AUDIT COMMITTEE

Wednesday 12 November 2008

Session 3

£5.00

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

CONTENTS

Wednesday 12 November 2008

AUDIT COMMITTEE
16th 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)
*Cathie Craigie (Cumbernauld and Kilsyth) (Lab)
*George Foulkes (Lothians) (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)
Angela Canning (Audit Scotland)
Caroline Gardner (Audit Scotland)
Tricia Meldrum (Audit Scotland)
Ronnie Nicol (Audit Scotland)

CLERK TO THE COMMITTEE

Tracey Reilly

SENIOR ASSISTANT CLERK

Joanna Hardy

ASSISTANT CLERK

Rebecca Lamb

LOCATION

Committee Room 4

Scottish Parliament

Audit Committee

Wednesday 12 November 2008

[THE CONVENER *opened the meeting at 10:00*]

Decision on Taking Business in Private

The Convener (Hugh Henry): I welcome members, the press, the public and Audit Scotland staff to the 16th meeting of the Audit Committee in 2008. I ask everyone to ensure that mobile phones are switched off.

Do we agree to take item 8 in private?

Members *indicated agreement*.

The Convener: Do we also agree to take in private all future consideration of our draft report on the Auditor General for Scotland's report "A review of free personal and nursing care"?

Members *indicated agreement*.

"Living and Dying Well: A national action plan for palliative and end of life care in Scotland"

10:00

The Convener: Item 2 concerns a section 23 report on palliative care services. I ask the Auditor General to introduce the item.

Mr Robert Black (Auditor General for Scotland): When the committee considered palliative care, we gave an undertaking that, once the Scottish Government had published its statement on the matter, we would give a brief outline of the significant issues. Angela Canning is happy to do that, if it would assist the committee.

Angela Canning (Audit Scotland): The Audit Scotland report on palliative care, which was published on 21 August, made a number of recommendations about improving access to specialist palliative care for everyone who needs it; providing education, training and support for generalist staff; applying good practice guidance everywhere that patients receive care; and putting in place better links between services.

On 2 October, the Scottish Government published its action plan on palliative care, which is called "Living and Dying Well: A national action plan for palliative and end of life care in Scotland". The action plan is not the Scottish Government's response to the Audit Scotland report—it was already being developed before we published our report—but it takes account of our findings and recommendations. The accompanying letter to board chief executives states that national health service boards should give sufficient priority to implementing the recommendations in our report and the requirements that are set out in the Government's action plan. The overall aim of the action plan is

"to ensure that good palliative and end of life care is available for all patients and families who need it in a consistent, comprehensive, appropriate and equitable manner across all care settings in Scotland."

That is in line with the key recommendations in the Audit Scotland report.

The action plan identifies a number of areas for development in which short-life working groups have been set up. They include a group that is developing criteria for referral to specialist palliative care services and a group that is considering developing new standards for palliative and end-of-life care as recommended in our report.

The plan includes a number of specific actions that relate to promoting equity of access for all patients with palliative and end-of-life care needs regardless of their condition, location or other life circumstances, such as age, ethnicity and religion. It also includes a number of actions on training for generalist staff, promoting the use of best practice guidance across care settings and improving communication across providers in and out of hours. It is being supported by £3 million to introduce a palliative care-directed enhanced service for Scotland.

Members will see from the briefing paper that we have mapped the national action plan against the recommendations in our report. Overall, the action plan, the further development work, the supporting guidance that has been issued to boards and the new directed enhanced service address the recommendations. The only recommendation that is not addressed is that boards' commissioning and monitoring arrangements should ensure value for money. As the briefing note says:

"There are no specific actions on recording consistent information across NHS boards, but these are expected to follow from the actions on consistent use of recognised tools and the work of the Palliative Care eHealth advisory group",

which is a new group.

Boards are required to produce local delivery plans detailing their local priorities and actions against the national action plan and to submit them to the Scottish Government by the end of March 2009. The short-life working groups are due to report by March 2010. Audit Scotland will keep a watching brief on the implementation of the plan.

The Convener: Thank you for that.

Andrew Welsh (Angus) (SNP): I would like to clarify what is meant by:

"There are no specific actions on recording consistent information across NHS boards, but these are expected to follow from the actions on consistent use of recognised tools and the work of the Palliative Care eHealth advisory group."

Does that mean that the recording of consistent information is built into the boards' processes, or that it is implied from the actions on the "use of recognised tools" and the work of the e-health advisory group? What does it mean? I note the use of the phrase

"are expected to follow from",

rather than "will be implemented through". Perhaps they will not be implemented through the actions in question.

Tricia Meldrum (Audit Scotland): The action plan makes reference to a number of recognised tools and techniques that boards should use. Recommendations that are targeted at boards, at community health partnerships and at council partners should result in consistent records being kept of patients' needs, how they are addressed and what has been put in place as regards carers' assessments. A standard set of information should be recorded for all patients who are identified as having palliative or end-of-care needs and their carers.

In parallel to that is the work of the e-health advisory group, which has a fairly broad remit. As well as identifying specific actions on out-of-hours work and the electronic care summary, it has a broader remit, which is to do with making the best use of information that is already available. It should be building on the fact that that standard information is now in place and assessing how that can best be used across the country.

Andrew Welsh: In other words, the recording of consistent information will evolve from the actions that are outlined. There is a big difference between driving the situation and allowing matters to evolve. Surely the boards must be aware of the targets that they are aiming at.

Tricia Meldrum: Yes.

Andrew Welsh: One thing that bothers me is that although nine of the 26 recommendations have been addressed, 17 have not. Although your briefing looks good at first, alongside the heading "Addressed" are categories such as "Partly addressed", "Mostly addressed", "Work in progress", "Implied/work in progress", "To be addressed", "future development", "Not specifically addressed", "Not addressed" and "Addressed/Work in progress". What at first appears to be solid progress begins to break up on further examination.

Angela Canning: In the briefing, we tried to outline issues that are specifically addressed in the action plan, but you will see that the third column in the table is "Other developments/Further information", so even though it might not be detailed in the action plan, we are aware of other work that is going on, such as the short-life working groups that are being set up to progress specific actions.

Andrew Welsh: You can probably understand our concern about vagueness. Everyone wants the finest palliative care to be available, but I am not sure that we have been provided with a clear pathway towards that. There is a lot of in-built vagueness. Although Audit Scotland made 26 recommendations, 17 of them have not been addressed. I would have liked much more precision on the way forward.

The Convener: Before I bring in Willie Coffey, I would like to ask what the key issues are that have not been taken into account or addressed.

Tricia Meldrum: The only issue that we identified that the action plan did not pick up or address specifically was that of ensuring that boards have robust commissioning arrangements with their partners for the delivery of palliative care services and that those arrangements are monitored to ensure value for money. Through the review, we picked up on the arrangements that boards have with the voluntary sector, for example, and the contracts that are in place there. We had difficulty identifying exactly what those contracts looked like, how much funding was going to individual providers and how that was monitored. We could not see any specific actions that related to that recommendation.

We note that the Government has asked the boards and their partners to say how they expect the action plans that they develop under "Living and Dying Well" to be funded and to flag up any affordability issues. We think that that is a separate issue; it does not relate to the contracts that are in place between the boards and the other providers. That was the only issue that we felt that the action plan did not address.

Other issues arose, particularly on the do not attempt resuscitation policy. We saw that things were happening there, but it was not clear that those would fully address our recommendation for a national approach. We felt that there was still the potential for our recommendation to be followed in different ways throughout the country.

The Convener: There is also the issue of consistent recording.

Mr Black: We have highlighted in our report that three recommendations were not covered, the most important of which relate to information recording, and commissioning and monitoring arrangements, without which there cannot be absolute certainty that the implementation of the strategy is on track.

The Convener: Those are three fairly big issues, which I will come back to.

Willie Coffey (Kilmarnock and Loudoun) (SNP): The question how palliative care services are delivered in remote and rural communities was not specifically addressed. Although it is a generic strategy, there are presumably peculiar needs in those communities, which, as I understand it, were not picked up by the Government's action plan. I was hoping that there might be further details on that.

I recall a previous discussion in which we noted an imbalance between palliative care services for non-cancer related diseases and those for cancer-related diseases. There are historical reasons for that, obviously, but I did not see anything in the action plan that might begin to redress the balance. Can you provide any further information on that?

Tricia Meldrum: The introduction to the action plan makes it clear that the plan is expected to apply equally to people throughout the country, wherever they live and whatever their condition. There are no specific recommendations about how the plan might be delivered in remote and rural communities. We would expect that when the boards develop their delivery plans they will spell out how the plan will be delivered locally. The boards are due to produce their delivery plans by the end of March next year. We will want to consider those documents to see how the issues in the action plan have been picked up. It is very much in the spirit of the action plan that we have not got down to that level of detail and described how the action plan might work for such communities.

On the issue of services for people with cancer and those for people who have other conditions, a big thrust of the action plan has been to ensure that there are moves towards more equity. It is recognised that there has been inequity, and the foreword to the document and the document itself talk about ensuring that services are not purely focused on people with cancer and that services are opened up.

Cathie Craigie (Cumbernauld and Kilsyth) (Lab): My question has perhaps been addressed. I am sure that we are all aware of the large contribution of the voluntary sector in providing palliative care. As my committee colleague Andrew Welsh said, it is a matter of concern that we do not have a process in place to ensure that joint working between the health service and the voluntary sector takes place and that we are getting value for money. The issue of resources is a difficult one for the voluntary sector in particular. Perhaps we can pursue that further, convener.

The Convener: We will decide later in the meeting what we want to do about the action plan. Are there other issues that require clarification at this point?

George Foulkes (Lothians) (Lab): Paragraph 38, on page 18 of the action plan, says that

"the timely sharing of information between primary and secondary care, especially at times of admission and discharge and including transfer between home, care homes and hospitals, remains a challenge to be addressed."

In my experience, one of the biggest problems is that when elderly people move from their home to hospital or from hospital to a hospice and so on, information is not transferred. Doctors use all sorts of spurious reasons for not doing so. The situation does not seem to have improved over the years.

The report refers to

"a challenge to be addressed."

Do we know how it will be addressed and by whom, so that the information is not knocked about from pillar to post when elderly people are being moved around?

10:15

Tricia Meldrum: A new national e-health group has been set up and is looking at issues around palliative care. I believe that that is being led by the national clinical lead—that is a key appointment by the Government. The e-health group is one of the short-life working groups that have been set up and is trying to explore electronic communication and more ready access to information at points of transfer, such as between in-hours services and out-of-hours services. The action plan talks about involving all partners in that discussion—boards, the voluntary sector and council partners. It is work in progress.

George Foulkes: I wish that the Government would find a better term than "short-life working group", which is a bit inappropriate.

The glossy publications are lovely, but things do not seem to improve much on the ground. Are we able to quantify how things are improving for elderly people who are being dealt with by different agencies over what might be a two, three or four-year period? Are there any ways of measuring that or monitoring it better?

Tricia Meldrum: In our work, initially we want to look initially at what is happening in relation to processes. We want to consider what the delivery plans look like, what is coming out of the working groups that are being set up and what is happening with care for elderly people in hospitals and care homes. The report focuses on training for generalist staff, such as general practitioners, district nurses and staff who work in care homes. We know that there has been action on that. NHS Education for Scotland is recruiting somebody to lead a new programme of work to develop that generalist training. We are starting to see some of the actions that should put in place the processes that will lead to improved outcomes and improved quality of care for the groups involved.

Caroline Gardner (Audit Scotland): That is another example—like the example raised in Mr Coffey's questions—that shows why it is so important that the health service has consistent information. It needs that information so that it can monitor what is actually happening in relation to palliative care, rather than just the processes. That is one of the gaps that we have highlighted.

George Foulkes: That is going to be followed up.

Caroline Gardner: Yes.

The Convener: I thank the Audit Scotland staff for their contribution.

Section 23 Reports: Responses

"Review of the new General Medical Services contract"

10:18

The Convener: The next item on the agenda is a response from the accountable officer to the Auditor General for Scotland's report, "Review of the new General Medical Services contract". Do members have any comments?

Andrew Welsh: On workforce planning, the Auditor General told the committee:

"there is no comprehensive set of important basic information to assist in managing the NHS and planning its workforce effectively."—[*Official Report*, *Audit Committee*, 10 September 2008; c 611.]

If we do not have that, what can we do? That links back to the previous discussion: unless the information is correct, decisions are based on incorrect information, which does not make for good decision making. That is a great worry.

Murdo Fraser (Mid Scotland and Fife) (Con): When we took evidence from the Auditor General, I remember that one of the issues that came out of the report was whether there had been value for money for the public purse from the new contract. We put that specific point in our letter to Kevin Woods. His reply is interesting, but it does not entirely address our point.

In the section on value for money, Dr Woods acknowledges:

"there is clear evidence that recruitment and retention issues have been addressed successfully, reflected in a significant growth in the number of applications to become GP registrars, as general practice has become more attractive as a career".

I think that we all knew that already. If the amount of money paid to GPs is substantially increased, it is no wonder that more applicants are attracted to the profession. The back page of annex B to the letter gives GP income figures and shows how net profit increased between 2003-04 and 2006-07. The money that is paid to GPs as independent contractors increased substantially, so nobody should be surprised that GPs are happier than they were. That was not the point. The point was to examine whether substantially increasing the reward for GPs has been beneficial in delivering improvements in the care that they provide and whether it has represented good value for money. I am not convinced that Dr Woods has replied satisfactorily to those questions.

George Foulkes: When was the new GP contract agreed? How many years ago did it start?

Caroline Gardner: The contract started in 2004-05.

George Foulkes: That was four years ago.

Caroline Gardner: That is right.

George Foulkes: So the contract has run for four years.

Under the heading "Impact of the contract elsewhere in the NHS" on the second-last page of his letter, Kevin Woods says:

"We are also looking in more detail at the trends in unscheduled care services".

We asked about the knock-on effect on such services. The letter says:

"We intend to use this work to tell us more about how the GP contract affects these services, as well as how we may be able to influence other, external, factors".

Why has it taken four years to start that work? I presume that it has been evident to most people—as it certainly has been to me—how much the GP contract has affected other services. Can anyone answer that question? I know that we should ask Dr Woods—not that we would receive a decent reply.

The Convener: Given the comments by Andrew Welsh, Murdo Fraser and George Foulkes, the question is what more we can do. Are we at the stage of noting the response? Do we have points that we still want to pursue? Should the Health and Sport committee now consider some issues? The main decision that we need to make today is what we do with the report.

Andrew Welsh: I have a great problem with the whole NHS organisation and system, which is full of acronyms, committees and groups. They all seem to meet and talk, yet the NHS does not have some fundamental information—for example, the letter refers to

"a lack of comprehensive workforce data for GPs and GP practice staff."

We know from the previous agenda item that we have a national clinical lead for palliative care, who was appointed in 2008, and executive leads for palliative care. The attitude in the whole organisation is lead—as in balloon. It is almost self-perpetuating and inward looking rather than concerned with the task out there in hospitals and GP practices. If the organisation does not have the fundamental information, it cannot make sensible decisions. If, when information is received, it disappears into committees and working groups that produce nothing, there is something wrong with the organisation. I have seen that for about 20 years, if not more.

I have difficulty with all that. We have a nice wee answer, but I am not sure whether it takes us further forward. All of us are willing the NHS to be

good at what it does and to take the proper action, but I am not sure whether we are seeing that happen.

The Convener: Does the Auditor General intend to do further work on the GP contract?

Mr Black: Yes. What comes through from Dr Woods's letter is the fact that the task is still work in progress. I noted the observation that the Government should perhaps have been further along the road sooner, but I am not in a position to comment on that.

The response says that the Government has attempted to contain the cost through the inflationary uplift and through reducing the money for the correction factor, which provides financial compensation without any direct benefit. It says that the quality and outcomes framework is being used to try to address what GPs are doing. Dr Woods also says that trends in unscheduled care services will be examined in more detail. All that supports the view that the matter is work in progress.

We have in mind two studies. One will be a fairly major study of the unscheduled care system, which will throw further light on exactly what is happening.

The second study will be in the forward work programme that we will bring to the committee in the new year—it will come towards the end of the next programme. The study will examine the major pay policies that have been implemented in the NHS over the past few years—the consultants contract, the agenda for change and the general medical services contract being the three major ones. We want to take a slightly longer look—after more time has passed—at whether there is evidence of value-for-money benefits coming through. It will be a couple of years before we can bring the results back to you.

The Convener: So the dilemma is what we do now.

Cathie Craigie: Before we move on, can I have some explanation of the final paragraph on the second-last page of Dr Woods's letter, under the heading "The Quality and Outcomes Framework (QOF)"? It talks about

"substantial changes to QOF in 2006/07 with 166 points recycled and 9 new clinical areas. A further 58 points were recycled".

What does that mean? Recycling is a good thing to do, but I do not quite understand—perhaps because I am a new member of the committee—what the paragraph means.

The Convener: It means that the highest level of recycling of any Government agency or department has been achieved.

Andrew Welsh: Cathie Craigie can rest easy, because I am delighted to see that

"An even more independent process for the development of new QOF indicators is being considered at present and should in future involve NHS QIS."

There you are—we can all rest easy. Over the decades, I have seen a certain attitude of mind—an organisation that exists for itself.

Willie Coffey: I will throw in another comment. We asked specifically about how to target deprivation. The response in the letter suggests that we should look for communities where there are higher incidences of disease and target additional resources in that way. As everybody knows, the Scottish index of multiple deprivation gives us clear and specific information about pockets of deprivation in Scottish communities. I would expect the index to be used as a more accurate indicator of where we should distribute resources, rather than just looking around for pockets of incidence of disease. I am sure that there is a correlation, but I am pretty certain that the SIMD index is a far more reliable source.

The Convener: I suppose that we have three choices. One is to pursue further with Dr Woods some of the concerns that we have raised this morning and to consider whether we want to report on those, if warranted. The second option is to refer any outstanding issues to the Health and Sport Committee for its consideration. The third option is to simply note the report.

Murdo Fraser: Poor old Dr Woods must think that this committee is his nemesis. I do not think that there is much to be gained from having another torturous evidence-taking session with him. Some serious issues have not been addressed in the response, but I suspect that the committee has taken matters as far as it can at this stage. We should report to the Health and Sport Committee where we have got to and suggest that it pursues the issues further if they are of interest to it.

It was interesting to hear what the Auditor General had to say about the work that Audit Scotland continues to do in the area; no doubt we can revisit that in a couple of years when we see what comes out of the Auditor General's office.

Andrew Welsh: We could express our serious concerns to the Health and Sport Committee about the substance behind the work and hope that it monitors the situation and tries to encourage appropriate action. There are plenty of action points that must be followed through to ensure that things happen properly. We are in the land of jargon, which obscures the issue. There should be some fundamental thinking about what the system is meant to do and how it can do it better.

The Convener: Do we agree to refer the matter to the Health and Sport Committee?

Members *indicated agreement.*

"Day surgery in Scotland—Reviewing progress"

10:30

The Convener: Item 4 is a response from the accountable officer on the report "Day surgery in Scotland—Reviewing Progress". I invite thoughts and comments. Could it just be a question of noting the report?

Andrew Welsh: I want to ask about the significance of the second paragraph on the second page of the response. It says:

"Boards … are now shifting a significant amount of activity into outpatient settings. The accuracy of clinical coding pertaining to procedures delivered in an outpatient setting is considered to have an adverse impact on reported national performance figures."

The end of that paragraph says:

"An associated analysis suggests that there are also a number of patients within each NHS Board whose procedure is delivered as a day case but whose attendance is coded as an in-patient admission."

What is the significance of that? It sounds rather confused.

Mr Black: It is the same issue as before. It is about how information is recorded. We constantly come up against that and it is an area that requires development.

Andrew Welsh: But there are BADS, HEAT and the other acronyms that they throw at us.

Caroline Gardner: When people were admitted as in-patients to get operations done, that was pretty easy to count and measure. Now, people can be treated as in-patients, day cases or out-patients for the same condition, so it is much less clear now that the information is full and complete. That is what that paragraph means.

The Convener: If the information is not full and complete, is that because of negligence on the part of those who record information, because of a failure in each location to apply recognised procedures properly, or because the systems and procedures are not there to apply consistently across the country?

Caroline Gardner: It is closest to being the third of those. The underlying problem is that the systems for collecting the information have not kept pace with changes in the way in which treatment is provided. It used to be straightforward: everybody who was admitted to an in-patient ward was counted as they came in and went out. However, with people coming into day-case units for part of the day or turning up at out-patient units for a couple of hours, it is more complex to collect consistent information about, for example, the total number of patients having a cataract done—as well as the numbers for each of three settings. The systems have not kept up to date with the changes.

The Convener: How difficult or cumbersome is it for the NHS as a whole to apply consistent systems and for people to use and adapt them?

Caroline Gardner: There is obviously a question around ensuring that the systems are straightforward and easy to use and that people know how to use them and understand the importance of using them. Many of our reports show that they are not working so well in a range of areas. We are aware of that in day surgery, which is the subject of the report in front of us, and we also came across it earlier in relation to the palliative care system. One of the themes that have come through in our work over a number of years, particularly on the health service, is that collecting information is much harder than it appears. It needs serious attention, given the importance of information for planning and managing services.

Mr Black: We are not for a moment suggesting that the health service should collect more and more information; we are suggesting that the information that is collected should be fit for purpose in managing the NHS.

Cathie Craigie: The visits of patients are being recorded differently, depending on whether they are they are there for three hours, 24 hours or longer. If boards are collecting information in different ways, what impact could that have on the recording of the targets that they are expected to meet for the various aspects of day-care and in-patient services? Are there benefits for boards in recording different areas of information differently?

Caroline Gardner: The short answer is that there should not be benefits to doing that now. There might have been in the past, particularly when contracting systems were in place, under which people got paid different amounts of money for different procedures, but those systems do not apply any more.

There are two serious effects. First, it is hard for us to tell which boards are doing better and which are doing less well if they are not being consistent in how they collect information. Secondly, and much more importantly, and as Bob Black has said, the health service might not have the right information to determine how it can improve the care that it provides or the value for money that it offers by treating patients' needs in a more appropriate place. That is the problem as we see it.

Andrew Welsh: A problem that I have always had is that, in the final analysis, statistics are simply a means to an end; they are not in themselves the end. We seem to be getting many statistics for their own sake rather than for a purpose or a practical end result. I have a difficulty with that. There is a difference between reality and dealing with statistical effects only. For example, Dr Woods's letter refers to the estimate that

"a 5-10% improvement in overall same day care rates could be demonstrated through a simple improvement in procedure coding."

There is a danger that, simply by changing the statistics or the way in which things are looked at, it will appear that improvements have been made when they have not necessarily been. That is a general problem.

The Convener: I would like to leave the report that we are discussing to the side for the moment and make a suggestion, although I do not know whether it is appropriate. Members are saying—the Auditor General has also raised the matter—that there is a consistent issue. The same thing comes up time and again with a range of issues in the NHS—I do not know whether the same happens elsewhere. Could you do a short piece of work for us that identifies recording and statistical issues in the NHS under topic headings so that we can find out whether we can suggest changes to achieve consistency, improvement and better management? Repeating the same discussion time and again does not seem to be a good use of our time. Can something be done to pull things together?

Mr Black: I am sure that Audit Scotland can revisit reports that we have produced in the reasonably recent past and derive common themes.

Caroline Gardner: I agree with the Auditor General. A number of reports that we have produced over the past couple of years have had an underlying theme. Baseline information on new policies that have been introduced has not been clear, and we have reported several times that the information in clinical areas such as day surgery did not give a full picture of what was happening. We would be happy to look back at those reports and produce a short piece of work for the committee that summarises things.

The Convener: That would certainly be helpful. Thank you.

Is there anything further that members would like to do in response to the report on day surgery in Scotland? If not, we can simply note it.

Stuart McMillan (West of Scotland) (SNP): I have quite a pedantic point to make, but Cathie Craigie will subscribe to it—I say the same in Justice Committee meetings from time to time. It might be an idea if letters were proofread—by the health directorates in this case—before they are sent to us. There are quite a few errors in the final sentence alone in the first paragraph on the final page of Dr Woods's response. The point is pedantic, but if the directorates cannot even proofread letters, the information in them—

The Convener: We can certainly send a letter to Dr Woods asking for that to happen.

Tracey Reilly (Clerk): I shall pass that on.

Andrew Welsh: We are pointing to a problem in the central organisation. It is dealing with a complicated situation throughout the country, but a reporting and statistics industry exists that is unrelated to actual needs. I have seen the same in education colleges—staff produced reports simply for headquarters. That is a fundamental organisational problem. Everybody must accept that the situation is complex, but it is the organisation's job to get order out of that complexity and use statistics to get the work done. An industry is working on its own that is somewhat unrelated to the real world.

George Foulkes: Convener, will you remind me whether the health committee gets the Auditor General's reports on issues for which it is responsible?

Mr Black: Every MSP receives a copy of the reports that Audit Scotland produces.

George Foulkes: But the health committee does not consider reports in the way that we do.

Mr Black: No. All reports that are produced for me go to the Audit Committee. That is the parliamentary procedure. However, the other committees may request briefings from us on our reports on individual topics.

George Foulkes: The reason why I ask is that we have had a lot of reports about the health service. Andrew Welsh has represented better than anyone our dissatisfaction with many of them. Should we have some kind of interaction with the health committee to raise that general point? We can say that we have received those reports and that there seems to be a generic issue, and then ask the health committee to consider picking up the issue. I do not know what the best way of doing that would be.

The Convener: Okay. We will leave that sticking for now.

Nicol Stephen (Aberdeen South) (LD): I want to return to your point, convener, about a piece of work that looks across the whole of the Government. My experience of how statistics are collected in the Government is that there are differences from department to department. Some departments have substantial teams to collect

statistics. Some of those teams are reasonably well integrated into the senior management of the department but, in other cases, the integration is poor. I do not have direct experience of the health department, but it does not look good when the senior official in the department says that the statistics are unreliable—in effect, that is the answer that we are given when he talks about coding difficulties. If senior managers start to believe that some or most of the statistics are unreliable, the statistics become a particularly useless management tool.

That takes us back to Andrew Welsh's point that a substantial number of people are gathering statistics as an industry in its own right, not to assist with the management and improvement of a department or organisation. Shining a far clearer and sharper light on that would deliver results and would be valuable, provided that the Government acted on the outcome. I get increasingly frustrated by the constant and consistent rebuttal of any criticism or attempt to support and improve the service. When we raise concerns or find inconsistencies between health boards, we are told consistently that it is difficult to say that there are differences and that the issues that we have found can be explained by the way in which statistics are gathered—they are not gathered very well in some health board areas. I have seen exactly the same explanations about statistics in education. That becomes frustrating, not just for MSPs but for any patient, pupil or parent who is observing the situation and wants improvement. Anybody who is interested in health or education in Scotland deserves better.

The Convener: The question is what we do on the bigger issue and on the specific issue. On the bigger issue, certainly in relation to health, we can consider inviting the Health and Sport Committee or its convener and deputy convener to come along for a short discussion. If members leave that with me, we will consider the best way in which to proceed. We will come back to the statistics issue once Audit Scotland has done further work on it.

Our options on the day surgery report are to note it, take up some of the specific issues again or refer it on to the Health and Sport Committee. Any referral to the Health and Sport Committee should probably wait until we have had the general discussion about what is happening, as well as the discussion on the statistical recording issues. I am not sure that there is anything further that we can usefully do on day surgery, so I am inclined simply to note the report, unless members think that something more specific should be done.

10:45

Andrew Welsh: We cannot pre-empt in any way—nor should we—the work of the Health and Sport Committee. However, we can alert it to matters that affect its work, and therefore we could bring the report to its attention. In other words, we should hand the tools to the Health and Sport Committee to allow it to do its work.

The Convener: Okay. Do we agree to note the day surgery report and pursue both the interface with the Health and Sport Committee and the recording of statistics?

Members *indicated agreement*.

"A performance overview of sport in Scotland"

The Convener: The Health and Sport Committee will love us. Item 5 is a response from the accountable officer to "A performance overview of sport in Scotland". The Health and Sport Committee is doing some work on the issue, and what we have is relevant to that. Are there any issues that members want to be clarified or pursued, or do we agree simply to refer the report to the Health and Sport Committee?

Andrew Welsh: I have a question of clarification. The last sentence in paragraph 2 of the response states:

"Activities take place in and around the school day with over half taking place immediately after school and the rest at lunchtime, break time, before and during the school day as well as in the evening and at weekends."

What does that mean? It seems to say that more than half of activities take place after school and, if I am reading it correctly, half during school and at other times. Could we get some clarification on what that means?

The Convener: We can certainly ask for that. Do you want to hold the report pending that clarification?

Andrew Welsh: No, not necessarily.

The Convener: Okay, we can seek clarification on that and agree to refer the matter to the Health and Sport Committee, along with any reply that we receive, for its consideration.

Cathie Craigie: I am disappointed by paragraph 7 of the response. The committee has done some work on this, although I have not been involved in all of it. The committee wanted to find out whether and when there would be a survey on participation levels. I am disappointed to note that, after giving all the reasons for the previous survey and stating how things would be calculated, the letter states:

"There are … currently no plans to carry out a follow up survey."

We all agree that encouraging young people to become involved in sport is good for both their educational experience and health, and therefore good for the future of the country as a whole, so it

is disappointing that there are no plans to conduct a follow-up survey on how effective, or otherwise, the policy is.

The Convener: We could certainly ask either Dr Woods or the minister how they intend to monitor the introduction of two hours of physical education.

Stuart McMillan: I agree with Cathie Craigie on paragraph 7. I am sure that parents in Renfrewshire and East Renfrewshire will be delighted with some of the information in paragraph 11, but the letter has not been proofread properly. This is a pedantic point, but it says "form" instead of "from" and "S1 to S"—S what? Some of the responses are shoddy and extremely unprofessional.

The Convener: Those mistakes prompt other questions. When the letter says that Her Majesty's Inspectorate of Education is

"finding schools which are providing more than 2 hours of physical education each week",

does it mean that all schools are doing that, or that HMIE stumbled across one such school, enabling it to say that it is "finding schools"?

Cathie Craigie: The response uses such language all the way through. It is empty, and there is nothing specific to home in on.

The Convener: We could clarify how many such schools have been found—either from Dr Woods or from HMIE directly.

Willie Coffey: My question also refers to paragraph 11. I thought from our previous discussion that levels of participation in sport were lower in the west of Scotland than elsewhere. That was a very clear message, but paragraph 11 seems to contradict that by dint of the HMIE report finding a couple of isolated cases of good practice in the west of Scotland. It needs to be clarified that the strong message was that there were lower levels of participation in the west of Scotland. We need to understand why that is the case.

Murdo Fraser: My question goes back to Cathie Craigie's point and it ties in with Willie Coffey's point and some of the other points that have been made. A baseline survey was done in 2004-05. The convener said that we should ask how the Government intends to assess progress. The answer is in paragraph 7 of the response, which states that it was intended

"that HMIE would monitor progress".

The problem with the HMIE system is that it is very much piecemeal and it measures individual schools on a case-by-case basis, so we cannot get a complete picture. That is a fundamental issue. It would be helpful, not necessarily now but in the future, to have a further survey so that we can draw a direct comparison with the 2004-05 survey and see what progress has been made. We should make that point.

George Foulkes: I wonder whether some of the people who write these reports ever get out and about. I was talking the other day to Gavin Brown, who had been down at Tynecastle to see some of the work that is being done there—lots of youngsters come in as part of Heart of Midlothian Football Club's youth football programme and community programme. I am led to believe that other clubs do something similar. That never seems to come up. All that we hear about is a narrow part of the spectrum of what is happening. There is an awful—I nearly said "hell of a"—lot more going on. Are Scottish Government officials aware of such programmes?

The Convener: Those issues are certainly relevant to officials, but they are not particularly relevant to the remit of the committee on this issue.

I suggest that we refer the response to the Health and Sport Committee for its consideration but indicate that we are pursuing some outstanding issues. For example, we will ask about monitoring and about gaps in the service provided by HMIE, we will ask how many positive examples of schools HMIE found in Renfrewshire and East Renfrewshire and we will ask about a couple of other issues that have been raised. We will ask those questions and come back to the issue but, in the meantime, we will refer the response to the Health and Sport Committee.

Stuart McMillan: In respect of the reference to Renfrewshire and East Renfrewshire in paragraph 11, I would be keen to establish what the missing number is in the phrase "S1 to S"

The Convener: We will clarify that point.

Cathie Craigie: Are you referring the matter on to the health committee?

The Convener: Yes.

Cathie Craigie: Why is it being referred to the health committee rather than the education and sport committee?

Tracey Reilly: I understand that sport comes within the health committee's remit.

The Convener: The Health and Sport Committee is currently doing some work on the issue.

George Foulkes: Does sport come within health?

The Convener: Yes, Nicola Sturgeon is the responsible cabinet secretary.

Nicol Stephen: I will follow that point up in relation to HMIE reporting on physical education.

Is that still a responsibility of the education department? Is Nicola Sturgeon responsible for PE and sport issues in relation to the development of the curriculum for excellence and the pressures that there might be on the school curriculum in both primary and secondary schools?

The Convener: We can find that out. HMIE is accountable to and reports to Fiona Hyslop rather than Nicola Sturgeon. We will ask a specific question on that point. Do we agree on that course of action?

Members *indicated agreement*.

"Police call management—An initial review"

The Convener: Item 6 is consideration of the response on "Police call management—An initial review". I am sure that members will have comments to make.

Murdo Fraser: Kenny MacAskill's response is pretty depressing and uninspiring, particularly on the single non-emergency number, which is an issue that we have pursued. His approach is to say that the Government's attitude is one of decentralisation, whereby it should be up to local government to decide which approach works best locally. That completely misses the point. It would be a nonsense to have one number in Tayside, another number in Fife and yet another in Aberdeen. The whole point of having a single non-emergency number is that there is just one number and that people immediately know what it is. There is no point in people thinking that they should phone such-and-such a number if they are in Dundee but a different number if they cross the Tay bridge to Newport. The public will simply not recognise that as a joined-up system. This is exactly the kind of issue on which the committee felt that the Government needed to provide leadership and pursue a national approach. Unfortunately, it seems that the Government has no interest in doing so and is just batting the issue back to local authorities. Although I support local decision making in many cases, this is a perfect example of an issue on which the lead needs to be taken nationally, and it is extremely disappointing that the Government is not prepared to do that.

George Foulkes: I never thought that I would say this, but I agree with Murdo Fraser 100 per cent—he is absolutely right. I asked a parliamentary question on the subject the other day and got a highly negative response, which was similar to what the minister says in his letter. He almost attacks us when he says:

"ongoing talk of a central initiative creates uncertainty and discourages such local innovation".

It is as if he is saying that we are holding back local innovation by continuing to talk about the desirability of having a single number. I think that we should pursue the matter further. Setting up a single non-emergency number would be one of the most popular measures that a Government could take, so I am not sure why I am suggesting that the Scottish National Party Government should pursue the idea, but it needs to do something popular, especially after the Glenrothes by-election.

It would be really good and would capture the imagination if we had a single number, such as 101, that everyone in Scotland recognised. We would be ahead of the rest of the UK and many other countries. I now know a bit more about the technology—I will not go into detail—and know that it could be done. It would not be a huge enterprise to have a single non-emergency number, given what modern technology can do; it is certainly achievable.

Murdo Fraser is right, so how can we pursue the matter? Can we invite someone along? I do not mean Robert Gordon. Perhaps we could invite Kenny MacAskill to speak to us.

The Convener: I will come back to that.

Willie Coffey: I have a separate point about non-emergency response times, which I have raised at previous meetings. I think that I am encouraged by the minister's statement that

"Work is underway to agree a national indicator",

but for the life of me I could never understand why the issue was so difficult to report on. We are talking about the public's perception of how long it takes for the police to arrive once they have been called, which I do not think is difficult to track. That is what the people whom I represent ask me: in general, how long does it take the police to arrive when they are called to deal with non-emergency situations? Despite the message in the minister's response, we must make progress on an indicator. I see that Ronnie Nicol has joined us. Can you shed any light on what progress is being made on an indicator for non-emergency response times?

Ronnie Nicol (Audit Scotland): Quite a lot of work is being done on a range of policing performance issues. Part of the difficulty is that non-emergency response times are just one of a number of issues that a range of stakeholders might want to have specific information on.

A few years ago, we introduced some statutory performance indicators on general satisfaction with how the police responded to the public and we asked for that information to be gathered every three years through surveys, to give us a broader picture. At the moment, there is an indicator on response times to emergency 999 calls and there is no practical reason why an indicator cannot be established for non-emergency calls, too.

11:00

The new framework will evolve over the next few years. We are just about to receive the results of its initial year. The picture of policing performance that they will paint will allow us to discuss any gaps that might be addressed or anything that might be improved by developing new indicators. As the Cabinet Secretary for Justice has said, a response time in that regard is being considered for commencement next April. I do not have an up-to-date story on how well that development is progressing, but I will be attending the strategic group meeting next month. In any case, that is what the plan is. This is only one of a range of things that people would like to know about police performance, and it is a question of having a reasonably manageable framework.

Willie Coffey: That is encouraging.

The Convener: Another issue is the accountability of the Association of Chief Police Officers in Scotland. Although the cabinet secretary says that he does not

"share the view that ACPOS is … unaccountable",

he does not explain how he thinks it is accountable. I am certainly interested in hearing more about that accountability. Who makes appointments to ACPOS? Given that it is a company limited by guarantee, who decides the company's role and to whom is the company responsible?

Issues such as single non-emergency numbers, response times and the accountability of ACPOS are certainly worthy of further comment, and I think that the concerns are sufficient for us to consider making a short report. The question is whether there is any value in getting the cabinet secretary back or whether we simply do the report.

George Foulkes: I have a suggestion that might help. Did we not raise questions about the accountability of the Scottish Police Services Authority? Have I got its name right?

If we have not raised the issue before, I wish to do so now, because the situation is similar. I spoke recently to the Scottish Police Services Authority forensic services in Edinburgh and I gather that in Aberdeen and now in Edinburgh there is some concern about the centralisation of forensic services. If we are going to bring Kenny MacAskill back before the committee, can we ask him about that issue?

The Convener: Although you raise legitimate public concerns that should be considered by the Parliament, this report does not give the committee the justification to pursue them. There is no Audit Scotland report on that matter—

George Foulkes: So Audit Scotland has not looked at the SPSA.

The Convener: Although, as I have said, the issue is of legitimate public concern, I do not think that what you suggest is relevant to the committee's examination of this report.

George Foulkes: I thought that the Auditor General had looked at the SPSA.

The Convener: Not in relation to this report.

Cathie Craigie: In its recent inquiry into policing, the Justice Committee took evidence from various organisations. The clerks might wish to pull out the parts of its report that refer to the SPSA.

Mr Black: A performance audit of the SPSA was an option in our forward work programme. Given the very positive response to the suggestion, it is likely that we will include it in our next programme of work.

George Foulkes: Excellent.

The Convener: Did you want to say something, Stuart?

Stuart McMillan: I was about to say that we discussed that very issue at a meeting a couple of weeks ago.

The Convener: Do members agree to put together a short report? I do not think that we need to bring the cabinet secretary back.

Members *indicated agreement*.

The Convener: We will also get some clarification on the other issues that were raised.

"A financial overview of Scotland's colleges 2006/07"

The Convener: The next item is consideration of a response to the section 23 report "A financial overview of Scotland's colleges 2006/07". Do members have any comments, or do we agree simply to note the response?

Murdo Fraser: All that we were asking for was a copy of the guidance, which has been provided. I suggest that we note the response and close our consideration of the issue.

The Convener: Okay. We will agree to note the response—

Nicol Stephen: Have we got the guidance?

The Convener: Sorry?

Nicol Stephen: The response says that the guidance will be available

"by the end of October".

So it is available. That is fine.

The Convener: Okay.

As agreed, we now move into private for item 8. I ask members of the public to leave.

Murdo Fraser: There aren't any.

11:05

Meeting continued in private until 11:26.

Members who would like a printed copy of the *Official Report* to be forwarded to them should give notice at the Document Supply Centre.

No proofs of the *Official Report* can be supplied. Members who want to suggest corrections for the archive edition should mark them clearly in the daily edition, and send it to the Official Report, Scottish Parliament, Edinburgh EH99 1SP. Suggested corrections in any other form cannot be accepted.

The deadline for corrections to this edition is:

Monday 24 November 2008

PRICES AND SUBSCRIPTION RATES

OFFICIAL REPORT daily editions

Single copies: £5.00
Meetings of the Parliament annual subscriptions: £350.00

The archive edition of the *Official Report* of meetings of the Parliament, written answers and public meetings of committees will be published on CD-ROM.

WRITTEN ANSWERS TO PARLIAMENTARY QUESTIONS weekly compilation

Single copies: £3.75
Annual subscriptions: £150.00

Standing orders will be accepted at Document Supply.

Published in Edinburgh by RR Donnelley and available from:

Blackwell's Bookshop

53 South Bridge
Edinburgh EH1 1YS
0131 622 8222

Blackwell's Bookshops:
243-244 High Holborn
London WC1 7DZ
Tel 020 7831 9501

All trade orders for Scottish Parliament documents should be placed through Blackwell's Edinburgh.

Blackwell's Scottish Parliament Documentation Helpline may be able to assist with additional information on publications of or about the Scottish Parliament, their availability and cost:

Telephone orders and inquiries
0131 622 8283 or
0131 622 8258

Fax orders
0131 557 8149

E-mail orders
business.edinburgh@blackwell.co.uk

Subscriptions & Standing Orders
business.edinburgh@blackwell.co.uk

Scottish Parliament

RNID Typetalk calls welcome on
18001 0131 348 5000
Textphone 0845 270 0152

sp.info@scottish.parliament.uk

All documents are available on the Scottish Parliament website at:

www.scottish.parliament.uk

Accredited Agents
(see Yellow Pages)

and through good booksellers

Printed in Scotland by RR Donnelley