AUDIT COMMITTEE

Wednesday 24 September 2008

Session 3

£5.00

Produced and published in Scotland on behalf of the Scottish Parliamentary Corporate Body by RR Donnelley.

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AUDIT COMMITTEE
13th Meeting 2008, Session 3

CONVENER

*Hugh Henry (Paisley South) (Lab)

DEPUTY CONVENER

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

COMMITTEE MEMBERS

*Willie Coffey (Kilmarnock and Loudoun) (SNP)
*George Foulkes (Lothians) (Lab)
Charlie Gordon (Glasgow Cathcart) (Lab)
*Stuart McMillan (West of Scotland) (SNP)
Nicol Stephen (Aberdeen South) (LD)
*Andrew Welsh (Angus) (SNP)

COMMITTEE SUBSTITUTES

Derek Brownlee (South of Scotland) (Con)
James Kelly (Glasgow Rutherglen) (Lab)
*John Farquhar Munro (Ross, Skye and Inverness West) (LD)
Sandra White (Glasgow) (SNP)

*attended

THE FOLLOWING ALSO ATTENDED:

Mr Robert Black (Auditor General for Scotland)
Nick Hex (Audit Scotland)
Barbara Hurst (Audit Scotland)

CLERK TO THE COMMITTEE

Tracey Reilly

SENIOR ASSISTANT CLERK

Joanna Hardy

ASSISTANT CLERK

Rebecca Lamb

LOCATION

Committee Room 2

Scottish Parliament

Audit Committee

Wednesday 24 September 2008

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

Interests

The Convener (Hugh Henry): Good morning, and welcome to the Audit Committee's 13th meeting in 2008. I welcome members of the public and press and the representatives of Audit Scotland. I ask everyone to ensure that mobile phones are switched off. I have received apologies from Nicol Stephen and Charlie Gordon. I welcome John Farquhar Munro, who is here as a substitute for Nicol Stephen, and I invite him to declare any interests.

John Farquhar Munro (Ross, Skye and Inverness West) (LD): I have no interests to declare. The only thing is that I will have to leave at 11 o'clock, because I have another meeting arranged.

The Convener: Thank you for that notice.

Section 23 Report

"Day surgery in Scotland—reviewing progress"

The Convener: The next agenda item is a briefing from the Auditor General for Scotland on "Day surgery in Scotland—reviewing progress".

Mr Robert Black (Auditor General for Scotland): Barbara Hurst, who led on the project, will introduce the item.

Barbara Hurst (Audit Scotland): Over the years, we have carried out several reviews of day surgery. The most recent short follow-up review compares progress against the targets that we have considered previously, which are for 19 procedures that are widely accepted as suitable to be carried out as day surgery. The targets were set 10 years ago and the procedures include cataract removal, internal investigative procedures and keyhole surgery. The procedures represent about 30 per cent of all surgical procedures, so we think that they are a fair representation of performance against day surgery targets.

Given medical advances, some of the procedures can now be carried out in out-patient settings. In the report, we have combined the data on day surgery and out-patient activity, which is known as same-day care. For the purposes of the review, we analysed national published information that was based on the national health service board of treatment. Exhibit 1 on page 3 outlines the benefits to patients and the health service of using day surgery or same-day care as the norm for appropriate procedures. Obviously, some patients have a range of health conditions and may still need to be treated on an in-patient basis. Equally, some complex operations will continue to be done on an in-patient basis.

I come to our findings. First, there is evidence of progress throughout Scotland as a whole, with the rates of same-day care continuing to increase for most procedures. The 1998 targets were achieved for 10 of the 19 procedures, compared with just seven in 2002-03. That is shown in exhibit 3 on page 7. However, Scotland still tends to have lower rates than those in England, which suggests that there is room for continuing improvement. Secondly, all boards have improved, but there continues to be wide variation among boards. That is shown in the exhibits on pages 8 and 9 and in appendix 2. For example, Dumfries and Galloway NHS Board carries out almost 100 per cent of cataract removals as same-day care, which is the highest figure in Scotland, but it performs less well on the target for arthroscopy. It is not that any one board is brilliant at everything; there are obviously differences between specialties.

A national target that 75 per cent of planned operations should be carried out as same-day care has recently been introduced. Using the health service's own estimates for the cost of an overnight stay in hospital, we have calculated that it could free up around £8 million of resources per year if it achieved that target.

It is good to see that the health directorates have taken a far more active approach over the past two years to encourage greater use of same-day care. They have introduced a directory outlining more procedures for which same-day care is appropriate and have carried out detailed work on setting case-mix adjusted targets for wards.

Appendix 3 gives some information about the work that boards have been doing, which shows that Fife NHS Board continues to be the best-performing board, irrespective of the way in which performance is measured.

We continue to have concerns about the limited recording of out-patient activity. We first highlighted that in a report on out-patients back in 2003. This is not about collecting information for the sake of it: if medical advances are leading to different ways of delivering services, how we collect management information needs to keep pace with those changes. At the moment, that looks as if it is in danger of lagging behind, because we are not getting a good picture of what is happening with out-patients.

As ever, we are happy to take any questions that the committee has.

The Convener: You said that Fife NHS Board is consistently up there in terms of performance. Is it doing anything obvious that the others could copy?

Barbara Hurst: We did not go into individual health boards to investigate what was happening on the ground; we just carried out a data analysis exercise. However, the factors that emerged from previous audits were how boards organised their day-case unit and operating list and whether the clinicians were willing to carry out day surgery. For Fife's performance to be what it is, all those things must be operating better there than they are elsewhere.

Murdo Fraser (Mid Scotland and Fife) (Con): I was very interested in what you had to say about the cost savings to the NHS of increased same-day care. I was also intrigued by exhibit 8, which shows a comparison between rates in Scotland and rates in England. There are substantially better rates in certain procedures in England, such as the treatment of hernias, varicose vein stripping or bunion operations. It is difficult to tell from the graph exactly what the percentages are, but it is clear that there are substantial differences and that England is well ahead of us. Were you able to detect any reason why Scotland does not perform as well as England does in terms of the number of same-day care cases?

Barbara Hurst: We think that there are probably two reasons for that, although there may well be others. England started looking at the issue earlier and was more active in promoting day surgery in the past. We think that day surgery was targeted in England because there are significantly fewer hospital beds in England than there are in Scotland, Wales or Northern Ireland.

Murdo Fraser: That is interesting. You managed to put a figure of £8 million on the potential savings to the NHS if the target of 75 per cent of procedures being carried out as same-day cases was achieved. Did you consider what cost savings could be made if we achieved the same rates as are being achieved in England?

Barbara Hurst: No, but that would have been an interesting analysis.

Murdo Fraser: You would not like to speculate on what the ball-park figure might be.

Barbara Hurst: Absolutely not. Next time round, we will try to do the analysis that you suggest.

Andrew Welsh (Angus) (SNP): The summary of the report states:

"In 2006/07, the 1998 targets were achieved for ten of the basket of 19 procedures across Scotland."

It has taken about 10 years to achieve about half the targets. Were the 1998 targets unrealistic? How were they arrived at? What criteria were used? Why is NHS Tayside so far behind the other boards?

Barbara Hurst: The procedures that were chosen for the targets came through a detailed piece of work that the Audit Commission in England did with the British Association of Day Surgery. That work was comprehensively consulted on and the discussions ensured that there was buy-in from the clinicians in relation to the procedures being the appropriate ones. The targets were reached in the same way.

I may have missed a question. If I have, please tell me.

NHS Tayside was one of the poorer-performing boards back in 2002-03. We have had discussions with the board about that. In its view, its performance measurement may be being skewed because it does not include the number of patients who are sent to Stracathro hospital. As I said in my opening remarks, the data are based on the board of treatment, so we have not included Stracathro hospital or the Golden Jubilee hospital. All boards send patients to either of those hospitals in order to meet their waiting times targets.

We are quite pleased that, following the discussions that we have had with NHS Tayside, the board is actively considering whether part of the reason for its apparent poor performance is the fact that it is not submitting the correct information. We think that that is a good exercise for it to go through. The real difficulty is with out-patient activity. If the right figures for that activity are not collected, it might look as though the board is performing less well.

NHS Tayside also argued that it had to deal with more complicated cases. However, appendix 3 of the report, which shows the case-mix adjusted targets, makes it clear that the board still has a long way to go. It needs to start looking at how it carries out day surgery and same-day care.

Andrew Welsh: I will encourage it so to do.

On the subject of comparisons with England, the report says that NHS boards should

"establish where same-day case rates are low and take action as appropriate."

What kind of action?

Barbara Hurst: Sorry, where is that?

Andrew Welsh: On page 10, the recommendation is:

"NHS boards should monitor the levels of same-day surgery by hospital and specialty, establish where same-day case rates are low and take action as appropriate."

What action?

Barbara Hurst: Boards should analyse whether people are being treated on an in-patient basis when they could be treated on a day basis. Also, they should work with their consultants to increase the rate of same-day care.

Andrew Welsh: That seems easy, straightforward and common sense—if it is done.

George Foulkes (Lothians) (Lab): This is another fascinating report from Audit Scotland. I read it on the train, on the way back from an exciting visit to Manchester, and I was enthused to see not the comparisons with England, but the differentials within Scotland. Having read it carefully, I believe that it raises a big question that it does not answer: why do those differentials exist? NHS Fife achieved 83 per cent of its targets for same-day care, whereas NHS Tayside achieved only 29 per cent—there is a huge differential, yet those health boards are next door to each other and a lot of their indicators are significantly similar.

It occurs to me that there might be two reasons for such differentials. One might be the clinical expertise of the consultants or registrars who deal with cases. The medics would need to examine that, and it could be a delicate matter. The other possible reason, to which Barbara Hurst has alluded, is the structure of the organisation and the way in which it deals with the throughput—whether it can get more patients through. However, all the recommendations are about improving the information system and monitoring. If we want to do something about the situation, I wonder whether one of the recommendations should be that we undertake a further study to find out why the differentials exist.

10:15

Barbara Hurst: I accept your point that the report simply analyses the detail without getting underneath it.

The health directorates are doing a lot of work on encouraging boards to look at the matter actively and increase the rates of same-day care. However, your point about the expertise of medical staff is totally outside the area that we can comment on. In any case, I suspect that that is not the issue, because the procedures in question are fairly standard. It is much more likely that the issue is to do with organisation in hospitals and willingness to carry out such procedures under same-day care rather than under in-patient care.

Boards have many opportunities to influence the increase in same-day care rates. For example, under the consultant contract, all consultants must have agreed job plans, and boards could legitimately work with their consultants through those plans to increase the rates.

George Foulkes: That is very helpful. I know that we will consider ways of following up the report under our final agenda item.

I have to say that I would not completely rule out the possibility of differences between clinicians. I might be straying into hearsay, but in Ayrshire there was a lot of belief—I think that that is the word I am looking for—that while one of the orthopaedic surgeons was very expert and could get through a lot of work quickly the other, who had been around for a long time, struggled a bit and took a lot longer over his work. Of course, I realise that that issue is more difficult to examine.

Should we also look at the various structures? In previous meetings, we have discussed NHS Lothian's work with GE Healthcare Ltd on—

Barbara Hurst: I think that it is called kaizen.

George Foulkes: That is right. I wonder whether NHS Fife has some structure, procedure or way of working that is more efficient and effective than that in Tayside and which we might be able to examine and include in our recommendations.

Mr Black: Barbara Hurst will remind me of the details, but in our main report on day surgery, which was published some years ago, we were quite struck by the fact that for some interventions there was no relationship involving sparsity and highly populated areas and found it quite remarkable that boards such as Highland were doing quite well in one or two interventions.

It is important for the health boards to grasp the issue. As Barbara Hurst rightly emphasised, the new consultant contract provides an opportunity for health boards to use their clinical strategies to question in a supportive though challenging way established clinical practice and to set it alongside performance in other parts of Scotland to see whether it can be moved on. I am reasonably optimistic that the situation will continue to improve, although I do not know whether that improvement will be rapid enough.

I should also point out that it is up to clinical directors, supported by bodies such as NHS Quality Improvement Scotland that consider clinical standards, to take up some of this work and drive it forward. After all, if one NHS board is doing significantly better than others on the high-level numbers, the other boards should be addressing the issue themselves without Audit Scotland having to use its scarce resources to support them. That said, I absolutely agree that the issues raised by Lord Foulkes should not be simply left here.

George Foulkes: That is very helpful.

Willie Coffey (Kilmarnock and Loudoun) (SNP): In a nice contrast to where George Foulkes read the report, I read it on an exciting train journey to Glenrothes.

I want to ask about the BADS information system to which you refer in the report. It says clearly on page 5 that the health directorates introduced the system two or so years ago, but on page 15, it says that not all NHS boards have adopted it yet. Why is that the case if the system was introduced two years ago? What was boards' problem with adopting the system? You stress the urgent need to improve the collection of data on out-patient activity. Does the BADS management information system incorporate such data, or is it simply a good system that may need to be extended to include such a process?

Barbara Hurst: Two things are going on; Nick Hex might be able to help me explain. The BADS system is almost like a clinical tool for making sure that the procedures that it says can be done as day surgery or same-day care are grouped and for doing the case-mix adjustment. The information system that we are talking about that captures out-patient activity information is a different system. I invite Nick Hex to comment if I stray outside my comfort zone, but the BADS system is really about the procedures that boards would be expected to consider actively as same-day care procedures.

Appendix 3 is an interesting if relatively complicated analysis of all those procedures, where boards currently sit and where the health directorates expect them to move. Ayrshire and Arran, which is at the top of the list, is currently doing 72 per cent of those procedures as same-day care. The health directorates are saying, "Actually, we think you can do 82 per cent." It is a more comprehensive tool than the system with individual targets that our report talks about, but it will include those procedures.

Nick Hex (Audit Scotland): The BADS system encompasses about 160 procedures, and there are around 320 surgical procedures in total. Many more procedures are included in the BADS directory than are in the basket that we have looked at over the past 10 years.

As Barbara Hurst pointed out, the system now sets more specific targets for boards. It examines issues such as case mix, so it is much more sophisticated than a simple look at a straightforward percentage of procedures carried out as day surgery. We are recommending that, because the system is fairly new, all boards need to start to look at their information because it is more sophisticated than previous information was, and they should try to use it to improve their overall performance on day surgery.

Willie Coffey: That is interesting. I asked because the system was introduced two years ago, but not all boards have adopted it yet. How can we improve the collection of patient procedures data, which you said was crucial? What is your recommendation? You say that the boards should do that, but how should they do it?

Barbara Hurst: Back in 2003, or whenever we did our out-patients report, we pushed strongly for boards to try to understand what was happening with out-patients because of the perverse incentive. If the target focuses just on day surgery, there is a bit of a perverse incentive, because although medical advances might mean that certain procedures can be done in the out-patients department, a board will not do them in that way because it wants to hit its day surgery target.

We have been thinking through that situation and working closely with the Information Services Division. It collects all the national data and quality assures them. It has been working actively with the health service to develop some of the out-patient activity data that are collected. I think that the difficulty was that a lot of that out-patient activity was not just consultant-led. There was a complicated set of discussions around whether just the consultant-led activity data should be

collected, or whether data for all the other health care professionals should be collected. However, in day-case data only the consultant-led activity is needed, because that is what we are talking about.

The ISD has done a lot of work. Clearly, however, there are still some glitches, as we do not see all the activity. We made some adjustments in the data to allow for some underreporting. That needs to be worked on. The next step will come as activity moves from out-patient services into the community. If the data do not keep up with all the changes in how services are delivered, we will have no idea how productive the health service is.

Stuart McMillan (West of Scotland) (SNP): My point follows on from one that George Foulkes made. I refer to paragraph 17 on page 8 of the report. Would it be reasonable to suggest that health boards should plan, fund and provide assurance to hospitals and their staff—perhaps using five-year or 10-year plans—so as to guarantee that hospitals have a future and that services will be provided at them? That would remove any potential animosity or conflicts, and more targets could be met.

Barbara Hurst: That is very much beyond what we considered. As I understand your point, you are suggesting that if more gets done in out-patient services, there is less need for district general hospitals. Is that behind your question?

Stuart McMillan: I was thinking about some of the issues around hospitals and services that have arisen in the west of Scotland in recent years, and the lack of a future for services or the lack of a guarantee that services will be provided at particular hospitals. I was also thinking of the effects on those hospitals.

Barbara Hurst: It is difficult for us to answer that question on the back of our work on the report that is before the committee. We considered the activity that is being carried out and performance against targets. We did not consider how hospitals are configured to provide different services and whether they have a future. I am sorry that I cannot answer the question.

Stuart McMillan: That is no problem—thank you.

The Convener: I thank Audit Scotland for the report. We will return to the subject.

Decision on Taking Business in Private

10:27

The Convener: I should now correct an oversight on my part—I should have dealt with this item earlier. Do members agree to take item 10 in private?

Members *indicated agreement.*

Section 23 Reports: Responses

"Managing increasing prisoner numbers in Scotland"

10:28

The Convener: Under this item, we will consider a response from the relevant accountable officers on the Auditor General's report, "Managing increasing prisoner numbers in Scotland". The responses are very good and very full. It is apposite that Mike Ewart, the head of the Scottish Prison Service, commented this week on contradictions in legal responsibilities and described how he manages competing responsibilities. There is clearly a major problem.

Without pre-empting the discussion, I would say that we have asked the questions and have got some good replies, containing useful information. It might now be time for us to pass the matter over to the Justice Committee, which I think is considering the whole question of prisons.

Murdo Fraser: I agree that the response is comprehensive and helpful. Rather than dealing separately with the issue, Robert Gordon and Mike Ewart collaborated on a joint response, which was useful. As for where we go from here, we are in danger of straying into policy issues and it is more appropriate to pass the matter to the Justice Committee, which is considering the whole issue of prisons, particularly the question of capacity. I endorse your view, convener, that having noted the response, we pass it on to the Justice Committee.

Stuart McMillan: I am sure that my colleagues on the Justice Committee will be delighted when a new report arrives.

10:30

Andrew Welsh: It strikes me that some of the responses are loaded with jargon. There are acronyms in every second paragraph. For example, one response states:

"The SPS have CJA Liaison Managers who work closely with CJAs in the planning process … Work has already begun to make prison populations more community focused which could assist prisoner access to appropriate support and services. This is the early stages of 'community facing prisons', one key consideration will be matching prisoner populations with prison facilities within specified catchment areas".

What does the phrase "community facing prisons" actually mean? We have received the most jargon-ridden answer that we have received in a long time. The "ICM" process, a "Core Screening process" and a "Community Integration Plan" are referred to. We are told that

"Both the ICM Action plan and CIP are 'live' processes".

I presume that that contrasts with dead processes.

One response states:

"SPS has appointed a new Offender Outcomes Manager for Relationships who is about to take up post."

That sounds to me like social work, which local government also organises. I wonder whether there is any linkage of work as opposed to resources being duplicated. We have received vague, waffling answers to most of the specific questions that were posed.

There could be a systemic problem. I thought that the NHS was riddled with jargon and acronyms, but its use of those is nothing compared with that in the answers that we have received. I hope that the Justice Committee will take that into account and try to do something about it.

The Convener: Notwithstanding, an attempt has been made to answer questions about fairly complicated issues. I accept what you say about jargon. The public sector often uses jargon when it tries to describe things, but it is clear that there has been an attempt to focus more on policy issues.

You are right. Closer co-operation between social workers and the Scottish Prison Service is needed, and the community justice authorities should attempt to encourage that.

The committee has done its bit in the audit process. It is now a matter of passing the report and the response on.

George Foulkes: I assumed that jargon and terms such as "proactively", "on an on-going basis", and "Cognisance is also taken" came from Robert Gordon and the facts came from Mike Ewart.

The Convener: That might be unfair. All civil servants are pretty well versed in the school of jargon.

Andrew Welsh: Policy issues are for policy committees, but it is difficult to consider policy if the answers to questions are vague. Under the straightforward heading:

"Assess the effectiveness of HDC in achieving its objectives",

the response is that there is an

"intention to carry out a review of the Home Detention Curfew Scheme when HM Prison Addiewell is operational in 2009.

Since introduction in July 2006 over 4000 prisoners have been released on Home Detention Curfew. 25% of prisoners have been recalled to custody, the vast majority for breach of their curfew terms; less than 1% are recalled for alleged reoffending

7.1% of recalled prisoners appeal to the Parole Board for Scotland against their recall to custody. Of that number 60.6% of those appeals against recall are successful."

It should not take long to assess that. There is vague and unhelpful thinking in response to a specific question. That points to a systemic problem, which I hope the appropriate committee will investigate and do something about.

The Convener: I note the points that you have made, but I think that some of those issues are on the policy agenda.

Mr Black: I will provide a little assistance to the committee by linking some of the numbers together, which is what we do best. In "Managing increasing prisoner numbers in Scotland", we mentioned the last projections of prisoner numbers that the Government had. At that time—it was 2007—the Government projected that the number, including home detention curfew prisoners, would reach 8,100 by 2010-11 and 8,500 by 2016-17.

In a fairly comprehensive response, we are told that the Prison Service has judged the assessed operational limit, which is the safe limit, to be 8,126. According to the coverage given to Mike Ewart's recent statements, the prison population has now reached 8,137. The point is that, not by 2010 but by 2008, we are over the edge of the assessed operational and safe limit as identified by the chief executive of the Prison Service. That reflects the seriousness of the situation as Mike Ewart sees it. For that reason, I strongly support your inclination to draw the Justice Committee's attention to the report.

Andrew Welsh: It is clear that prisons are overcrowded and that there is a massive accommodation problem. If open prisons are to be used to house prisoners because of overcrowding elsewhere in the system, where does that leave the concept of open prisons? That leads me to ask the simple question: what are prisons for? I hope that the appropriate committee will pursue that.

The Convener: Fortunately, that is not a question for us. Others can wrestle with it. Do we agree to note the responses and pass the report to the Justice Committee for its consideration?

Members *indicated agreement*.

"Financial overview of Scotland's colleges 2006/07"

The Convener: The next item is on responses to the report "Financial overview of Scotland's colleges 2006/07". Again, we have received fairly full information. The police investigation at Kilmarnock College is continuing, so we cannot go into any of that. I am not sure that there is much else that we can do. I do not know whether the Education, Lifelong Learning and Culture Committee is looking into any of the aspects. If not, my inclination would be just to note the responses.

Murdo Fraser: One point arises from Philip Rycroft's letter. He said that the Association of Scotland's Colleges published guidance on college boards and management in June. When we addressed the issue, we looked into how robustly management boards were holding college principals to account. It might be worth asking for sight of that guidance if it is now publicly available.

The Convener: We can do that and hold the item until the guidance is made available. Is that agreed?

Members *indicated agreement*.

George Foulkes: I presume that the minister will be keeping an eye on developments.

The Convener: Ultimately, it will be the responsibility of ministers. As far as committees are concerned, it would be the Education, Lifelong Learning and Culture Committee.

Tracey Reilly (Clerk): I understand that that committee is likely to take some evidence on funding in the higher education sector as part of its budget scrutiny this year.

George Foulkes: Are we sending it the information that we have?

Tracey Reilly: Yes.

The Convener: We will hold the item until we receive the information that Murdo Fraser has requested. However, the issue that he mentioned is about more than just funding; it is about the ability of boards to hold college principals to account and about what happens if a board fails. There is some information from the Scottish Further and Higher Education Funding Council on that, so we will hold on to the item for now.

"Improving the school estate"

The Convener: The next item is on the response to the report "Improving the school estate". Frankly, the response is somewhat disappointing, but I do not think that we can do much more at this stage. We may return to the item once the further work has been produced.

Murdo Fraser: It is all tied up with much wider political issues about the Scottish Futures Trust. I suspect that there is not a lot that the committee can do to progress that. We just need to keep a watching brief on the matter.

George Foulkes: Apart from the spelling errors in the letter from the director general, education—that is astonishing; I do not know where he went to school—my main concern is that the chairman of the Scottish Futures Trust was appointed without

use of the Nolan procedures and without open competition, but that is nothing to do with the committee.

The Convener: That is nothing to do with this item.

Andrew Welsh: I am not sure why you use the word "disappointing", convener. There is now £2 billion of committed investment in schools, there have been seven major local authority building projects since May, another four are in the pipeline and so on. The response provides information about what is on-going, so I am not sure that the use of the word "disappointing" is appropriate.

The Convener: The school strategy would need to be examined. There still seems to be a lack of clarity about exactly what is being done and whether some of the work that is now being done is a continuation of work that was previously initiated and is now coming to fruition. Nor is there clarity about when the next phase of the work will be commissioned and when it will start. We cannot do much more now but, as Murdo Fraser says, we should keep a watching brief on the matter and return to it as required. Is that agreed?

Members *indicated agreement*.

"Dealing with offending by young people"

The Convener: The next item is on the response to the report "Dealing with offending by young people". It is another item that we have probably taken as far as we can.

Some useful information has come back. The letter from Philip Rycroft provides some detail on how the Proceeds of Crime Act 2002 money is spent. It has confirmed that data on young offenders will continue to be collected, albeit that the Government does not think that that is a meaningful way to measure progress. The letter answers the questions that we posed. As no one has any further comments, do we agree to note the response and thank the Government for it?

Members *indicated agreement*.

"Overview of Scotland's health and NHS performance in 2006/07"

The Convener: Do we agree to note the response?

Members *indicated agreement*.

"National Fraud Initiative in Scotland 2006/07" (Government Response)

10:43

The Convener: Under this item, I welcome the confirmation that there is provision for the matter in the legislative programme. We asked about that. Do members want to comment?

Murdo Fraser: The letter from Kenny MacAskill, which is dated back in June, says that he will be happy to confirm for the committee which bill will be used to address the issue once the legislative programme has been announced. Given that that has now happened, have we had any communication from Mr MacAskill as to which bill will be used?

Tracey Reilly: My understanding is that the provision is likely to be included in a fairly wide-ranging justice bill, which is to be introduced early next year, but we can seek confirmation.

Murdo Fraser: It would be helpful to get confirmation, so that we can effectively close the matter.

The Convener: Okay. We note the response.

That brings us to our final agenda item, so we will move into private session.

10:44

Meeting continued in private until 11:11.

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