AUDIT COMMITTEE

Tuesday 5 December 2006

Session 2

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AUDIT COMMITTEE
17th Meeting 2006, Session 2

CONVENER

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

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)
*Mrs Mary Mulligan (Linlithgow) (Lab)
*Margaret Smith (Edinburgh West) (LD)

COMMITTEE SUBSTITUTES

Mr David Davidson (North East Scotland) (Con)
Marlyn Glen (North East Scotland) (Lab)
Eleanor Scott (Highlands and Islands) (Green)
Mr John Swinney (North Tayside) (SNP)

*attended

THE FOLLOWING ALSO ATTENDED:

Mr Robert Black (Auditor General for Scotland)
Roddy Ferguson (Audit Scotland)
Caroline Gardner (Audit Scotland)
Graeme Greenhill (Audit Scotland)
Barbara Hurst (Audit Scotland)
Rhona Jack (Audit Scotland)
Tricia Meldrum (Audit Scotland)

THE FOLLOWING GAVE EVIDENCE:

Dr Andrew Goudie (Scottish Executive Finance and Central Services Department)
Paul Gray (Scottish Executive Health Department)
Mike Neilson (Scottish Executive Development Department)

CLERK TO THE COMMITTEE

Shelagh McKinlay

SENIOR ASSISTANT CLERK

Joanna Hardy

ASSISTANT CLERK

Clare O'Neill

LOCATION

Committee Room 2

Scottish Parliament

Audit Committee

Tuesday 5 December 2006

[THE CONVENER *opened the meeting at 10:01*]

Decision on Taking Business in Private

The Convener (Mr Brian Monteith): I call the 17th meeting in 2006 of the Scottish Parliament's Audit Committee to order. We have had apologies from Susan Deacon, who will be late because she is attending to some constituency business. I ask members to switch off their mobile phones and pagers, and I welcome the Auditor General for Scotland, his team from Audit Scotland and members of the public and the press.

Agenda item 1 is to ask the committee to agree to take in private items 6 and 7, if it is so minded. Under item 6, the committee will consider arrangements for its inquiry into the Auditor General's report "Relocation of Scottish Executive departments, agencies and NDPBs", and under item 7 it will consider its approaches to reports on which we will have received briefings earlier in the meeting. Do members agree to take in private items 6 and 7?

Members *indicated agreement*.

"Informed to care: Managing IT to deliver information in the NHS in Scotland"

10:02

The Convener: Under item 2, the Auditor General will present a briefing on his report "Informed to care: Managing IT to deliver information in the NHS in Scotland".

Mr Robert Black (Auditor General for Scotland): Good morning. I am sure that the committee agrees that there is great potential in the health service for information technology to provide clinical and management information quickly and securely, but that that requires substantial investment and that the whole process must be managed well. Against that background, I published on 23 November a report on information management and technology—which I will refer to as IM&T from now on—in the national health service in Scotland. The report covers the arrangements for delivering information through IT to meet the future needs of the NHS and examines national arrangements in three areas: leadership; involving the stakeholders who use the information; and programme and project management.

The Scottish Executive Health Department's strategy, "Delivering for Health", makes it quite clear that a more corporate approach is now required. That will represent a significant cultural shift in how IT is managed in the NHS, which I acknowledge will take time to plan and implement, but at the time of our review the Health Department did not have fully developed arrangements in place to demonstrate that leadership, stakeholder involvement and project management meet internationally recognised good practice standards. We concluded that there was scope for improvement in each of those areas. Throughout the report, we give examples of good practice and best practice, which we hope will be of some assistance to the department in implementing the strategy.

Many of the problems stemmed from fragmentation as a result of the previous trust and board freedoms to procure and implement local solutions prior to the move to single-system working. The department has taken steps to improve its management arrangements, but at this stage we cannot say whether the changes will be sufficient to address the issues that are raised in the report.

Leadership was the first key area that was considered. Clear leadership is vital so that people know who is in charge and where accountabilities and responsibilities lie. Leaders must ensure that

there is a clear line of sight from national health service policy and business strategy to an information strategy and an associated IT strategy. Given that the national budget for IT in 2006-07 is £100 million and that the budget is scheduled to rise to £140 million in 2007-08, it is vital that NHS funding arrangements for new and on-going programmes and projects are robust.

In 2004, the department published a strategy that focused on e-health. Exhibit 3 on page 9 of the report lists all the current IT projects. We encourage the department to ensure that, in future, the IM&T strategy is clear about overall information requirements across the full range of stakeholders, which includes clinicians, managers, planners and policy makers, and that it provides a sound basis for developing implementation plans at both national and local level.

The situation is constantly changing, but it was not clear at the time of our audit who was accountable for directing IM&T strategy development and implementation. In particular, the roles of the Health Department and NHS National Services Scotland needed to be clarified and agreement was still needed on the balance between national standards and the freedom for local boards to implement local solutions. Tensions still exist between national and local priorities, and boards occasionally opt in or out of national systems depending on local circumstances. The examples that are mentioned in the report may reflect the fact that the NHS in Scotland is in transition. We found that the overall strategy must be revised to reflect the full range of information needs and recent policy initiatives. We were told that the department recently considered a paper on bringing about the convergence of national strategies and local policies and plans.

Good governance is part of good leadership. The report comments on the governance arrangements and identifies areas of significant weakness. The department recognises that the arrangements need to improve in line with the good practice that we outlined in appendix 3 of the report. Since the completion of the fieldwork for our report, the department has announced a new organisational structure for managing IM&T, which is outlined in exhibit 9 on page 16. That structure is in line with good practice, but at this stage we do not know in detail how far it has been implemented or how effective it will be.

Ensuring that the benefits of IM&T are delivered requires good programme and project management so that systems are delivered to specification, on time and within budget. People must be sure at the outset about what benefits are expected and they must know what success will look like once the systems are implemented. The report says that the department does not have key performance indicators to monitor the implementation of the strategy. A number of information initiatives are under way in the department, which exhibit 10 on page 17 summarises. I recommend that the department consider exhibit 11 on page 18, which suggests a set of performance indicators that might be typical of an IM&T strategy.

The report also suggests that the department review the funding arrangements for IM&T. For example, we would encourage more widespread use of business cases before projects are committed and the rigorous adoption of the gateway approach, in which funds are released on a phased basis, depending on the achievement of certain specified outcomes.

The second major area that we considered was how the users of information are involved in planning and delivery. Information technology is not an end in itself—it is a tool to support the health service in providing good patient care. To achieve that, it is essential to get and keep stakeholders such as clinicians and managers on board. We suggest that more formal and rigorous processes for involving stakeholders are needed. The department is taking action to improve matters in that area.

We found examples of good practice in programme and project management, which was our third theme, but more must be done. For example, our case studies show that programme and project management skills vary throughout the NHS in Scotland. In particular, the skill level in local boards generally needs to improve. Another example is the need for a more rigorous approach to identify the anticipated benefits of investing in projects. At a later stage, an evaluation should be carried out of whether the benefits are being achieved. One example that is mentioned in the report is GPASS—the general practice administration system for Scotland—which has involved significant investment under a top-slicing funding arrangement for a number of years, even though a significant number of general practitioners are not convinced that the investment continues to represent good value for money.

Given the importance of investing in IM&T in the health service, I have asked Audit Scotland to keep the implementation of the strategy under review and I intend to keep an open mind on whether a further report might be appropriate in due course to assess progress. As ever, my colleagues and I are happy to attempt to answer any questions that the committee may have.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): You mentioned GPs' view that GPASS does not provide value for money. On what basis did they make that observation?

Mr Black: GPASS is not one of the four projects that we considered in detail, but we are aware of a recent review that the Health Department has undertaken of how GPASS is operating. Rhona Jack may be able to give an indication of the current state of play on that.

Rhona Jack (Audit Scotland): GPASS has been a source of anxiety for GPs since about 2001. Several reports on it have been produced, such as that by Professor Lewis Ritchie. The most recent one was an independent piece of work that the Scottish Executive Health Department commissioned from a company called Deloitte. In essence, Deloitte concluded that the current product does not meet current clinical requirements, although the GPASS-clinical module should help if it is successfully delivered. However, Deloitte says that, even if that module is delivered successfully, GPASS will not meet the long-term requirements of GPs and other allied health professionals who work in the community, such as physiotherapists. The Deloitte report recommends that the Scottish health service go for a more commercial approach, using at least one commercial supplier.

Margaret Jamieson: Do we have a guarantee that 100 per cent of GPs will buy in to such an approach? My understanding is that part of the problem with GPASS is that some GPs refuse to use it.

Rhona Jack: That is certainly a problem. GPs are independent and they have rights—

Margaret Jamieson: So do patients.

Rhona Jack: Indeed. Under their contract, GPs have rights to select a suitable supplier for their information technology. It will take considerable effort to get GPs, as key stakeholders, on board and to keep them there, but it will be well worth it. However, there is no guarantee.

Mr Black: On page 23 of the report, we attempt to capture some of the concerns about GPASS. Central to them is the concern about how functional the system is in meeting clinical needs. There are some technical issues to do with the length of records, which can mean that inappropriate information is recorded and used. The concerns are real. This is an example of the importance of involving stakeholders at the outset to ensure that clinical needs are addressed when systems are being designed. It also shows the importance of ensuring that a good business plan is in place that assesses the business needs against the technical functionality of such systems before they are implemented and of carrying out a regular review against the standards as the project is rolled out.

Rhona Jack: The British Medical Association's GP sub-committee, which represents at least some GPs, has said that it is very keen to work with the Health Department. Everybody acknowledges that if different systems proliferate throughout the country, that will have a cost and help nobody.

10:15

Mrs Mary Mulligan (Linlithgow) (Lab): I do not want to sound sceptical or a complete luddite but, given the problems that you have just outlined in even attempting to sign up GPs to something as simple as GPASS, is it really possible for us to design an IM&T system that encompasses all the facets of the national health service to which people will be signed up and which will deliver by improving patient care and meeting the needs of people who do the job, at an affordable rate? We continue to put vast sums of money into IT, but all we seem to do is decide that one system will not meet needs and move on to the next one.

Mr Black: The short answer to your question whether it is possible to design a strategy is yes. Many of the programmes and projects that we outline in appendix 2 are progressing well and will achieve their purpose. The problem is that a fully integrated and up-to-date strategy does not yet exist to explain how all the projects fit together into a strategy that is directed primarily at improving the delivery of health care at the front end.

In quite a number of areas, design and project management could be improved so that the risks that are associated with those complex projects are managed well. In a sense, the report is interim. It comes at a time when the department has changed direction towards a more strategic approach. For that reason, we put quite a lot of effort into identifying examples of good practice and best practice standards that we think the health service should follow more rigorously to achieve the objective of managing those projects well and managing the risks out.

Mrs Mulligan: Do the ability and leadership to make the changes that will make it possible to design such a strategy exist?

Mr Black: One issue on which we commented at length when we produced the report—the fieldwork was done until spring this year—was that we had some difficulty identifying clearly who was in charge of the overall strategy and direction. More recently, the department has introduced a new management structure. We describe that in exhibit 9 on page 16, which shows the new post of director of e-health and several structures to support that. That is in line with best practice, but the structure is not yet fully implemented, so it is too early to say how effective it will be. For that reason, I will ask Audit Scotland to continue to monitor developments.

Rhona Jack: That goes back to your initial question about whether the implication is almost that some super-duper single IT system will answer all the questions that everybody in the health service has. The answer is that the health service is huge and very complex. What is required is a series of different systems that support individual elements, contribute to the whole and, when brought together, start to answer some of the complex questions, such as what, if we invest £X million of additional moneys, the productivity gain will be. That is when the power of being able to bring together in one place different systems that cover activity, quality, outcomes and cost is felt, as it offers the hope of answering such questions, which, when people such as members ask them at the moment, are difficult to answer.

Mr Andrew Welsh (Angus) (SNP): We all want to know whether anyone has a firm grip on what is obviously a complex situation. It is never easy to integrate IT systems, especially large and dispersed systems. You mention that what is required is a

"significant cultural shift in the way in which IT is managed"

and that it

"will take time to plan and implement."

Can you give us an idea of the timescale and of how the systems will be integrated?

Mr Black: What we mean by that comment is that the strategy published in 2004 gave a clear commitment that there would be more strategic corporate direction of the major systems needed for a modern and efficient health service. That strategy is barely two years old, so the Health Department and the health service are at the transition stage.

What we mean by a cultural shift is that, before the strategy was published, the emphasis was on health boards and trusts developing systems that met local needs in the context of their local business plans. What has changed is that there is recognition of the importance of the health service in Scotland as a whole having a core strategy that covers all the major information requirements. The strategy must ensure that certain core systems are designed that are relevant across the whole of the health service and that those are applied by individual boards. A transition is now taking place, because a number of important systems have not necessarily been adopted by all health boards. There is a complex and mixed pattern. The culture of change is moving towards recognition of the importance of balancing strategic information requirements across the whole of the health service with the need for discretion at a local level to develop systems that meet local business needs.

Mr Welsh: Given the complexity of the matter, there will be local and national gravitational pulls, so strong direction and a clear strategy are required. The timetable is important. Secondly, there are always spiralling costs when we deal with IT. It is concerning to learn that the NHS in Scotland does not know exactly how much it spends on information management and technology overall. Why is that the case? What monitoring systems are in place to give us an idea of the costs?

Mr Black: Can Rhona Jack help to answer that, please?

Rhona Jack: It comes back to the fragmentation that we have mentioned and the local freedoms that existed. There has been spend on IM&T at national level and at local level. They were recorded in different ways, so it was not possible to find out how much was being spent. The Health Department conducted a one-off exercise to try to do that, but people allocated costs to different headings and so on, so it was difficult to identify how much was being spent on IM&T at local level. As a result of that, the Health Department has committed, as part of the new governance arrangements, to consider how the funding arrangements are put in place so that in future it can specify the initial and on-going costs of different projects.

Mr Welsh: Does the Health Department need that complex financial information, or could it bypass it in planning a system that works?

Rhona Jack: The difficulty is that you want to make a decision based not only on the purchase of a system, but on its on-going costs. An issue is at what point you say, "Here is the cut-off. We will not invest in that system any more because it is being overtaken by other systems." An example of that is GPASS, which has received substantial investment over the years. At what point is it appropriate to pull the plug, as it were, and say, "No. Now is the time to move on and invest in something else"? Without appropriate financial information, it becomes difficult to make such decisions rationally.

The Convener: I will pick up on an issue that Andrew Welsh touched on. You mentioned that tensions exist with boards opting in and out of certain strategies. Does that happen because boards believe that that strategy or IM&T is not what they require, or is it because of financial pressures in the sense that opting in has a price tag and they calculate that it is not worth the investment?

Mr Black: There are several factors that help to explain the situation, some of which are implied by your question.

One factor is that some of the systems have been developed over several years, so they have not had applied to them the same business planning discipline that is being applied to some of the bigger schemes that have been developed more recently. Boards have the opportunity to decide whether to opt in or out of some of the systems that have been around for a few years. We give some examples on page 12 of the report. The Scottish care information store is at different stages of adoption among NHS boards. There are different versions of it in operation and boards can decide whether to take them up. One of the problems with that project is that it does not have a business case with a benefits plan that indicates what it is meant to achieve.

A second feature that explains some of the tensions is that some key systems have been developed from the bottom up. In other words, a health board—or a group of boards—has developed to meet its own business needs a system that is thought to have some value nationally. The accident and emergency system is an example of that. Some boards were allowed to opt out of the national system for accident and emergency when the existing system meant having national standards. That opting out might have an impact on the overall rigour of the system and on the cost of developing such systems. It is fair to say that different factors are at play.

It might be significant that the department will fund the development of key software for the whole of Scotland, but the cost of implementation will fall to be met by health boards through local business planning. Health boards will consider their priorities and the pressures within their limited budgets. For reasons that might make perfect sense at a local level, boards might decide to opt out of a system or to go in a different direction.

Those are examples of what we mean when we talk about the NHS's development of a coherent IT strategy being in transition. Rhona Jack might have more to say about it.

Rhona Jack: When a local health board is under financial pressure, it is difficult for it to be seen to be investing in systems, particularly if they are not patient-based systems. For example, we looked at BPI—best procurement implementation—which is basically a supply system. If a board is under real pressure and having to close wards, why would it invest in a supply system? The answer is that 30 per cent of costs are made up of supplies and services and the whole purpose of that system is to provide better quality supplies and services and to achieve some of the efficient government targets. The board might need to spend to save, but it could be extremely difficult to handle that locally if it were under pressure.

Mr Welsh: Surely the current fragmentation must mean that there is an inevitable lack of communication between existing systems, which is a major problem given that people will be comfortable with the existing systems. Who will drive through to get co-ordination, and at what cost?

Mr Black: The short answer is that the Health Department has a new structure in place for managing IM&T projects. The structure is outlined in exhibit 9. Although it is not yet fully in place, we believe that it is a very positive move. It should offer the prospect of better integration, which is what you seem to be, quite rightly, suggesting.

10:30

Mr Welsh: Or leadership towards a common goal.

Mr Black: Indeed.

Mrs Mulligan: I have just one short question. Will there ever be a comprehensive, cost-effective system that allows people to opt out and go somewhere else?

Mr Black: The short answer to that, rather like that to the previous question, is yes, it should certainly be possible. Such a system requires a clear strategy that links the information requirements of the whole health service to the strategy of the NHS in Scotland. It also requires business propositions for developing IT that support those information requirements. And it must recognise that alongside the comprehensive system there might well be a need for a locally developed system to meet local needs—although a core of activity and system support should be common throughout the health service.

Mrs Mulligan: You say that there needs to be a core. Unless we have that, it will be difficult to bring it all together to provide the comprehensive patient information that is necessary to deliver the service.

Mr Black: That is true.

Rhona Jack: Although that is true, the good news is that people are seeing the benefits of going for a co-ordinated corporate approach rather than everybody going their own way. There might well be situations in which it is appropriate to tailor systems, but every time someone tailors something to their specific needs, a cost is attached—so they ought to be able to justify why that cost is being incurred. That kind of thing takes time, which is why stakeholder engagement is crucial.

The Convener: The Auditor General mentioned that he is planning a follow-up study on which he will report. Can you give us an idea of the timescale for that?

Mr Black: I find that difficult to do at this stage, although it is unlikely to happen in 2007. It will be appropriate to review how the strategy develops and take a judgment at the back end of next year as to whether it would be appropriate to report again and to what timescale.

The Convener: The committee will discuss under agenda item 7 how it will proceed after the briefing on the report "Informed to Care—Managing IT to deliver information in the NHS in Scotland". I thank Rhona Jack for her help on item 2.

"Catering for patients: A follow-up report"

10:33

The Convener: Item 3 is on the Auditor General's report entitled, "Catering for patients: A follow-up report". Barbara Hurst has a briefing for us.

Barbara Hurst (Audit Scotland): Our recently published report on catering follows up the recommendations in a baseline report that we did in November 2003. Some committee members might remember the discussions at that time. We examined hospital food because it plays such an important part in helping patients to get better. The baseline report made a series of recommendations on nutrition, quality, patient satisfaction, cost and management of catering services. The follow-up study assessed progress in implementing those recommendations in 149 hospitals and 16 health boards—the 14 territorial boards plus two special boards.

In 2004-05, catering costs were in the region of £73 million, which is just under 1 per cent of total NHS costs. They have risen by about one third since the baseline report, but that is due largely to implementation of the local pay agreement. Catering is a large employer with over 3,000 staff serving over 17 million meals a year.

During the course of the audit, we worked closely with NHS Quality Improvement Scotland to provide a comprehensive picture of work in this area and to ensure that we did not duplicate each other's work. QIS focused on nutritional care of patients while our review focused on delivery of catering services, thus placing reliance on the QIS review of nutritional standards.

We found that catering services have improved in a number of ways: for example, patients are given more choice; they can order food closer to meal times; they can select from a range of portion sizes; and they have access to snacks outside normal meal times. That is promising.

Financial management of catering services has also improved, and all boards are set to have trading accounts by the end of the financial year. We could not use the information from trading accounts because they are not in place everywhere, but they will be a significant benefit in helping us to understand the costs of the service.

Hospitals have reduced the amount of wasted food since the baseline report. Almost 90 per cent of hospitals meet the target of 10 per cent or less wastage. However, progress is needed in two key areas. First, working with NHS QIS, boards need to do more to ensure that patients get the

nutritional care that they need. Against the QIS standards, not all patients are, on admission to hospital, screened for risk of undernutrition, although such screening is clearly important. Secondly, the Health Department is yet to develop a national catering and nutrition specification for the health service in Scotland, as was recommended in our baseline report. The date that was given for that is April 2007.

We found that just under half of the heath boards carry out full nutritional analyses of their hospital menus. Like the screening of patients for undernutrition, the analysis of menus is important. There has been encouraging progress with boards seeking patients' views and using them to improve the service, but not all boards are doing that systematically. However, we found good examples of innovative work in a number of boards and we encourage the sharing of that good practice throughout the boards.

In brief, we found that there has been significant progress in some areas but that there is more still to do around nutritional care. We are happy to take questions.

Mr Welsh: The report states:

"The SEHD has not yet produced a national catering and nutrition specification for the NHS in Scotland".

What steps and progress are being made towards that? How is the work organised and who is in charge of nutritional needs in hospitals?

Roddy Ferguson (Audit Scotland): The Health Department appointed Helen Davidson as food and nutrition adviser. She has spent the past nine months trying to develop the standards. Before that, there was a set of draft standards and a specification had been produced that was never fully realised. Helen Davidson is consulting widely with catering managers and dieticians to try to publish the specification by next April.

Mr Welsh: A fully functioning national e-procurement system for catering is not yet in place in the NHS in Scotland. A number of limitations in the professional electronic commerce online system—PECOS—have delayed its progress. To me, they seem to be fundamental problems. When, how and by whom will the system be sorted out?

Barbara Hurst: You are right that the system has significant limitations—they are mainly to do with its responsiveness at the front end. It can be slow, although that might be a network problem, which takes us back to our previous discussion about information management and technology. If the system can be made to work, it should have significant benefits, but it is not functioning as well as it should.

Mr Welsh: It would be fine if the program actually worked.

Barbara Hurst: The program is working, albeit slowly, but in a fast-moving world, people might choose to order supplies in a different way.

Margaret Jamieson: How does the centralisation of procurement fit with the objective to increase nutritional standards? In schools, we are developing local purchasing to ensure that schoolchildren get the benefit of local high-quality produce, such as fruit and vegetables that were picked the previous day. How do we extend that approach to the health service? Does it consider nutrition in a silo, without examining what is being done elsewhere?

Barbara Hurst: That is a really interesting question. I remember that we had the same discussion about sourcing food locally three years ago. When Roddy Ferguson was scoping the study, he had a number of discussions with the central purchasing bodies. At that time, the direction in which things were going was clearly towards national contracts, which cuts across the possibility of local sourcing, unless it is possible to link the two. National contracts have reduced the cost of some food, but we have not considered local sourcing further.

Margaret Jamieson: If the award of the contracts is based solely on reducing cost, that can impact on the quality and nutritional value of the produce. What interests me is how we square that circle, but I see nothing in the report on which we could hang that.

Barbara Hurst: No. We did not follow that through because we did not consider it in the initial report and because, in scoping the study, we found that the drive was towards national procurement. You are right to say that, if we are going to buy nationally, we need real quality standards that we can apply to orders. To take it one step back, that is why we have in the report focused on some of NHS QIS's findings on the need to meet nutritional standards. That links with our finding that menus need also to be nutritionally analysed. Catering is complex. It looks quite straightforward, but it links in with the nutritional spec that the Health Department should produce by next April.

Margaret Jamieson: How do we screen the nutritional needs of the patients in an acute hospital—I mean one that has the whole gamut of patients, such as acute admissions, elderly patients, psychiatric patients, maternity patients and paediatric patients—and have the catering service fulfil those needs when, as far as I can determine, no qualifications are required of the staff who deliver that service?

Barbara Hurst: We are clear that nutritional care for patients is not only the responsibility of the catering service. Of course it is not; screening patients and ensuring that they then get the right food are also clinical responsibilities. Hospitals need enough dieticians to fulfil those responsibilities and they need to ensure that they have time to assess patients' needs properly on admission. They will also pay more attention to people who are in for longer—particularly vulnerable older people, I expect—than to those who are in for two or three days for a quick operation and then out again. If resources are tight, it is necessary to target them on the more vulnerable patients.

Nutrition is really important. There is a lot of evidence that significant numbers of people are malnourished in hospital.

Tricia Meldrum (Audit Scotland): NHS QIS went into a bit more detail in its report. It outlined what nutritional screening tools it would expect to be used and gave examples of tools that are in use and what it would expect them to cover. It provided guidance on what hospitals should do and stressed the point that nutritional screening is a multidisciplinary responsibility that is not the responsibility of one group of staff. It is aware that nutritional screening is quite a big undertaking and a different way of working for hospitals.

Margaret Jamieson: I asked a question about the qualifications of the catering staff: it was not answered. I am concerned about qualifications because we are asking people to provide patients with food that is nutritionally sound. I read nothing in the report about investment in staff through modern apprenticeships, for example. In the generality of catering staff, some are qualified and some are unqualified. In the future, how can we ensure that staff understand what they are trying to achieve? If they do not have the basis of that information in the form of a qualification, how can we move forward?

10:45

Barbara Hurst: Agenda for change should help on that front. The idea is to link staff to the skills that are needed to do the job. It was too early for us to assess what was happening under agenda for change because it is still being implemented across all NHS boards. However, it would be the mechanism to ensure that what Margaret Jamieson described happens.

Tricia Meldrum: The QIS standards also relate to ensuring that staff have appropriate education and training about nutritional care, and about food and fluids. It was found that there is a lot more to be done on that.

Margaret Jamieson: Does not that indicate that we have been using unqualified people for too long? If they were qualified, they would understand the fundamental aspects of nutritional care, which is part of the qualification.

Tricia Meldrum: Yes. It is certainly an area that needs to be improved.

Margaret Jamieson: In the drive to reduce costs, offering of qualifications has suffered in the health service. Boards would employ people who had qualifications but would not help them to add to them. That should be addressed.

Barbara Hurst: That links to recruitment and retention of staff. We are still finding high vacancy rates in some areas. We fully agree with Margaret Jamieson. If organisations invest in their staff and ensure that they know what they are doing and that they are valued, that can reduce vacancy rates.

Robin Harper (Lothians) (Green): The 1 per cent of the total budget that is spent on hospital catering seems to be an irreducible minimum. However, I want to pursue Margaret Jamieson's point about local procurement because a national strategy should not preclude local procurement. Are figures available on the percentage of food that hospitals procure locally and on how many hospitals, like Edinburgh royal infirmary, buy pre-prepared food in bulk from another country?

Barbara Hurst: I am not sure of the answer to that question. Did it come up through the study?

Roddy Ferguson: We did not examine such figures. It might be helpful to take a step back to Margaret Jamieson's question, which was about what the Health Department is doing. Some work on local procurement and organic produce is being done in schools. I understand that Gillian Kynoch from the Executive intends to learn the lessons from the schools work rather than try to do the work in every area. The health sector is considering what is happening in schools, prisons and other public sector areas, and because of the emphasis in other areas, we did not consider it particularly in the report. The figures are not terribly clear.

The Convener: You mention that 30 per cent of boards carry out quarterly patient-satisfaction surveys. Is there any correlation between carrying out that work and learning from it, for example by delivering good practice in nutritional standards or savings in unserved meals?

Barbara Hurst: When we did the original baseline report, we carried out our own patient-satisfaction survey, which was quite a big enterprise. We found no correlation between levels of satisfaction and any of the other indicators that we examined.

However, when doing work of that sort it is not enough just to ask patients what they think about the food; it is necessary to do something with the information. This time we expected boards to do that work, given that we had flagged it up as an important issue. We identified some really good examples. One was the state hospital in Lanarkshire, which has to take a different approach to learning from patients and feeding that information into the process. It is good if improvements are implemented on the back of that feedback. It is our strong view that if boards ask for feedback and do nothing with it, they should not bother asking for feedback. There is now a standard patient survey that can be applied to all hospitals, but boards must do something with the findings.

Mr Welsh: My question relates to non-patient catering and subsidisation. Boards are required to produce trading accounts for catering departments in 2006-07, which will make those costs more transparent. Will the accounts include the private contractors that would not provide information in three hospitals?

Barbara Hurst: No.

Mr Welsh: So there will not be a complete picture.

Barbara Hurst: No—but we did not have a complete picture the first time around.

The Convener: There are no further questions. The committee will discuss its reaction to the report in private under agenda item 7. I thank Barbara Hurst and her team—Tricia Meldrum and Roddy Ferguson—for providing us with that briefing.

Transport in Scotland

10:52

The Convener: We have copies of the Scottish Executive's response to the Auditor General's report "Scottish Executive: an overview of the performance of transport in Scotland". Members will have the opportunity to discuss the Executive's reaction to the comments that we made. We sought clarification from the Enterprise, Transport and Lifelong Learning Department on a number of issues.

The department states:

"implementation of the cap"

on payments

"is unlikely to be necessary."

I hope that it holds to that position, because later in the response it states:

"In our view there is no reason to think that the operation of the Scheme will be affected by anything other than a major breach of the cap".

I hope that that will not be necessary. I have the impression from the department's letter that the risk about which the committee was concerned is not on the horizon but, with subsidies, financial circumstances can change very quickly.

Mr Welsh: We are told that

"early indications are that implementation of the cap is unlikely to be necessary",

but how is the scheme being monitored, and how quickly and effectively can action be taken, if needed? I notice that

"Transport Scotland collects some bus survey information to benchmark operator claims on passenger numbers and fare foregone."

What is meant by "some bus survey information"? How big is the sample, how often is the information collected and how effective is it?

The Convener: I am not in a position to answer that question. I am not sure that Audit Scotland is either, but Graeme Greenhill will tell us what he knows.

Graeme Greenhill (Audit Scotland): I will have a go at the first question, but I am afraid that the second question is beyond me. As one would expect, the Executive monitors expenditure monthly, so it should be in a position to respond quickly if there is any indication that its budgets are threatened. I do not know about sample sizes and frequency of inspections.

Audit Scotland knows that the Scottish Executive's audit unit recently commenced a review of the scheme, in which it will examine

monitoring and management arrangements. Clearly, the review is of interest to our auditors, who will monitor the results of the unit's work with a view to using it to inform their audit of Transport Scotland.

The Convener: Thank you.

Mr Welsh: We are told that the Executive is "looking to commission research", but it gives no indication as to the timescale or depth of the research. What exactly does the Executive mean by "looking to commission"? That is not the same as commissioning. I would like to know whether and when the research will happen.

The Convener: Can you answer that question, Graeme?

Graeme Greenhill: The committee will need to put that question to the Executive.

The Convener: I thought as much. Our options are to note the response and keep a watching brief or to write again to the Executive asking for further clarification. Of course, the second option could lead to a constant exchange of letters.

Margaret Smith (Edinburgh West) (LD): We asked:

"Does the Department undertake any work to compare the process of project implementation in Scotland and other parts of the UK with that in other countries in order to find ways in which projects can be managed more cost effectively and quickly?"

However, we got only a partial answer. The Executive talked a bit about trunk roads without giving a great deal of detail and then went on to say something about rail. I would like to have seen a bit more on current major projects, such as the Edinburgh tram system. Previously, I have expressed concern that we do not seem to have much in the way of an on-going audit of costs in such major projects. When we find ourselves faced with escalating costs in a project, it might prove useful to have audits of the gateways or exit points along the way. A system of on-going audit would mean that we would not have to wait for projects' completion, which can take several years. I suggest that we ask the Executive whether an on-going audit process could be used to benchmark its major public transport infrastructure projects against what is happening elsewhere in the world. As I said, we received only a partial answer to that question.

The Convener: I get the impression that members feel the need to raise other issues with the Executive. Obviously, at our meeting of 24 October, we decided not to do a report. However, it is open to us to write again to the Executive.

Mr Welsh: I do not want a constant exchange of letters; I simply seek clarification of the facts and the action that the Executive is pursuing. We have received answers that appear to tell us everything, but which in fact do not: there are answers and there is the appearance of answers.

The Convener: Sure. Do you have anything to say on the point that Margaret Smith raised on the need for on-going audit, Graeme?

Graeme Greenhill: I will be informed by advice from the Auditor General and Caroline Gardner, but the Auditor General's forward study programme includes a project in which Audit Scotland would look at major capital projects. The issue might come up as part of that work.

Caroline Gardner (Audit Scotland): I have little to add other than that we have previously mentioned our view that there is mileage in examining such significant areas of investment. Obviously, transport accounts for considerable expenditure. Over time, in addition to looking at what progress has been made, we may be able to develop benchmarking measures.

The Convener: That being the case, I do not see much point in following up the issue at this stage.

11:00

Margaret Smith: I understand that many of the issues that crop up in such projects occur not just in Scotland or the United Kingdom but in similar projects around the world, so benchmarking might prove to be quite useful.

The Convener: That being the case, we can seek clarification on only two points from Andrew Welsh's list. We can send a relatively short letter. I do not want to encourage a response that will result in our having a further long discussion on the subject, but I am happy to have clarification of the points that Andrew Welsh feels are not lucid enough.

Margaret Smith: I would still like more information on auditing of major projects. I appreciate what the deputy auditor general said on the matter, but I have raised the issue before. In the short term, we should at least seek a response from the Executive. We can consider the issue again in the future.

The Convener: I propose that the clerks, when they have seen the *Official Report* of today's meeting, should draft a short letter seeking clarification of those points and noting the rest of the response. Is that agreed?

Members *indicated agreement*.

The Convener: We have completed the process for agenda item 4, so I thank Graeme Greenhill and Caroline Gardner for the clarification that they have provided.

Agenda item 5 is oral evidence taking for our review of community planning partnerships. Before we start that, we will have a short break. We will recommence at 10 past 11.

11:01

Meeting suspended.

11:11

On resuming—

Community Planning Partnerships

The Convener: I welcome Dr Andrew Goudie and his team. We will be taking evidence on "Community Planning: an initial review", a report that has been prepared for the Auditor General and the Accounts Commission. At a previous meeting in November, we heard evidence from a number of senior community planning practitioners about some of the issues that are raised in the report. Members of the committee also visited East Ayrshire community planning partnership in October, which gave us an opportunity to see community planning in practice. In today's session, we shall focus on issues relating to funding streams, and integration and prioritisation of national policy objectives. Those issues were highlighted in the Auditor General's report and by our previous witnesses as areas of particular concern in respect of community planning.

I invite Dr Goudie to introduce his team to us and to make his opening statement.

Dr Andrew Goudie (Scottish Executive Finance and Central Services Department): We have been trying to think about the areas that we might most usefully cover today, so I thought it important to illustrate some of the broader comments that we have made with some specific examples.

Paul Gray is a director in the Scottish Executive Heath Department, Mike Neilson is a director in the Scottish Executive Development Department, and David Henderson is the head of local government finance. I hope that, between us, we can cover the areas that it will be useful to touch on.

I will not say too much by way of introduction, but I have a few introductory comments to make. As members know, Scottish Executive ministers have long believed that community planning has a central role to play in meeting the challenges in improving public services. It is making a difference to the lives of the people who use those services by joining national policy outcomes with the needs of each area. We know that that is happening around Scotland and we are committed to supporting partnerships as they progress that work by marrying the efficiency gains of joint working with the benefits of local engagement, and by developing services that are truly sustainable.

Audit Scotland's initial review of community planning reflected many of the conclusions that had been set out in the Executive's consultation document, "Transforming Public Services: The

Next Phase of Reform". At the time of its publication, the Minister for Finance and Public Service Reform welcomed the review's acknowledgement of the progress that has been made to date by community planning partnerships, and the view that a great deal more remained to be done to improve public services for the benefit of individuals and their communities. The recommendations of the review are consistent with the public service reform agenda that was set by ministers, whose basic intention is to rationalise and simplify initiatives and funding streams wherever possible, and to create greater local freedoms and flexibilities for community planning partners to respond to local needs.

Feedback from the public sector reform dialogue over the summer suggests that respondents from throughout Scotland also see significant potential in community planning and recognise that it is a platform on which we can all build. We are therefore already exploring how community planning might best move forward. The Executive is committed to helping local partnerships to find the appropriate mechanisms to maximise the potential of planning in each area.

We are supporting partnerships in a wide variety of ways. In particular, the Executive is facilitating the community planning network, Communities Scotland is providing direct support and individual members of the management group of the Executive are systematically maintaining links with each community planning partnership. The development of community planning is, above all, a key element of the wider work of public sector reform. As ministers take forward their thinking in that broader context, the role of community planning will necessarily be to the fore.

That is all I need to say by way of introduction.

11:15

The Convener: Thank you. The first area that we will inquire about is the fragmented nature of funding streams. I invite Margaret Jamieson to start the questioning.

Margaret Jamieson: You said that the Executive is seeking ways in which to respond to the needs of local communities via community planning partnerships. When local authorities join their health colleagues and together make a policy decision, they must still approach different Executive departments for funding. How can you ensure that local impacts are taken into account when one department says yes but the other says no?

Dr Goudie: One of the key things that we have been trying to achieve is greater clarity about outcomes in specific work. In clarifying outcomes, we can have the sort of conversations that you are talking about and we can see how the different partners may come into play. There are already several examples—which my colleagues may pick up on—of work for which partnerships have been formed and about which those conversations are taking place.

Work on children's services is a good example of partners coming together. We have brought together—among others—local authorities, the health service, youth justice and social work so that they can form a common view about how to make progress. Although that may not have been done explicitly within the community planning framework, it is a good example of how joint working has allowed greater understanding of the purpose of the work.

Other work is perhaps more tightly defined in one sense, in respect of outcome agreements. The regeneration outcome agreements are a good example of different interests coming together to form a common vision. Mike Neilson has been involved in that work and might want to say more about it. It is a good example of different views of a common picture focusing work around that picture.

Mike Neilson (Scottish Executive Development Department): It is worth considering regeneration outcome agreements, as they are one of the most concrete examples of trying to put the outcome agreement approach into practice in quite an ambitious way. The outcome agreement involves all local partners, not just the local authority, and it is in the cross-cutting area of regeneration. Quite a lot of important lessons have come out of that around the relationship between allowing flexibility for local players and setting national priorities, which is one of the big issues.

It is interesting that we have found that, in some respects, we should be more specific about priorities in the future because the current arrangements have made it more difficult to align them. The lessons that we have learned are that the priorities that we establish nationally need to give sufficient guidance and that we need to build evidence around the baseline for improvements.

I think that Margaret Jamieson asked how agreement is reached across the Executive when partnerships want to do something. The regeneration outcome agreement approach, whereby integrated outcomes are sought, has been effective in making the system work. In areas in which the approach has been based on integrated outcomes rather than just bidding for funding, it has been possible to align outcomes for regeneration with other frameworks. However, there is no doubt that we must continue to work on how the regeneration outcome framework links to targets for health and education.

Margaret Jamieson: What you described is very much a top-down and not a bottom-up approach, which is why I asked the question. My question was particularly about local government and health, which in some areas in Scotland have agreed that the best way of delivering outcomes for communities is to have co-location and a one-door approach. However, when they want to access moneys, health boards must go to the Health Department but local authorities must take a different route. Even if funding from one funding source is approved in principle, there might be a six-month delay before the other funding source gives its approval. How will the Executive rationalise how it works? Community planning partners appear to have got their act together on co-location and shared services, but you guys at the Executive have not quite come out of the silo—that is demonstrated by the fact that four of you are here.

Dr Goudie: There were two parts to your question. First there are issues about how we join up and work with local government. As you know, in the Audit Scotland report comments were made about the fragmentation of funding streams and the fact that the Executive has a variety of initiatives, each of which has its own planning and performance processes. As I am sure you know, ministers have acknowledged that that is an issue and have asked us to consider how we might consolidate and remove some of the current bureaucracy. That is an important part of the work.

I will briefly describe some of the work that we are doing to tackle the issue. For some time we have been undertaking an internal review of issues to do with streamlining bureaucracy, to consider in particular how we might measurably reduce the number of funding streams with local authorities and the number of plans and performance reporting lines that we request. We asked each portfolio closely to consider its relationship with local government, to ascertain how such cuts might be made, and we are currently considering the progress that portfolios have made in that regard during the past six months. I am jumping the gun a little when I say that the indications are promising. We concede that more can be done, but the initial progress is encouraging. If there is a real need to create a new stream or programme, we try hard to ensure that that need is met in the context of a general reduction in the number of funding streams.

Another piece of work is to do with smaller funding streams and is important because such funding streams can generate a disproportionate amount of bureaucracy. We have particularly considered funding streams of less than £10 million, to ascertain whether they can be consolidated or integrated with other programmes. We are trying to tackle the issues that were raised in the report and in the document that ministers published during the summer.

Another important piece of work is consideration of how statistical reporting is done in local authorities, whether it involves formal sample surveys or the collection of administrative data from local government. We did not have an overall picture, but we have now collated a baseline of the demands that are made on local government by departments throughout the Executive. Now that the work has reached that point, we are asking those involved to look methodically through the information and identify the precise need that underlies each request. For each item, we are asking what it informs us about, whether it is about performance tracking or about target tracking, and what precisely is the purpose of the data collection. There is a presumption that, where there are undefined or ill-defined reasons for data collection, we will look much more closely at whether it should continue.

Another dimension is that, even if data are required for various reasons, we can reduce the duplication that occurs when different portfolios ask for broadly similar data. Such duplication is obviously unnecessary and, in principle, the collection of those data can be made much clearer. We are also considering ways in which collection can be made simpler, perhaps through electronic data capture rather than manual means. A variety of work is being done and it is going well. That perhaps answers the part of your question about local government.

The other part of your question related more to the coming together of different sectors. I want to tell the committee about the exploratory work that ministers asked us to do on outcome agreements. Mike Neilson described the good progress that has been made on the regeneration side in recent years, but we are open about saying that that is a lesson-learning process. It was, in one sense, the piloting of an idea. Most people think that it went well in principle, but we also agree with you that a lot can be learned. It is clear that community planning partners have some concerns and interests and we need to capture those.

There are three strands to the work on outcome agreements. First, as I am sure you are aware, we are working with West Lothian Council and East Renfrewshire Council on the scope for designing a single outcome agreement that would capture all the resources that go into local government. That depends on defining outcomes up front in a clear and methodical way. It also depends on defining ways of tracking performance and knowing how to analyse the agreement at the end of the period. That raises some important questions.

The second strand is the work that we are doing with two community planning partnerships from

North and South Lanarkshire, which have submitted proposals to us. They are looking to take forward what I regard as the thematic example of deprivation by building on the work that has been done on regeneration outcome agreements. We hope that that will be another forum for bringing together the various groupings.

Thirdly, work is being done on some other thematic areas. Mike Neilson might want to comment on those because two of them are in his area. One is to explore the possibility of having an outcome agreement around the children's service work. That work has gone ahead rapidly and it is a good example of joint working, but it is not necessarily within the framework of an outcome agreement. The second area is around older people and potentially around other areas as well. Mike Neilson might want to comment on where we have got to with that.

11:30

Mike Neilson: Before I do that, I would like to return to the important point about getting different people to say yes at the right time. There is a set of issues around national priorities and local priorities and there is a set of issues around different policy areas, but there is no perfect way of cutting that cake that will always give us the right answers.

There is a set of short-term issues and a set of longer-term issues. As far as the short-term issues are concerned, I will cite the urban regeneration companies—which, strictly speaking, do not fall into the category of community planning—as an illustration of what we are trying to do, whereby all the local players come together to consider the regeneration of a particular area. The role that the Executive has played in that has been to say that if issues emerge in relation to the Scottish Further and Higher Education Funding Council and its plans to build, for example, we will ensure that our approach is joined up so that answers are provided coherently. That is quite a good model for practical, specific examples.

To pick up on what Andrew Goudie said about the longer term, it would be easier to fit things together if we had a more coherent, outcome-based approach. In the case of older people, we are considering running a pathfinder, which would cover, at the very least, health care and housing and which would also take account of active aging. We want to identify what would be the right scope of that, which local players would need to be involved to make it work most effectively and what funding streams could be brought together. That poses quite a big challenge for us, because it means that we have to go back to health, housing and care policies to assess how they fit together. We think that having a particular agreement for a particular service group is probably a good way of achieving greater integration between policies.

Margaret Jamieson: I am interested in what you have said about an urban regeneration company looking at a particular area and getting different players involved. I see no difference between that and a community partnership identifying what it needs for an area. If such a system can work quickly for regeneration and other individuals can be pulled in, why can that approach not be rolled out across the Executive?

Mike Neilson: Our approach has been that if a well-defined local objective has required a set of decisions, we have told the local authority to work out what it wants to do and to come and tell us if it finds a barrier. I am quite familiar with some of the issues in Glasgow, where the experience has been that a great deal can be achieved before insuperable barriers are encountered. When that happens, people come and talk to us or to the Health Department.

The Convener: I want to pick up on those answers by referring to paragraph 49 of "Community planning: an initial review", which mentions community planning partnerships being required to develop regeneration outcome agreements. It says that some CPPs

"found the process of developing ROAs resource intensive and the specific guidance on where resources should be spent not always relevant to their local communities. In some areas, work on the ROA significantly delayed progress on other local priorities."

To what extent can that be avoided?

Mike Neilson: We have examined the experience of regeneration outcome agreements and a number of interesting points have emerged. First, it is important to emphasise that regeneration outcome agreements were envisaged not just as a way to describe how the community regeneration fund would be used, but as a way to set out a regeneration strategy for the area and all the players in it. It is partly because what we have sought to achieve is quite difficult that meeting such a high aspiration has proved hard.

The second point to bear in mind relates to ROAs not necessarily fitting in with local priorities. To a large extent, there has been a geographic focus on ensuring that 80 per cent of the money is spent in the 15 per cent of areas in which deprivation is greatest. That we should focus on the most disadvantaged areas is an important policy objective but, in practice, we have tried to show some flexibility, with the result that in some areas the spread has been rather wider. However, the basic principle of ensuring that the most disadvantaged areas get most of the funding is extremely important.

The third issue is intensity of funding. One of the issues that came out of the evaluation is that the approach probably needs to be more in proportion to the level of funding. At one end, we have Glasgow, which receives £32 million, whereas one or two local authorities receive hundreds of thousands of pounds. It is reasonable to expect a more attenuated approach.

Those are some of the lessons that we are learning for the next round. I stress that the agreements were the first effort to have a genuinely outcome-based approach in community planning partnerships. The process is a challenge and, the first time round, it was difficult.

The Convener: Dr Goudie, in response to an earlier question, you mentioned work with partnerships in North and South Lanarkshire. Can you give us a timescale for that? To what extent are other community planning partnerships being encouraged to take the same approach?

Dr Goudie: I cannot give you an absolute comment on the timescale, for the important reason that ministers have asked us to explore the proposals that have been produced. At present, we are considering the technical nature of the outcome agreements and exploring the ideas, particularly on single-outcome agreements, as that approach has not been taken before. Ultimately, the proposals will need to go back to ministers for comment and a decision, which I cannot pre-empt. The intention at present is that if ministers want to move, they would look to try to introduce the proposed measures in the next year or two. However, we have a long way to go before we are at the point of making a decision.

Margaret Smith: To an extent, I have picked up a certain amount of reassurance from comments that have been made. My question comes from experience at the grass-roots level. Part of my constituency is an area that was previously in the social inclusion partnership in north Edinburgh. Half of the North Edinburgh Area Renewal area is in my constituency and the other half is in the Edinburgh North and Leith constituency. During the past decade, people have moved from considering purely housing and regeneration issues to working with health partners and local businesses. On the ground, in north-west Edinburgh—I am sure that the area is not alone in this—people have been doing community planning for nearly a decade and have structures, funding streams and ways of working in place.

For the most part, community planning can be thought of as being about bringing people up and increasing community partnership working—that is certainly the case in parts of my constituency—but, in areas where such working has been a way of life for several years, there is a concern that people will almost have to move backwards to accommodate the new arrangements. I seek assurances on that. How will such areas get the flexibility that they need from the Executive and councils to continue the work that they have been doing, bearing in mind, of course, the need for full accountability? What will the funding stream picture be for them and how will it compare with their previous situation?

Dr Goudie: One important point about the progress with community planning, which is explicit in the legislation, is that the process must allow for local initiative and innovation. The process is deliberately not intended to be prescriptive about the way in which local communities should develop their planning partnerships. That is important, because it means that some partnerships will inevitably move at different speeds and some will have different approaches to the way in which they define their models. I am not familiar with the particular example that Margaret Smith raises, but with individual areas where such work has been going on for a long period and which have a genuine sense of joint working and a joint vision toward which they have been working for some time, I do not see why they should feel that they are being pushed back.

The Executive's approach is to work with existing partnerships rather than to redefine them according to some kind of blueprint. Indeed, across the public sector reform agenda, ministers have made it clear that, as a matter of principle, they are looking for a bottom-up approach to the reform process rather than an approach that imposes a particular model. For issues such as the streamlining of bureaucracy or funding streams, I see no reason why we should constrain the way in which a community planning partnership decides to take its thinking forward.

Margaret Smith: On Mr Neilson's point about targeting resources into deprived areas, I think that different situations on the ground might require slightly different approaches, such as different boundaries, so there will be some changes. In general, will the approach that has been outlined still be the direction of travel that the Executive will set for local councils in such areas?

Mike Neilson: That is right. In effect, local community planning will cover all areas, whereas SIPs or other structures previously covered only the most disadvantaged areas. We want a more strategic and comprehensive approach so that local community planning happens everywhere. However, we also recognise explicitly that we need to build on what is already happening in areas where community planning is in effect functioning and we need to continue to target resources on the most disadvantaged areas. That

implies that we must build on the strengths that exist.

However, we must also recognise that some change will be part of the process. Change might be involved as a result of the community planning agenda or, in Edinburgh, the neighbourhood management agenda, which is important in getting big decisions down into neighbourhood level in a more integrated way.

The Convener: Let me turn our line of questioning round slightly. How does the Executive intend to give community planning partnerships greater flexibility to respond to local needs in using specific areas of funding, as opposed to pooling everything?

Dr Goudie: Implicit in the direction of travel that I talked about earlier is the exploratory work that we are doing on outcome agreements, of which the community services work that I described is perhaps one of the earlier examples. That work is important because, in essence, outcome agreements will focus on the impact on the client group or beneficiary while putting much less emphasis on the means by which the outcome objectives are achieved. We are currently exploring the extent to which, in such agreements or contracts, greater flexibility might be given to the combination of different agencies so that they can work on an outcome in the way that they feel is most appropriate to the local setting. In many ways, that is the essence of an outcome agreement. Outcome agreements could address several of the perceived barriers or challenges to taking forward community planning. A key challenge is to bring in the local dimension and local knowledge in a way that allows people to address the problem in their own particular way. That is an important strand of our thinking that has a very direct impact on the issue that you asked about in your question.

The Convener: We have no more questions on funding streams, so we will move on to the next area of questioning, which is integration and prioritisation of national policies.

Mr Welsh: My question is on the balance between the centre and the locality in the setting of goals and priorities. What consideration is being given to setting a smaller number of strategic priorities when community planning could add value and is supported by agreed outcomes?

Dr Goudie: In "Transforming Public Services: The Next Phase of Reform", which ministers published in the summer, one of the key thrusts was, as I think the question suggests, that we should look much more towards an outcome-based approach of some sort—although the document did not specify precisely what that approach might turn out to be. Ministers also asked us to consider ways in which different partners might participate in that process.

11:45

Mr Welsh: The report states:

"The Highland Council has estimated that 29 separate plans and strategies are required for different Scottish Executive departments".

Does that not conflict with what you have just said?

Dr Goudie: We must see what has been proposed as part of the wider public sector reform agenda. We are looking towards a fundamental transformational change in that sector. The document that was published in the summer does not answer all the questions; rather, it flags up the immensity of the challenges that ministers have seen, which include the kind of challenges that have been mentioned. The examples that I gave earlier point towards the activities that we have now put in place to address the overall picture. As I have suggested, our initial look at what has recently been done in individual portfolios suggests that there has been a considerable move towards addressing the overall picture; indeed, on-the-ground changes have already been made that address the issues that have been mentioned.

Mr Welsh: I know that the situation is complex centrally and locally, but the report also states:

"There is … no clear direction … from the Scottish Executive on which national priorities should have precedence for implementation at local level."

Is greater clarity needed?

Dr Goudie: Ministers have said that they want more sharpness about what the outcomes are and on prioritising actions to achieve those outcomes. The context that I have described is such that we will be able to focus more on having greater clarity.

Mr Welsh: What changes have been made in how central Government operates and organises to deal with sometimes complex local problems in different organisations and to get action?

Dr Goudie: Perhaps it would be best to answer that question by way of a couple of examples. Mike Neilson and Paul Gray can give specific examples.

Paul Gray (Scottish Executive Heath Department): An example that is worth drawing attention to is children's services. I do not deal directly with children's services, but I have an interest in them. A single, integrated children's services plan that pulls in several previous requirements and makes a real effort to focus on the child is now required.

On strategic priorities, a number of plans relate to particular areas or particular groups, such as looked-after children and kids not in employment or training. Whatever framework exists, we will want to be reassured that certain issues are being targeted as priorities and that tackling one of the issues is not a higher priority than tackling another; we will want to be reassured that action on all the issues is being driven forward. Young people who are not in education, employment or training are a good example in that context. It is good for the Executive to say that action must be taken to address their problems and that there must be a new approach in areas in which the problem is most significant.

We are trying to pull together several housing plans. Local housing strategies will integrate supporting people planning and fuel poverty planning among other types of planning. However, there is an issue to do with homelessness strategies. At the least, there are housing supply and social care support elements to tackling homelessness, which do not fit neatly into the housing side of things or the community care side of things. There is a challenge in finding a way of continuing to focus on homelessness as a priority while recognising that a wide range of interventions is involved.

Mr Welsh: I am interested in what you are saying because you are talking about a big change from how things used to be run. Ensuring that maximum efficiency is achieved is a complicated matter because clarity is required both centrally and locally for such complex processes to work.

I will give you another local view that we have received:

"Different national priorities are set for the different partner organisations; finding priorities which are relevant across all partners is difficult".

There was a plea for national guidance, which would help.

Dr Goudie: It is worth picking up the example from the health side, which goes some way to addressing that. I will hand over to Paul Gray on that.

Paul Gray: I will touch briefly on three examples. One is our work on the hub initiative, which is about building joint premises and touches on issues that Ms Jamieson raised earlier. I chair the steering group on that initiative, and Mike Neilson is a member of it. The group attempts to ensure that departments are joining up on the initiative and allowing local authorities, health boards and other sectors that might be interested, such as the voluntary sector, to have a say in joint premises and to manage the rather disparate funding streams in a way that produces a good outcome.

The second example is the work that we are doing on outcomes—Dr Goudie has referred to some of it already. A couple of weeks ago, we brought together the range of people who are involved in what has, up to now, been called the joint future work—the national health service, the local authorities, the Scottish Executive and the voluntary sector—so that, instead of each department producing a set of outcomes and then thinking about how we could weld them together, we could start from the other end. We asked what outcomes would make sense to the delivery agents against what they know about Executive policy.

In that context, it is worth pointing out that the outcomes that are sought from the implementation of "Changing Lives: Report of the 21st Century Social Work Review", which is the broad, overarching policy in our approach to social work, and "Delivering for Health", which is our broad, overarching policy on health services for the next 15 to 20 years, are closely aligned. That is by design rather than accident.

The third point is that one of the key roles that the Executive can play is to know when not to try to intervene. The Glasgow addiction service partnership is a prime example of that. The NHS board, the local council and voluntary providers got together to support a redesigned service and our job was not to interfere with that. They did it within the established lines of governance and within proper accountability. It is an excellent service and our job is simply to support the partners in achieving their aim.

Mr Welsh: What you have said makes reassuring sense in the search for focus and effectiveness. How will the Executive ensure that, if a smaller number of priorities are agreed, all departments will adopt a consistent approach to prioritising them within their own departmental policies and to holding their local delivery organisations accountable for delivering them?

Dr Goudie: Ultimately, the view that the Executive takes on the key outcome priorities will necessarily be determined by ministers. That is an important point, because the way in which we take the matter forward is driven by ministers' priorities. Let us take the next Administration by way of example. Once it has clarified what directions it wishes to move in, it will be for the departmental structure, under the permanent secretary, to make the links of which you speak.

We can give you a degree of reassurance that we are now working in a more joined-up way throughout the Executive—although I would not wish to exaggerate that, because one can always

do a great deal more. For example, Paul Gray has described some of the links that he has with Mike Neilson. Our recent work on young people who are not in education, employment or training is another good example of much more real joined-up working across the Executive to try to address some of the issues of which you speak.

Once we are given a strong lead on what the key objectives and priorities are, I agree that it will be for us to forge the structures that allow joint working and joint activities and the single communication process with community planning partnerships, local government or whatever the relevant agency is, so that we have a clear process of communicating with those groups.

Mr Welsh: In complexity, the common interest is in having a focus and consistency.

Dr Goudie: Yes.

The Convener: I welcome Susan Deacon to the meeting. We already gave apologies for her, so she need not worry.

Robin Harper: Children's services have been mentioned several times—Mike Neilson mentioned them. Of course, one of the bases for such work is children's records of needs, which are provided to share knowledge about children's needs, so that the needs of all children who have records of needs are—we hope—addressed. A requirement to review records of needs applies, so all the services that are involved can know how a child is progressing—a constant survey takes place. Will a quantitative overall evaluation of how that is progressing be made? In other words, are children's needs being addressed more effectively? Would you be able to measure that? More generally, how will you monitor and report effectively the delivery of the outcomes on all the strategic priorities that you have identified?

Dr Goudie: I think that you are referring to the work that is being done on the getting it right for every child agenda. That is a good example of how the key partners have come together collectively to define a single assessment process, a single reporting process and a single record for children. The impact on the system and the effectiveness of that work are important. They will be important parts of the joint inspection process, which is in train. Some progress has been made on joint inspections of child protection services, which are closely related. I understand that, in the not-too-distant future, the aim is to have joint inspections for the full range of children's services, but that is a little further down the track. The inspections will be a tangible way of addressing the question that you ask, which is what joint working is achieving.

I fundamentally agree that one key test for all the public sector reform agenda is what the ultimate impact is on the client group—the beneficiaries. The inspection process provides a strong, robust and independent way of digging out precisely how effective we are. The other part of the inspection process, which is extremely important, is its use for analysing what can be done better. That provides feedback into a process of continual improvement. I agree that we must ask about the importance of the process.

Robin Harper: I will pursue that. We have heard evidence that hubs can make significant improvements in the quantity of services and the efficiency with which services are delivered. Obviously, one also needs to know about the quality of services and what is being achieved, rather than just the number of people who go through the processes. For that, baselines are needed. I presume that quite a lot of baselines could be identified already for the performance of the separate social services, health services and the gamut of other services. Does the Executive intend to gather such figures or to require baselines to be set as hubs are established? I hope that more hubs will be established, as I think that they will be extremely successful. Are you thinking of setting qualitative and quantitative baselines according to the previous performance of the separate services, against which you can measure how much better they do when they work together?

12:00

Paul Gray: I have three points to make. First, I do not want to mislead the committee into thinking that hub services will be the answer to every problem that we have ever had. We are trying to provide a more streamlined way of procuring joint premises, involve people who would have done that anyway had it been possible and remove the barriers that might make it impossible at present.

Secondly, we would expect anyone who wanted to establish a hub to have a business case for it. The business case should not be merely a financial one; part of it would have to revolve around the better delivery of joint services.

The third part of my answer relates to what Dr Goudie said about the delivery of outcomes. We expect the partners who engage in the provision of hub services to do so against the background that co-location will make it easier for them to deliver their outcomes. We expect that to be tested in the normal way in which we take evidence and statistics from those organisations. The hub is a means to an end and you are asking whether we will test the end as well as the means. The answer to that has to be yes.

Robin Harper: I have a gut feeling that where hubs are set up, there will be a higher quality of

services as well as more efficient services. It is very important for the individual who takes advantage of the services offered through a hub that there is some way of assessing that the quality of the services is better than it was when there were separate services that did not operate together in that way.

Paul Gray: One of the challenges that we face is to find appropriate means of measuring outcomes for people. Much of a person's experience contributes to their feeling about the outcome. From a health perspective, it is as important that they get polite as well as appropriate clinical treatment.

A live example of improvement is the Strathbrock partnership centre in West Lothian, where primary care, general practice, pharmacy, social work, mental health services, local authority services such as housing and residential care services for the elderly are all located in one place. The benefit to the individual is substantial because, on a simple level, they do not have to go to the GP and then find a pharmacy elsewhere to get their prescription. On a broader level, if someone has a range of issues, they can access all the services in one place. That reduces the need to use transport and also means that they are more likely to take up the treatment that is offered to them because it is easier for them to get at it.

To be frank, finding an absolute measure to show that that is better is quite difficult. Nonetheless, if the hub model gives an advantage to the client—in this case, the patient—it is worth pursuing. That is quite apart from the financial advantages to the various organisations that take part in such a partnership in terms of the efficiency and effectiveness of the delivery of their services; we are looking at the hub from the client's perspective.

The Convener: Mary Mulligan will begin questions on supporting community planning, including co-location of premises and sharing information.

Mrs Mulligan: Just while we are talking about Strathbrock, I will add that the partnership is also much more efficient for MSPs, who can get all their questions answered in one afternoon, as I found yesterday, as everybody whom I needed to see was in the same place. Do you think that co-location is necessary to develop community planning?

Dr Goudie: I will offer some general comments and my colleagues may want to comment on their areas of expertise. I hesitate to say that co-location is necessary for community planning to work. As with most things, the key issue is the relationship between different organisations and people, not merely their physical location. However, there are undoubtedly some good examples of co-location facilitating and encouraging joint working. A couple of weeks ago, I had experience of an excellent example of co-location—an integrated community service and hospital, where several key professional groupings, including the hospital, GPs, dentists and social workers have been brought together in the same building. During my visit, they demonstrated admirably how powerful linkages were being made. Although co-location may not be necessary to develop community planning, I agree with the thrust of your question—that it often provides significant advantages.

Over the past year or two, we have done quite a lot of work on getting people to think much more about the possible benefits of co-location. As members will know, some of that has been rooted in other pieces of work, including efficient government work on the potential for savings, which ministers see as very legitimate. On the benefits side of the equation are the issues that I have just spoken about, such as services working together more closely to improve provision of services and to increase benefit to users, which is the key purpose of everything that we are doing. Co-location has the potential to bring a variety of benefits.

I will cite a couple of examples. Members may be familiar with the on-the-ground work that is being done in the Environment and Rural Affairs Department family. The department is examining how 10 public bodies throughout Scotland can be brought together in the same facilities, with the same set of multiple objectives. The aim of the work is partly to secure efficiency savings, but it also has a great deal to do with the visibility and accessibility of the different bodies. The ultimate purpose is to deliver a much better service to people on the ground.

Members are probably familiar with the work that has been done recently in individual sectors. Local government, in combination with the Improvement Service, is carrying out an assessment of its assets. Paul Gray has already described what has been happening in health. We can point to different activities that are under way and that we have tried to encourage and promote, with the multiple objectives that I have mentioned in mind.

Mrs Mulligan: You have said that you do not think that co-location is necessary, although there are desired outcomes that we would like to progress. I will come on to the issue of what happens where we do not have co-location. It has been suggested to us that, where we do, managing the different accounting responsibilities of the different agencies—health, local government and so on—may prove difficult. How

can you address that issue, to make it easier for bodies to co-locate?

Dr Goudie: Are you talking about accounting in a financial sense?

Mrs Mulligan: Yes.

Dr Goudie: I will mention one other thread of the work that we are doing at the moment. Ministers have asked us to look particularly at some of the potential barriers to joined-up working, of which barriers to co-location are one specific example. One piece of work that is already in train is focused on the potential legal or accountability obstacles to joint working. We are also on the point of setting up a piece of work that will respond more directly to your question. We plan to look at the possible obstacles to joined-up working on the financial and audit side. Different bodies come with different financial and audit customs and traditions, which may inhibit joined-up working. We are aware that that is a potential difficulty. In the early months of next year, we will look more closely at that. We recognise that the issue must be addressed so that co-location can go ahead in those places where local partners deem it to be valuable for the various reasons that I mentioned.

Mrs Mulligan: Where we do not have co-location—as you said, it is not always necessary—surely it is important that different bodies work together. Mike Neilson referred to children's services, which are a good example of an area where we need to ensure that information is shared. How do you propose to encourage that? For example, in the round-table session, it was suggested that the Executive should be more directive in setting out the ways in which information could and should be shared. How do you intend to take that forward?

Dr Goudie: Again, I will make a general comment on the work that is going forward at the moment and others may wish to chip in from their angle. One of the important threads of that work is the national data-sharing forum. As you may be aware, the forum was established to bring together the many different partners across the public sector. I think that representation is based on the health board geographies. The forum is looking at the fundamental question of how to create a secure environment in which data can be brought together and shared in the way in which you suggest. A great deal is being done on that front at the moment. The work is partly technical in nature and partly to do with the requirement to meet certain standards and protocols in terms of confidentiality and to have other safeguards in place. The work is being driven by a clear recognition that bringing together the data in a way that can be shared has the potential to create tremendous efficiency and much better services for clients. Mike Neilson may wish to comment from his particular angle.

Mike Neilson: In order to allow joint inspections to happen, we had to legislate on the exchange of information among inspectors. The conclusion that was reached at the time was that there were no insuperable barriers to information exchange among service providers. It was also agreed that a priority of joint inspections is not only the sharing of information but having in place the practices that ensure that information gets picked up on. The Executive has reinforced to local authority and health board chief executives in particular that that is a priority for Scottish ministers.

Dr Goudie: It might be helpful if Paul Gray were to say something about e-care.

Paul Gray: I will not give a lot of technical detail on the e-care framework. Basically, the Executive has developed a system that allows information to be shared securely among different agencies. Information sharing can be difficult when it takes place within agencies and it becomes increasingly difficult when it is put into practice across agency boundaries, whether health or social care. The e-care system deals with the issues around who is allowed to see what. In any information-sharing exercise, one of the critical issues is to ensure the proper protection of the individual about whom information is being shared, as well as of the practitioners who are sharing the information. The Executive has put in place some work and some funding. The Lanarkshire child protection messaging system, which went live in November 2005, has now been evaluated. We are putting systems and processes in place and then looking at whether and in what way they work.

To return to the question whether people should be co-located, the crucial component of any information-sharing protocol is not the system or process but the trust and confidence between the people who share the information. I believe that people adhere to high professional standards and work within the existing legal framework. Ultimately, the only answer is to get together groups of people who trust one another and who are therefore willing to discuss cases, particularly those that are difficult, sensitive and complex.

If we depend entirely on technology and systems—I am not in any way suggesting that that is what Mary Mulligan was proposing—we will fail. Dr Goudie mentioned the national data-sharing forum, which is such an important development in getting people together. All the local data-sharing partnership chairs are now in place and have been since June. We recognise that it is about getting people to work together and trust one another. The Executive's job is to provide the underpinnings that allow that to happen successfully.

12:15

Mrs Mulligan: In the evidence that we have received, we have been told that people are looking for guidance and encouragement. You are absolutely right that, when people work in the same office, they are more likely to be able to share information. However, we recognise that that is not always possible and that we need to ensure that there are other ways of passing on information while protecting the individuals who are involved.

You say that there are partnership chairs and so on in place. What is your end point? When will you be in a position to say that you have got all the supports and encouragements that you propose in place?

Paul Gray: At the risk of giving a glib answer, I have to say that I do not see an end point. I think that information sharing is something to which we will have to give continued attention and support. The Executive's role is to provide the leadership, the framework and the support to allow people to behave in that way. If, in five years' time, information sharing is confident, secure and trusted, our job will be simply to step back and maintain the underlying systems that we have provided. However, at this stage, we want to continue to encourage and nurture that atmosphere of confidence and trust. It is too early to predict when we should step back from that.

Mrs Mulligan: I have one other question, convener.

The Convener: We are pressed for time. I suggest that we put your question together with a question from Susan Deacon.

Mrs Mulligan: We have talked about co-location and sharing information. The other aspect of joint working is the sharing of responsibilities. There is an issue that arises with the joint approach because people coming from different backgrounds—for example, care workers, local authority officials and health service workers—might have different terms and conditions and pay rates. How can we bring about uniformity of terms and conditions in community planning, to ensure that we get the right person to do the job, no matter what their title is?

Susan Deacon (Edinburgh East and Musselburgh) (Lab): I apologise for missing the beginning of the session and part of the previous discussion on community planning. I am happy to be cut off at any point if I stray into the wrong area or repeat a question that was asked earlier.

I was late in getting here because, among other things, I was taking part in a local planning inquiry. In the course of that, I commented on community planning and the aims and expectations that people have regarding the community planning process. I was reminded of the challenges that are involved in making a reality of the public's expectations of the process. Different leadership skills and approaches are required by people who work for the various public services and agencies that are involved in community planning partnerships. In the case of local authorities, that includes the elected members who are involved.

I know that you have touched on this, but I am interested to know more about the role that the Executive might play in trying to build and develop the kind of leadership skills and capacity that are required in the partnerships to translate rhetoric into reality so that what the public sees, feels and touches lives up to the aspirations that the policy document sets out both nationally and locally.

Dr Goudie: I ask Paul Gray to comment on the first question. Mike Neilson might want to say something about engagement. I will then pick up Ms Deacon's question at the end.

Paul Gray: We are going to wrestle for a while yet with Mrs Mulligan's question about where the service delivery person comes from. That fact that people are employed by different employers creates different pay rates and terms and conditions. In the community health partnership context, we try to ensure that the skills and abilities of the individuals who contribute to delivering a service are properly recognised. Through the structures, we try to ensure that everyone feels that their contribution is properly valued.

We cannot escape from the fact that, up to a point, people define the value that is placed on them by the amount that they get paid. It is not the only factor, but it is certainly an important one, and we cannot ignore that. Through agenda for change in the health service, we have tried to ensure that jobs of equal weight are paid at an equal rate. The concern that, depending on where they come from, people might be recognised in different ways has come out through the feedback on the transforming public services work that ministers have been leading. I will not attempt to offer a panacea answer, except to say that we recognise the concern and that, in our work on joint outcomes, we are trying to ensure that everyone is appropriately recognised. To be honest, we must also ensure that we do not take advantage of people by asking them to do work that is outwith their skills or for which no training is available.

That begins to shade into Ms Deacon's question about leadership skills. For me, the issue is about the skills that are needed throughout the delivery chain and ensuring that appropriate attention is given to providing people with the necessary training and skills so that they can deliver effectively.

That is not a complete answer to the question and I would not pretend that it was.

Mike Neilson: I will stick to engagement. It is one stream of skills that needs to be developed—collaborative working is the other big one. The standards for community engagement that were developed by Communities Scotland have been used usefully across Scotland by community planning partnerships. Financial and other support has been given to almost all community planning partnerships to help them to apply those standards. There are good examples of where that has happened among a range of organisations to secure effective joined-up community engagement.

In community planning, there is an opportunity to engage people in their interests in a joined-up way, rather than having discrete streams of community engagement around particular silos. That is part of what the standards for community engagement and our work with community planning partnerships are intended to help. A range of activity is helping on the community engagement skills.

I refer in passing to the pretty intense debates about community engagement in planning. A consultation is currently taking place and planning is at the core. The debate will be followed up through best practice and guidance to secure early engagement in planning. That is different from community planning.

Dr Goudie: I want briefly to comment on the question of leadership, for no other reason than to say that ministers would argue strongly that leadership in public sector reform and the development of community planning are a crucial part of making progress and achieving our key objectives. It is a central issue.

I can mention two particular examples to illustrate the importance that we attach to leadership. First, the committee knows that we have established the Scottish Leadership Foundation. The committee has examined it in the past and agreed that it is an important development in building the skills and knowledge of our senior leaders. In response to some of the work that was done by Audit Scotland, we will put more resources into the foundation over the next three years because we regard it as fundamental. The signals that are sent from the top of organisations and senior leaders across the public sector are also fundamental.

The second example is also a very powerful instrument and demonstration of the importance of leadership. It is the bringing together of the Scottish government forum. The committee is probably aware that the permanent secretary was very concerned that he should demonstrate the ability of senior leaders to come together and talk about problems, and to develop a sense of common purpose and vision. The first meeting took place about a year ago and there will be a second meeting this week, with the intention of going beyond the sharing of the common purpose and vision and talking much more about the detailed way in which senior leaders can implement joint working. Again, that reinforces the point that the signals that are sent down from the leadership at the top of organisations are crucial, and getting the leaders together in the same room to explore that not only creates networks that allow others to step in behind and implement joint working, but sends important signals through their organisations and the whole system.

The Convener: I thank Dr Goudie and his team. That session has been very useful for the committee. There will probably be several points on which we will want to follow up and we will do that in writing once we have seen the *Official Report* of the meeting. I thank you for your time and look forward to your response when we issue our report.

12:27

Meeting suspended until 12:29 and thereafter continued in private until 12:34.

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