AUDIT COMMITTEE

Wednesday 12 September 2007

Session 3

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AUDIT COMMITTEE
3rd Meeting 2007, Session 3

CONVENER

*Charlie Gordon (Glasgow Cathcart) (Lab)

DEPUTY CONVENER

*Murdo Fraser (Mid Scotland and Fife) (Con)

COMMITTEE MEMBERS

*Willie Coffey (Kilmarnock and Loudoun) (SNP)
*Jim Hume (South of Scotland) (LD)
*Stuart McMillan (West of Scotland) (SNP)
*Mary Mulligan (Linlithgow) (Lab)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)
*Andrew Welsh (Angus) (SNP)

COMMITTEE SUBSTITUTES

Derek Brownlee (South of Scotland) (Con)
James Kelly (Glasgow Rutherglen) (Lab)
Iain Smith (North East Fife) (LD)
Sandra White (Glasgow) (SNP)

*attended

THE FOLLOWING ALSO ATTENDED:

Mr Robert Black (Auditor General for Scotland)
Antony Clark (Audit Scotland)
Caroline Gardner (Audit Scotland)
Barbara Hurst (Audit Scotland)
Jillian Matthew (Audit Scotland)
Claire Sweeney (Audit Scotland)

CLERK TO THE COMMITTEE

Tracey Reilly

SENIOR ASSISTANT CLERK

Joanna Hardy

ASSISTANT CLERK

Rebecca Lamb

LOCATION

Committee Room 5

Scottish Parliament

Audit Committee

Wednesday 12 September 2007

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

Decision on Taking Business in Private

The Convener (Charlie Gordon): Good morning, colleagues. I welcome the press and the public to the meeting. I also welcome the Auditor General for Scotland and his staff from Audit Scotland. I ask everyone in the room to ensure that their mobile phones and pagers are switched off. We have a full complement of members so there are no apologies.

Later, under agenda item 7, we will have an opportunity to discuss our approach to the Auditor General for Scotland's reports "Managing long-term conditions", "Primary care out-of-hours services" and "Dealing with offending by young people". We might discuss whether to undertake an inquiry into any of those reports and consider areas of interest, including which witnesses to call, if any, in the event of an inquiry. As members are aware from previous meetings, it is the norm to take such agenda items in private so that discussions about potential witnesses do not go into the public domain too early.

Are we agreed to take item 7 in private?

Members *indicated agreement*.

"Managing long-term conditions"

10:01

The Convener: Item 2 is the first of the reports that I mentioned. I invite the Auditor General to brief the committee on the report.

Mr Robert Black (Auditor General for Scotland): With your agreement, Barbara Hurst, who is our director of public reporting, will lead on the report.

Barbara Hurst (Audit Scotland): "Managing long-term conditions" is a joint report for the Auditor General and the Accounts Commission. The main focus of the work is on the way in which the national health service is developing community-based services for people with long-term or chronic conditions. We also considered the extent to which health and social care services for those people are joined up. To consider what is happening in more detail, we examined two tracer conditions: chronic obstructive pulmonary disease, or COPD as it is more commonly known, which includes chronic bronchitis, for example, and epilepsy. We chose those conditions because they are not widely researched, unlike diabetes or asthma, but information is available from the new general medical services contract for general practitioners. Where possible, however, we also took elements of good practice from other conditions and built those into the report.

We examined the management of long-term conditions because it is seen as the biggest health care challenge worldwide, so it is pretty significant. More than 1 million people in Scotland have at least one long-term condition and many have more than one. Not surprisingly, people with long-term conditions make the most use of hospital bed days—they account for about 60 per cent. The introduction of the policy to move services from acute to community settings and to provide integrated health and social care services gave us an opportunity to consider the incentives for that in the system, to examine what is happening on the ground, and to consider whether the policy is being rolled out throughout Scotland.

We found that better information is needed on the costs and effectiveness of services. Without that information, the sharing of good practice throughout Scotland will be limited. Specifically, we found that the Scottish Executive did not estimate the cost of implementing new models of care in its policy document "Delivering for Health". Locally, cost information is not collected consistently in different parts of the health service or between the health service and social care. The consistent collection of such information is important if we are to have more joined-up care.

We estimated the costs of health services for people with COPD to be just over £98.5 million. For epilepsy, we estimated the cost to be just under £38 million. Those are significant sums. However, we were unable to estimate the costs of social care in relation to those conditions.

As I said, we were concerned that very little work is done on the cost-effectiveness of services, which means that decisions on the use of resources are still being made with limited evidence about what works. The health service must improve on that. It must also get much better at sharing good practice and rolling it out more widely. We found a number of examples of good practice, such as epilepsy services in Forth valley and community rehabilitation services for people with COPD in Dundee and Glasgow. However, those were often down to the enthusiasm of local professionals rather than the result of a strategic approach.

We found that the move to provide more community-based care is mixed across the country. The picture looks quite good for people with diabetes and asthma, but it is far less well developed for other conditions. I will bring a number of key issues to the committee's attention. We found that community health partnerships were at different stages of development. Many were still addressing the key issues of governance and getting themselves going, so they were not yet key players in developing community services throughout the country. We found little, if any, real incentive to move resources from acute to community settings, with the exception of the quality and outcomes framework under the new general practitioner contract. We accept that it is not necessarily easy to move resources from hospitals into the community, but we expected to see more evidence of that happening.

The lack of access to comprehensive information on patients was seen by professionals as a barrier to joined-up care. There are some signs in the health services, such as the emergency care summary, that health professionals can now access information on patients, but it is not shared with social care professionals. That is a barrier to integrated health and social care.

Finally, and probably most important, we spoke to about 100 patients throughout Scotland. The message that came from them was clear. What they really want is better information, particularly at the time of diagnosis when they find it difficult to take in the full implications of their condition, and better support to enable them to be involved in managing their own care. It strikes us that it is not too difficult to fix that. We know that voluntary organisations produce a wealth of information, which could be made available to patients early on when they are diagnosed.

The study was quite a full one. We are happy to take any questions that the committee may have.

The Convener: Thank you. I throw the discussion open to committee members to ask questions and make comments on the factual issues identified in the report. I remind members that we will discuss what the committee will do with the report under agenda item 7.

Mary Mulligan (Linlithgow) (Lab): I understand that the quality of life of people with long-term conditions should be paramount, but let us talk figures. Was it possible to put a figure on the cost of treating someone in an emergency setting, when they have difficulties that require hospital or emergency out-of-hours treatment, as opposed to the cost of on-going community-based care, to see whether a saving could be made? If a saving was possible, who would make the decision? Barbara Hurst said that there was not much evidence of a transfer of resources from secondary to primary care. Who should lead on that work, analyse the various costs and decide whether such a transfer should take place?

Barbara Hurst: Those issues also exercised us during the study, so we commissioned a health economist to carry out quite an extensive piece of work on the costs of different services in different settings. The health economist examined whether savings could be made by moving services into the community as opposed to retaining hospital-based services. As a result, the report contains a number of detailed exhibits—in particular, exhibits 13 to 15—that try to break down the costs of treating people in different settings. However, I should issue a health warning about the figures, as they are estimates and it was quite a difficult exercise.

An interesting point is made in exhibit 18, on page 16, which shows the health economist's conclusions about the various types of treatment for people with COPD. Not surprisingly, stopping people smoking is the biggest saver for the health service. Of course, that does not necessarily come under the health service's budget. In Scotland, we are in a good position because the smoking ban should save money in the longer term. Indeed, it has been reported this week that the smoking ban is reducing people's risk of heart attacks.

However, some clear issues arise. We are not saying that we do not expect people to be admitted to hospital—of course there will be stages when people need to go into hospital—but it certainly looks like some services could lead to money being saved, such as pulmonary rehabilitation in the community. There is a fantastic example of that in Glasgow that both increases people's quality of life and should save money. We have taken the issue as far as we can in our report, but we think that the health service

has a responsibility to start doing those calculations.

On the second part of your question, which was about who should make the decisions, I think that it must be the health board, given that the health board controls both the acute and the community budgets. Presumably, many doctors—excluding the more forward-looking ones—do not want the money to shift from the hospitals budget into the community budget, but we feel that health boards need to take a far more strategic approach. Health boards need to work with social work to ensure that health is not considered separately from the social care that is provided.

I am sorry if that is a long-winded answer, but the issue is quite important.

Mary Mulligan: You mentioned that the CHPs are at various stages of development, with some more developed than others. Is there evidence to suggest that resource transfers are more likely to be possible where CHPs are more established? Can we be optimistic about the role that CHPs will play in that?

Barbara Hurst: We have to be optimistic that CHPs will play a key part. Places such as Tayside are getting on top of the issue by building in plans at CHP level that feed into the board's overall plan on the management of long-term conditions. We have some evidence of pretty good practice, but it has not yet been rolled out across the country.

Andrew Welsh (Angus) (SNP): If one fifth of the Scottish population are affected by a long-term condition, the report obviously highlights a massive problem. I note that the report states:

"However, decisions on the best use of resources are currently being made on limited evidence – there is little information … about the activity, cost and effectiveness of services for people with long-term conditions."

Why is that? How easy or difficult is it to obtain that information? In other words, who has the information and how do we get it if it is required for good decision making?

Barbara Hurst: Because the health service is so massive, there is a real risk that the service will just carry on treating people in the same way. To change that, we need to use the evidence and the knowledge of the professionals. As they have the patient's interests at heart, they are the people who are most likely to come up with new ways of providing services.

In our report we suggest that, if a new way of providing a service is introduced, we must look not only at whether patients are satisfied with it but at whether it reduces hospital admissions and whether its costs are equivalent to or less than having to admit patients to hospital and other such outcomes. Although a lot of innovation is going on, evaluation at the latter end of the process is not so good, and it is up to health boards to ensure that their pilot projects are properly evaluated. Indeed, the Scottish Government must also ensure that any good practice that is identified is rolled out.

10:15

Andrew Welsh: The report says:

"There is a need to … ensure that relevant staff have access to comprehensive information on people's health needs".

How can that happen if no accurate data exist?

Barbara Hurst: That question links to on-going discussions around access to patients' single health records. Mr Welsh will recall that the previous Audit Committee, of which he was a member, discussed our report on information management and technology in the health service, which highlighted the fact that progress in that area is still slow. Since then, measures such as the emergency care summary have been rolled out, but we still need to ensure that any individual who treats a patient—particularly one with on-going health needs—has access to their entire medical record. We are highlighting that point again to give some impetus to improving the situation.

Andrew Welsh: I have more questions, but I will let other folk in.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): As Barbara Hurst has made clear, the roll-out of good practice has been poor, which clearly poses a major problem for services such as the chronic obstructive pulmonary disease community service in Dundee, which has been running for six years and which, as exhibit 17 shows, has reduced the level of hospital admissions and GP and out-patient appointments. On the face of it, the service appears highly cost-effective. Why are the current mechanisms in NHS Quality Improvement Scotland and the Government's innovation division so ineffective in rolling out the best practice represented by the Dundee COPD service, the Forth valley epilepsy service and, indeed, the many other services that treat chronic conditions?

Related to that is the fact that if outcomes were audited effectively, health boards would know whether their services were working properly. Did the health boards that Audit Scotland reviewed carry out good audits of COPD services?

Barbara Hurst: On your first question, as NHS QIS evaluates against set standards, its role would have to be extended if it were charged with examining services and recommending the roll-out of best practice in other areas.

I know that the health directorates have a small team that helps boards to work on innovative practices, but given the current focus on waiting times, that team might not have the resources to take your proposal on board. That said, it is not beyond the wit of people in Scotland to find a more systematic way of rolling out some of that good practice and we hope that, by highlighting the issue in the report, boards will take it seriously. Indeed, the report contains a self-assessment tool that we expect all boards to check their own work against. That might help to get the discussion going.

As the study's project manager, Jillian Matthew has more detailed knowledge of what was going on in the boards, so I will ask her to answer your question about the COPD audits.

Jillian Matthew (Audit Scotland): I assume that the question is about clinical audits. We did not really examine clinical audits of COPD, as the issue was slightly outwith our remit. Instead, we examined the overall management of COPD services. As members will see, the effects differed from area to area.

As Barbara Hurst mentioned earlier, progress depended on enthusiastic individuals within the board—either community nurses or a consultant—taking matters forward and considering different ways of providing the services. Although there were enthusiastic individuals in other areas, they were not getting the permission or the funding to go ahead with the initiatives that they wanted. Therefore, it also depended partly on the view of the board about how to take matters forward.

Dr Simpson: The issue is more the existence of the clinical audit than the quality of it. Does it exist in every health board for, say, COPD? I would like to know whether someone is actually doing it, because there is no outcome audit in many areas.

I will take the totally different example of benzodiazepines, which first came out in 1963. The first report on adverse reactions to them was published in 1964, but it was not until 1990 that the profession decided that prescribing benzodiazepines might not be a good idea and that treatment needed to be more focused. The average period for such responses is getting shorter, although it took 35 years for us to ban the use of amphetamines for weight loss and all sorts of other things. It takes an inordinate amount of time for good practice to be adopted, and we need to find a mechanism for its better adoption.

The other question that I want to ask—if I may, convener, and then I will shut up—is about the major problem of the lack of both vertical and horizontal integration. Despite all the changes that the previous Administration tried to introduce, we still have a hospital sector and a community sector, and the degree of integration on a patient-focused basis is minimal.

In the case of the COPD service, in which there were many specialist nurses, what degree of integration was there with general practice so that the general, day-to-day management of the 4,120 patients on whom you reported was supported by professionals with a particular interest in primary care? When such numbers and such common conditions are involved, unless there is a degree of vertical integration and the primary care side is properly engaged, day-to-day management of patients will be difficult. Primary care will still pick up acute exacerbations, if not acute admissions, rather than become involved in day-to-day management.

Did you find any evidence in the COPD service of a horizontal integration with social work, benefits and housing—in other words, the management of the disability that a person faced? For example, adaptations in a person's house can be as important as almost anything else. To what degree were services functioning on a whole-patient basis as opposed to being the classic fractured, siloed services that we generally have, which just do not work for patients—or clients or whatever we want to call them?

Barbara Hurst: I will pick up on the last bit of your question and then hand over to Jillian Matthew to deal with vertical integration.

The honest answer is that we do not know whether the CHP can be a mechanism for horizontal integration. We could not get information from the social care end. Patients are not categorised in the same way for social care, so we could not track a patient through the system, although such tracking is crucial to joining up health services, social care, benefits and the community equipment that might be needed. In Scotland, we are at quite an early stage in the management of services for patients, because of the lack of shared ownership of the information that is held on individuals.

Jillian Matthew: The Dundee community service seemed to be fully integrated as far as we could tell. The nurses who treated the patients with COPD went round all the practices in Dundee. If anyone was picked up as having COPD, they were referred to those nurses as well as being supported by their GP. It was not a separate service; the GPs still saw those people in their practices, but they were supported by other staff as necessary. The patients could also be referred directly to a dietician or a physiotherapist, if required. The system seemed to work very well and the nurses were well accepted by the other staff.

Dr Simpson: So at the moment, there is a good vertical model, but a poor horizontal one in terms of development.

Jillian Matthew: It does not seem to have spread to the social work side.

Stuart McMillan (West of Scotland) (SNP): I return to Andrew Welsh's point about access to comprehensive information on people's health needs. I accept the requirement—and the need—to have more joined-up working, but my concern is that if any of the information on a patient's health record is factually incorrect and more staff gain access to it their future treatment could be prejudiced.

Barbara Hurst: It certainly would, if that happened. However, we cannot use bad cases to make judgments about how things should develop. If the patient has access to the record, there is no reason why they cannot try to ensure that their records are accurate. However, I take the point: accurate record keeping is crucial, particularly if the information is shared beyond the immediate, one-to-one relationship.

Stuart McMillan: I asked the question because I know of an individual who, over quite some time, has had many problems with their health board to do with the number of people who have access to their health record, to the extent that their health has been adversely affected.

The Convener: We have spent some time on the report, but I will let Andrew Welsh in if he puts his question briefly.

Andrew Welsh: When it comes to the availability of comprehensive information, how long will it take to introduce in a systematic way the required level of such information?

Barbara Hurst: Obviously, the area is complex. No health care system in the world has an all-singing, all-dancing patient information system. Certainly, we know of the serious difficulties that are being faced in England with the attempt to roll out such a system. In Scotland, a patient's heath record will not be presented as a single record, but as a set of linked records—a patient's test results will be linked up with their health record. That is the way in which the system would be built up.

Although I cannot give you a definite answer today, I can say that, on the back of our previous report on information management and technology, we are proposing to return to the subject to see what progress has been made.

Andrew Welsh: Obviously, the feasibility of solutions is a crucial factor in all of this. I note from the paper that

"national and local assessment tools are being developed"

and that

"Intensive care management approaches are still being developed and piloted".

Clearly, something is going on. Do we have any indication of how long it will take for those tools and approaches to be effective? What will the financing and cost consequences be? In other words, are calculations being made of the consequential budgetary effects of those decisions?

Barbara Hurst: I would like you to put that question to the Scottish Government health directorates. I am not in a position to know what they are doing to cost such models. However, in relation to such intensive care management, the aim is to ensure that resources are targeted at people who are most in need. Many people can manage their condition effectively themselves, with the aid of their general practitioner. The pilots are being undertaken to identify the small number of people who need much more complex care packages involving social care and health care. The number involved will be much smaller than 1 million, which is the number of people with a long-term condition.

Andrew Welsh: Thank you.

10:30

Mr Black: I will offer some general comments on why we think that the study is significant, as I sense that members might be coming to the end of their questions.

First, as Barbara Hurst mentioned, the study is significant because there is a lack of specific investigations into chronic obstructive pulmonary disease and epilepsy. That is important. Secondly, the incidence of those diseases in the community is growing. Linked to that is the huge resource commitment that is going into them, which will grow enormously over the next few years.

My third comment is a thought that I want to share with the committee. The whole thrust of thinking in the health service, and in social care generally, is around moving resources from acute settings to primary and community settings. What really comes out of the study, in which we have focused on a couple of conditions, is how difficult it is proving to move significant resources from acute settings into community settings. The department expects health boards to take responsibility for that, but we have not seen information about activity levels being joined up, or indeed about the resources that are being committed. We do not have the basic information that would allow that to happen.

We also find in the report that significant resource transfer is not taking place. That is scarcely surprising if we do not understand the level of activities and the costings that are in

place. The significant issue for the whole of public service is how we get out of this locked position. The study is pointing towards that—I would like to think persuasively—as one of the biggest challenges in the implementation of public policy over the next few years.

Dr Simpson: The most successful achievement has been in the area of mental health. We have largely closed the chronic mental health bins—the old asylums have all been closed. The problem for the first 20 years after the decision was made to make that shift was how to move people out of long-stay wards into the community when there were no community services. The only way in which that was achieved—as in the area of learning disability—was to get some of the community services up and running so that they were ready for the transfer. There have to be good innovative examples and then pump priming, so that people have a short period of transitional funding. That worked particularly well in learning disability—it has been hugely successful. The number of people with learning disability in long-stay wards is tiny. When I first started in the early 1970s, we had 1,800 beds in Forth valley; there are now 50. That is a staggering shift, but it was achieved by having services in the community, such as new housing.

The Convener: You raise a particularly interesting example, which I can relate to my own experience. I found initial resistance among my then constituents—I was in local government at the time—because they regarded the old services that were being closed down as being of higher quality than those of the old-fashioned social work day care model. Other issues, to do with the consumers of the services, also have to be taken into account.

Dr Simpson: Absolutely.

The Convener: We will have the opportunity for a broader discussion under item 7, which we will take in private.

"Primary care out-of-hours services"

10:33

The Convener: Item 3 is another report from the Auditor General for Scotland, on primary care out-of-hours services.

Caroline Gardner (Audit Scotland): I would like briefly to introduce the report to the committee, focusing first on the background, then on planning, cost and quality for the new contracts, and finally on their impacts and future sustainability. Members know that for most people, contact with the NHS begins and ends in primary care, usually during the working day. However, there are more than 1 million contacts with primary care out-of-hours services each year throughout Scotland, in the evenings, at weekends and on holidays. Those contacts affect mainly children, older people and, as we have just been discussing, people with long-term conditions, palliative care needs and mental health problems.

In 2004, a new GP contract was introduced, which aimed to address the increasing commitment to on-call services among GPs and the effect that that was having on recruitment and retention, among other matters. As part of that contract, GPs are able to opt out of providing 24-hour care for their patients. By December 2004, 95 per cent of practices in Scotland had opted out and responsibility for those services had passed to NHS boards.

The changed role of GPs is important, but it is not the only change affecting out-of-hours services in Scotland. There is also the development of NHS 24 as the first point of contact for out-of-hours services and the introduction of new contracts for consultants, nurses and other health professionals, pharmacists and other NHS staff. All that means that the context in which NHS boards plan and manage their out-of-hours services has changed significantly.

On cost and quality, it is important to be clear that it is not possible to make a like-for-like comparison of the cost of out-of-hours services before the introduction of the new contract and following its introduction. That is mainly because the cost of the previous system is unclear. Some payments were made directly to GPs, but GPs picked up some costs themselves within the broader payments to which they were entitled. We highlight in the report that in future the Scottish Government should produce detailed national cost models before implementing major schemes. Such information should be used to inform negotiations around pay deals.

On the effect on individual practices, those who opted out of providing out-of-hours care had their income reduced by 6 per cent—that is known as the clawback. There were often only limited alternatives in particular parts of Scotland in which GP practices opted out, which meant that NHS boards had to buy back, on a sessional basis, the services of the GPs who had opted out. There are no national rates for that work and health boards across Scotland have had to work hard to contain the rates that they pay to individual GPs. Overall, out-of-hours services cost NHS boards about £68 million in 2006-07. Costs are much higher in remote and rural areas because they have had to fund a much higher proportion of the services themselves.

On quality, NHS boards have largely met the NHS Quality Improvement Scotland standards, which is important. However, those standards tend to focus on the processes and policies that are in place rather than on the real impact of the quality of care that patients receive directly. We think that there is more to do to understand that.

The impact of the changes was greater on the more remote and rural boards. That is partly because their patients are more dispersed, but it is also because fewer GPs are available in those areas to provide out-of-hours services under the new arrangements. Generally, fewer GPs are working to provide out-of-hours services across Scotland, but the shortage is particularly acute in remote and rural areas. We think that there is a significant risk that out-of-hours services may become unsustainable in the future in those areas.

There is a downward trend in the number of GPs who want to contract back to provide out-of-hours care, which cannot be allowed to continue indefinitely. One answer must be for boards to consider different ways of providing out-of-hours services, for example linking more with NHS 24 and the Scottish Ambulance Service, and considering extended roles for other health professionals such as nurses and paramedics.

We think that better information is needed throughout Scotland about how staff are being used and how their roles are being developed. We found examples of good practice, but we do not know comprehensively what is happening. We think that the links with NHS 24 and the Ambulance Service must continue to be developed and rolled out to ensure that they are as effective as possible, and that people should understand how integration is working in their area.

As part of the study, we surveyed a large number of patients to get a sense of how the system is working for them. We were pleased to find that more than 80 per cent are satisfied with the services, right through from initial contact to receiving advice from a GP or a local out-of-hours treatment centre. We also surveyed all GPs in Scotland about the impact of the changes on them. Eighty-eight per cent of those who replied to our survey told us that they are relieved that they no longer have 24-hour responsibility for their patients. However, it is significant that only 11 per cent of those GPs felt that patient care had improved as a result.

I will leave it there, convener, but we will do our best to answer members' questions.

The Convener: Thank you.

This is another meaty report from Audit Scotland. I throw the floor open to members, but I remind them that our discussion of this report will take place under agenda item 7. I ask for questions and comments of a mainly factual nature, please, on issues around the report. We will start with the deputy convener, Murdo Fraser.

Murdo Fraser (Mid Scotland and Fife) (Con): Thank you, convener, and good morning. This is an important report that has serious messages for us. I have a couple of questions.

I will start with the comment with which Caroline Gardner finished, which was on the survey of GPs. Your finding that they feel positive about being able to opt out might be called stating the bleeding obvious; I think that we would all have imagined that that would be the case. What work is being done on considering value for money in the new GP contract? Obviously, that will tie in with the wider issue of how out-of-hours services are operating.

Caroline Gardner: I think that our report is the first significant piece of work that has looked at the impact of the contract in terms of cost and quality. It is difficult to make a judgment about value for money for two reasons. First, we do not have a good enough knowledge of the cost of the previous service to be able to make a comparison. Secondly, we are not collecting enough information about the quality of services—we do not have the performance information about how well patients' needs are being met, rather than simply whether the systems are in place, which is the focus of the NHS QIS work. One of the recommendations that we make in the report is that the health service should be doing more of that evaluation on a continuing basis, given how important out-of-hours services are to people across Scotland. We think that that matters.

A particular gap that we highlight is that, although the contract was clearly intended to focus on improving recruitment and retention, information on that is not now being collected centrally. A voluntary survey is done of the number of GPs and the number of vacancies, but there are no firm figures on whether recruitment and

retention have improved across Scotland. That is an example of why it is hard for the health directorates to be able to demonstrate that value for money is being achieved.

Murdo Fraser: Are you doing some work on the new GP contract?

Caroline Gardner: We have a study under way on the wider GMS contract, which takes in the GP contract but also examines the other changes that were intended to be brought about, such as the quality and outcomes framework.

Murdo Fraser: I want to pick up on what you said about current models of service delivery not being sustainable in the long term. The report makes a comment about the need for new ways of working. Were you able to identify the extent to which health boards are making progress on that? Are you satisfied that enough work is being done to get new ways of working into place?

Caroline Gardner: The situation is variable. Some boards faced such pressures in the first few years of the new contract that they had no choice but to put in place new models—NHS Borders is a good example of that. It has made significant advances in the number of salaried GPs that it employs, which gives it much more flexibility in the use of GPs across the area.

Similarly, in other parts of Scotland, there have been trials involving paramedics taking on wider roles in the treatment of patients outwith hospital settings, without bringing them into accident and emergency departments. That is another area in which more monitoring is needed nationally. We must examine what the different groups in the workforce are doing, evaluate what works best and roll out good practice.

Andrew Welsh: We are talking about massive and important changes in out-of-hours services, but the same problem arises of a fundamental lack of preparation. The lack of national data means that the overall impact of the change in the provision of out-of-hours services is not clear. We do not seem to have performance measures or baseline information. How doable is it to obtain such measures and information?

Caroline Gardner: We think that that can be done and, more important, that it must be done. If the declining trend in the number of GPs who want to contract back in to provide out-of-hours services continues, it simply will not be possible to keep on providing 24-hour care in the way that we now expect. We need better information about the ways in which health boards are developing their solutions to the problem so that we can identify good practice, and we need to know much more about patients' experience of out-of-hours services when they require to use them. Some of that information could be collected fairly readily, but a national, co-ordinated approach is necessary and there must be agreement on what the key bits of information are so that we do not create a mini-industry in its own right, which none of us wants to do.

Andrew Welsh: What you have said is common sense.

You believe that new ways of working are required, but is it acknowledged by the Scottish Government and NHS boards that such new ways of working exist? In other words, is there consensus about how such a joined-up system would work?

Caroline Gardner: Different solutions are emerging in different parts of Scotland. To some extent, that is entirely appropriate. What works in the Borders or the Highlands will not necessarily be appropriate in Glasgow. However, it is also fair to say that we are not doing enough evaluation to understand what works best and are not collecting enough information about changes in demand and the quality of service that is provided to allow us to make decisions for the future.

10:45

Mary Mulligan: We changed the system to try to acknowledge the pressures on recruitment and retention in rural and remote areas, but we are not able to say whether the change has made a difference. We hear anecdotally that it has not made a difference: the GPs who still provide the out-of-hours service still work 24/7, and those who do not are worried about how patients will be provided for. I am concerned that the change has not had the desired effect.

Recently I met GPs in West Lothian who spoke about the way in which their service is now being provided from a central venue. Rather than GPs going out to visit people in the middle of the night, people are asked to come to the central venue. Taxis are ordered to take them to the central venue and then away again. Do you know how much that service costs?

What additional costs have been placed on accident and emergency services and the Ambulance Service? There is a sense that people are not confident in the new, redesigned service and that they simply dial 999.

Caroline Gardner: I will answer the second part of your question and ask Claire Sweeney to answer the first part.

You are right to suggest that we were very interested to know whether the change had affected accident and emergency services, the Ambulance Service and NHS 24. The patterns in the three services appear to be different. We did not find any evidence of increased activity in

accident and emergency services as a result of the change to out-of-hours services. However, we noticed that demand for the Ambulance Service had risen quite significantly when the out-of-hours change was introduced. The Ambulance Service does not know why that it is. It is doing more analysis to try to understand what is going on—whether the increase is related to the change in the out-of-hours service, or whether it happened for quite different reasons.

The NHS 24 service had to roll out across Scotland much more quickly than had been planned as the change to the out-of-hours service came in. Evidence suggests that NHS 24 struggled a lot in the early stages, with long delays and high levels of call back. However, during 2006-07, the situation was brought well under control.

Overall, the evidence is mixed, but it all tends to reinforce the need to manage the system as one system rather than as single parts of one system.

Claire Sweeney will answer your question on the costs of local transport.

Claire Sweeney (Audit Scotland): We collected information from all boards in Scotland and then broke it down into issues such as patient transport services. As Caroline Gardner suggested, the boards provide the services in very different ways.

It is fair to say that it was expected that, because of the change to out-of-hours services, transport issues would lead to financial concerns and to concerns over how the services would be organised. As Mary Mulligan rightly said, many patients are now expected to travel to a centre rather than having someone go out to see them. However, from our detailed work with a sample of boards, that did not seem to have been quite the issue that people had expected it to be. Some areas had put transport services in place, but the services were not being used as much as had been expected.

In our report, we highlight the point that boards worked very hard at the beginning to try to maintain services for patients. Part of that work was consideration of how to address transport issues. The boards took a cautious approach, but the impact on transport has not been as great as they expected. When we did a survey of patients, we asked about transport and it did not come up as a key concern. People seem ready to travel to centres and they understand the need for that.

Mary Mulligan: That is interesting. We appreciate the value of a doctor's time, and we have to weigh that against the cost of the transport, but it is interesting that it does not seem to have been such an issue.

I have a quick supplementary question on NHS 24. We have spoken about recruitment and retention issues for rural and remote GPs. From discussions that I have had, it seems that NHS 24 is also experiencing difficulties with recruitment and retention—because of the workload that NHS 24 now has, and perhaps because of the pressure that is put on it by the media. Did you pick up on that?

Caroline Gardner: We did not examine NHS 24 directly, other than with respect to the pattern of demand that it has picked up as a result of the changes that have been made.

Dr Simpson: You referred to the links between different services. Some of the studies that were done in the late 1990s clearly demonstrated that up to 40 per cent of accident and emergency cases were more properly primary care matters. You found no increase in A and E cases, but did you find a shift the other way? Has there been a transmission of individuals into the correct service? I refer to linkages between NHS 24 and referrals to A and E or to out-of-hours primary care services. Did you detect anything of that sort?

Caroline Gardner: We did not test that directly. In fact, a full clinical audit would be required to do that. It is a fair assumption that having a single point of contact for out-of-hours services, through NHS 24, is likely to lead to better decisions for individual patients. They might be passed on to telephone advice and then triaged and passed through, or referred to an out-of-hours treatment centre or A and E if required. Having that single point of contact is likely to have improved the situation—although, as I said, we did not test that.

Dr Simpson: You said at the beginning that quality standards were broadly being met. However, exhibit 13 in your report seems to tell a slightly different story:

"No service has a full set of Key Performance Indicators in place".

You indicated that having key performance indicators is pretty important. Exhibit 13 goes on to mention that four NHS boards are working on that. One would have thought that, three years into the new service, some, if not all, key performance indicators should be in place by now. Did you get any indication from the NHS boards about how much of a priority that is for them?

Claire Sweeney: Understanding the scale of change that has taken place is one of the central issues. When we interviewed service managers, their reactions were quite telling. Following the introduction of the GP opt-out through the new contract, they had a sense of the boards being responsible and they were considering how to implement a safe service for patients. There was a lot of concern among the boards about how to

deal with that. As you would expect from such a situation, the focus was very much on maintaining the service.

I sense that the QIS standards, as they were initially developed, intended to reflect the context. Now, consideration needs to be given to the direct impact on patients. Clearer monitoring data are required on what is going on in the new service as it has been sustained so far. In addition, models have been changing over time.

Willie Coffey (Kilmarnock and Loudoun) (SNP): I have a couple of questions for Caroline Gardner about the public perception of the service. Page 27 of the report contains figures that show quite high levels of satisfaction—85 per cent of the 600 people asked were quite happy with their out-of-hours care service. I presume that that very high figure is higher than the previous figure.

The figure seems to contradict some of the experiences that I have heard about. Members of the public sometimes find themselves attending A and E for treatment and, for a number of reasons, they do not enjoy their experiences there. Judging by representations that have been made to me in the past, people have felt almost as if they were waiting to be served at a bank, although they might have turned up bruised and bleeding. They have ended up talking to people through the curtain of their cubicle, giving out their private and personal details. I am surprised that the report makes no mention of that aspect of the patient experience. Is there more detail available that could be shared?

Caroline Gardner: Yes. We have published a report supplement, which contains all the findings from the survey. We employed a market research firm to find 600 patients who had used out-of-hours services over the past year and to trace their experience from first contact to the end of the process. They were asked about the time that they had to wait, the attitude of the staff who dealt with them, the number of times that they had to give their name and address and what the problem was.

Although there were differences between groups of patients, depending on where they were being seen, we were surprised by how happy patients were, overall, with what they were getting. As with most public services, if we ask people how satisfied they are, surprisingly high levels of satisfaction come through. We did not pick up the sorts of concerns that you have mentioned from that large and statistically significant sample of people. Claire Sweeney might be able to add some colour to that.

Claire Sweeney: Given the high profile of the service, we hear regularly about cases in which it has not been satisfactory or from people who are not happy with the care that they have received. As Caroline Gardner said, we expected issues such as transportation to arise. If people had to travel to get somewhere, they were less likely to be happy with the care that they received. We also expected that patients having to get used to people other than GPs treating them would be an issue, but that did not come across in the survey. As Caroline Gardner said, we asked questions about the service from NHS 24 right the way through to accident and emergency; we asked how happy people were with every service with which they had come into contact. We found that the experiences were generally positive.

"Dealing with offending by young people"

10:55

The Convener: Agenda item 4 is the Auditor General for Scotland's report, "Dealing with offending by young people".

Mr Black: This report is on a complex and wide-ranging area of public policy that involves many agencies and budgets. I will introduce the report, but in answering your questions I will rely on Antony Clark, who ran the project, and David Pia, who is the director of public reporting.

The report is the third piece of work that Audit Scotland has done in the area of youth offending. We produced a report in 2002 and a follow-up report in 2003, both of which involved me and the Accounts Commission. The current report is a review of progress since the earlier reports were made to Parliament.

As committee members are fully aware, there has been a lot of activity in this area, such as initiatives, new legislation and programmes. We have tried to capture them in the report, but the world has moved on significantly since 2002.

The youth justice improvement programme, which was published towards the end of the term of the previous Administration, is interesting. Much of what is in it echoes earlier Executive policy commitments, recommendations by the previous Audit Committee in its 2003 report and recommendations in our report. That indicates just how intractable some of the problems are and the limited progress that has been made in securing effective implementation of policy in the area.

We had difficulty estimating how much is spent on dealing with youth offending in Scotland. Our best estimate is that funding increased from £235 million in 2000-01 to £336 million in 2005-06. We also concluded that the priority in policy terms that has been given to youth justice services in recent years has delivered positive changes, but it is still not possible to demonstrate clearly that the resources are providing value for money or that they are being used to best effect.

My remarks come under three broad headings: the first is national standards and programmes at Scotland level, the second is targets and the third is timeliness of reporting.

The introduction of the national standards has contributed to service improvements, but there are still significant weaknesses in the performance management arrangements and some important national targets have not been met. The national targets that were introduced in 2002 provided a clear set of guidelines and expectations for the work of the local youth justice strategy groups. In doing so, they strengthened the focus on youth justice across the partnership agencies involved, which helped to support improvements in integrated working. However, there has been no comprehensive national reporting on progress against the standards and there are significant gaps in the available performance information, which is a significant issue.

Some of the programmes and services for young people who offend, such as the restorative justice services, recognise the improvements and developments in policy in this area. Generally, partnership working has improved, mainly through the work of the youth justice strategy groups, but there is a widespread view—which we picked up in the study—that there needs to be a stronger emphasis on prevention and early intervention. As part of that, we found a significant need in many parts of Scotland for much better engagement of education and health services. That is a significant issue.

11:00

The achievement of the Scottish Executive's target to reduce the number of persistent young offenders in Scotland by 10 per cent was central to the national standards. However, the number of persistent young offenders rose by 19 per cent between 2003-04 and 2006-07, so the trend was in completely the wrong direction, unfortunately. Of course, as I am sure members are aware, the persistent young offender target was a narrow measure of service performance as it focused on one small group of young people within the youth justice system. We must recognise that.

I will comment briefly on some of the youth justice legislation. The introduction of antisocial behaviour orders for 12 to 15-year-olds has created tensions with other approaches to dealing with young offenders. It is not clear how far the Scottish Executive was able to consider the impact of the antisocial behaviour legislation on existing arrangements for dealing with offending by young people prior to the legislation's introduction. We have picked up evidence that many councils have found it quite difficult to strike a balance between the child-centred focus of the children's hearings system and the antisocial behaviour legislation, which is designed to protect and support communities.

There were significant improvements in the timeliness of police reporting in 2006-07. The Scottish Children's Reporter Administration received 85 per cent of offence-based police reports within the time standard of 14 calendar days. There have also been noticeable improvements in the times involved in reporter

decision making. Since 2002-03, the average time taken from the receipt of an offence-based referral by the reporter to a decision being reached by a children's hearing has fallen from 95 to 71 days, so it is pretty well at target.

However, despite a small improvement, the time taken for social work reporting remains unacceptably long. In 2006-07, only 48 per cent of offence-based social work reports were submitted to the reporter within the time standard, which was within 20 working days of request. The target is 75 per cent, so social work services are achieving 48 per cent against the target. That is a 16 per cent improvement since the baseline data were collected in 2003-04, but that small improvement takes place at a time of significant increases in the number of social work reports that are being requested, so social work services have a problem of volume, and are still falling well short of target.

There is a lot in the report and we will do our best to answer any questions that you have.

The Convener: Indeed. Once again, I throw the questioning open to members.

Andrew Welsh: Mr Black mentioned the problem of the different focus of antisocial behaviour orders as opposed to other approaches to dealing with young offenders. I ask him to expand on that. Does that difference in focus create problems between public services rather than being simply—or perhaps it is not simple—a difficulty for councils? How major a problem is it?

Mr Black: We are picking up the sense that it is a significant problem. The children's hearings system is focused on the consideration of the child's position and what needs to happen to help that child in their personal situation, whereas the antisocial behaviour legislation is geared much more towards the interests of the community whose quality of life is being affected by persistent young offenders. Therefore, there is a tension between the interests of housing departments in maintaining the quality of life in housing areas and the work of the children's hearings system. I am sure that Antony Clark will be able to expand on that.

Antony Clark (Audit Scotland): We identified the issue as being quite significant, but we also need to refer to another finding in the report, which is that the introduction of the national standards has improved partnership working. Yes, it was difficult for police, social work and other agencies when the antisocial behaviour legislation was introduced, but we found evidence of the difficulty being addressed by better partnership working at the local level. It is a problem, but it may be becoming less of a problem as new approaches become more embedded in the different agencies' working practices.

Andrew Welsh: There is a better line, then.

Antony Clark: Yes.

Jim Hume (South of Scotland) (LD): Mr Black mentioned that the number of persistent young offenders has gone up by 19 per cent. Is there a difference between offenders who go into penal institutions and those who are on community programmes? Is there a higher chance of them becoming persistent offenders if they interact with other young offenders?

Mr Black: It is important to bear in mind that we are talking about comparatively small numbers. Although a real problem exists in some parts of Scotland, throughout Scotland as a whole 1,400 youngsters are classified as persistent young offenders, which is 0.3 per cent of children aged eight to 16. Relatively small numbers of children have severe problems—it is important to consider the issue in that context. The study did not examine directly the issue that the member mentioned, but the team may be able to provide some information.

Antony Clark: Mr Black is right that we did not examine in detail the different trajectories of persistent young offenders, the services that they receive or the outcomes from those service interventions. One issue that we identify in the report is the need for much better information about which services are effective and lead to improved outcomes for young people, such as improved job opportunities and life chances.

Willie Coffey: Is there any evidence to suggest that the rising number of persistent young offenders is attributable to the influence and impact of community wardens on the ground liaising with young people and referring to various agencies, including the police, incidences of offenders in the community? I imagine that the wardens are bound to have had an effect on the figures. Although we think that such an unexpected turnaround in the figure is negative, it could be a result of the fact that community wardens have been playing the role that many of us expected them to play.

Mr Black: Mr Coffey's point is reasonable, but one of the key findings from the report is about the lack of good evaluation of the effectiveness of interventions. The fact that we cannot answer your question demonstrates that.

To take the discussion on slightly, I mentioned a moment ago that a comparatively small number of youngsters are persistent young offenders. Several factors influence that number, and it can be volatile for several reasons. For example, if a significant number of the persistent young offenders are 15 to 16-year-olds, they might enter the adult justice system fairly soon. Their offending pattern might not change, but the number of

persistent young offenders will reduce. Another factor that may be significant is that, given that the target is an important national one, local agencies, through partnership working, will have put extra resources into achieving it. In this study and in others, we have found that, if one is considering an issue more intently, the number of reported incidents often goes up. That effect might influence the number. As we are talking about a small number in the first instance, we can understand why the figure is volatile.

Fundamentally, we need better local evaluation of the interaction of all the programmes. That cannot be done through a national evaluation study; it must be done locally.

Antony Clark may have something to add.

Antony Clark: Mr Coffey's main point is picked up in the report, which points out that the increased resources that are being put into community wardens and other measures are likely to lead to increased detection.

Andrew Welsh: Mr Black mentioned the time taken for social work reporting, which remains unacceptably long. Will you explore that comment further? Is there only a volume problem, or are there implied resource and staffing problems?

Mr Black: The number of social workers has increased significantly in recent years—we report the numbers in part 5 of the report. The number of filled posts has increased by almost 40 per cent since 2000, which is getting on for 500 extra social workers. However, I have two points on that. First, although the number of social workers has increased significantly, many of them are comparatively young and inexperienced. One issue that we raise in the report is whether a challenge exists for social work authorities to provide the relatively new staff with the support and guidance that they need to be effective. Clearly, the staff will be more effective if they are part of good teamworking between the agencies.

My second point is to reflect the growing volume of activity that social workers are expected to undertake. As I mentioned a moment ago, time standards are not being observed as the volume of work that they are expected to undertake increases. The Association of Directors of Social Work is not terribly comfortable with the time target. I understand that the association's view is that, unlike the police, social workers need to engage to a much greater extent with the young person and their family circumstances before they make their report, which takes time and effort, so it is more difficult for social workers to control how long such cases take to process. Mr Welsh points to the need for social workers to develop much better management information so that managers have a handle on what is happening at the local level.

Antony Clark: I agree with Mr Black. At paragraph 79 of the report, I highlight a couple of points that we received from the Social Work Inspection Agency concerning social work practice. The agency highlighted a number of difficulties with some of the management practices in social work departments, around quality of assessments and supervision. That might have a bearing on the timings of social work reporting.

The Convener: Allow me to pursue the operational implications of what you say. I know of experiments in which social workers have been deployed in schools to liaise with guidance staff, who are often the first to pick up that young people are in trouble. Could that type of operational practice impact on timeous reporting?

Antony Clark: I am sorry to say that the way in which we approached the study was to follow up on the recommendations that we made in previous reports. No recommendation focused on the area that you mention, so we did not look at it in great detail as part of the study. However, it is an interesting question, and I am sure that the Social Work Inspection Agency will want to pick up on it if it follows up on such issues in the future.

Mr Black: As I might have mentioned earlier, the general issue on which we comment in the report is the need in many of the local partnership areas for education and health authorities to engage more positively with the problem, not least for the reason that the convener outlined.

Dr Simpson: I was struck by the variation in the number of offence referrals as opposed to the number of care and protection referrals shown in exhibit 15, which is referred to in paragraph 65. You say that you do not know why there is major variation, but when I see such huge variation a light bulb immediately goes off in my head and I want to know what is going on. I wonder whether the variation is linked to the Tayside pre-referral screening group that is mentioned in the first paragraph of exhibit 16. Does that group account for the fact that overall referrals in Tayside appear to be much lower? Can you add any colour to that? Although it is clear in your report that you could not draw any conclusions, it is an interesting area to follow up.

Antony Clark: It is an enormously interesting area to follow up, and an issue that has been around for some time. In the report, we talk about the Scottish Executive's commitment to what it calls the getting it right for every child agenda, which is based on the review of the children's hearings system. The review was designed to make effective use of the children's hearings system to ensure that children are referred to the system only when it is the most appropriate avenue for them to follow.

I suspect that the variation in referral rates reflects differences in police practices. Although I do not want to be too categorical, it is possible that the good practice in Tayside reflects the effective joint working in that area. Picking up on the points in the previous reports that the committee has discussed, sharing good practice and absorbing it throughout the system in different parts of the country apply equally to youth justice as to out-of-hours services and long-term conditions. There is an issue here about understanding the good practice of partnership working and ensuring that resources are targeted effectively.

Dr Simpson: That is helpful. I have heard anecdotally from the police that when they make referrals to the hearings system, they bounce straight back. Although they make more referrals, nothing happens and the process just goes round another wheel. It is the same wheel that is used for older people, even though the outcome is not a custodial sentence.

The Convener: At this stage, we will have a five-minute comfort stop.

11:14

Meeting suspended.

11:22

On resuming—

"Relocation of Scottish Executive departments, agencies and NDPBs"

The Convener: Under item 5, the committee will consider a response from the Scottish Government to the previous Audit Committee's report entitled "Relocation of Scottish Executive departments, agencies and NDPBs".

Tracey Reilly (Clerk): The item is on the agenda to allow members to consider the Scottish Government's response to the report that was published by the previous Audit Committee. Its purpose is to invite comments from members and Audit Scotland and to allow the committee to reach agreement on any action that it wants to take.

I draw members' attention to one aspect of the report. On page 15 of the Government's response, which is contained in paper AU/S3/07/3/4, the use of written authorities is discussed. The Government agreed that, when the committee and the Auditor General receive a written authority, it should be

"accompanied by an explanation from the Accountable Officer of his grounds for requesting a written authority."

Recently, we received a written authority relating to prisons from the Scottish Prison Service, but it appears that we did not receive an accompanying explanation. Therefore, with the committee's permission, I will write back and follow up that matter.

The Convener: We should agree to that, as a new procedure was recently agreed. We might as well try to enforce it from day one.

Andrew Welsh: I have a question.

The Convener: Is it on the broader issue?

Andrew Welsh: Yes. I am happy that the Executive agreed with the committee about certain things, but its replies tend not to say terribly much, although they can be beautifully written. For example, on page 1 of its reply, it states in response to paragraph 27 of the committee's report:

"There is potential to improve the definition of success … This is being taken forward through the development of a consistent evaluation framework for all relocations."

No timescale is given. It is good that action is being taken, but it would help if a timescale for implementation of that framework were attached.

Paragraph 47 of the committee's report recommended that

"Where relocation is pursued despite higher redundancy costs, the reasons for this must be clearly articulated."

The Executive agreed with that, but I look forward to hearing such reasons. There was an earlier example of our not getting the explanation that we asked for.

In paragraph 50, the committee said:

"It is unacceptable that the Executive has failed to give a clear explanation of the reasons behind each choice of location, despite giving an undertaking to Parliament to do so."

The Executive rejects that conclusion and states:

"The Executive has set out a clear explanation of all location decisions in line with its commitment to Parliament."

Has it? Where is the explanation? I would like to be enlightened on that point. We get beautifully sculpted, well-written documents, but they do not always take us forward. We are seeking action on these matters.

The Convener: Are you suggesting that Sir Humphrey lives on, even in post-devolution Scotland?

Andrew Welsh: No, convener—I would not dare.

Murdo Fraser: I am in general agreement with the points that Andrew Welsh has made. There are a number of ways in which the Executive response is unsatisfactory. In particular, there is a lack of suitably robust evidence and reasoning that would make its rejection of some of the committee's recommendations stack up. However, is it worth the committee spending a lot of time pursuing the matter, given that there has been a change in Administration since the response was produced, and given that there may be a change in relocation policy? I understand that the Finance Committee is looking at the issue. If we decided to pursue it, would we not be duplicating what is happening elsewhere?

The Convener: Your last point is very apposite. Andrew Welsh is the convener of the Finance Committee. Given that that committee intends to consider the issue on a six-monthly basis, I assume that Andrew Welsh is not proposing that the Audit Committee should do any more than note it at this stage.

Andrew Welsh: I was raising a general issue that we have come across time and again. We all seek sharper government—action and clearly defined goals. We have seen in previous reports what a lack of such goals can lead to. I have always had a general problem with Executive responses. I would like carefully thought-through recommendations to be seen to be acted on or for us to be given a clear statement of why that cannot happen. Government should be about action.

The Convener: As members have nothing further to say, I ask the Auditor General to comment.

Mr Black: Thank you for that opportunity, convener, but I have nothing to add.

The Convener: The issues that have arisen will clearly be pursued in another place, not least by Andrew Welsh. At this stage, we will note the report.

Andrew Welsh: Thank you, convener.

"Community planning: an initial review"

11:28

The Convener: The next item on our agenda is consideration of a response from the Scottish Government to the previous Audit Committee's second report of 2007, on "Community planning: an initial review".

Willie Coffey: My experience over the past few years at local authority level, in East Ayrshire Council, has been that many of the documents relating to community planning, especially what we call regeneration outcome agreements, are very challenging and hard to understand. Many of them focus on the outputs that the local authority hopes to deliver, rather than on the outcomes that we hope it will achieve. Sometimes there is confusion between the two at local authority level. In any ROA, targets and outputs are set out clearly, but that tells us nothing about how effective and successful implementation has been. We must seek more clarity at local authority level and ask councils to do more work on outcomes, benefits and impact, rather than outputs.

The Convener: Your point is well made. I am smiling at Mary Mulligan, because I remember a huge meeting with community representatives, when she was Deputy Minister for Communities and I was leader of Glasgow City Council, at which we tried to persuade people to become involved in the wonderful world of community planning in Glasgow. I will not say how I think people are getting on, but some documents and processes are bound to be challenging, in particular for community representatives.

11:30

Andrew Welsh: I have similar problems with the response. In paragraph 42 of its report, the committee said:

"The move towards an outcome-based approach is overdue."

The Executive has not accepted that, but its response to paragraph 42 contains phrases such as "moving towards", "work is in hand", "we intend to", "we are currently developing", "hope to implement shortly", and "working … to explore". The word "developing" is used twice. The committee said that the approach is "overdue"—in other words, it thought that something should have been done. However, the response talks about intentions and work in progress. It does not say when an outcome-based approach will be in place, although "overdue" carries a sense of urgency. When will an outcome-based approach be implemented? I would be happier if the response had given a timescale for action.

Mary Mulligan: I am encouraged to comment by the convener's remarks—

The Convener: You rose to the bait.

Mary Mulligan: I remember that meeting vividly. Our views on community planning were well received in Glasgow.

I agree completely with Willie Coffey and Andrew Welsh. We should look for outcomes, and timescales should be attached to work in progress. I was involved in the production of the previous Audit Committee's report, and committee members were encouraged by the people involved in community planning who came to speak to us. There is a lot of optimism about what can be done and we have talked a lot about how interagency working can improve services for people in our communities. I am a little less encouraged by what the Executive's response tells us about how it supports the work that is going on in communities. I would have liked a more positive response.

However, as we said during our discussion under the previous item, there has been a change in Administration and I am interested in what progress will be made. I am not sure that the committee would derive any benefit from responding to what is now an out-of-date response. I hope that the Audit Committee will keep the issue on its agenda, because in future we might want to consider what progress has been made, in particular on the two issues that have been raised, but also on support for community planning in general.

The Convener: I might regret having provoked Mary Mulligan into commenting, because she appears to have provoked other members into re-entering the discussion.

Dr Simpson: I do not disagree with members' comments about the need to move to an outcome-based approach—there is clearly such a need. However, I make two cautionary points. First, if the outcomes do not emerge from people's normal work—in other words, if trying to determine what happens represents an additional load—a whole new level of audit must be put in place. Unless information systems are robust and continue to be so, so that outcomes emerge from people's processes, it is difficult to identify outcomes.

Secondly, I am disturbed by the lack of prioritisation in the seven bullet points in the response to paragraph 42, all of which refer to development, discussion and exploration. According to the response, a range of high-level outcome options are being explored with ministers

"to inform their choices for the forthcoming Strategic Spending Review",

but it does not say what stage those explorations have reached. I would have thought that the information should be published by now—perhaps it has been. We should be getting it now. It is the only response that has a date on it, and we should be seeing the work now. It should be being explored and open for discussion now, and the other points should be prioritised.

Stuart McMillan: Page 6 of the response refers to the recommendation in paragraph 18 of our report to

"reduce the number of reports that community planning partners need to make to different Executive Departments."

I take that to mean cutting down some of the bureaucracy. The Executive response states:

"Progress is being made across the Executive and we will report this to the incoming administration."

If there has been a report, I would be keen to find out what it says and what progress has been made.

Andrew Welsh: Let me say to Mary Mulligan that it is a new Administration but they are the same civil service advisers.

The Convener: You are not getting your excuses in, are you?

Andrew Welsh: Yes.

At paragraph 18(2) of our report, we said that the Executive should

"build skills and capacity among staff to better support those organisations tasked with delivering services".

The Executive has agreed with that, but it says only that there are training programmes for staff in developing and implementing public policy and that

"Further work is under way"

on a

"project to clarify the skills required for Policy Delivery and to embed them in the annual Performance Appraisal process."

The Executive also refers to

"the Scottish Leadership Foundation to deliver a joint programme of Change Management training",

which is great, but elsewhere we are told about a lack of statistical evidence on which to base policy and programme decisions.

In other words, we are about to get the skills but the information is not there. We all want to see joined-up government. Although the Executive has agreed with the committee's point of view, I do not see any implementation of that agreement, and I am concerned about the gap. It is good to see that training is being done, but the civil service can act only on the basis of accurate information.

The Convener: The points are all very well made, and we will decide on them in a moment or two. If there are no more points from members, I will ask Mr Black to comment.

Mr Black: I have just a quick comment that might be helpful. The original Audit Scotland report was an ambitious piece of work, as some committee members might recall, and the committee took extensive evidence. It is at least encouraging that the Executive has responded to the recommendations.

The report was difficult to produce because we found it so difficult to answer the basic question: what impact is community planning having on the quality of services that people receive? The answer was that we could find little evidence at that stage, in part due to the fact that community planning is at an early stage. However, we have given a commitment that we will revisit it at some point in the future, and the Accounts Commission has signed up to that as well. We will need to get a clear focus on what impact community planning is having on the quality of services that people receive. We will do our best, but I suspect that it will not be easy, for all the usual reasons about the quality of available information.

The Convener: Colleagues, there are three options open to us: we could note the response; we could correspond with the Government or Executive on the issues that members have raised; or we could request an update, which does not apply in this instance. Do members want to note the report, having heard Mr Black say that he and the Accounts Commission will revisit the subject at some point in the future? Alternatively, do we want to raise particular queries in the form of a letter signed off by me on the committee's behalf?

Andrew Welsh: I have not raised the issues lightly, nor was I making an attack of any kind on the civil service. I raised specific points about good government and the response to the committee's well-thought-through report, based on research and findings by Audit Scotland. In the end, what we share with the Executive and civil service is that we want to deliver for the people of Scotland, and I would like a response on the specific points about how that will come about.

The Convener: Fair enough. I do not think that the committee should divide on whether to note the response or raise some points in correspondence. All the points that members have made—there may be others—will be written up by the clerks and we will draft a letter that I will send on the committee's behalf. Are members happy with that?

Members *indicated agreement*.

The Convener: Item 7 is consideration of our approach to the various reports. As we decided at the beginning of the meeting, we will move into private session for this item, so I ask the press and public to withdraw.

11:40

Meeting continued in private until 11:55

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