at the moment there is a gap in the community with regard to healthcare regulation. Given that, as earlier witnesses have suggested, many care-at-home and care home issues are actually physical clinical matters, we must ensure that there is proper clinical input into care home and community inspections.

One of the issues that the care inspectorate has raised with us is that while we might look at clinical care and acute hospitals, what we are not doing is looking at care in hospitals. There is an overlap right along the pathway, which we feel has to be far more integrated.

That integration, however, initially requires us to come together with common methodologies. The way in which the national care standards are configured does not really incorporate some of the clinical standards that we would be looking at in hospitals. We are required to pull together methodologies, which is not impossible—it can be done. At the moment, the care inspectorate is resourced for inspecting care homes and we are resourced for inspecting acute hospitals. We do not have a common resource to allow us to do joint inspections across the pathway.

Jim Eadie: NHS Quality Improvement Scotland had a strong track record in devising detailed, comprehensive clinical standards across a range of disease therapy areas. As the successor body to that organisation, are you saying that those standards should be part of the regulatory process where care is provided, regardless of which setting it is provided in? If so, it strikes me that that will be quite a tall ask and rather an ambitious objective because health boards have a tough job in implementing those standards at the moment.

Dr Elliot: I suggest to the committee that it is impractical to consider updating all our current clinical standards. It would be much more sensible to consider the review of the national care standards and to incorporate appropriate clinical elements within those standards so that they are genuinely integrated across health and social care. That would provide a much better basis for joint inspection work across the regulatory bodies, with the professional regulatory bodies being brought in where appropriate.

Jim Eadie: Will you expand on that answer? How might you do that, and what metrics would be put in place to measure the progress that was being made?

Dr Elliot: As an organisation, HIS is moving away from long standards documents to much more targeted and focused documents. Our new healthcare scrutiny model relies on a simplified standard for generic services based on person-centred, safe and effective care.

With many of our existing clinical standards we can devise appropriate quality indicators. We are doing that at the moment with cancer standards. We have started working with the Scottish Government, carers and users of cancer services to ensure that those services are appropriate and that the standards are recognised by patients receiving care. We could use our existing standards to pull out the most important aspects and identify indicators that could link to updated national care standards and our own general standard, which has been updated in the past year and on which we are just coming to the end of a consultation process.

Jim Eadie: That is a helpful response in terms of where you want to get to, but what progress, if any, has been made in achieving that? Are you at the very early stage of scoping that proposal?

Dr Elliot: We are just about to conclude our consultation on the healthcare quality standard. The response to that has been extremely positive

and supportive across a range of stakeholders. We have developed cancer quality indicators, working with a range of carers, users and other stakeholders. We are very clear that there is good public and lay input to what we are doing.

We are on the journey, and we have developed one set. We would have to look at a prioritisation process for the next most important things to tackle. However, given our work programme for 2012-13, it is perfectly feasible for us to start to identify what those things might be if they are to feed into the national care standards.

The Convener: What does that gap mean for someone who is being cared for in a community residential setting, who might find themselves disappearing in the acute sector? What about those standards? How is continuity provided? Is that done through early intervention, or through the tracking of medicines? How does that work in practice? What does it mean to a family member who has a loved one in that situation? How can we communicate with them?

11:45

Dr Elliot: I can give an example of our work on some of our mental health care pathways. We have integrated care pathways for a number of conditions that cross primary and secondary care and from time to time involve social care. We accredit the care pathways—they are based on evidence about the right thing to do at the right point in time on the pathway. We are developing indicators to show where the services along the routes of the pathways are in relation to others across the NHS and how robust they are in delivering. We could use that mechanism to expand the system to look at how the healthcare input to the national care standards could be incorporated.

Dr Coia: I will give another practical example. For us, care at home is a key issue, and we feel increasingly that that area has to be strengthened. For families caring for someone at home, there are issues—which were alluded to earlier—about the training of people who go into the home and how they recognise clinical problems. For example, some of the commonest admissions to acute hospitals are due to delirium because people are dehydrated and are not receiving proper nutrition and fluids, because they have a urinary tract infection or because their catheters are blocked.

Although we cannot investigate all the specific events in a home, those admissions can be prevented by giving people appropriate training so that they know that those are common occurrences that bring the elderly into acute hospitals. The regulator's role in that is linked to the training to ensure that the people who go into homes are able to recognise the common clinical symptoms when they occur.

Mary Scanlon: I want to ask about that specific point. In your submission, under the heading "Are there any particular weaknesses in the current system?" you state that a weakness is the current system of assessing the quality of health and social care. Am I to understand from what you have said about your work programme and the new quality standards that personal care for someone who is cared for in their own home is assessed—the quality of care and support, the environment, staffing, management and leadership—but there is no assessment, inspection or monitoring of their health needs? Surely that is serious.

Dr Elliot: Yes. Up until now, our predecessor organisation did not have a direct locus to go into someone's own home to assess care. That was the role of the care commission, and it now lies with the care inspectorate. Our responsibility has been much more in the area of healthcare settings. One thing that we suggest needs to be looked at is how the integrated approach across the regulators can start from the person's home, irrespective of the setting—whether it is a community or longer-term care placement—and allow us to track their care when they come into acute care settings in hospital, too. At the moment, the system is not as integrated as it could be.

Mary Scanlon: I want to understand this. I assume that you are bringing forward a national quality standard for care at home that relates to a person's health—in our inquiry, we are looking at elderly people. However, the health needs of people at home are not being looked at just now. How would that area be inspected by the care inspectorate? Are the inspectors fit and able to assess someone's health needs, or are we looking at a completely separate system?

Dr Elliot: We have completely separate systems. It is Healthcare Improvement Scotland's responsibility to look at healthcare needs. Our responsibility is to identify the appropriate evidence to develop standards and quality measures for healthcare. The care inspectorate looks after the social care and care elements. It may not be easy, but it would be possible to ask us to consider jointly how we might bring those things together. With the Government drive on the integration of health and social care, it is a necessary and fundamental step for the future.

Mary Scanlon: I appreciate that that is your responsibility at the moment. However, many people with highly complex needs are cared for at home, including those with significant health needs. What is Healthcare Improvement Scotland doing at present to ensure that the healthcare

needs of those receiving care in their homes are being met?

Dr Coia: We are pushing strongly to have the ability, as two new organisations, to carry out joint inspections. There is an overarching scrutiny group in the Scottish Government, whose meetings I attend; Frank Clark from the care inspectorate also attends them. We have pushed strongly for joint inspections of care pathways so that we do not just focus on acute hospitals—as HIS does at present—and on care homes. Rather, we should look at the whole pathway and start to see that it is about the person rather than where the person happens to be.

Mary Scanlon: I have a final question.

The Convener: It is your final question.

Mary Scanlon: I thought that it would be. Dr Coia told me what she is pushing for but my question was about what is happening at the moment. Is she saying there is no monitoring, inspecting of a person's health needs, and no ensuring that those health needs are being met? I appreciate that she is pushing for that to happen, but does that mean that nothing is happening at the moment?

Dr Elliot: We do not go into homes. Part of the development of the new standards is to think through what inspection methodologies we will use. Looking at care services in an individual's home is very different from looking at care services in a larger setting.

Fiona McLeod: It is becoming increasingly apparent from the evidence that we know care will be provided at home but that, as HIS has just told us, aspects of care are not being inspected. HIS told us about going to the Government to propose considering care pathways. How is that being accepted? Is it being welcomed and will we get there quickly, or does the committee need to insist that that happens?

Dr Elliot: It is being received very well by the Government. Groups are working with us, the care inspectorate and the Mental Welfare Commission for Scotland to look at the dementia standards and consider how, collectively, we should inspect services against those standards both in the community and in care institutions. There is an open-door approach to such discussions; the problem is that we have not necessarily had the vehicles or methodologies to do inspections in a comprehensive and integrated way. The challenge is to get up to speed rapidly on these things.

Dr Coia: We would certainly appreciate the committee recommending that approach.

The Convener: It is always easier to recommend when one knows the answer.

Fiona McLeod: Can HIS give us any evidence to back up that recommendation?

Dr Coia: We are happy to give you written evidence on that point.

Malcolm Chisholm: What has been said is really interesting. HIS has not been in the spotlight to the same extent as SCSWIS, which is probably a good thing because it means that HIS has been doing such a good job over the years. Dr Denise Coia said that HIS is looking at clinical care in hospitals but not wider care aspects—which is looking at the same issue from the hospital point of view, I suppose. In Edinburgh, there was a big controversy about that a few years ago and Anne Jarvie produced a big report on how care aspects could be improved. To what extent has that been carried forward? Does HIS not regard that wider care aspect as part of its remit within hospitals?

Dr Coia: We certainly do.

Dr Elliot: Yes. There has been a greater emphasis on issues such as dignity and respect—many of the human rights issues that were discussed in the earlier part of this meeting—the agenda around food, fluids and nutritional care, and the agenda around tissue viability and preventing pressure sores and other ulcers. That work has become an important part of our clinical standards. There are a number of improvement activities in operation in hospitals and in the community across the areas of general care.

Malcolm Chisholm: Will you talk briefly about how inspection in acute hospitals works? The process is quite different from what happens in care homes.

Dr Elliot: In June, the Cabinet Secretary for Health, Wellbeing and Cities Strategy announced a programme of acute hospital inspections to look at the care of older people. We are finalising the inspection methodologies and tools that we will use, and we will start the inspections next month—I think that we will start at the beginning of November. We plan to have a series of initial, announced inspections and then unannounced inspections in hospitals, to look at care of older people.

Malcolm Chisholm: Is that a new development?

Dr Elliot: Yes. It came out of the cabinet secretary's request in June.

Gil Paterson: Self-assessment is very much part of the process. Can the witnesses suggest how it can be improved? Who should be involved in making changes?

Dr Elliot: We propose to use self-assessment as part of our new healthcare quality standard, because it is important that organisations

understand where they are on the continuum of delivering quality care and that they regularly monitor measures and report in public on what they do.

Self-assessment is intended to be the first stage of the scrutiny process. The healthcare provider organisation will look at our standards and determine where it is against them. Our scrutiny role is to triangulate the assessment with other evidence and intelligence that our organisation has, to ensure that we test out where the organisation thinks it is against the standards. We will then be able either to confirm the organisation's assessment or to identify areas where improvement is required. Self-assessment is an important aspect of the process, but it must be triangulated with other evidence, to test it out.

Dr Coia: The Scottish health council, which is part of our organisation, is firmly involved with the participation standard and the older people's standards. As well as the information that we get from self-assessment and through boards and the Scottish Government, it is crucial that we add the third corner of the information triangle, which is about the public and patients themselves. There must be user involvement. As chair of the new organisation, I feel strongly about the third corner. We will want to see more and more such involvement during the next couple of years.

The Convener: I confess that I do not know any of the members of my local health council. Is that a problem for you?

Dr Elliot: That tells me that we need to make sure that you have that information—

The Convener: Is it a problem in the context of engagement with the public? I do not know whether my experience is common to other members of the committee. Do members know members of their health council?

Mary Scanlon: There is one, national health council. I do not know its members.

The Convener: Oh, is it a national organisation?

Dr Elliot: We have local offices, where staff work with the boards—

The Convener: There used to be local health councils. Are they still in operation?

Dr Coia: Yes. You made an important point, which we need to take back to the health council.

The Convener: Yes, because it brings us back to the discussion that we had when we spoke to users and carers last week, when we talked about advocacy and how people know what to expect and what their rights are in the process. Have you done work on that?

Dr Elliot: Yes. When we develop our standards and quality indicators we do a lot of work to ensure that we have patient and carer involvement. There is a lot of lay input—that is a mandatory part of our process. We also test our standards out. As part of our inspection model, which we introduced with the healthcare environment inspectorate and will use for looking at older people's care in acute hospitals, trained lay inspectors are involved in the process. Part of their role is to talk to patients—and carers, if they want to talk—when they go out to look at the care setting, so that they get a clear view from patients about their experience. What is important is the lived experience of what happens to patients, not the theory about what happens.

The Convener: The use of antipsychotic drugs to manage people has come up in our inquiry, although the issue has not been raised in this meeting. Can you give advice on that? Relatives might not be sure about the on-going discussions that should take place in relation to the use of sedatives and antipsychotic drugs.

12:00

Dr Coia: Medicines management is particularly crucial for older people in acute hospitals, who can often be on about 20 drugs in one go, and in care homes, but it is also crucial for care at home. There is a gap in that regard because, although primary care takes responsibility in that area, people are often on huge amounts of medication that are not assessed when they are at home, which is one of the reasons why they can end up in hospital. Guidance in that regard is certainly an issue for us.

SIGN produces a range of guidance, which is now going on to apps for iPhones. At the moment, there are only apps for clinicians to access, but there are going to be apps on medication that the public can access.

Dr Elliot: We produced material for patients and carers when we produced the clinical professional guidance, so that is part of the package of information that goes out. Again, the information is available on the public website so that carers and users can access it.

The Convener: Is it easy to understand and is it easily available?

Dr Elliot: Yes. We get lay input to the production of our materials to ensure that it is easily readable and understandable. There is always room for improvement, but we do try.

Fiona McLeod: Dr Coia talked about the third corner of the triangle, which I want to explore a wee bit more because I am that third corner. You have lay inspectors, but how do you recruit patients and their carers to tell you what happened

when the patient was in hospital? You talked about SIGN guidelines having information for patients and carers, but how do you disseminate that information? Having it on a website is great for someone such as me, but how do we ensure that people know that it is available? Care homes could have lovely charts for assessment of tissue viability and so on, but only the patient or carer could tell you whether it was ever filled in. When you tell a service that it must improve, what sort of weapons do you have in your armoury to ensure that that happens?

Dr Elliot: I may forget some of those points, so bear with me. We have regular public adverts for lay inspectors, whom we then train and involve in our activities. When we carry out inspections, their task is to speak directly to the patients and solicit their views. They go into wards and care settings and ask to speak to patients who would like to talk to them about their experience of care. Hospitals know when an announced visit will take place, so we can involve carers in that way.

On our guidance and evidence going out, we have events for a broad section of stakeholders and service users, whom we also involve in the distribution of materials when we publish our final guidance or reports. We therefore take an integrated approach to that across all our work.

Since the new organisation Healthcare Improvement Scotland came into being on 1 April, we have had more formal follow-up of our inspection activity. We expect to see improvement action plans. The teams from the healthcare environment inspectorate go back on unannounced inspections to follow up and check that the actions that the boards said they would take are being taken, so we have a mechanism for that. Ultimately, if we as a regulatory body are not satisfied that due action has been taken, we have an escalation process back to the Scottish Government health and social care directorate through our sponsor division, which can then undertake action on any issues in relation to performance management of the care systems and the boards. That would be our route back if we did not see adequate progress.

Dr Coia: I will pick up two points. Fiona McLeod asked about the input of patients and carers. What I will say might sound flippant, but all of us have been carers of older people—it is pretty hard to go around Scotland and not find somebody who has a granny or a grandpa. The experience around Scotland is cumulative. The public certainly keep raising five or six key issues, and the challenge now is to resolve those problems—determining what they are is not complicated. In relation to carers and patients, we should remember that we are all in this together.

To be fair, we would say that we are not very keen on announced visits. We have been asked to make one or two initial announced visits to services for older people to pilot the system but, after that, we would be extremely reluctant to make announced visits.

The Convener: Is a list of health council members and lay inspectors available for us to access locally?

Dr Elliot: Yes.

The Convener: For our casework, it would be pretty interesting to have a local contact to explore issues with. In our constituencies, being aware of and communicating with such individuals would be a matter of courtesy. It would be useful if such a list was available.

Jim Eadie: A witness on the previous panel said that a funding gap will open up as the demographic shift to an older or ageing population takes place. Some of Dr Coia's comments provide a clue as to how we might close that gap and how the regulatory process might drive the shift in resources from the acute sector to care in the community. You gave three examples—I wrote down that they related to urinary tract infections, catheter care and delirium—of how more appropriate care in the community would have prevented unplanned hospital admissions.

You talked about the role of medicines management. The chief pharmaceutical officer used to give me a row for using that phrase—he prefers "pharmaceutical care", but the point is the same. If a person's medication is managed more closely and if their medicine is reviewed regularly, problems might be picked up before they result in admission to hospital.

I am excited about the holy grail of how we unlock the money that is caught up in the acute sector and shift it into the community. I am interested in how you as the regulator see your role in developing quality indicators to inform updated care standards and in how disseminating good practice can bring about that shift.

Dr Elliot: I can give you a comprehensive answer, but I probably do not have time to do so today.

Jim Eadie: Will you write to us?

Dr Elliot: We will write to the committee.

Good evidence developed from the multi-agency inspection of services for older people about the systems across health and social care. Where good, integrated care-at-home and community services operate, admissions—emergency admissions in particular—are reduced for the over-75 population and health and social care costs are lower, because much more

integrated care is delivered. If those good examples became the norm across Scotland, the balance of care would shift automatically.

Our organisational role in supporting improvement—rather than wearing our regulatory hat—is demonstrated in the Scottish patient safety programme, which involves standardised care bundles in acute hospital care. In March, no patient in an acute hospital in Scotland had a central line infection, for the first time ever. That is an important aspect of critical care delivery.

The improvement processes that we are putting in place are delivering benefits and are avoiding care complications and the spending of additional resources in acute care. That frees up resource for more patients to be seen in hospital and does not necessarily shift the balance of care, but variation in care can be tackled and we have improvement methodologies to do that. I can give the committee detail about elements on which we are working.

If we brought everybody up to the level of the best examples, we would have more resource available to look after the ageing population, with all the complexity that that brings.

Jim Eadie: For clarification, what is your organisation's role in relation to good practice in preventing unplanned admissions?

Dr Elliot: We develop the evidence about what works. Our improvement programmes try to get that put into practice and our regulatory and scrutiny activity checks that it is happening. It is important that we bring all those activities together around what we describe as our integrated cycle of improvement. A key role that we have as a regulatory body is to close the loop with scrutiny to identify what further improvements are needed.

Dr Coia: But we would like to do that in the community as well as in acute hospitals.

Bob Doris: I will backtrack slightly. You mentioned the pilot joint inspections that you have done with social care colleagues. That is interesting and the committee should perhaps look at that in more detail outwith the meeting. You said that the two organisations' different methodologies and approaches to inspection were a barrier to more efficient joint inspection. Have you spoken to the care inspectorate about that? Is work being done on it? What is the timeline for getting the work joined up so that all the ducks are pointing in the right direction for joint inspections?

I think that the committee grasps the idea of joint inspections where a larger number of older people are together in one setting, whether it be in a hospital, a care home or a nursing home. The big issue for us is the inspection of social and medical care that is provided in people's own homes. The picture is painted of a dozen people traipsing into everyone's house with clipboards, which clearly cannot happen and would be counterproductive.

It is important that we get a bit of clarity on such joint inspection work, so I have two questions. First, what would it look like? Secondly—this might be slightly controversial—when an integrated approach is taken, is it always necessary to have a clinical expert and a social care expert, or can there be an inspector who is qualified to do both those things?

Dr Elliot: We believe, because we have inspectors from both healthcare and social care backgrounds in our organisation, that what is important is the standards against which the provision is being measured and inspected. There must be a clear standard and a methodology that picks up both the social care and general care elements of the care that is being delivered as well as the specific healthcare elements.

On the work on older people in acute hospitals, we ensure that we get expertise from geriatricians, consultant psychiatrists, psychogeriatricians and nursing and allied health professions to ensure that we pick up the key issues from their perspective.

Once the inspector knows what they are doing, it does not entirely matter whether they are from a health or social care background. If they are inspecting and are clear about what they are doing, that person can cover many of the elements. However, one must be careful that they are trained to do that; training and education are extremely important. As Geraldine Doherty said in the previous evidence session on professional regulation, validation and quality assurance to ensure that they inspect consistently against the standards are also extremely important. It is necessary to have a quality assurance process, but it is also about good training and education, the clarity of the standards that are being inspected against and the methodology that will pick up those matters. It has to be possible to do that in a sensible way to avoid having lots of people going into individual care settings at home.

Dr Coia: As chair of HIS—I know that the chair of the care inspectorate would make the same point—I point out that we are currently not resourced to do that. That is quite a large piece of work and, although we are keen to do it, we do not have the capacity in either organisation to take it forward.

Bob Doris: Are you talking about working out the joint methodology and then the training, so that one person is trained to inspect in both areas?

Dr Coia: No.

Dr Elliot: No. From our perspective—I am sure that colleagues from the care inspectorate would give a similar response—we can work out the methodologies, but a key underpinning is our methods of risk assessment, as risk assessment in health is sometimes different from risk assessment in social care, because we come at it from different perspectives. We need to get a shared language and a process for assessing risk in community settings and in care at home. If we develop that and the appropriate inspection tools, it is then about the prioritisation of the process of determining which care settings we go into, which we would need to discuss with Scottish Government colleagues.

12:15

The Convener: Mary Fee has a last, brief question.

Mary Fee: I will be very brief. In any case, I think that the witnesses have already sort of answered my question, which ties in with what Jim Eadie was asking. What is your opinion on the length of time that it is taking to register care staff? Furthermore, what should be the minimum level of training for those who care at home? It strikes me that, if those people were trained to a certain level, they would be able to recognise and deal with the catheter problems, the delirium and the other medical issues that you mentioned. Although that training might be more expensive, it might in the long run save money by preventing people from being admitted to hospital.

Dr Coia: Before I bring in Frances Elliot, I should point out that, as Ron Culley suggested, there is a danger in not looking at this issue in the round. We expect people to be trained, but primary care has a responsibility in this respect and there is an issue to do with how district nurses, GPs and the primary care setting itself are managed. A witness in the previous session suggested that GPs could comment on care home regulation, but we must ensure that the NHS is playing its part. After all, this is not just about more training for social care providers; the NHS primary care sector should also be trained to pick up on these matters.

Dr Elliot: NHS Education for Scotland has provided training for care assistants who are not healthcare professionals but who work in healthcare in community settings and provide support in residential care homes and nursing homes. It is not our role to comment on what happens in the care inspectorate, but there are care assistants who work with healthcare professionals and can recognise some of these basic care needs. Given the training demands on healthcare professionals across the spectrum of disciplines, that has proved a very cost-effective way of supplementing what they can do. There are ways in which care assistants' skills can be augmented. There are, for example, SVQs and other qualifications; indeed, Skills for Health has a number of modules for engaging and upskilling care assistants.

The Convener: I thank Dr Coia and Dr Elliot for attending this morning and providing very significant and important evidence to our inquiry.

We move to item 6 which, as previously agreed, we will take in private.

12:17

Meeting continued in private until 12:37.

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