AUDIT COMMITTEE

Tuesday 23 November 2004

Session 2

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CONTENTS

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AUDIT COMMITTEE
21st Meeting 2004, Session 2

CONVENER

*Mr Brian Monteith (Mid Scotland and Fife) (Con)

DEPUTY CONVENER

*Mr Andrew Welsh (Angus) (SNP)

COMMITTEE MEMBERS

*Susan Deacon (Edinburgh East and Musselburgh) (Lab)
*Robin Harper (Lothians) (Green)
*Margaret Jamieson (Kilmarnock and Loudoun) (Lab)
*George Lyon (Argyll and Bute) (LD)
*Mrs Mary Mulligan (Linlithgow) (Lab)

COMMITTEE SUBSTITUTES

Chris Ballance (South of Scotland) (Green)
Mr Ted Brocklebank (Mid Scotland and Fife) (Con)
Marlyn Glen (North East Scotland) (Lab)
Mr John Swinney (North Tayside) (SNP)

*attended

THE FOLLOWING ALSO ATTENDED:

Mr Robert Black (Auditor General for Scotland)

THE FOLLOWING GAVE EVIDENCE:

Dr Peter Collings (Scottish Executive Health Department)
Mr Ian Gordon (Scottish Executive Health Department and NHS Scotland)
Fiona March (Scottish Executive Health Department)

CLERK TO THE COMMITTEE

Shelagh McKinlay

SENIOR ASSISTANT CLERK

David McLaren

ASSISTANT CLERK

Clare O'Neill

LOCATION

Committee Room 2

Scottish Parliament

Audit Committee

Tuesday 23 November 2004

[THE CONVENER *opened the meeting at 09:48*]

Items in Private

The Convener (Mr Brian Monteith): My electronic gavel has let me down. Not to worry. I call the meeting to order.

This is the 21st meeting in 2004 of the Audit Committee, and I am pleased to welcome the Auditor General for Scotland and his team from Audit Scotland. I do not see any members of the public, which is probably just as well because, after climbing up to this floor, the first item on the agenda is to seek the agreement of the committee to take items 2 and 6 in private.

Item 2 is to consider lines of questioning for witnesses on the reports by the Auditor General entitled "Commissioning community care services for older people" and "Adapting to the future: Management of community equipment and adaptations". Item 6 is to enable the committee to consider the evidence taken under agenda item 5 on the reports by the Auditor General for Scotland that I have just mentioned.

The question is, therefore, whether to discuss agenda items 2 and 6 in private. Is that agreed?

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): Could I suggest an amendment to that question? I believe that item 3, which is consideration of a draft letter, should also be discussed in private.

The Convener: The intention was not to consider that draft letter in detail but to hear general themes for any redrafting that members want. Are there specific issues that you want to raise?

Margaret Jamieson: Given my previous experience of working with the committee, I just feel that it would be appropriate for us to consider in private a draft letter that is written by the clerk.

The Convener: I have no particular difficulty with that suggestion. I shall first put the question on items 2 and 6, on which nobody has commented. Do members agree to take those items in private?

Members *indicated agreement*.

The Convener: Do members have anything else that they wish to add in relation to item 3?

Mr Andrew Welsh (Angus) (SNP): If item 3 were taken in private, it would then become public, so it would be covered. It is certainly not anything secret. I accept Margaret Jamieson's point—the letter will eventually come into the public domain once it is agreed, so I would be happy to take item 3 in private.

The Convener: All items come into the public domain. I am not sure what distinction you are making.

Mr Welsh: I accept Margaret Jamieson's point about the letter being a draft by the clerk. To hold the item in private would allow proper discussion of the draft. As the letter will eventually come into the public domain, there is no secrecy in that.

The Convener: I see what you mean. There is no secrecy because the letter will eventually come into the public domain. I thought that you were suggesting that if we discussed the letter in private, it would then somehow, mysteriously, become public.

Mr Welsh: No.

The Convener: I was rather disturbed by the notion that we discuss things in private so that they become public.

Mr Welsh: I can calm your fears on that.

The Convener: Do members agree that item 3 be taken in private?

Members *indicated agreement*.

09:51

Meeting continued in private.

10:16

Meeting continued in public.

Subordinate Legislation

Public Finance and Accountability (Scotland) Act 2000 (Economy, efficiency and effectiveness examinations) (Specified bodies etc) Order 2004 (SSI 2004/482)

The Convener: I remind everyone to switch off their mobile phones and pagers, if they have not already done so. Agenda item 4 is subordinate legislation. We will consider under the negative procedure a Scottish statutory instrument that has been made under the Public Finance and Accountability (Scotland) Act 2000. Full details on content and parliamentary procedures are included in the accompanying papers.

It will probably help members and the public if I inform them that the instrument was laid on 9 November 2004 and that the deadline by which the Parliament must deal with it is 18 December 2004—in other words, no later than 40 days after the laying of the instrument. If any member wished to lodge a motion to annul, that would be debated at the committee meeting on 7 December. If the committee wished to recommend that the instrument be annulled, it would have to report by 13 December. Members now have the opportunity to comment on the instrument, although it is entirely likely that it will be on the agenda again at a later date. I think that Robin Harper has a query.

Robin Harper (Lothians) (Green): I want to clarify whether we can find out what are the selection criteria for the bodies that will come under the legislation.

The Convener: I think that that is referred to in the fourth paragraph of the accompanying Executive note. I invite the Auditor General to add to what is in the paper.

Mr Robert Black (Auditor General for Scotland): I have the power to undertake value-for-money studies of any bodies for which I appoint the auditors or for which I am the auditor. The SSI relates to bodies for which I am not the auditor, but which are dependent on the public purse—through the funds of the Scottish Parliament—for significant sums of money. It is permissible for an order to be made that allows me to undertake value-for-money studies of any body that receives more than £500,000, or more than a quarter of its income, from the public purse.

A previous similar instrument contained a long list of bodies; the instrument that is under consideration seeks to add more bodies to that list. I am sure that it would be perfectly possible to provide the committee with the full list for its next meeting, to give members a context within which to consider the matter.

Robin Harper: That will be quite a long list.

Mr Black: Yes, it is quite a long list. Some of the obvious organisations are not escaping—let me put it in those terms. They are already captured by a previous instrument.

Margaret Jamieson: How will the instrument impact on Audit Scotland's workload and budget?

Mr Black: When we consider our forward work programme of studies, it will be possible for me to embrace those bodies, and indeed the bodies on the earlier list, in considering where we should apply our resources. The instrument will allow Audit Scotland to cover a wider range of bodies. It means that the selection of studies will, to ensure that we address priorities, need to be made more carefully.

The Convener: The Subordinate Legislation Committee will report formally on the instrument on 28 November. We will consider its report at the next meeting of the Audit Committee, on 7 December. I propose that we note the instrument and agree to consider it further on 7 December. Is that agreed?

Members *indicated agreement*.

"Commissioning community care services for older people" and "Adapting to the future: Management of community equipment and adaptations"

10:22

The Convener: We move on to agenda item 5, which is an evidence-taking session on commissioning community care services for older people and the management of community equipment. I welcome the witnesses from the Scottish Executive Health Department. Ian Gordon is the accountable officer and head of the Scottish Executive Health Department and chief executive of NHS Scotland; Dr Peter Collings is director of performance management and finance and is a well-kent face at our committee meetings. Fiona March is a policy officer in the community care division.

This is our first evidence-taking session on commissioning community care services for older people and the future management of community equipment and adaptations. We have the Auditor General for Scotland's reports, and I invite Mr Gordon to say a few words before we move on to questions.

Mr Ian Gordon (Scottish Executive Health Department and NHS Scotland): I will make the briefest of opening statements to confirm that the Scottish Executive welcomes both reports from Audit Scotland. We think that they are helpful in trying to send signals about the proper management of community care services, particularly the provision of equipment. The areas that they cover are complex and we emphasise the need for individualised packages of care and the need for care to be delivered at home. That illustrates the difficulty with measuring the value of those services, and indeed with measuring the activity, but there are helpful signals in the reports.

I make it clear that we accept the recommendations that are addressed to us. There is one recommendation in the general report on commissioning community care services and three recommendations in the report on equipment. We stand ready to support local government and its national health service partners in implementing the reports in the interests of improving the management of services. On that basis, I am happy to answer questions.

The Convener: Thank you for providing us with papers before the meeting. We have a number of questions on the two reports. I ask Andrew Welsh to start us off.

Mr Welsh: You said that you accept the recommendations. I presume that that includes paragraph 35 and recommendation 7 in "Commissioning community care services for older people", which highlight the need for the Executive to collect information about the take-up, impact on quality of life and cost of free personal care, to assess its success and to forecast future expenditure. When the Executive introduced free personal care, what were the criteria by which the success of its implementation was to be evaluated?

Mr Gordon: I am not sure that I can give a specific answer to the question. We would, of course, have considered the objectives that were set in the care development group report. We intend to review implementation of the policy during the course of next year, which is, in effect, the third anniversary of its introduction. For that purpose, we will commission research: of course, in specifying the research, we will address the objectives that were set out in the care development group report.

Mr Welsh: So, you are not sure about the criteria for evaluation and you are looking towards a review and research. Are there no performance indicators to tell you whether the policy works in practice?

Mr Gordon: Our first emphasis was on implementation of the recommendation that personal care be provided free. The Executive provided resources to local government and asked it to measure take-up. We asked local government to report on the number of people in receipt of free personal care and whether they receive it in care homes or in their own homes. We also asked local government to report expenditure under those two headings and to report separately on expenditure on nursing care. The figures will allow us to measure the rate at which the service is being taken up across local authority areas.

Mr Welsh: You will get figures on take-up and expenditure, but how can you measure the success of the take-up or expenditure?

Mr Gordon: Surely the purpose of the policy was to ensure that people who needed free personal care received it free. Two issues are involved: the need to ensure that people are assessed and, secondly, that they receive the service freely.

Mr Welsh: So, you are examining take-up rather than evaluation. In your submission, you say:

"The Department is currently developing a proposal for research into the implementation and operation of Free Personal Care."

Why, at the very start, did you not consider scoping the research?

Mr Gordon: I am not sure how I can answer the question. The original emphasis was to ensure that the policy was implemented promptly and on the provision of guidance to local government. The Executive wanted authorities to understand exactly the intention behind the personal care that was to be provided free—the care that was not to be charged for in the future. The emphasis was on getting the guidance out and on helping local government to prepare itself for implementation of the policy.

Mr Welsh: So, scoping is an afterthought. Is that normal?

Mr Gordon: The ideal must be to have a more explicit set of objectives at the start—indeed, it must be to ensure that we measure the things that we need to measure. From our point of view, the priority was to ensure that the policy was implemented promptly and effectively. For that to be done, the key measure that is to be measured is take-up of the policy.

Mr Welsh: Free personal care is not only an important matter; it is one that affects vulnerable people. Everybody wants to see it succeed. However, does what you say in your submission about

"the scale of unmet need"

mean that you still do not know the cost impact of implementing free personal care?

10:30

Mr Gordon: Clearly, the costs will evolve. The best possible estimates were made at the time. Although I tried to set out fully in our submission the exact basis of the estimates, it is in the nature of such things that the estimates will be wrong in one way or another.

In assessing actual expenditure against projected expenditure, we need to take into account a variety of factors such as demographic projections of numbers of older people and the take-up of care services. That latter factor raises questions about people who had been receiving care services informally and who are now entitled to receive personal care at public expense; about people who had not come forward for public care services but who now know that they are entitled to receive care at public expense, which I think is what is meant by unmet need; and about the implementation of needs assessment by local government. In that respect, the figures that we published in September show a wide range of numbers of people per 1,000 of the population receiving free personal care and a wide range of expenditure by local authorities on such care. That must give rise to questions about how needs assessment works across the country. We must have regard to such considerations when we consider how projections of expenditure have turned out in practice.

Mr Welsh: I appreciate that the issue is complex, but it strikes me that it has all been something of a leap in the dark. I find it a bit difficult to correlate your comments with the tables that you have provided, which set out specific figures. For example, throughout your letter, you use phrases such as

"estimated cost to local authorities … estimated cost of personal care services being provided from the private sector … no centrally collected data on private home care services"

and you say that a certain number is "difficult to quantify". You also mention the

"estimated cost of meeting existing unmet need for personal care "

and talk about "assumed" unmet need and "assumed" changes in pensioner and household income. If those estimates are unclear, why do your tables set out single figures instead of a range of figures?

Mr Gordon: The estimates allow us to take decisions on the amount of money that should be provided to local government. A decision had to be reached and an estimate made. Of course, any estimate will give rise to a range of uncertainty; however, ministers had to decide on the amount of money that would be provided, and required our best estimate of what the policy would cost, hence the need for a single figure. I hope that the table to which you referred fully sets out the components that made up the single figure and shows that we sought to address all the extra costs that local government would have to meet.

It should not be necessary for me to explain that a good number of people were already receiving free personal care before the policy was introduced. As a result, we were required to consider the extra costs that would fall on local government in providing personal care that an individual did not have to pay for themselves.

Mr Welsh: Forgive me, but all that means is that local authorities received resources based on very vague estimates.

Mr Gordon: I suggest that the estimates are not vague; indeed, they are very precisely defined in the table, although any estimates must be the subject of some uncertainty. The most obvious illustration of that can be found in the projections of the numbers of older people in different categories, which will continue to change upwards and downwards over time. The policy will need to be kept under review for public expenditure planning purposes.

Mr Welsh: Your figures appear to provide certainty on this complex issue. However, they are simply estimates.

Given the expected increase in the older population and the increasing demand for free personal care, will the funding that is needed for such care impact on what is available locally for other community care services?

Mr Gordon: There is bound to be some interaction between the various forms of care. In allocating resources, local authorities will need to prioritise a variety of needs, and to meet them from the funds that they make available for community care services.

Free personal care is a new obligation, which Parliament imposed on local authorities two years ago. Additional resources were made available to local authorities; we are trying to understand to what extent the increase in expenditure by local authorities on home care services and care homes is attributable to the provision of free personal care, as opposed to an increase in demand from other sources.

Mr Welsh: The population is aging and the proportion of people over 80 is increasing. In annex A of your submission you state that that has "clear implications" for local authorities. How clear are those implications and what will be the impact on other care services?

Mr Gordon: The recalculation of the estimates of expenditure to take account of changes in numbers of old people is, of course, one of the easiest things to do. We can simply feed the new projections of the numbers of older people into the calculations that were done three years ago, which is relatively straightforward. It is much more difficult to understand more intangible changes in the way in which the service is delivered in practice, such as the extent to which people who previously relied on informal care are coming forward or the extent to which local government implementation of needs assessments is changing over time.

Mr Welsh: How soon can we expect an evaluation and clarification of the situation? Are there plans to produce performance indicators?

Mr Gordon: I am not sure what you mean in relation to performance indicators. Our essential purpose has been to make available free personal care. We measure the numbers of people who receive personal care and we have recently published information on the provision of personal care.

Mr Welsh: I will therefore finish by reiterating my initial point. The Executive needs to collect information about the take-up, the impact on quality of life and the cost of free personal care in order to assess the policy's success and to forecast future expenditure. Can we expect any of that to happen?

Mr Gordon: We must have regard to such questions as we commission research next year to ascertain how the policy has worked in practice. If we are to understand the benefits that people feel that they receive from personal care, I presume that we will survey individuals who are in receipt of such care, but that does not need to be done all the time as we go along.

The Convener: Before we move on to consider community equipment and adaptations, do members have further questions on the cost of free personal care?

Margaret Jamieson: When costings were done, what attention was given to case-mix complexity? Obviously, some individuals' needs are not as great as those of other people, who might be older, for example. How were such considerations built into the overall cost projection?

Mr Gordon: The answer that we give to the first question in our written evidence explains that we established an average cost on the basis of existing practice at the time. I take Margaret Jamieson's point: the pattern of care might change over time, which would need to be reflected in the average costs. We will need to have regard to that matter.

Margaret Jamieson: Can I take it from your answer that local authority A, which does not have a complex case mix, could be advantaged, whereas another authority that has a significantly higher number of older people and greater case-mix complexity could be short-changed? That would appear to be the case if an average cost is used to allocate funding.

Mr Gordon: That is obviously right in principle. The mechanisms for distributing public money to local authorities are based on a variety of formulae that seek to reflect need. Those formulae have to be relatively simple to enable distribution on the basis of averages and numbers of people in particular categories. If we take as an example free personal care, some local authorities might benefit slightly from the way in which the distribution works and some local authorities might lose slightly. One has to have regard to the fact that that is just one service among a large number of services for which local government is centrally financed.

Margaret Jamieson: That argument raged in the health service for a long time. We came up with a new funding method—the Arbuthnott formula. Are you saying that you do not even double-check to ensure that local authorities are properly funded on the basis of that formula?

Mr Gordon: The Arbuthnott formula is used for funding national health service boards and it seeks to reflect a variety of indicators of need. However, it does so imperfectly, in that some boards might feel that they benefit from those indicators and some might feel that they lose from them.

The Arbuthnott formula works in the NHS, but there are separate mechanisms for distributing resources to local government. The distribution of money for free personal care works within the context of distribution to community care services, but it is a unique service. The extra expenditure on free personal care from local government does not so much reflect need for care services in deprived communities, but is distributed to those local authorities that have larger numbers of self-funders—those are the ones that will see greater increases in expenditure as a result of free personal care. The funding allocation system was adjusted to reflect the particular patterns of free personal care in that respect, but we have had to use averages to estimate total expenditure.

Susan Deacon (Edinburgh East and Musselburgh) (Lab): Mr Gordon, you said that the estimates were the best possible ones that could be made at the time. I want to probe that further. When was the figure of £125 million for the initial cost of implementation of the policy in year 1 first mooted as being the likely cost?

Mr Gordon: Neither I nor my colleagues were in post that far back, so I do not know exactly how the figure of £125 million emerged. If the committee would like, we will try to answer that question in writing after researching it. Different figures were provided to local government to reflect the short delay that was made necessary when implementing the policy. I understand that the figure of £125 million came from the care development group report, but I would prefer to check that and answer in writing, if that would be helpful.

The Convener: That would be acceptable if you cannot give us an oral answer at the moment.

Susan Deacon: Might it be possible for Dr Collings to comment, given that he was principal finance officer at the time? Am I not correct to say that the figure was mooted and earmarked as a sum for investment in the policy in advance of the care development group report?

Dr Peter Collings (Scottish Executive Health Department): That is also my recollection, although, with increasing years, I find that I sometimes get confused about what happened. However, I recollect that we arrived at a first rough estimate of £125 million. The care development group report produced more refined estimates subsequent to that. We set aside £125 million provisionally, which we had to adjust once we got the care development group figures.

10:45

Susan Deacon: I am grateful for that and I understand how difficult it is to remember years back—we all share that problem these days. The reason why I asked the question is that the figure was in the public domain and had been earmarked in advance of the care development group report. It is interesting to note that, when the report came out, it, too, came up with the figure of £125 million—which, as I said, had already been earmarked. Can you give us an indication of where the figure of £125 million originated, given that it did not come out first in the care development group report? How do you account for the coincidence that the report came up with the same figure? Was that because the sum that was earmarked earlier was a good estimate or was there a sense that the group report had somehow to fit the envelope that had been assigned? It is important for us to get a sense of where the estimate derived from.

Dr Collings: My recollection is that the £125 million came out of the work that was done following the Sutherland report, so there was a substantial amount of work behind it. It is therefore not surprising that, in producing its report, the care development group came out at roughly the same place. The group was not told that it had a certain amount of money; it was told what the policy was and was asked how much it would cost. Although the group flagged up the fact that the cost would increase over time, rather than being static, it came up with about the same amount.

Susan Deacon: I am grateful for that clarification. I note that the Sutherland report did not include detailed estimates and certainly did not include specific Scottish figures.

I have a question about table 1 in annex A to the letter. I refer to the line on non-recurring investment in community care services, which is part of the estimate for years 1 and 2 only. Will you elaborate on what that investment is, given that the bulk of the cost of free personal care relates to staff and so is, by its nature, a recurrent cost?

Mr Gordon: In paragraph 6 of the annex, we describe what the money was intended to cover, which is, in essence, a variety of one-off non-recurrent investment that local government would need to make to introduce, rather than to maintain, the policy. It was felt that it would be necessary to carry out intensive training of staff in the assessment processes and that it would be necessary to invest in information technology for

the collection of appropriate management information and expenditure.

Susan Deacon: So are you confident that the estimates relating to one-off items, which there was no need to repeat in year 3 and beyond, are robust?

Mr Gordon: I am sure that they were the best estimates made at the time. It is probably relevant to say that local government has not expressed concerns that that part was wrong.

Susan Deacon: May I ask two other questions?

The Convener: As long as they are on costings.

Susan Deacon: Yes. The point arises out of genuine curiosity. Having revisited the care development group report in advance of the meeting, I spent some time trying to compare table 1 in annex A of the letter and table 5.11 on page 51 of the care development group report, which is the key report on costings. The two tables are presented differently. Now that I have done my calculations, I see that that is a question of presentation. Why has there been a change in the presentation and in some of the subtotals and descriptors? I would have thought that you would want to repeat simpliciter the table presented by the care development group. I stress that the change is just presentational; I do not for a moment doubt the figures.

Fiona March (Scottish Executive Health Department): I was asked to change the presentation slightly because the way in which the figures were presented in the report might be misleading. Although the final total is the same, just adding up the totals could be misleading, which is why I changed the presentation.

Susan Deacon: Okay.

George Lyon (Argyll and Bute) (LD): Andrew Welsh asked about the single figure that is used in each of the policy elements and how you arrived at the cost. What was the range of the total cost of the policy and of the costs of the elements of the policy that were put to ministers before a final decision was reached?

Mr Gordon: I would need to research whether ranges were put—

George Lyon: I think that you stated the information in evidence to us.

Dr Collings: My recollection—this is from quite a long time ago—is that, when we were putting figures to ministers, we felt that the initial costs were reasonably firm. The main issues were around the rate at which those costs would grow, the two elements of which were the rate at which the unit costs of providing the care would grow and the rate at which the number of recipients would grow. I do not remember the precise variants that were considered, but I recollect that variants were looked at depending on, for example, the assumption that unit costs would grow in real terms at 2 per cent per annum. We asked questions such as what would happen if costs did not grow in that way, but instead were in line with inflation at 0 per cent. The variants that were examined at the time were very much around the growth rate, whereas there was no obvious way of producing options for the base numbers, which were fairly firm.

George Lyon: But you must have had some idea of the range. Was it 2 or 3 per cent? Was it 20 per cent? Was it 100 per cent? You must have had a range if you took the most pessimistic scenario versus the most optimistic. What was it?

Dr Collings: If one projected forward 10 years or more and changed one's assumptions on, say, unit costs by 2 per cent per annum, one would get something in excess of 20 per cent less than the care development group's figure. The issue on which there was no way of setting a range was the extent to which there might be a shift from informal to formal care, because there was absolutely no way of assessing the risk.

George Lyon: The first-year figures came in at £20 million above the estimates provided by the care development group. That is 20 per cent out in the first year, yet you said that you were confident with the figures for the first two years. Why is the figure 20 per cent above the estimated cost of £107 million?

Mr Gordon: We need to be careful that we compare like with like. Before the policy was introduced, people received care, some of which was what we now call personal care. For those who received it through local authorities, it was simply part of local authority expenditure on home care; it was not separately identified. After the policy of free personal care was introduced, we asked local authorities to estimate how much of their expenditure on home care was attributable to personal care. Some of that personal care was being provided before the policy of free personal care was introduced, so it was included in the expenditure on home care services. I am dealing with home care, not just expenditure in care homes, which are the figures to which you allude. We need to be careful about comparing like with like. The figures that are identified are what local authorities say that they are now spending on free personal care, some of which is additional expenditure, because of the policy of free personal care.

George Lyon: So how does the figure of £126 million for the actual cost that was published this year relate to the estimated cost of £107 million? Where is the difference? Is it an overspend? If so, from which areas does it come?

Mr Gordon: The figures that we published earlier this year were in two parts: expenditure in care homes on personal care and nursing care. Those two added together came to £54 million, which was very close to the estimate in the table. The figure for expenditure on personal care at home within the home care expenditure was £72 million. That figure is different from that for the provisions in our table, which, of course, deal with the extra cost on local government, for which central Government made provision when the policy was introduced.

George Lyon: So what about the extra £20 million that has been spent? What is the allocation?

Mr Gordon: There are various points to make. First, the figure that local government has given us reflects its estimate of what it is spending on personal care within total expenditure on home care. When it assesses an individual, provides a care package and costs the whole of that care package, it is required to estimate how much of that care package is for personal care. There is an estimate in that sense.

I have lost my train of thought, but I think that the second point that I was going to make was that we should recognise that local government was spending money on personal care before the policy was introduced, but it did not identify that expenditure.

Mr Welsh: I am surprised by that. Are you saying that, when local authorities gave you those estimates, they just did not know and got things wrong?

Mr Gordon: No—I am sorry. After the policy was introduced, we specifically asked the local authorities to identify in their expenditure on all home care how much was for personal care, which they now estimate. Before the policy was introduced, they were not asked to estimate how much was included for personal care, other than perhaps for the purposes of the care home projections.

George Lyon: So how else did that impact on funding to local government? There must be a balancing figure somewhere. You are saying that money that was spent by local authorities prior to the introduction of the policy is now shown in the budget line that is allocated to free personal care. Where is the £20 million that should come off somewhere else in local government's allocation from the Scottish Executive?

Mr Gordon: We would need to consider local government's total expenditure on home care services, which will have significantly increased between 2001-02 and 2002-03. A large part of that increase was due to the new expenditure on free personal care. Out of the larger figure for 2002-03, we have asked local authorities to extract how much they have spent on free personal care, which is the figure of £72 million. The balancing will be what they spend on the rest of the home care services.

Mr Welsh: An important policy was launched on estimates that still puzzle me. The care development group estimated the cost of free personal and nursing care to be £125 million a year, as was said earlier. That cost comprised six elements. Those elements are given in your letter, which mentions the

"estimated cost to local authorities of delivering personal care at no charge to clients previously charged for this service—£10m."

The paper states:

"This figure was subsequently acknowledged to be an underestimate of the total cost of delivering this service".

Secondly, the paper mentions the

"estimated cost of personal care services being provided from the private sector which would transfer to the local authority—£10m."

It states that

"there was no centrally collected data on private home care services"

but that

"The cost was estimated to be £10m."

It strikes me as strange and amazing that so many estimates come in at exactly £10 million. Can you explain why they do so?

Mr Gordon: Not without revisiting the original papers.

Mr Welsh: But the figures are integral to the £125 million estimate on which the whole policy was launched.

Mr Gordon: A degree of coincidence is involved, but one is bound to make estimates when introducing new policies. Few policies will be so clear and so certain that one will make precise forecasts that are guaranteed to be correct. It is in the nature of new policies that we work with degrees of uncertainty and limits to our knowledge. We must make the best estimates that we can for those aspects of the policy.

Mr Welsh: That leads me to ask why we have the specific figures and not a range of figures.

11:00

Mrs Mary Mulligan (Linlithgow) (Lab): I have a small question on the back of Susan Deacon's inquiry about the non-recurring investment. In answer to her question, Mr Gordon, you directed us to paragraph 6 of your letter. I recognise that, in introducing such a policy, there will be a step-up in

the requirements for training and IT, but will you clarify where that on-going cost will be met and what judgment has been made about it? I ask particularly about training because it has been indicated to us that turnovers, and therefore training costs, have been quite substantial.

Mr Gordon: The Government will account for expenditure on such things as training separately from expenditure on the free personal care service that it delivers. We have made additional provision for extra training among the other things that would be needed.

You are right to say that we have not made recurring provision for training. Local authorities will have a variety of pressures on their training budgets. In the spending review that was conducted earlier this year, the Convention of Scottish Local Authorities identified training as one of the significant pressures on their budgets in the community care context. That is obviously linked to the emergence of standards that are coming through from the Scottish Social Services Council in relation to professional development in care services. Continuing training needs are being taken in that context now.

Mrs Mulligan: Are you confident that that initial two-year boost will be enough to carry the local authorities until they start to receive the normal regular funding?

Mr Gordon: Since the figures were provided two and a half years ago, there has been a further spending review, in which local government identified pressures on the staff training. Those pressures were taken into account when we were reaching the settlement.

The Convener: There is one final question before we move on to talk about community equipment and adaptation.

Susan Deacon: I apologise if the answer to my question is already before us, but I have searched widely through the papers for it. How many years ahead is the department projecting the costs of the policy? The care development group used a period of 20 years and I have seen that referred to elsewhere. However, I think that I am right in saying that the General Register Office for Scotland can make demographic projections beyond that period, so I just wondered how far ahead the department is projecting the cost of the policy as well as the cost of other types of care for older people. I know that the Executive has done quite a lot of work on that.

Mr Gordon: There are two things to say about that. First, we have the capacity because we have the model for projecting the costs of free personal care. The figures originally went up to 2020, so we are still capable of reworking that model on the basis of new estimates. Secondly, we have recently issued a first report of a review on what is called the range and capacity of community care services. The report, which was put into the public domain a few months ago, makes projections on the basis of the latest demographic figures and makes assumptions about increases in unit costs of 2 per cent in real terms, as well as examining generic care services.

Susan Deacon: Are those projections still for 20 years or do they go further than that?

Dr Collings: The report was projecting for 15 years rather than 20.

The Convener: Thank you, Mr Gordon. It strikes me that there are a number of points that you will probably want to look up and about which you will want to come back to the committee. The clerk will write to you to summarise the areas on which we seek further clarification. The *Official Report* of the meeting will also be helpful in refreshing memories.

Staying with costs, but now moving on to community equipment and adaptations, I invite Margaret Jamieson to ask her questions.

Margaret Jamieson: Exhibit 6 in the recent Audit Scotland report, "Adapting to the future: Management of community equipment and adaptations", highlighted the important role that housing plays in community equipment and adaptations. How is the Development Department involved in developing policy around community equipment and adaptations as part of the joint future agenda?

Mr Gordon: The core of the joint future programme is housed in the Health Department, but it is in the nature of that programme that joint working is encouraged between various local government services and the health service. The extent of the partnerships varies across the country and in some cases housing services are brought in. We consult our colleagues in the housing part of the Development Department about aspects of community care services as they bear on accommodation issues, but I am not aware that there has been any explicit exercise in relation to equipment.

Margaret Jamieson: The issue is not just equipment, but the adaptations that would be required to sustain an individual in their own home.

Mr Gordon: I can confirm that housing departments are involved and consulted in the joint future agenda. Specifically, we have had a group working internally on what we call a strategy forum, which has involved a variety of bodies, not just within the Executive, to look at the development of policy for equipment and

adaptations. The Development Department is involved in that process.

Margaret Jamieson: When developing the joint future agenda, specifically with regard to community equipment and adaptations, did the Health Department examine existing guidance to ensure that the legislation that was in place was still relevant? For example, paragraphs 3.5 to 3.10 of the Audit Scotland report describe national guidance on equipment and adaptations as "confusing" and "out of date". What are you doing to address that?

I shall give one example of an area where I believe that the legislation is out of date. An owner-occupier who has been assessed and requires an adaptation to the home must apply for a grant, but an individual in the same circumstances who happens to be a council tenant automatically gets that work carried out.

Mr Gordon: As I said in my opening remarks, we have accepted the various recommendations in the report that are addressed to the Executive. Specifically, we recognise the need to revisit the various elements of guidance that have been available from the Executive on the way in which equipment and adaptations are provided. We have established a group to bring together the various parts of the department, and outsiders, to ensure that we understand what guidance there is and how we can make it more co-ordinated.

Margaret Jamieson: I accept that you have that group, but there is still the matter of implementation and of dealing with the various roles that local authorities have in meeting their audit processes. You could be accused of operating a two-tier system in the case of individuals who must apply for adaptations in their own home. Every MSP has had similar questions posed to them about the issue. An owner-occupier gets a specified budget and, once that budget is finished, they cannot access further support until the next financial year, irrespective of their need. Therefore, a two-tier system is operating.

Mr Gordon: I think that we acknowledge that there is a variety of guidance out there that has been developed over the years. One reason why we welcome the report is that it has highlighted the need for work to be done to bring the guidance together and make it more consistent. We have put such work in hand. I accept the point that there is divergence between the guidance of the various public bodies—we aim to tackle that issue.

Margaret Jamieson: What joint working is taking place on adaptations? An individual may be assessed by the health service and deemed to require equipment, but they cannot get the equipment, which would obviously improve their quality of life, because local authorities do not have the budget to provide adaptations. How do such situations meet the objectives of joint working? What steps are you taking to overcome the problem?

Mr Gordon: The provision of equipment and adaptations is one of the services that are recognised as subjects of the joint future framework. We think that local authority community care services and NHS services can work together on providing such equipment much better than they have done.

I am aware of cases around the country in which there have been significant developments in the establishment of single facilities and services. Through the use of the single shared assessment, genuine joint working is in place. To try to ensure that that is more standardised, we are developing a system of targets for local authority and NHS partnerships. We are trying to ensure that we have a proper focus on the outputs of the various services and on the outcomes that are achieved. The framework of targets is evolving. We have required local authority partnerships to produce provisional information this year and the targets will take full effect from next April. Within the framework of targets, we are setting specific requirements for equipment adaptation services. We envisage a focus on waiting lists and on waiting times as a way of measuring how the services are working in the various local partnerships.

To paraphrase myself, if I may, we think that the joint future framework provides a way for equipment adaptation services to be done jointly. There is evidence around the country of genuine joint working in certain localities and, through the use of output measures and the development of targets, we hope to try to make that common practice across the country.

Margaret Jamieson: How will you audit the outcomes and targets?

Mr Gordon: Local authorities agree with us that those measurements must be put in place to assess the quality of a range of services and measures, such as rapid response teams, efforts to reduce emergency admissions to hospitals, intensive home care, the provision of equipment and adaptations, and support for carers. We are asking local authorities to measure various strands of activity so that we can see that services are improving for the benefit of service users. We will rely on local authorities to collect the information and we will need to discuss with them how we quality assure it.

Margaret Jamieson: For the purposes of quality assurance, will you ask the people who access the service for their views? Surely that would be the

ultimate test of the paper exercise in which you will engage.

11:15

Mr Gordon: Rather than test the views of local service users centrally, we expect local partnerships to have in place mechanisms for doing so. The provision of care services is the responsibility of local government, so in the first instance it is for local government to reassure people locally that the quality of services is improving and to test the views of service users. The partnership is the mechanism for ensuring that such tests are conducted. If that was not working, the Executive would consider whether effort was required nationally, but I stress that the responsibility lies with the local partnerships.

Margaret Jamieson: We differ in that respect. You appear before the committee as the accountable officer for a policy that is being implemented, so you too must have that assurance.

Mr Gordon: The provision of community care services is a duty that is imposed by the Parliament on local government and there are mechanisms for ensuring that local government discharges its responsibilities. The responsibilities of NHS bodies are a matter for the Scottish Executive centrally and we certainly wish to monitor how NHS bodies perform their responsibilities. When NHS bodies and local government come together in joint future partnerships, we stress that in the first place the partnerships are responsible for the management of their service and for the collection of evidence about the performance of the service and the views of service users.

The Convener: We have completed our consideration of the costing and development of the cross-cutting policy, so we are halfway through this agenda item. We move on to consider the policy's implementation in relation to support, monitoring and evaluation.

Mrs Mulligan: I was interested in Mr Gordon's response to Margaret Jamieson's questions about the collection of information and I hope that such information will be disseminated. I am sure that Mr Gordon is aware that paragraphs 32 and 33 of "Commissioning community care services for older people" relate to information technology and describe the inability of some councils to provide complete data on the take-up of free personal care. We have been discussing the current situation, but I want to take a step back from that. Prior to the implementation of the policy, what consultation or discussions did you have with councils to ensure that their local information systems could provide the Scottish Executive Health Department with the information that it would need about take-up and expenditure on free personal care?

Dr Collings: Officials in the department's analytical services division have a range of mechanisms for talking to people in local authorities about their systems and what they can provide. They have been discussing what can be done. For example, one of the authorities that have had the most problems is introducing new systems, which will be able to provide the information—there is a timing issue, but there is not a long-term problem.

Mrs Mulligan: Were the local authorities that needed additional support given guarantees about the funding that they might expect, given the information that they were to provide?

Dr Collings: We would not normally do that, because if we were to provide extra support to authorities that had not invested in information systems, authorities that had invested in such systems would immediately complain that they were being unfairly treated because they had gone ahead and established good systems. It is for local authorities to set up such systems within the general funding that they are allocated.

Mrs Mulligan: I am interested to hear that you are working with only one local authority at present. In your submission, you cite three councils

"which have been unable to provide any figures on numbers receiving free personal care."

The committee also notes, in the recently published statistics release, that several councils continue to estimate the number of people who are in receipt of free personal care. Is that good enough? If not, will you expand on what is being done to ensure that all authorities provide the information? If, at the end of the day, the information is not provided, what will you do?

Dr Collings: First, the councils that are struggling to provide good information on case numbers are giving us financial information, so we have a basis for estimating case numbers in those areas.

As the member says, our submission states that three local authorities have been able to provide financial information but unable to provide information on the case numbers. In those cases, we have had to infer the number of cases by basing our projections on the assumption that those authorities have similar costs to other authorities. We are in discussion with the local authorities concerned to encourage them to get on with things and put in place adequate information systems. We cannot do that for them; the local authorities need to do it for themselves.

Mrs Mulligan: You said that, although you do not have case numbers, you have financial information. However, surely you need the case numbers to assess the policy's success in delivery terms?

Dr Collings: Absolutely; we want both. What I was saying was that, in the instances in which we do not have case numbers, we have financial information. The figures give us the basis upon which to estimate the likely case numbers in those local authority areas. The financial information is not an adequate substitute for case numbers, but it is a stopgap until we start to get proper case number figures.

Mrs Mulligan: When do you expect that all the local authorities will be providing all the necessary information? Do you have a timescale for that?

Dr Collings: We do not. We have made it clear to the local authorities that we expect them to produce the information. However, at the moment, we do not have a guarantee from them on when that will happen.

George Lyon: I return to the outturn figure for the current year. The Executive's statistics release shows that councils' expenditure for the first nine months was £126 million. From annex B of your submission, we can see that that figure exceeds the original Health Department estimate of £107 million. So far, you have not explained satisfactorily the cause of the difference. Why is there a 20 per cent difference between the estimate and the outturn figures?

Mr Gordon: We must ensure that we are comparing like with like. The figures that we produced in September report on local government's estimates of its expenditure on free personal care.

George Lyon: So, the figures in the statistics release are estimates; they are not actual figures.

Mr Gordon: They are what local authorities can count in their total spending on home care. For example, in 2002-03 the total local authority spend on home care services for older people was £262 million. Within that total, local authorities spent £71.9 million on personal care. They have to estimate that figure because, when they produce a care package for an individual, the package includes personal care services and a variety of other care services. It is easier in some cases than in others to distinguish the exact costs, but often an arbitrary estimate has to be made. Local authorities estimate their expenditure on personal care within their total expenditure on home care services.

Within the £262 million, about £72 million was spent on personal care. I am told that in the previous year, local authorities spent £197 million on home care services, so there has been an increase of £65 million. Within the £197 million, there was some expenditure on personal care, but it was not identified separately because, at that time, there was no policy of free personal care. Local authorities provided care services and charged some people for some of them. There are separate figures on income.

George Lyon: So you are saying that that element was missed out in the calculations that produced the figure of £197 million.

Mr Gordon: You are comparing local authorities' total expenditure on personal care in 2002-03 with our estimate of what the extra expenditure would be. Does that help?

George Lyon: Right. That means that you are confident that £107 million is an accurate and robust figure for the extra cost in the first nine months. Is that what you are saying?

Mr Gordon: The figure for extra expenditure is based on assumptions. We need to understand how much of the £72 million in 2002-03 would have been spent anyway, without the introduction of free personal care.

George Lyon: Are you confident that the £107 million figure is accurate? I take it that you based your budget for the two years 2004-05 and 2005-06 on that. The total allocation in your recent announcement was £300 million. Is that figure based on the £107 million cost of free personal care in the first nine months or on another figure? Can you tell us?

Mr Gordon: We think that the figure is proving to be robust. One piece of evidence in favour of that is the limited number of complaints from local government about the inadequacy of provision for free personal care. Only a very small number of local authorities have had questions about the distribution of money for free personal care. There is acceptance that the estimates are robust and nobody has come back to us to suggest that they are not.

George Lyon: So expenditure for the next two years is based on the £107 million figure.

Mr Gordon: It is, but we are seeing a significant increase in the number of people who receive home care, and indeed free personal care. Chart 5 in our statistics release shows the number of people who receive free personal care at home rising from about 23,000 to about 40,000. That is a significant increase, and it is one reason why we need to revisit the estimates, as we will do next year.

Another interesting factor is the wide range in the number of people who receive free personal care as a percentage of the population. If members look at chart 7, which is entitled "Free

Personal Care Expenditure on Care Home Residents per 1,000 Population Aged 65+ by Local Authority", they will note the wide range of expenditure. That disparity is another reason why we want to revisit the original estimates to understand what has been changing in the past three years.

11:30

George Lyon: What monitoring is being done to establish whether the financial allocations to councils are sufficient? What are you doing to ensure that each council receives the proper amount?

Mr Gordon: We have estimates of councils' expenditure on free personal care, on home care and indeed on care in care homes. We can compare those estimates with the distribution of funding that was provided for them and we will monitor that year by year. We have on-going discussions with the local authorities about that. I am aware of only one local authority that has continuing reservations; others have had reservations that have arisen and then gone away. We are monitoring actual expenditure against the expenditure allocations.

Susan Deacon: A couple of questions spring to mind, particularly about some of the charts that you have shown us, in the light of George Lyon's questions. I hope that I do not go off at too much of a tangent, but I want to clarify where thinking is going in this area. The categories within which you collect data are based on the classifications of nursing care and personal care, and you make distinctions between different care home settings and so on. Many of those distinctions become increasingly blurred in the practical delivery of care. A lot of the conceptual distinctions between nursing and personal care, for example, were never set in stone anyway—that is well recognised in the Sutherland report.

Making those distinctions was a means of trying to identify the different types of care that people needed. In the light of experience, do you find those definitions and classifications readily applicable or should there be any refinement of not just the terminology, but critically, the way in which data are collected to take account of the blurring of care boundaries? I appreciate that you have to draw a line somewhere, but are the lines the right or the best ones and should we be considering that?

Mr Gordon: At this stage, I can say only that I recognise the force of the question, but that we do not have answers to what that means for our measurement of those services. I cannot tell you exactly how the development of more sheltered housing as a significant new category in the provision of care home services is reflected in the figures.

I return to the point that I made in my opening remarks about the difficulties of getting good measures of activity, quality and value from those services, which emphasise individualised care and care in people's homes where it is obviously difficult to measure such things. As you say, we have to cope with a spectrum of care in which different care services almost merge into each other.

Susan Deacon: I have a different point that has also been prompted by this line of discussion. The data that have been collected and reported on tell us little about the nature of the client group and the impact of the policy on the people who are receiving the care. For example, I am thinking about the income distribution of those people who are caught in the net of the policy. Are those data collected? I am also thinking about the disposal of property; one of the most significant drivers of the policy was reducing the number of people who had to sell their homes to fund their care. Now that the policy has been implemented for a few years, where we are with regard to the collection of data on its impact?

Mr Gordon: I suggest that one would not necessarily collect data on such measures regularly—on a quarterly basis—as significant surveys of the population would need to be done. One would conduct such surveys intermittently. It would be appropriate to consider those matters in the context of a three-year review of how the policy is being implemented and how it is working.

Susan Deacon: To your knowledge, is it fair to say that the Executive or local authorities are not systematically collecting such data at the moment?

Mr Gordon: We are not aware that local authorities are systematically collecting information about the assets of people who are in receipt of free personal care, although they would need to understand the financial situation of people who were in receipt of home care services because, within the framework of regulations and guidance, it is still open to local authorities to charge for services other than the provision of personal care.

Margaret Jamieson: I seek some clarification on the charts in the statistics release. The background information indicates that 17 local authorities return information regularly—every quarter—and that three of them have been unable to supply any information. What is the position of the other 12 local authorities in that regard and how does that impact on the information that we have before us?

Mr Gordon: Those local authorities have made returns in some quarters, but not in every quarter. Seventeen local authorities have made regular returns, quarter by quarter; three local authorities have made no returns; and the other local authorities have made intermittent returns.

Margaret Jamieson: Would it be possible for us to have the names of the councils that have provided information consistently and the names of those that have done so inconsistently? It would be interesting to find out what action you take to ensure that all councils provide you with that information on time. In some areas, we take action against individual authorities that do not comply.

Mr Gordon: I will deal with that in the reply on which local authorities provide information consistently.

The Convener: As regards cost and the factors that were used to arrive at an estimate of what the costs might be, three of the seven factors that you have given us in annex A relate to demographic projections. You have said that when you revisit the estimates, you will re-examine the demographic projections, which may have changed. However, with the other four factors—"Changes in unit costs of care", "Supply of informal care", "Unmet need" and "Changes in pensioner and household income"—assumptions are made. To what extent have you put in place monitoring of those four factors to ensure that the assumptions on which they are based take account of the experience of the policy's introduction? Although you may continue to make assumptions, if they are based on information that is gathered from any monitoring, we can hope that they become more robust.

Mr Gordon: We will need to revisit such assumptions next year. I am not sure that I can tell you the extent to which we are actively collecting information that is relevant to those assumptions.

Dr Collings: The simplest assumption is that relating to costs. Given that we collect information on both the number of recipients and how much money is spent, we can get some handle on how the costs are moving. Information is available about the changes in pension and household income, but it is difficult to come up with a model for the impact of those changes on the number who are coming forward for care. The issue is not about lack of monitoring, but about having a model for how changes impact on the numbers needing care.

The Convener: Thank you. We will now move on to more questions on community equipment and adaptations.

Susan Deacon: Do the members of the panel accept the recommendations and key findings in Audit Scotland's report "Adapting to the future" which, as I am sure they are aware, are set out on pages 63 and 64?

Mr Gordon: The short answer is that we accept the recommendations. The recommendations on page 64 of the report "Adapting to the future" deal with the dissemination of guidelines on decontamination and infection control of equipment. Guidance is in place and we are planning to reissue it to the service to remind people about what already exists. On the question of medical device alerts, I understand that we customarily issued alerts to local authorities until a few years ago. The system seems to have fallen into disuse so we are seeking to re-establish it and to ensure that the alerts go out to local authorities as well as to NHS bodies.

Susan Deacon: I appreciate the specific points that you make, which relate to one recommendation for the Scottish Executive. However, I want to consider more broadly the summary of recommendations across the board. Am I correct in assuming that you accept all the recommendations? Do you disagree with any specific recommendations? It would be helpful if you would tell us what work is being done to take forward the breadth of the recommendations that are set out in the report.

Mr Gordon: The bulk of the recommendations are, in essence, addressed to local authorities and their partners. We have had in hand an exercise to bring together various interests to take an overview of the provision of equipment and adaptation services, which will have to have regard to the report, "Adapting to the future", which was produced in August. I tried to signal earlier that we found the report helpful and that we would be working to try to encourage local government and its partners to address the issues constructively. I hope that we can further the objectives that are implicit in Audit Scotland's report.

Susan Deacon: Thank you for that answer. In a sense, it touches on what I suspect has been a frustration for many of us, which is that this is an area in which objectives are shared. Your written response to the committee and everything that you have said so far indicate that this is an area in which everyone involved wants to achieve better joint working and delivery of services.

I want you to specify what the Executive can do to foster more effective joint working. That agenda has been set for a number of years. We would welcome more information about what the Executive can do in tangible and practical terms to bring about improvements and create a more joined-up approach to community equipment and adaptation services. All too often, we all experience circumstances in which that connectedness fails to come about. You

mentioned guidance. Will you elaborate on how you are bringing together the different sectors in developing ways of working and thinking to bring that connectedness about?

11:45

Mr Gordon: There are two strands to that question. We have established a forum to bring together a variety of interests to focus specifically on the equipment and adaptations services and to examine various ways of improving services. The forum had been reaching its conclusions before the report was published, so we must now ensure that it takes account of the report's findings.

However, I detect that the real thrust of your question is about the ways in which the Executive fosters genuine collaborative working between local government and the NHS. Any answer to that should focus on the joint future framework on joint working, which allows the two partners to come together to identify services that they will provide jointly with teams under a single leadership and, where possible, with pooled resources and mechanisms for accounting separately to their parent organisations. That framework is well understood and there is now a strong consensus for such a voluntary administrative approach, rather than a statutory approach. Indeed, there are separate statutory mechanisms that encourage—indeed, require—collaborative working.

We are trying to take forward that administrative approach on a voluntary basis. In the next stage, we will emphasise the need for real benefits for service users to get past the framework of process that we have been focused on in recent years. Against that emphasis on outcomes and benefits for service users, the agenda over the past year has focused on identifying performance measures and establishing a system of targets that require local partnerships to put forward the targets that they think are appropriate. As we have collected those targets over the year, we have moved on to establish from the centre some common requirements that should apply across the system to ensure that we measure certain matters consistently. I refer Susan Deacon back to my earlier answer that one of those targets would focus on the provision of equipment and adaptations services and, in particular, on delays before people receive them.

As a result, we are trying to keep things moving forward by focusing on benefits to service users and providing some clarity about aspects of the provision of joint services that, at a national level, we think it important to measure. By having such measurements, we will—with a bit of luck—have a mechanism for identifying backmarkers in developing joint services.

Susan Deacon: You have partly answered my question, but I would like you to elaborate on the main incentives for local delivery agencies—notably the health service and local authorities—to come together to provide effective, joined-up equipment and adaptations services. What more could be done to provide further incentives? I should also ask about the other side of the coin. What action can or does the Health Department take in cases in which your monitoring processes show that services are not being delivered effectively on the ground?

Mr Gordon: The strongest incentive to front-line teams is the benefit that joint working yields for people who need the services. Front-line staff are motivated by the visible benefit of having quicker access to services; consistent working between the two services; and joint working to ensure that individuals, especially older people, who have to pass between the health service and community care services do not trip up over that boundary. Senior managers and the leaders of the services recognise that motivation. We must try to capture it by ensuring that there are measures of the benefits for service users and that those are publicised so that people can see that things are getting better.

On other incentives or sanctions, the thrust of the policy has been to rely on a consensual, voluntary approach. We are bringing into play a particular mechanism from the centre, through what we call a joint improvement team, which will identify best practice and try to ensure that it is being shared around the system. The English have a similar mechanism called a change agent team, which is a small core of people who mobilise a wider network of expert advisers to target partnerships that want support and assistance. We are providing such a mechanism at the centre to identify best practice and encourage its dissemination around the system.

Robin Harper: I have a more general question. We are getting a picture across the board that the level of information available is such that it is difficult, or almost impossible, at this stage to make sound judgments about value for money in the service. Is that a correct summary of the position?

Mr Gordon: I must acknowledge that we do not collect regularly all the information that would be necessary for judging value for money. We do so only intermittently.

Robin Harper: The Auditor General has made recommendations in that respect.

I have two further questions. One is about local councils and NHS partners working together in the joint future framework and in other ways. Where such partnerships do not work—or do not work as

well as they could—do you envisage accountability problems?

Mr Gordon: In principle, I do not think that there should be problems because Parliament has provided a statutory framework for delivering the various services to the public in Scotland. That framework specifies that local government will provide certain services and that the NHS will provide others. Both types of statutory body also rely on voluntary, independent bodies for the provision of services. However, the essential requirement is that the statutory organisations, but particularly the NHS, must account for their responsibilities, although that does not prescribe how they meet their responsibilities and deliver the services.

The joint future framework offers a way of getting the statutory organisations to work together within a coherent framework that should allow them to deliver their services better. However, such joint working does not absolve them of their responsibility for delivering services; it simply offers them a mechanism for doing so in a way that should benefit service users. Is that what you were driving at?

Robin Harper: I might want to pursue that issue later, but I am content with that answer just now.

I am not sure whether my second question is a fair one to ask at this stage.

The Convener: I will judge that.

Robin Harper: The convener will tell me whether I am wrong. Obviously, the Executive hopes to be able to judge value for money. How long will it take to move to that position?

Mr Gordon: We will do that next year for free personal care. It seems to us that the third anniversary of its introduction is the earliest that it would be sensible to try to understand the implications of what is a complex policy development.

The Convener: Thank you, Mr Gordon, Dr Collings and Ms March for your useful evidence. As I said earlier, we will allow you to provide further information for areas for which you could not do so today. That is standard practice.

We now move into private session.

11:55

Meeting continued in private until 12:41.

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