Health and Community Care Committee

AGENDA

18th Meeting, 2000 (Session 1)

Wednesday 21 June 2000

The Committee will meet at 9.45 am in the Chamber, Assembly Hall, The Mound, Edinburgh

1. **Item in Private:** The Committee will consider whether to consider item 8 in private

2. **Subordinate Legislation:** The Committee will consider the following negative instruments—

   - The Animal Feedingstuffs from Belgium (Control) (Scotland) Revocation Regulations (SSI 2000/158)
   - The Food (Animal Products from Belgium) (Emergency Control) (Scotland) Revocation Order (SSI 2000/159)
   - The National Health Service (Clinical Negligence and Other Risks Indemnity Scheme) (Scotland) Amendment Regulations 2000 (SSI 2000/168)

3. **Petition:** The Committee will consider the response from the Scottish Executive on Petition PE 185 on people who have contracted hepatitis C infection as a consequence of infected blood transfusions.

4. **Petitions:** The Committee will consider the proposed system for considering petitions

5. **The Healthy Scotland Convention: 3 July 2000:** The Committee will consider the invitation from the Minister for Health and Community Care to attend the Healthy Scotland Convention on 3 July 2000

6. **Community Care Inquiry:** The Committee will hear evidence from the following representatives from Northern Ireland as part of the inquiry—

   - Eric McCulloch, Chief Executive, Eastern Multifund
   - Brian Dornan, Director of Community Services, Down Lisburn Trust
   - Dr Gerry Burns, Executive Member of Multifund and Chairman of Clinical Issues Group
7. **Subordinate Legislation:** The Committee will consider the following emergency instrument—

The Food Protection (Emergency Prohibitions) (Paralytic Shellfish Poisoning) (Orkney) (Scotland) Order 2000 (SSI 2000/192)

8. **Annual Report:** The Committee will consider the draft Committee annual report

Jennifer Smart  
Clerk to the Committee  
Room 2.5  
Tel 85210  
email jennifer.smart@scottish.parliament.uk

The following papers are attached for this meeting:

**Agenda Item 2**

The Animal Feedingstuffs from Belgium (Control) (Scotland) Revocation Regulations (SSI 2000/158)  
HC/00/18/1

The Food (Animal Products from Belgium) (Emergency Control) (Scotland) Revocation Order (SSI 2000/159)  
HC/00/18/2

The National Health Service (Clinical Negligence and Other Risks Indemnity Scheme) (Scotland) Amendment Regulations 2000 (SSI 2000/168)  
HC/00/18/3

23rd Report from Subordinate Legislation Committee on SSI 2000/158 and SSI 2000/159  
HC/00/18/4

24th Report from Subordinate Legislation Committee on SSI 2000/168  
HC/00/18/5

**Agenda Item 3**

Letter from Scottish Executive  
HC/00/18/6

**Agenda Item 4**

Report on process for considering petitions  
HC/00/18/7

**Agenda Item 5**

Letter from Minister for Health and Community Care  
HC/00/18/8
Agenda Item 6
Submission from Northern Ireland representatives

Agenda Item 7
The Food Protection (Emergency Prohibitions) (Paralytic Shellfish Poisoning) (Orkney) (Scotland) Order 2000 (SSI 2000/192)

Agenda Item 8
Draft Committee Annual Report (PRIVATE)
Subordinate Legislation Committee

23rd Report, 2000

Subordinate Legislation


2. The Committee has determined that the attention of the Parliament need not be drawn to the instruments listed at Annexe A.

3. The report is addressed to the Parliament and the following committee as the lead committee for the instruments specified:

   Health and Community Care  SSI 2000/158
                                  SSI 2000/159
Negative Instruments

The Animal Feedingstuffs from Belgium (Control) (Scotland) Revocation Regulations 2000, (SSI 2000/158)

The Food (Animal Products from Belgium) (Emergency Control) (Scotland) Revocation Order 2000, (SSI 2000/159)

Instruments not subject to Parliamentary control


Subordinate Legislation Committee

24th Report, 2000

Subordinate Legislation

1. The Subordinate Legislation Committee met on 13th June 2000.

2. The Committee has determined that the attention of the Parliament need not be drawn to the instruments listed at Annexe A.

3. The report is addressed to the Parliament and the following committees as the lead committees for the instruments specified:

   Local Government
   The Docks and Harbours (Rateable Values) (Scotland) Order 2000, (SSI 2000/draft)
   The Electricity Lands and Water Undertakings (Rateable Values) (Scotland) Amendment Order 2000, (SSI 2000/draft)
   SSI 2000/166

   Health and Community Care
   SSI 2000/168

   Transport and the Environment
   SSI 2000/169
Draft Affirmative Instruments

The Docks and Harbours (Rateable Values) (Scotland) Order 2000, (SSI 2000/draft)

The Electricity Lands and Water Undertakings (Rateable Values) (Scotland) Amendment Order 2000, (SSI 2000/draft)

1. The Executive Notes that accompany most instruments are of considerable value both to the Committee and to the other Committees of the Parliament in the task of scrutinising instruments. The Committee therefore places great importance on the accuracy of the Notes and wishes to be assured that they are prepared contemporaneously with the instrument. It is therefore particularly important that the Notes are dated.

2. The Committee therefore asked the Executive to explain why the Notes accompanying the above instruments were not dated. The Executive in its response, reprinted at Appendix A, apologised for the oversight and informed the Committee that the Notes in question should have been dated 30th May 2000. The Committee noted and accepted the Executive’s apology and clarification.

Negative Instruments

The Council Tax (Administration and Enforcement) (Scotland) Amendment Regulations 2000, (SSI 2000/166)

The National Health Service (Clinical Negligence and Other Risks Indemnity Scheme) (Scotland) Amendment Regulations 2000, (SSI 2000/168)

The Sulphur Content of Liquid Fuels (Scotland) Regulations 2000, (SSI 2000/169)
The Docks and Harbours (Rateable Values) (Scotland) Order 2000, (SSI 2000/draft)

The Electricity Lands and Water Undertakings (Rateable Values) (Scotland) Amendment Order 2000, (SSI 2000/draft)

I am responding to your message of 6 June with regard to 2 Affirmative SIs considered by the SLC. The SSIs (one on “Docks & Harbours” the other an amendment Order covering “Water Undertakings” and “Electricity Lands”) were accompanied by Executive Notes prepared by myself.

The ENs were not dated but should have been 30 May 2000. Apologies for the omission.

Alex Mowat
Victoria Quay
LG 3-J
7th June 2000
Dear Jennifer

HEALTH AND COMMUNITY CARE COMMITTEE
HAEMOPHILIA AND HEPATITIS C

The Minister was grateful for the Convener’s letter of 7 June about Haemophilia and Hepatitis C. She is sorry that we were not able to reply by your deadline.

In the letter, the Convener asked whether the exercise the Minister instigated covers non-haemophiliacs who might have contracted Hepatitis C through contaminated blood products and, if not, to extend the remit to include them. She also asked whether the Minister would publish the results of the exercise by the first week in July, and attend the committee to discuss the findings.

The Minister instigated this exercise following specific concerns expressed a year ago about the circumstances surrounding the heat treatment of Factor VIII between Scotland and England in the period 1985-87. Having listened carefully to representations from the Haemophilia Society, the Minister made sure the remit of the exercise explicitly addressed this issue. It is, of course, the case that other people have contracted the Hepatitis C virus via blood in other ways – for example, through blood transfusions before a test was available to screen blood for the virus. (The virus was only isolated and identified in 1989.) Tragic though these cases are, the Minister is afraid she can see limited value in examining an issue on which we already know the outcome, and for this reason she does not intend to extend further the remit of this exercise.

With regard to the publication of the report, the Minister intends to publish the report before recess. She will, as she has previously indicated, provide a copy to the Health and Community Care Committee for their consideration.

GILL WYLIE
Private Secretary
1. Background

At the meeting of the Committee held on 31 May 2000 the issue of how the Committee dealt with petitions was considered.

Members noted the number of petitions that were being received by the Committee and felt that a more efficient system was required.

It was suggested that a system be implemented to give members an early view of the petitions and to allow them to decide in advance of Committee meetings whether they warranted full Committee consideration and possible inquiry.

This system would also ensure that all petitions be seen and considered by Committee Members.

2. Developments

The following system was recommended:

Petitions will be passed to all Members of the Committee as soon as they were received from the Public Petitions Committee by the Clerk.

Members will be asked to consider each petition and decide whether they wished it to be considered further by the Committee. Members will be given a set time to inform the Clerk of their decision.

The petitions received within a specified period will be placed on the agenda of a meeting of the Committee which has been previously agreed.

If no comments are received within this timescale then it will be assumed that Member wish no further action to be taken on the petition and that it will be placed on the agenda of the meeting for noting.

If comments are received then the petition will be placed on the agenda to allow Members to consider what action they wish to take.

It is suggested that the Committee consider petitions on a quarterly basis to allow them to be scheduled into the Committee’s timetable. It is suggested that they be considered at the second meetings in September, December, March and June.
3. **Next Step**

Some petitions have been received by the Clerks since this proposal raised at the meeting on 31 May 2000. If the Committee agrees that this system be implemented then these petitions will passed to all Members after the meeting and will be considered at the second meeting of the Committee in September. At present this is likely to be 13 September 2000.

4. **Recommendation**

Members are asked to consider the proposed system and decide whether they wish it to be implemented.

Jennifer Smart  
Clerk to the Committee
THE HEALTHY SCOTLAND CONVENTION: 3 JULY 2000

I am writing to inform you about the inaugural meeting of the Healthy Scotland Convention, which is to take place at the Glasgow Thistle Hotel on Monday 3 July, and to invite the Committee to be represented.

The aim of the Convention is to enable the Executive to meet with relevant organisations from across Scotland to review the steps taken so far to drive forward our public health agenda, and to consider how best we might expedite progress, taking account of the additional resources now available. This all day event will be participatory in nature, enabling those present to contribute views, experience and best practice and to discuss the way ahead with the Executive, and with colleagues from relevant sectors.

I would greatly welcome the presence of representatives from the Health and Community Care Committee at the Convention. I appreciate that setting aside a whole day for this purpose might not fit into already busy diaries; but it may be possible to arrange attendance for part of the day. To this end, I will send you the agenda immediately it is finalised. I would very much welcome your own presence, if that is convenient, along with up to, say, 4 or 5 other colleagues of the Committee’s choosing.
I look forward to hearing from you. If you would like a word about this, then please do not hesitate to let me know.

SUSAN DEACON
INTEGRATED PRIMARY HEALTH AND SOCIAL CARE IN DOWN LISBURN TRUST, NORTHERN IRELAND

VALUES AND PRINCIPLES

Health and Social Care needs are not distinct. The Clinical Standards Advisory Group (1998) found that practitioner respondents could not “identify the difference between health and social care except at the extremes of the continuum …”

At any time 85% of elderly people who are care managed in Down Lisburn Trust receive both health and social care services. As their needs continually change nearly all, over time, require both health and social services.

Services should be person centred. People are entitled to feel at the centre of their care with the ability to make choices. The one key choice each person is able to make is which GP list to join. It therefore makes sense to respect this choice and, where possible, base services around each practice list of patients.

THE DOWN LISBURN EXPERIENCE

Since 1973 Health and Social Services in Northern Ireland have been the responsibility of single agencies. For some years the full potential of this arrangement was not achieved. However, from 1990 the introduction of general management has led to increasing levels of integration in organisation and practice.

In Down Lisburn Trust, for example, since 1992, a primary health and social care team has been built around the patients in each GP practice. The team comprises GP’s, District Nurses, Health Visitors, Care Managers and support staff. Other specialist staff, including Child Care Social Workers, Occupational Therapists and Community Psychiatric Nurses and Social Workers are practice aligned and generally based with other primary care team colleagues.
Implementing this model also involved the extension and development of health centres and other local bases so that primary care teams could be based at the heart of the communities they serve.

In the course of developing the teams lessons were learned, as summarised below:-

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<tr>
<th>WHAT MUST BE AVOIDED</th>
<th>WHAT HAS PROVED IMPORTANT</th>
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<tr>
<td>• Nominal integration that is not reflected in practice</td>
<td>• Being based together, and particularly sharing a team room. Once practitioners share accommodation they build relationships and become advocates for that arrangement. Improved communication has been a significant benefit.</td>
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<td>• Lack of budgetary control by the Primary Care Team</td>
<td>• Devolution of budgets to locally based teams gives ownership and allows primary care practitioners to use resources flexibly and to set priorities, based on knowledge of local and individual need.</td>
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<td>• Domination of one tradition by another</td>
<td>• Respecting each profession. Only by demonstrating fairness and equity of esteem between disciplines can the active support of practitioners be achieved. Management arrangements must ensure that both health and social care traditions are represented and that practitioners are confident that this balance will be preserved.</td>
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<td>• Dilution of professional expertise</td>
<td>• Creating a professional structure for continuing professional development on a single, as well as a multi-professional basis, to ensure professional expertise.</td>
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<td>• Limited understanding of roles of others and emphasis on demarcation</td>
<td>• Training together as a means of both increasing understanding and promoting flexibility in practice.</td>
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<td>WHAT HAS PROVED IMPORTANT</td>
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<td>Undue focus on health and social services links at the expense of other agencies</td>
<td>Inter-agency working at both senior executive and primary care levels actively promoting links with partner agencies including education, housing, the police and the voluntary sector.</td>
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<td>Lack of confidence by practitioners working without single profession management</td>
<td>Continuous staff development promoting confidence amongst practitioners in their ability to be accountable for their own practice within a multi-disciplinary team.</td>
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<td>Personal and management development increasing the capacity of managers to undertake devolved responsibility.</td>
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<td>Arbitrary imposed change</td>
<td>Culture change takes several years. While actively promoting change be sure to bring professionals with you. They will later drive the process in a culture of devolution and empowerment.</td>
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<td>Fear of taking responsibility</td>
<td>Create an innovative culture based on evolution, devolution and empowerment. Reward creativity and initiative and do not blame when results are not as intended.</td>
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**PERSON CENTRED BENEFITS**

- Clarity that there is one entry point to all health and social care services through the health centre and primary care team.

- Access to a wide range of community health and community care services at a convenient location, usually within 15 minutes of home.

- Reduction in duplication and inflexible practice evidenced, for example, by the ability of a District Nurse to arrange home help service or a Care Manager to deliver aids or continence products.
RECENT AND FUTURE DEVELOPMENTS

Integrated working has extended beyond primary care to secondary level specialist services including:-

- Development of a Children’s Resource Centre bringing together –
  Children’s mental health services
  Paediatrics
  Children’s disability team
  Adoption and fostering
  Day care support and regulation
  Adolescence social work specialists
  Barnardo’s Family Centre

- Development of former elderly persons’ homes into Resource Centres with social care and nursing staff supporting both primary care and hospitals, providing step-up and step-down facilities, day care, outreach domiciliary care, and a 24 hour emergency helpline for professionals, carers and care managed and other vulnerable people.

PERSPECTIVES ON BENEFITS

- Research during 1999 identified that 95% of GP’s, 94% of Care Managers and 79% of District Nurses assessed the service to their patients/clients as having improved because of the development of integrated primary care teams. No practitioner felt that services were worse.

- Local MP’s and MLA’s have endorsed integrated arrangements as providing better services.

- The local paper in Lisburn listed the quality of health and social care as one of ten benefits of living in Lisburn.
REFERENCES


2. Dornan, B (1999), Teamwork in Integrated Primary Health and Social Care Teams, unpublished research project (publication pending).

Brian Dornan
Director of Community Services
6th June 2000