HEALTH AND COMMUNITY CARE COMMITTEE

Wednesday 26 June 2002
(*Morning*)

Session 1

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HEALTH AND COMMUNITY CARE COMMITTEE
18th Meeting 2002, Session 1

CONVENER

*Mrs Margaret Smith (Edinburgh West) (LD)

DEPUTY CONVENER

*Margaret Jamieson (Kilmarnock and Loudoun) (Lab)

COMMITTEE MEMBERS

*Bill Butler (Glasgow Anniesland) (Lab)
*Dorothy-Grace Elder (Glasgow) (Ind)
Janis Hughes (Glasgow Rutherglen) (Lab)
*Mr John McAllion (Dundee East) (Lab)
*Shona Robison (North-East Scotland) (SNP)
*Mary Scanlon (Highlands and Islands) (Con)
*Nicola Sturgeon (Glasgow) (SNP)

COMMITTEE SUBSTITUTES

Brian Adam (North-East Scotland) (SNP)
Ian Jenkins (Tweeddale, Ettrick and Lauderdale) (LD)
Ben Wallace (North-East Scotland) (Con)

*attended

WITNESSES

Peter Bates (Tayside NHS Board)
Tom Divers (Greater Glasgow NHS Board)
Heather Knox (Ayrshire and Arran Primary Care NHS Trust)
Fiona Lees (East Ayrshire Council)
Councillor Robin Presswood (Tayside NHS Board)

CLERK TO THE COMMITTEE

Jennifer Smart

SENIOR ASSISTANT CLERK

Peter McGrath

ASSISTANT CLERK

Michelle McLean

LOCATION

Committee Room 2

Scottish Parliament

Health and Community Care Committee

Wednesday 26 June 2002

(*Morning*)

[THE CONVENER *opened the meeting at 09:27*]

Items in Private

The Convener (Mrs Margaret Smith): Good morning and welcome to this morning's Health and Community Care Committee meeting. We have received apologies from Janis Hughes.

The first agenda item is to decide whether to discuss items in private this morning. It is suggested that the committee consider in private the following items for the following reasons: item 3 is on cancer services in Scotland—on which the committee has been doing some work—and we will be considering draft correspondence to the Executive; item 4 relates to a petition on chronic pain and the committee will discuss a draft questionnaire that is to be sent to health boards; and item 5 is the Public Appointments and Public Bodies etc (Scotland) Bill, for which we will be a secondary committee. The committee will consider possible witnesses for that bill. Is it agreed that we will discuss those items in private?

Members *indicated agreement.*

Local Government in Scotland Bill: Stage 1

The Convener: We move to agenda item 2, which is our consideration as a secondary committee of the Local Government in Scotland Bill. We are taking evidence first from Ayrshire and Arran Primary Care NHS Trust and East Ayrshire Council. Heather Knox and Fiona Lees are with us this morning. Thank you for your attendance and for your written submission, which we received in advance of the meeting. Do you want to make a short statement before we open the meeting to questions?

09:30

Heather Knox (Ayrshire and Arran Primary Care NHS Trust): I thought that it might be helpful to give practical examples, so that we can work on them together. First, thank you for inviting us and for giving us the chance to inform the committee of our experience of partnership working. As you said, we forwarded copies of our newsletter, which demonstrates the breadth of what we are doing, but it is important that we examine the service-delivery model, which we are trying to do, irrespective of community size. With our partners in the police and the local authority, we are trying to bring the right services under one roof, for the community.

The Dalmellington centre is at one end of the spectrum. It is a large project that houses almost the full range of council services. It contains a reasonable size health centre and the police have their local office there. At the other end of the spectrum is New Farm Loch, where we have a couple of rooms for council use and a couple of rooms for the health service. New Farm Loch is an isolated community and it is difficult for people there to access services readily. We are talking about deprivation and transport issues. The project is another vehicle to bring services to outlying communities. Fiona Lees may wish to add to that.

Fiona Lees (East Ayrshire Council): The only additional point is that people in the communities where we work—they are no different to the people in the communities that committee members represent—expect seamless public services. Increasingly, they welcome that and they will come to expect it. They expect us to plan together, work together and act together. We have made considerable progress in those areas. We welcome the opportunity today to highlight the additional barriers that need to be removed, so that we are able to make more progress in our communities.

The Convener: Before we move to questions from colleagues, what barriers have the projects encountered so far? Has there been a shift as you have progressed?

Fiona Lees: That is a difficult question to answer.

The Convener: Ah ha! Asking difficult questions is my job.

Fiona Lees: It is a good one. We do not see the barriers, because it is our job to find a way round them. In fact, we say "over, under, round or through." In doing that we sail close to the wind at times, to be frank, and although we have not actually broken rules, rules do need to be relaxed. We need greater flexibility. The Local Government in Scotland Bill makes considerable progress in certain areas, in particular in relation to councils. There need to be corresponding changes in other public services, so that they are able to participate fully in the local community planning process.

The Convener: That is a refreshing attitude. I am sure that it will be picked up on by colleagues.

Bill Butler (Glasgow Anniesland) (Lab): Could you outline for the committee whether you are broadly in favour of or against the principles of the Local Government in Scotland Bill?

Fiona Lees: I will kick off in general terms. From East Ayrshire Council's point of view, we welcome the principles behind the bill. We welcome the placing of a statutory duty on local councils to lead and support the community planning process, and the similar duty on other public partners to participate in the process. We welcome the duty in respect of best value and the removal of restrictions in respect of compulsory competitive tendering.

In particular, one of the highlights of the process of moving from consultation to the bill has been the inclusion of section 13, which gives considerable flexibility to local councils to move from best consideration to proposed consideration in the disposal of land. That is an important step for some of the partnership projects that we have been involved in. In general terms, the bill is to be welcomed. It is a good day for local government.

Heather Knox: My plea is for the national health service to have some of that flexibility, because if we are going to engender further partnership working, we need to have the same kind of mechanisms and more flexibility in how we operate.

The Convener: We have probably all come across potential projects in our own areas. I came across one recently in Queensferry. Having to get full market value for land in and around Edinburgh when there is a clear community need and interest has been a sticking point. It is important that we move in the right direction. I hope that that is what will happen in Queensferry.

Paragraph 41 of the policy memorandum to the bill states:

> "The statutory underpinning will be valuable in ensuring the on-going engagement of key participants and for maintaining the momentum and supporting difficult decisions which will need to be taken to improve the planning and delivery of services."

Do you feel that the current community planning process requires that statutory basis?

Fiona Lees: Speaking from the council's point of view, I do not think that we ever needed that. Our core values are quality, equality, access and partnership. We have always recognised that local government is in an ideal position, because it knows all the difficulties and challenges that face its citizens, but it does not necessarily own the solutions. It is in a pivotal position to be able to bring others together round the table.

As I look back over my lifetime in public service, I think that those arrangements, the success stories and the good practice have often depended on people getting on and on the circumstances in a community at particular times. We must move away from that approach to one in which, regardless of the people involved, it becomes part of everyone's business to plan and deliver together. To that end, community planning is very welcome.

Mary Scanlon (Highlands and Islands) (Con): Paragraph 49 of the policy memorandum states:

> "The Bill will place a requirement on local authorities to publish reports on implementation of the duty of Community Planning and what has been done".

Are reports necessary?

Fiona Lees: It is necessary for local authorities to be accountable—that is an important point for local democracy and the delivery of local services. We have no difficulty with the requirement to report on the progress that we are making on community planning, because people want that information. They want to know what is happening in their area, how public agencies are responding to the challenges and what progress those agencies are making.

In the regulations that will be introduced and, I hope, in the guidance that will come out, it would be helpful if we could ensure that we avoid duplication of effort in the statutory reporting mechanisms. The bill proposes some flexibility in and relaxation of the statutory performance indicators and the performance appraisal framework—that might be interesting, from the committee's point of view. To be honest, being able to obtain that sort of information is not a burning issue in local communities. For example, I

do not remember ever being asked about the cost of replacing a lamp standard in a housing scheme, but I remember being asked about how our services are tackling and responding to the needs of young people.

The requirements to make progress on community planning and to report that progress are not onerous and are to be welcomed. However, we would encourage further consideration of a corresponding removal of some of the other requirements to report information that we believe is less relevant and less valued by our citizens.

Mary Scanlon: I had a brief look through the bill—you are obviously more familiar with its contents than I am. I wondered what information you would include in those reports, and how you would measure that information. Paragraph 49 of the policy memorandum says:

"Such reports will contain a description of how equal opportunities has been promoted".

How do you measure equal opportunities? How do you measure the promotion of well-being?

Fiona Lees: We are anxious to move towards measuring that information. Let me give the example of a case study that we undertook on our pioneering project in Dalmellington, where, as evidenced in our newsletter, we provide a number of services under one roof. We are already beginning to measure outcomes from those services. We know that our front-line reception staff deal with 90 per cent more callers, which means that our backroom staff—they are more appropriately described as home-visiting and community-based staff—are doing the job that is important to them. They are out in the community, rather than dealing with the telephone and reception. Already, people are concentrating on doing to the best of their ability the jobs that they were trained to do. The take-up of lifelong learning opportunities has increased by 30 per cent and reported crime has increased by 33 per cent, which reflects greater community confidence and a much more accessible service.

Those statistics are almost outputs, but we need over time to move towards long-term outcomes and social results for communities. People do not want to know that the take up-of public services is being improved. They want to know that we are tackling the issues of jobs, health and educational attainment in the long term. We need to start building in those measurements, so that we are able to monitor step changes over time.

Mary Scanlon: I will pursue that point. In my opinion, the policy memorandum is vague about equal opportunities and how to promote well-being. Should the Executive suggest indicators and outcomes on crime, jobs or whatever? One example is bedblocking. I sat through the passage of the Community Care and Health (Scotland) Bill, during which I heard that partnership working between the NHS and social work is not always wonderful. Should partnership working be used as an indicator in future or are such indicators too vague to be set down?

Fiona Lees: No—partnership working should not be used as an indicator. Most people in communities know the kind of results that we want to see over the long term. Councils, their community planning partners and, indeed, the Parliament need to be satisfied that the kind of measures that are in place will lead to that kind of step change and to those social results. People in communities do not necessarily want to know about bedblocking, but they want to know that their community is getting healthier. We need to be able to measure long-term health gains in communities.

Mary Scanlon: People also want to measure whether the NHS and social work will work together. Reports from agencies can be different—that is a problem. Apart from equal opportunities, there is no guidance about the areas on which councils must report their performance. Some people can produce imaginative reports without achieving anything. What mechanisms need to be put in place to achieve the accountability, partnership working and community planning that we are all looking for?

Fiona Lees: We have to have maximum flexibility. We need also to trust that the public agencies locally will deliver services and ensure that citizens in communities will hold the agencies to account. The way we would go about trying to deliver social results in Kilmarnock is different from the way we would deliver them in rural coalfield areas.

Mary Scanlon: I will come back to the question of social results. Paragraph 48 of the memorandum notes that in community planning a balance should be struck between national and local priorities. Do you envisage that there will be difficulties in striking that balance?

Fiona Lees: Councils welcome the fact that the community planning and well-being powers in the bill would give councils sufficient power and responsibility at local level. A balance must be struck between national and local priorities. However the social justice agenda with its milestones, for example, provides a helpful national framework within which to operate. Community planners at local level must demonstrate how they will deliver the social justice agenda for their citizens.

Mary Scanlon: Does Government at national level work together adequately? Is national

government doing what local government is expected to do?

Fiona Lees: I am bound to say that there are issues about competing agendas and priorities. However, the bill gives a framework through community planning for linking the national agenda to local agendas. The framework that is articulated in the bill did not previously exist, but it does now.

Dorothy-Grace Elder (Glasgow) (Ind): In your written submission, you set out that

"A move away from a competitive bidding process to an up front budget allocation to promote partnership working would allow for proper and co-ordinated planning in respect of public sector bodies and for greater community and stakeholder involvement in the process."

Are you sympathetic to the view of the Society of Local Authority Chief Executives and Senior Managers and the community planning task force that community plan partnerships should be able to become legally incorporated? Do you agree that they should be able to receive cross-cutting funding directly, as do partnerships, or do you fear that that might be seen as another layer of bureaucracy?

Fiona Lees: I speak personally when I say that that is not necessary. We have to tread carefully when we create what might be another layer of local bureaucracy, because it might turn out to be a paper tiger. Community planning partnerships must decide what kind of mechanisms they need to put in place in order to do the business and get the result.

Our own preference would be to go for the lead-grant recipient model. If extra money comes in, we can agree round the table who will lead and who will be accountable. However, in that model, all the community partnership partners participate in the decision-making process on how the money should be spent.

I also think that to set up a different process almost misses the point. The important thing is that we change the way we work and that we bend the spend. It is important that we move away from seeing community planning as something that is bolted on to our daily business.

09:45

Dorothy-Grace Elder: You say that you see no advantage in legal incorporation and receiving the money directly in a partnership arrangement. That seems to conflict with your written evidence, although I might be wrong. That evidence says that you favour up-front budget allocation to promote partnership working, but you are telling us now that you do not want that to be set out in legal incorporation.

Fiona Lees: We do not think that we need to set up another body to spend the money. We are not saying that we do not need additional resources; we will always compete for any additional resources that are made available, but our first preference will always be a pro rata allocation linked to need.

Heather Knox: We are collaborating with the council and the police to provide a mechanism for providing services to the community together. I am not suggesting that we are better than anyone else but, from recent conferences that I have attended, I am aware that we are at the cutting edge in that regard. To promote such co-operation, help must be given to people throughout Scotland to set up mechanisms. The bill and additional measures in the national health service should make that work on the ground.

The Convener: I will not try to influence the next member by suggesting what area she might cover, because we all know that that is totally impossible.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): Obviously, Fiona Lees got up early this morning. She never misses a chance to try to get some more money for the people of Ayrshire and I am grateful to her for that.

The financial memorandum indicates that the Scottish Executive will assess whether some assistance will be required for the development of community planning, for example, to cover the development of systems of information sharing and to measure progress. Are such resources necessary, given that local authorities already carry out some of the activities that are associated with community planning?

Fiona Lees: We have recently considered the matter in relation to our response to the Executive's proposals for community budgeting. We were authorised to submit a preliminary expression of interest in that method and that funding stream on behalf of the council and its community planning partners. Clearly, it is important that we undertake research that we do not currently do and gather intelligence that we do not currently gather so that we are able to plan and deliver services. That will require us to work in a new way. Because the boundaries of the various organisations are not coterminous, we are having to do a lot of budget mapping and service mapping. It is important that the lessons from the pilot scheme are learned quickly, that the practices become part of our mainstream activity and that there is a corresponding change in the pro rata budgeting to accommodate that activity.

Margaret Jamieson: Might that system develop? The NHS board in Ayrshire undertakes a lifestyle survey every five years, but I do not know whether that is a collaborative survey. It appears

that the board believes that the results of the survey are NHS property and that they can be used only for NHS planning. Should the health service be joined with the three local authority partners in Ayrshire? That might be double the size of a normal survey, but would it be helpful?

Fiona Lees: We should do everything that we can to co-ordinate the way in which we gain information and seek feedback on public services. Although East Ayrshire might want slightly different information to our partner authorities, the scope for such joining would remain. Not only would there be economies of scale, but we would receive fully comprehensive information about our communities and the community would see us approaching it as one, rather than our killing people by consultation. It is important that we manage that process.

Heather Knox: There is growing recognition in the new NHS board that through social inclusion partnership activity—of which there is a great deal, particularly with East Ayrshire Council—there are other ways to work together. There is the better neighbourhood services fund and all the other ways to gain information about certain communities. We can gain information by working together.

Fiona Lees: Heather has given a good example. We are required to monitor progress against the local outcome agreement for the Executive's better neighbourhood services funding. We go back to the community through survey and consultation and we can do that as one body—the health service, the police, the council and other partners get to ask the questions that they want to ask. That is a good sign for the future.

Shona Robison (North-East Scotland) (SNP): You touched on some of the barriers to partnership working, but could you say more about the extent to which you think the proposed power of well-being will help to overcome those barriers?

Fiona Lees: The power of well-being is welcomed, particularly the fact that it is a power of first resort, rather than of last resort. I cannot think of anything that we have been prevented from doing that we wanted to do, but the proposed power would give councils flexibility and a degree of comfort. The limitation would be that it is a power that has been given only to councils. Other public agencies also need such opportunities so that they can participate fully in the community planning process.

The power of well-being is effective only where a prohibition or limitation does not currently exist. That is why section 13 of the Local Government in Scotland Bill is so welcome; without that section the power of well-being could not have overcome issues such as the disposal of land for less than market value. The power of well-being gives flexibility and comfort, but it does not remove existing limitations and prohibitions. It is important that the Parliament keep a close eye on that. As the community planning process develops, other limitations will become evident, so it is important that other legislation be repealed as and when required. We welcome the power of well-being, but section 13 is probably more important. It is probably more important, from the perspective of the Health and Community Care Committee, that other public agencies in the community planning process have the same flexibility and freedom to deliver locally.

The Convener: I presume that voluntary sector partners will benefit from the power. Is there anything that you want to say about that?

Heather Knox: As we said in our written evidence, in some of our partnership deals, particularly one in South Ayrshire Council, we have come to recognise that voluntary bodies support the statutory agencies, so we must therefore support them. It makes sense to help them to find a roof, perhaps by enabling them to share premises with other statutory agencies. The problem is that at the moment the rules mean that a partner must bring to the table money or land, which the voluntary bodies do not have. Somewhere in the mechanisms that we are considering for the future, we need to engender the principle that statutory agencies should support voluntary organisations more appropriately. I am not suggesting that they do not do that at the moment, but statutory agencies must be much more helpful than they have been in the past. That support should involve things like getting us all into one building and providing services. At the moment there are barriers to that because the voluntary bodies are not bringing anything to the table. That should not be to their detriment, but often it is.

The Convener: At the moment they are probably bringing service delivery to the table.

Heather Knox: Absolutely.

The Convener: They do not have hard cash or a roof over their heads, but what they do bring is good and flexible.

Heather Knox: However, the current rules mean that I would have to charge them rent. To my mind, that is taking away the money that enables them to deliver a service. Surely we should find a way of not charging them rent.

The Convener: I am all for that. It sounds very good.

Your evidence draws attention to the need for budget allocations to facilitate partnership working.

For the sake of clarity, will you say whether you envisage a need for additional funds to be allocated at health board or local authority level? Alternatively, is there a need to ring fence existing budget allocation for the purpose of partnership working arrangements?

Heather Knox: One of our main problems with budgeting for partnership working is losses on property transactions. That is a huge problem for us.

We will be running a scheme in north-west Kilmarnock. I am going to gift to East Ayrshire Council a clinic that is valued at £480,000. That is not what the clinic is worth, but that is its value on the books. In the past, the trust was able to use surpluses for property transactions. Surpluses were built up on an income and expenditure account. We were able to use those surpluses for property transactions, and we could sustain any losses and stay within our financial duties. As a trust, we have always met our financial obligations.

We have done a projection—I can supply it to the committee if required—of all of the possible partnership schemes in the next five years. The NHS's new rule has put a threshold of £175,000 on our trust. Next year therefore, north-west Kilmarnock is going to bust the bank immediately and we are going to be bankrupt.

In terms of additional money, there is a mechanism whereby we can go back to the Executive for extra money for partnership working. I am concerned about that because there is no more money if we do go back. The money is out there, but it is not mainstream funding. Partnership working must become mainstream because it is the obvious way to do business. We were able to create the Dalmellington centre because that new rule was not there to break. Now that it exists, we will have to find a way around it or we will not be able to fulfil our financial duties, which does not seem right.

The Convener: No. That is the left hand not knowing what the right hand is doing.

Fiona Lees: If the trust that Heather works for had a facility as described in section 13 of the Local Government in Scotland Bill, that would allow the trust to dispose of the building without having regard to best consideration.

Margaret Jamieson: I had better declare an interest in north-west Kilmarnock. It is crazy that one of the partners there might well find itself bankrupt and without the finance that is required to ensure that the building there is capable of delivering the services required by that deprived community. No one has put a value on the improved health and well-being of that community, and that does not seem to add up. We still seem to be in a situation where the pounds are there and the bean counters have to satisfy specific requirements within current legislation. I know that the legislation exists to protect the public pound, but it is the same public pound whether it is in the books of the primary care trust or in the council's books. We must find a mechanism that allows us to move round the public pound to ensure we get best value for the health and well-being of the community. Do you believe we are on the right track?

10:00

Heather Knox: Absolutely—I am desperate for the bill to apply to me, too. The problem for the north-west Kilmarnock project is ownership of what is a public entity; that should not prevent us from doing what we want to do. We will find a way round the problem, but other people in Scotland are not taking the same steps because they might have to bend things to make it happen. There must be a change in the rules to facilitate this kind of working.

Margaret Jamieson: The Ayrshire and Arran Primary Care NHS Trust performance assessment is in August. You will have to demonstrate that you have spent money appropriately and that you have complied with the financial standing instructions manual. Are you not taking a backwards step? If we are true to keeping partnership at the core of what we deliver to the communities we all serve, should the partners—the councils and the police, among others—not be at the table when that performance assessment takes place?

Heather Knox: That is what we are aiming for, although we are not there yet. The performance assessment framework is new and the health service is still grappling with it, never mind extending it elsewhere. You are right that, as a group in community planning, we are accountable for making partnership working happen properly and for providing the services that we say we will provide. The financial mechanisms have to change or partnership working will not succeed and it will not continue.

Margaret Jamieson: Do you believe that the council should have input into the performance assessment framework for Ayrshire and Arran Primary Care NHS Trust?

Fiona Lees: Yes, in the same way that the health service and other community planning partners should be commenting on the council's performance. The performance monitoring that is envisaged for community planning provides a framework at a higher level for that to happen. That higher-level reporting engages much more public interest and we might be able to remove some of the other requirements.

Shona Robison: Do you have any comments or suggestions that should be included in the forthcoming guidance that the Executive will issue on joint working arrangements?

Heather Knox: Recently, we came across an issue concerning capital procurement. North-west Kilmarnock is jointly commissioning and procuring a building. We are lucky in that, for once, the NHS guidance is good and better than the council's guidance. We considered the ratio between quality and cost. We had a long debate about the health service guidance, which states clearly that the ratio for quality versus cost in capital procurement for buildings—including procuring a design team and a contractor—should be 75:25. The best ratio my colleagues in partnership working had achieved at that point was 60 per cent cost versus 40 per cent quality. Immediately we had a major problem. We had a United Nations-style meeting and eventually agreed that if I would direct the project, we could use my quality ratio as opposed to a cost ratio.

We must consider cost because it is a practical aspect, but in the long term, capital procurement, quality of the design team and quality of the product are far more important at that stage than the cost. The whole-life cost of a building is the killer—it is not the sum that is put in at the beginning. That might bring some solace. That is the way it works.

We mentioned partner contributions from the voluntary sector. We feel that it needs to be able to contribute in the right way.

Dorothy-Grace Elder: Your written submissions go into the sale of hospital land and property in helpful detail. Do you think that that issue could be addressed by an amendment at stage 2?

Heather Knox: Yes.

Dorothy-Grace Elder: How strong would you like an amendment to be?

Heather Knox: It would be helpful if it were fairly strong.

Dorothy-Grace Elder: It is obvious that there are sales of hospital property and land throughout Scotland. We seem unable to find out exactly where the money goes. Are your views based on experiences in your area? Has money been lost to the community that should have gone back into the community?

Heather Knox: I am not aware that that has happened in Ayrshire. Every penny is accounted for and put back into the community—we have a strong track record in that respect.

Dorothy-Grace Elder: So you want to protect the public interest in other parts of Scotland, as large sums of money can be involved. Many millions of pounds can be involved in sales of hospital land and the issue is best dealt with by an amendment at stage 2.

Heather Knox: Yes.

Dorothy-Grace Elder: Should the bill have already made that issue a priority?

Fiona Lees: The bill applies to local government and perhaps we would not expect it to have done. However, amendments to section 13 could be lodged in relation to its application to public bodies and community planning partners in particular.

Dorothy-Grace Elder: What difference would it make if that land and property could be adapted and the value assured to every local community? Is there a real premises problem?

Heather Knox: As you know, there is currently a major shift from secondary care to primary care, which we must face. There will be a huge shift in respect of premises, as we will need to deliver far more services at local level. There are a number of community hospitals in Ayrshire and we must consider how they are managed, as the step-down facility from acute to primary care is not working as well as it might. There is a culture change for many consultants. Perhaps I should not have said that, but I have.

We need to provide more flexible premises. The Dalmellington model, in which all the services come together, is the way forward. Health centres and the range of services that we deliver should be extended, as technology and other mechanisms mean that we can provide much more at a local level.

Fiona Lees: I have a supplementary point. The issue is not only for the health service but for any public service provider. We have all inherited premises that are not necessarily fit for purpose or are not where they need to be. It is important to review such matters together. We are indebted to Ayrshire and Arran NHS Board for the property strategy that it is rolling out, which involves the three local authorities. We are looking at the services that we need to deliver in communities—the strategy should be service driven in the first instance—and the kind of properties that we need to have. We are looking across our respective property portfolios at who is best placed to provide services.

Dorothy-Grace Elder: You are saying that the first option on such properties should be given to the public interest and that sale prices should be at district valuers' rates to cut out massive speculation by simply selling off to anyone. The property and land might be needed for the public community interest.

Fiona Lees: Yes. That is why section 13 is so helpful. It recognises that there is a de minimis

principle. It also recognises that there will be a margin and requires local authorities to set out their stall as to why they are not accepting market considerations. That is about not only the public pound but the public benefit.

Dorothy-Grace Elder: For many years, valuable hospital land has been sold off.

Margaret Jamieson: How does the way in which VAT is recovered from the health service differ from the way in which it is recovered from local government? In some cases, a considerable sum of money is involved, which could be used to provide many services if VAT did not have to be paid.

Heather Knox: I am not an expert on VAT, although I have some notes on it. The regulations on the treatment of VAT that apply to local authorities and those that apply to the NHS are significantly different. Councils can recover VAT that is incurred on construction contracts, but the NHS cannot.

We stumbled—I may have used that word ill-advisedly—across that problem when we were working on the Dalmellington project, for which we brought in a VAT expert. Fiona Lees took the lead—the project is based in an East Ayrshire Council building—and the money from our successful primary care modernisation bid to the Executive was ploughed into the building. That money immediately transferred from capital to revenue—I can come back to that. Ergo, Fiona had a threshold for VAT that we had to get round—or rather, to be aware of.

Fiona Lees: We had to work within it.

Heather Knox: Yes—we had to work within it.

At the end of the day, we did not pay VAT, but because our bid had VAT money attached to it, we were able to use that money to install the mezzanine floor. That was very much appreciated in Dalmellington because we were able to put in more services.

I understand that the situation will be dealt with in a bill that is to be introduced later in the year—I am not quite sure which one. That is all that I can tell you about the VAT issue.

Fiona Lees: If we want to capture those funds and reinvest them in the community, that will skew decisions about ownership. However, the bottom line is that we will not turn down more money and that we will look for the maximum investment.

The transfer of funds from capital to revenue has a further complication for the health service.

Heather Knox: That is correct. Recently, the Executive, quite rightly, introduced measures to control the transfer of funds from capital to revenue. Some trusts were using capital moneys to pay for staff, but that is purely a revenue matter. In the modernisation schemes and partnership work that we have been involved in, our capital is transferred to revenue for facilities and structures. Unfortunately, the same rules apply to all revenue. Ayrshire as a whole is allowed about £2.135 million as a threshold for 2003-04, but north-west Kilmarnock, on its own, will take up 92 per cent of that limit. Those measures were introduced, quite rightly, to govern funds and to ensure that people are made accountable and use capital appropriately. In this instance, the measures have hit a target that they were not intended to hit. We must review the measures because, for example, the rules will prevent me from repeating what we did in Dalmellington.

The decisions that we make in our partnership work will be skewed because I have to pay capital charges if the asset remains in my portfolio. Our decisions on how to progress schemes should not be based on who owns the asset at the end of the day. That is the tail wagging the dog.

The Convener: We should have a level playing field so that you can make the decision about whether it is most appropriate that an asset is managed in the trust's portfolio or in that of the council. That would be better than one organisation getting a financial benefit and, as you have described so graphically, the other having a negative reason for making the decision.

Will you give the committee some written background on your point about capital going to revenue?

Heather Knox: Yes, we can do that.

Dorothy-Grace Elder: Is section 33, on VAT, a shelter on public authority deals?

The Convener: It would be helpful if the witnesses would give us their written evidence on the issues of VAT and capital to revenue.

I thank the witnesses for giving evidence this morning and for their written evidence. You have been a breath of fresh air and have obviously won awards for the stuff that you have been doing on the ground in your local communities. We are pleased to see that and will try to do whatever we can to assist you and we hope that north Kilmarnock will not break the bank.

The next person in front of the committee is Tom Divers who is chief executive of Greater Glasgow NHS Board. Good morning, and thank you for your attendance. Will you begin by making a short statement before we move on to questions?

10:15

Tom Divers (Greater Glasgow NHS Board): I have a short statement that will take a maximum of two or three minutes and which will amplify my

written submission. The perspective from which I offer my submission is twofold. I am a member of the ministerial community planning task force that was established early last year and I have chaired the group that is working on engaging communities. Prior to that, I was a member of the joint Convention of Scottish Local Authorities and Scottish Office working group that in 1998 produced the original recommendations on community planning and its role.

My second perspective is the one that I bring from my work on community planning in Lanarkshire over the previous three years, and in the past six or seven months since I returned to greater Glasgow.

In section 2 of my short paper, I make the point that the legislation is welcome. If some of us have been nervous over the course of the past year, that was because we thought community planning might not be made mainstream to the tasks of improving community well-being and service delivery across Scotland. The significance of the proposed legislation is that community planning appropriately appears at centre stage. As I say in paragraph 3.1 of my submission,

"Clause 16 contains the key message that Community Planning is not an option but is viewed as essential to the delivery of better services and the achievement of overall community well-being."

Flipping back briefly to paragraph 2.3 of my submission, one of the things that has struck me over the past couple of years has been that, at times, we might not have recognised a number of successful examples of community planning that are already in operation. The work that health, social care, housing, the voluntary sector and other agencies have been doing on community care, and more specifically and recently in implementing the key recommendations from the joint future report are powerful and relevant examples of community planning in action. We need to learn from those. As I mention in paragraph 2.3 of my submission, there are important lessons to be learned about how agencies put resources together in order to support the programmes and plans that we develop over the course of the coming months and years.

In paragraph 3.2 of my short paper, I have commented that the one significant partner who has been around the community planning board tables since day one, and who is not covered by the duties imposed by section 17 of the bill, is Communities Scotland. I acknowledge that its designation and status has altered recently, but that organisation is an important partner in this work, not least given its role in leading on community regeneration. There is an issue around how a duty for Communities Scotland might be expressed.

I move on to section 4 of my paper, and my response to one of the specific questions posed by the committee in its briefing note. I have offered a perspective on the extensive opportunity that there was for consultation prior to the bill coming before the Parliament. The community planning task force has been able to support the consultative process, not least through some of the major seminars that we have run in recent months in which we have tested out the key elements of the guidance on which we have been working.

The Convener: You might have already answered the question that Bill Butler is going to ask, but I will give him the opportunity to ask it anyway, along with anything else that pops in his head.

Bill Butler: In your written submission and your opening statement, you made it clear that you welcome the Local Government in Scotland Bill, especially in relation to community planning. Would you elaborate on why you think that the principles that are enshrined in the bill are positive ones and on the way in which they might work in practice? You have alluded to some of the practical ways in which community planning can be a positive force, but I would like you to say a little more on that.

Tom Divers: I would like to deal with the question mainly from a health perspective. One of the huge steps forward in the past two to three years has been the clear policy articulation of the existence of health inequalities and the importance of agencies working together to address the determinants of poor health. I believe that community planning is the best vehicle for addressing that.

Within the health sector guidance, there is an explicit linkage between health improvement and community planning in that each local authority is now working actively to develop a health improvement plan and is taking the lead in the development of that plan with the health agencies and others. That health improvement plan is a subset of the community plan. It also links explicitly into the local health plans that NHS boards are responsible for developing as their key strategic vehicles.

The bill strengthens what was contained in the 1999 public health white paper, "Towards a Healthier Scotland", by bringing into play a statutory underpinning. The duties in sections 16 and 17 mean that there is a requirement on the key agencies to participate in the processes that are led by local government, to involve a broad range of community interests of all descriptions and to account publicly on an annual basis for what has been achieved and delivered.

Bill Butler: Do you agree that the bill provides

the framework by which progress is possible by formalising best practice?

Tom Divers: Yes. Significantly, the fact that the duty is being extended across the public sector agencies and a wide range of partners implies that the same responsibility is placed on the departments of the Scottish Executive. That should ensure that cohesion and coherence are sought after at a policy level.

Mary Scanlon: Paragraph 49 of the policy memorandum says that the bill

"will place a requirement on local authorities to publish reports on implementation of the duty of Community Planning and what has been done by way of Community Planning".

Is there a need for more reports into the activities of health service agencies other than to highlight failures?

Tom Divers: The requirement on community planning partnerships led by local authorities to report regularly is an important part of the process. We must be able to demonstrate that that conjoined effort helps to improve service delivery and community well-being and we need to account for that effort against specific action plans that are agreed and published each year. I have been involved with mechanisms in Lanarkshire whereby there are annual community conferences and progress and failure against previous years' action plans are laid out and made the subject of debate. Such open accountability is important.

In the health sector, issues relating to accountability are increasingly becoming more explicit and public. Members will know that we operate not under a best-value banner but under three limbs of governance that cover financial governance, clinical governance and staff governance, which is a new responsibility. Margaret Jamieson discussed the accountability review process and the performance assessment framework that underpins it with Heather Knox. This year, for the first time, the outcome of accountability review meetings between the health department and local NHS systems will be in the public domain. There was a meeting in greater Glasgow last Thursday and I expect the record of the eight key agenda items that were discussed at it to be in the public domain in the next two to three weeks. The report of that event should feature in the NHS board's annual report.

The level of scrutiny that is increasingly being brought to bear on clinical governance is a key issue in the health sector. What quality of clinical care is being delivered? The quality standards board for Scotland will bring together the work of the Clinical Standards Board for Scotland, the Scottish Health Advisory Service and other bodies. Their reports are now in the public domain and come before NHS boards in public session. There is much more public scrutiny and accountability than there was three or four years ago.

Mary Scanlon: I think that we are all signed up to scrutiny, accountability and transparency, but the paragraph of the policy memorandum to which I referred states:

"Such reports will contain a description of how equal opportunities has been promoted as part of the process."

That seems to provide the only guidance on measurement. How are equal opportunities and well-being measured? The previous witnesses mentioned "social results". Is not it likely that positive figures that may result from better policing, for example, will be picked out and published? What will be measured? How are equal opportunities, well-being and social results measured? How can an outcome be said to be the result of community planning rather than of one agency doing something better?

Tom Divers: You have mentioned a handful of issues.

The Convener: That is a typical Mary Scanlon question.

Tom Divers: The first key point about community plans is that they set out explicit commitments over the short and medium term. That should avoid the fear that only positive results will be presented.

The task force's work has involved considering the 32 community plans in Scotland and differences in approach. One of the commonest issues that has emerged is the themed approach that the majority of community plans take. There are five key themes within the community plan: health and well-being; community safety; education and learning; employment; and transport and environmental issues. My sense is that the plans should set out a commitment to a number of success indicators for each of those themes. On health improvement, commitments should be made to achieve a measurable improvement over a period of three to five years and those commitments should be published.

10:30

Mary Scanlon: So you are saying that there should be more guidance in the plan and that it should be more prescriptive—as opposed to the vague reference in your submission—in order to hold agencies to account under the various headings.

Tom Divers: There is a framework. One of the four sub-groups of the community planning task force—the one chaired by Caroline Gardner from Audit Scotland—has been examining success criteria and has done work on charting progress. As part of the guidance that the task force will

produce in draft form within the next two to three weeks, there will be a set of recommendations on how progress should be measured over the lifetime of plans. That should sit alongside the framework that you have drawn on.

Mary Scanlon: So you are saying that we are moving towards the measurement of social results, well-being and equal opportunities.

Tom Divers: Yes. My expectation is that the individual community planning partnerships will reflect on the key emphases of their local community plans.

Mary Scanlon: You did not answer one part of my question. How do we know whether a positive outcome in, say, employment or transport is not the result of one agency doing its job very well? How can it be claimed that the result is due to community planning?

Tom Divers: I come at that issue slightly differently. I do not think that it is critical to be able to point to community planning having been the vehicle by which a success has been achieved. All the agencies that are part of community planning partnerships continue to carry their existing core responsibilities. That should lead to improvements. The thrust of community planning is that, by threading things together better, there is an opportunity to gain added value. Over time, the test will be whether added value has been delivered.

Mary Scanlon: The policy memorandum states that local authorities must

"publish reports on implementation of the duty of Community Planning and what has been done by way of Community Planning".

Tom Divers: Yes. I accept that with community plans there is an explicit requirement to set out what will be achieved. At times, we can chase shadows in grappling with whether something has been delivered because of the community plan. The situation will become clearer over the years.

Mary Scanlon: Paragraph 48 of the policy memorandum notes that a balance needs to be struck between national and local priorities in community planning partnerships. Do you envisage difficulties in striking that balance? Do you agree with the Executive that

"Individual agencies ... will ultimately be responsible for their individual actions within this context"?

Tom Divers: I do not envisage a difficulty in striking a balance between national and local priorities. In the work that we have undertaken in community planning partnerships thus far, it has been possible to synthesise the issues comfortably while still leaving space at a local level for the issues that may not form part of the national priorities. For example, in health, the national priorities—which are to improve the figures for premature mortality from coronary heart disease and cancer, to focus on services for children and young people and to continue to work to improve mental health services—have fitted comfortably within community planning, as have the broader responsibilities that were set out in the white paper "Towards a Healthier Scotland" to improve the general health of the public. I do not see a tension there.

Each of the agencies will continue to deliver their core responsibilities. The added value comes at the point where we are consciously blurring the responsibilities among some of our agencies to enable us to commit resources for the wider general good. From the work within the social inclusion partnerships and the work that has been done on health improvement funding, we have learned some powerful lessons about how pump-priming money from the Executive can help to get cross-cutting initiatives started and how those initiatives can subsequently be maintained in the longer term from mainstream funding. We are already going down that path.

Mary Scanlon: You mentioned the health improvement plan. We used to get trust improvement plans, then we got a national health service plan, a cancer plan and a diabetes framework. You are saying that all those plans dovetail.

Will the bill help in relation to issues such as the Stobhill hospital, the acute services review in Glasgow and the problems at the Glasgow royal infirmary's heart transplant unit and at the Beatson oncology unit? I am from the Highlands, so I am not familiar with all those issues, but they have all come before the committee. Will community planning help to overcome the problems that the committee has had to deal with?

Tom Divers: There are two different issues. The issue around the Beatson oncology centre and the heart transplant unit resulted from a lack of key clinical staff, particularly at consultant level. That is a different problem from the ones that have arisen around Stobhill, secure care and acute services, which are to do with how strategic decisions are made and how communities can be engaged with those issues. I do not know how much detail you want me to give on those subjects.

Mary Scanlon: Will the bill make things better in relation to the situation at Stobhill and so on?

Tom Divers: The bill brings the work of the partnerships closer together and causes us to work jointly with communities more closely than we have done previously. Will the bill make a decision about the location of a secure care centre a less contentious issue? I have some doubts about whether the proposals will deliver in relation

to an issue that is as sensitive as that. I do not think that many communities would positively welcome the location of such a facility in their area. However, if we can get discussions with communities established on a structured and regular basis, there will be an opportunity for us to articulate what lies behind the policy issues rather better and with less angst than has been the case previously. However, some issues will always be thorny and difficult regardless of the extent to which communities are engaged.

Mr John McAllion (Dundee East) (Lab): One of the key considerations is accountability, as you have said. It is difficult to get accountability across various agencies. It is probably easier to get it with elected local authorities than it is with unelected health boards, but that is a different issue.

Are you sympathetic to the view of SOLACE and the community planning task group that community planning partnerships should be able to incorporate legally and receive cross-cutting funds as partnerships, which would make them accountable for their work? Would that be preferable to the present situation, in which all sorts of bodies are involved?

Tom Divers: I have sympathy with that view. There are already examples of inter-agency work in which the arrangements for accountability are far from clear. One of my responsibilities as chief executive of Greater Glasgow NHS Board is to chair the drug action team, which is responsible for the delivery of a corporate plan and for channelling the substantial additional resources that the Executive has made available to improve treatment and rehabilitation. However, the drug action team has no clear-cut accountability line. Although I chair that body, the resources are routed through at least 10 agencies and the set-up has no collective accountability. There are some analogies between that situation and the work of community planning partnerships.

Mr McAllion: Previous witnesses told us that another body does not need to be created before they can spend the money. Do you disagree with that?

Tom Divers: Community planning partnerships exist in the city of Glasgow, East Dunbartonshire and South Lanarkshire, but, in my judgment, although those bodies have engaged the key partners round the table, they do not have a formal, accountable status. We do not need to go away and create another body, but we must consider carefully how accountability can be better described. That should not be done by bringing into existence a new entity. We should keep the same people involved and consider whether there is some means of incorporation around a structure.

Mr McAllion: Is it not the case that different agencies, with different budgets, are involved and that ultimately those agencies are concerned only about their own budgets?

Tom Divers: Agencies have a primary responsibility for their core budgets, but the legislation is telling us, "A key responsibility for all of you is to work together on this agenda and"—

Mr McAllion: Is it not true that a local authority chief executive's key responsibility is to his council, rather than to a joint body?

Tom Divers: That is true.

Mr McAllion: The same applies to a health board chief executive.

Tom Divers: Sections 16 and 17 say powerfully to me, "One of your responsibilities as an accountable officer is to ensure that Greater Glasgow NHS Board is engaging in those community planning processes."

Mr McAllion: My problem with your position is that, ultimately, members of local authorities are seeking to get re-elected and so are concerned only with their own budgets. Health boards are accountable to the Minister for Health and Community Care for their budgets and that is what they are concerned about. Although they may wish to work together to achieve those things, no one will be held accountable if the community planning partnerships fall down.

Tom Divers: Under the present circumstances, I think that that is the case. However, the challenge that lies before us is one that tells me, "In addition to the direct accountability that you, Divers, hold for that health spend, you have a wider accountability, alongside these other chief executives and organisations, for the broader well-being of the community and for the delivery of better services, and you can and should be doing that better together."

Mr McAllion: You will not lose your job if you do not deliver that.

Tom Divers: That depends on how, in accountability terms, community planning moves forward. A different sort of accountability will be brought to bear if it is a key success criterion for chief executives that the challenges and commitments that are set out in the community plan are delivered, just as it is key that those that are set out in the health plan are delivered. I do not disagree with your analysis that that accountability does not exist at present. We have to look at increasing accountability around the pool of resources that the agencies bring together, corporately and collectively, to deliver some of those priorities.

Mr McAllion: Do you think that legal incorporation would help that process?

Tom Divers: Yes. I think that it could.

Nicola Sturgeon (Glasgow) (SNP): I have a quick question about resources. The financial memorandum flags up the potential need for the Scottish Executive to provide some assistance with the development of community planning, such as assisting with information-sharing systems and systems to measure progress. You said that many of the activities that are associated with community planning are being undertaken already, principally by local authorities. To what extent might the Executive's assistance be necessary?

Tom Divers: A lot of resource has been committed within agencies. A number of the proposals that have been approved by the modernising government fund will help to take forward a lot of that inter-agency work, not least by facilitating the establishment of comparable, shared and compatible data systems.

A key issue that came through the task force's work was the need for additional resource to help to enhance and develop community capacity and to ensure that community interests can participate to the fullest extent in community planning. We have come across a number of examples of community groups that have no funding support or that have short-term funding support but do not know whether, in six or nine months, they will be able to sustain the arrangements that are in place now. Over the course of the next three to four months, the task force will consider that issue, particularly in relation to support for the development of community capacity and involvement.

Margaret Jamieson: Let me take you back to the work of the joint future group, which seems like a long time ago. Are there still lessons to be learned from the group's report that could assist the implementation of the bill?

10:45

Tom Divers: Yes. I refer back to Mr McAllion's questions, because the bottom-line requirement, as it is now called, of the joint future group's recommendations is that agencies must work together. Specifically, in the first instance, they must work together on services for older people, through joint resourcing and joint management of single shared assessment.

As for accountability for those matters, in the Greater Glasgow NHS Board area we are starting to create different bodies, not in addition to others, but to replace them. We have replaced the joint planning forum that existed between Glasgow City Council, Greater Glasgow NHS Board and other agencies with a formally constituted joint community care committee, which operates as a sub-committee of both the council and the health board. That model has been tweaked and developed in West Dunbartonshire, where the focus is slightly broader, in that a health and social justice sub-committee has been created. East Dunbartonshire Council is discussing the creation of a similar body. We are beginning to develop different mechanisms so that we can pick up those questions about accountability.

You will hear more from Peter Bates about the stage that Tayside has reached, which may be more advanced than the one that Greater Glasgow NHS Board has reached. As far as putting resources together is concerned, the Greater Glasgow NHS Board area is not yet at the stage of having pooled budgets for elderly care, mental health or learning disability services. However, we have aligned budgets and agreed financial frameworks in which the parties have committed to a specific level of resource in order to support the implementation of the joint strategies that have been agreed for each of those vulnerable care groups.

That is a step on a continuum that is designed to meet the joint future group's requirement of pooled budgets, in which the money is in a single pot and for which there is one line of accountability. We are migrating towards that position. It is important to remember that we are nine years on from 1 April 1993, when the provisions of the National Health Service and Community Care Act 1990 came into effect. We need to be a little patient about the pace at which community planning partnerships mature and reach the levels of sophistication that community care planning structures are now beginning to reach. We can and must learn from the developments that have taken place in community care.

Margaret Jamieson: Do you think that you can learn from what we heard from Ayrshire and Arran Primary Care NHS Trust and East Ayrshire Council this morning? Do you have anything similar in Glasgow?

Tom Divers: Yes. It is interesting how we cut into the issues in different ways. I have been aware of the Dalmellington project for several months. In visiting community planning partnerships, the task force has tried to find out where the successes are and who has joined up the work in a way that is exciting and innovative and that is leading to improvements on the ground. There are myriad examples of that up and down Scotland, to which we hope to give more prominence in the coming weeks.

A lot of the social inclusion partnership working in Lanarkshire has been particularly powerful. Several projects with a health improvement

banner—around leisure, exercise and dealing with stress—that were initially funded through cross-cutting funding from either social inclusion funding or health improvement funding are now being mainstreamed. Each of the agencies, including the NHS board, is committing in its forward financial plan not a few thousand pounds, but hundreds of thousands of pounds over a three to five-year period to sustain the developments and to ensure that they can continue.

Shona Robison: In your submission, you mention the money that is available to fund posts to support joint working. Can you elaborate on that? How much funding and how many posts are you talking about?

Tom Divers: The funding was money from the Executive to allow the creation of posts to support the development of health improvement plans in each local authority area. The Executive contributed 50 per cent of the funding and the balance of the funding was found by the partner agencies locally. The posts have helped agencies to focus specifically on the development of health improvement plans.

Alongside that, additional capacity has been built in at the level of local health care co-operatives in primary care trusts to support the development of public health expertise in each of the localities. In my submission, I make an important point about local networking. The extra capacity is really beginning to take off where those posts are being threaded into the wider public health network in NHS board and council areas. The posts are not individual posts in the local authorities or the local health care co-operatives; they are part of a broader public health network that is being created, which involves the public health departments in the NHS boards working alongside and in support of them. They have been important in giving some dedicated capacity to lead the work on health improvement planning in local authority areas and they will produce a worthwhile return over the next two to three years.

Shona Robison: To whom do those posts report?

Tom Divers: No single set of arrangements has been prescribed for that. In some of the local authority areas with which I am involved, they report to the member of the corporate management team who has responsibility for community planning. In other areas, where a member of the corporate management team carries a lead responsibility for health and social care in the local authority, the individuals report to them. The important thing is that the posts are well connected to the structures, both in local government and, more broadly, across the partner agencies.

Dorothy-Grace Elder: We read in written evidence submitted to us that

"where any public body is seeking to divest itself of land/property, the first option should be to consider whether it would benefit any community planning proposals … where there is an area of land/property with high financial values"—

as has indeed been the case with hospital land in Glasgow—

"there could usefully be some mechanism to facilitate local authorities in prioritising community facilities"

to be sold or offered at district valuers' prices. Do you agree that that should be done, so as to create a more level playing field for the public interest and to cut out huge, speculative bids?

Tom Divers: Yes, I do. I may even want to go slightly beyond that. I do not have the detailed knowledge of specific transactions that my colleagues from Ayrshire were displaying, but let me take one specific issue in greater Glasgow: the carewell initiative, located in the grounds of what was Lenzie hospital, a care-of-the-elderly hospital.

An inter-agency agreement about a way forward for the proposal on that site was uncontentiously concluded following public consultation more than nine months ago. Then, the proposal got snared up in the whole issue about the value attached to the capital receipt. The district valuers' evaluation is fine, and would be accepted as a benchmark, but the issue that emerged with the carewell initiative is that the desire to provide some sheltered and very sheltered housing accommodation on the land as part of the proposal could have a material impact on the value of the site.

If there is a facility in public ownership and if there is agreement that there is a local need to implement our joint strategy for older people and to provide such facilities, we need some help in order to ensure that we do not get scuppered on the issue of land disposal and land valuation. If we had to move the scheme elsewhere, it would almost certainly cost more. We are still too hung up on the issue. Accountability issues are important, but, where the project is demonstrably in the public interest, it would be enormously helpful if—as a consequence of the committee's interest—it could be facilitated.

Dorothy-Grace Elder: Your board has—although perhaps before your time—been involved in quite a number of land sales. Do you know where the money has gone? You have referred to the carewell initiative at Lenzie hospital, but that is a large, plush site. The carewell initiative will not take up all the land there. There is also Lennox Castle, which is prime real estate, as the Americans would put it. Where has the money gone?

Tom Divers: I can account for where the capital receipts associated with any NHS disposal have gone in terms of the use that is made of them locally. There is a cut-off level, below which the resource may be committed locally. That resource has to be explicitly accounted for in the capital plan that is developed in each NHS board area. There is no possibility that significant capital receipts have somehow disappeared into the ether.

Dorothy-Grace Elder: I was not suggesting that. I have to move on to another question now, but I just add that there is no guarantee that some of the money has not gone into trusts to offset the deficits. That does not necessarily apply to your area, but it applies to other areas of Scotland. We have not seen any great new buildings created in the public interest from the proceeds of land sales, have we?

The Convener: We know that there is more to the health service than great big buildings.

Tom Divers: Are you aware of the Kirkintilloch initiative?

Dorothy-Grace Elder: I have heard of it.

Tom Divers: That is a much bigger and better example than—

Dorothy-Grace Elder: I am over my time, which is unfair on you. Perhaps you could give us a wee bit of written evidence afterwards.

Tom Divers: I will do so on the disposal of Woodilee hospital, which is a vast site.

Dorothy-Grace Elder: Thank you.

Tom Divers: I will come back quickly and share with the committee what is being done. A way through a number of the issues that surround the disposal of valuable sites has been found through a partnership approach.

The Convener: That would be helpful.

Dorothy-Grace Elder: Is there a place in the bill for a section along the lines of section 31 of the Health Act 1999, which sets out possible arrangements for payments towards expenditure incurred in the exercise of partnership functions?

11:00

Tom Divers: That issue has arisen in relation to the involvement of community groups and individuals. I do not know whether that is the context of the section that you cite. One of the flexibility issues that we have considered as part of the task force guidance concerned such matters. In the task force guidance, we will offer advice on the financial support and arrangements that might be considered to further the engagement and involvement of community interests and individuals. I am not sure whether that is the same as the provision that you mention.

The Convener: Thank you for your oral and written evidence and for the fact that you have been rash enough to say that you will give us more. Thank you for attending.

Tom Divers: Thank you.

The Convener: I welcome the next set of witnesses to the Health and Community Care Committee. You may make a short statement before we ask questions. Alternatively, if you are happy for us to go straight to questions, we will do that. It is entirely up to you.

Peter Bates (Tayside NHS Board): I will not make a statement. I simply thank the committee for inviting us to attend to give evidence. I am the chairman of Tayside NHS Board. I invited Robin Presswood to join me and I am grateful that that was acceptable to the committee. In addition to being a non-executive member of the NHS board, he chairs the newly established health improvement committee, which we decided to establish to address inequality in health. That has a direct bearing on community planning.

The Convener: Thank you very much for attending and for sending your written submission in advance.

Bill Butler: In their written submission, the witnesses made it clear that they consider the general principles of the bill—especially community planning—to be "a positive step forward". Will they elaborate on that view and give specific examples of why they hold that view?

Peter Bates: Following what Tom Divers said, it is clear that, if we are to make the improvements that we need to make to promote health and to address inequalities in health and the impact of inequality and poverty on citizens, and if we are to ensure that we get best value from the resources that we spend—which plays a part in the joint future agenda—it is crucial that we all do better at ensuring that local government and the national health service combine time, energy and expertise and that we ensure that, where we can reduce bureaucracy and improve efficiency, we are able to do so.

We in Tayside NHS Board warmly welcome the bill and the raising of the standing and importance of the community planning process, because that places clear duties and responsibilities on the key agencies to work together much more effectively. I have worked in public services in Scotland for more than 30 years and I know that introducing a process alone does not bring about changes. The questions that members asked the other witnesses highlighted that point. The bill makes it clear that the Parliament expects the health

service, local government and other partners to work together much more closely than they have done in the past. We warmly welcome that development.

Robin Presswood will discuss inequality in health and the way in which we are tackling that in Tayside NHS Board, which relates to our discussion of the community planning process.

Councillor Robin Presswood (Tayside NHS Board): I am here not in support of the production of a community plan in each community but in support of the community planning process. The setting out of our vision in a single glossy document once a year should not be seen as the extent of the outcomes. The process of bringing together the public sector agencies to tackle problems creatively by working across agency boundaries is what most excites me about the proposals in the bill.

We identify significant benefit in a large number of areas. Most important, we can obtain better-quality, streamlined decision making if the Scottish Executive provides adequate support by reducing the requirement to produce large numbers of plans in which there is sometimes considerable crossover. For example, we are required by different Executive departments to produce a children's services plan for local authority work with children and a separate child health strategy. That is a classic case of where two documents could be integrated at a local level if the Executive gave us support in relation to joined-up government.

The community planning process will assist us in a number of other regards. One of the previous witnesses spoke about shared information resources, which are one of the key priorities that we have identified. We do not have enough information about the health needs of local communities. We need to pool information resources with the local authority to obtain better-quality information to facilitate planning within the same resources.

The bill introduces significant potential for cost sharing between local authority and health partners, which will drag down the cost of providing services while improving the quality of the services that are provided. There could be benefits in many back-office functions as a result of the ending of restrictions on local authority trading.

The bill offers the potential for the community planning process to facilitate inter-agency investment, which could reduce future revenue costs. I will cite the example of a project in which I have been involved in my capacity as convener of planning and transportation at Dundee City Council. We have done a lot of work on the cost to the public sector of accidents. It sounds somewhat callous to reduce accidents to consideration of the cost to the public sector. The human tragedy of any accident must be paramount in everyone's mind.

The analysis that we have done, which is based on figures from the Department of Transport, Local Government and the Regions, shows that the cost to the health service of a serious injury accident in Dundee is about £9,000 or £10,000. During the past six years, we have been extremely successful in reducing serious injury accidents in Dundee. We have reduced the number of such accidents from about 150 per annum to about 100 per annum. The cost of achieving that reduction by means of traffic calming measures, junction redesign, pedestrian guardrails and so on equates to about £20,000 per accident, so the payback period for achieving savings to the NHS alone will be very short.

I hope that such thinking, whereby we justify higher investment in accident prevention measures because of the revenue saving to the NHS, the police and other community planning partners, can be developed through the community planning mechanism.

Peter Bates asked me specifically to mention the health inequalities agenda. The greatest policy problem for Dundee is that we do not yet have a cohesive response to health inequalities. I represent Ardler, which is one of the most deprived communities in Dundee. The average life expectancy of males in Ardler could be up to 10 years less than in males such as me who live in fairly prosperous middle-class communities. The public sector must do something about that situation, which is absolutely immoral. We cannot allow the buck to be passed between the public agencies.

Community planning allows us to tackle health inequalities at a strategic level by asking the big questions about why inequalities exist and how the public sector can work as a team to turn them around. As Peter Bates said, Tayside NHS Board has established a health improvement committee, which is a full standing committee of the board and which includes the three local authority chief executives, the medical directors of the two trusts, representatives of the local healthcare co-operatives, and staff representatives. There will also be citizens' representatives when we have agreed a mechanism for appointing them. That high-level committee is aimed at transforming policy into action. It will oversee the community planning process in relation to health improvement. The committee is fairly young—there have been only three or four meetings—but it has made significant changes to health improvement in a small number of tangible areas.

The health improvement committee has allowed us to begin shifting leadership in health improvement from Tayside NHS Board to the local authorities. Local government has a budget of about £0.5 million for health improvement and employs about 20,000 people, most of whom are client facing, such as teachers, librarians, leisure workers and swimming pool staff. They can influence peoples' lifestyles and health outcomes more directly than the health promotion workers in the NHS can. The process of assisting and facilitating local government to take the lead on public health work and on tackling health inequalities is the most exciting aspect of community planning.

The Convener: The bill will put community planning on a statutory basis. Will that be beneficial? At present, we rely on people working together in good faith. In some parts of the country that might be developed with enthusiasm and there might be a positive response, but that is not true of other areas.

Peter Bates: The board believes that putting the community planning process on a statutory basis makes it clear that we must find ways of working more effectively than we do at present. That is why we welcome the statutory requirement.

Shona Robison: What the witnesses have said about community planning and the opportunities to move beyond the barriers is positive. However, one constraint will be the availability of resources. Robin Presswood mentioned that health in the widest sense must be taken into account. How far will the board go in doing that? Judgments will have to be made about competing demands such as traffic calming measures and the health department's policy on waiting times. How will you strike that balance?

Peter Bates: Members know better than anyone that citizens—which includes everyone around the table—rightly want all aspects of the health service and local government to deliver. That results in tension. The question is important. It would be easy for me to say rhetorically that we want investment and work to be shifted from the acute sector to the primary and prevention sectors. Of course we want that, but the issue must be handled with enormous sensitivity. We must ensure that we take clinicians, staff and citizens with us as we make changes. If we do not and we make dramatic changes, there will be even greater tension in the acute sector.

There is a challenge for the national health service. I do not think for one minute that we have got things right in Tayside. We still have a lot of work to do to ensure that the NHS system as a whole works much more effectively. Part of my role is to ensure that primary care, secondary care and acute care see themselves as a single integrated system and work effectively together.

11:15

There should be a common understanding that the NHS is not the only agency that has responsibility for health or that can make a difference to health. It is not the only agency in which there should be investment to promote the well-being of communities. To reach such an understanding will not be easy; it will involve a gradual change of culture in the NHS. That is why the community planning process is important. We learn by doing and understanding things together. We do not learn from shouting at each other from opposite sides of a table. Through that process, I hope that the NHS will start to appreciate the added value from investing jointly with local government in a wide range of initiatives.

Robin Presswood mentioned road accidents and traffic calming measures. Consider the work that we have to do around nutrition, diet and exercise and the important partnerships between health and education in that respect. Consider looked-after children who suffer all sorts of added problems. The relationship between social work and health needs to be better. The whole joint future agenda demonstrates that health and local government still have a long way to go. A balanced approach is required, which will not be achieved by sudden and dramatic shifts that leave the acute sector exposed. There are great pressures and, more than any other member, Shona Robison knows that we must progress gradually, thoughtfully and in a measured way.

Shona Robison: The financial memorandum to the bill says that the Scottish Executive will assess whether financial assistance is required for the development of community planning—for example, the development of systems for information sharing and measuring progress. Are such resources necessary, given that local authorities already carry out many activities that are associated with community planning?

Peter Bates: My starting point in answering that question is to state that best value is a process that should drive continuous improvement in performance in local government and health. That is the first challenge. Local government and health services—for Tayside, that means Tayside NHS Board—must ensure that their own houses are in order. Therefore, if there are separate information systems or separate systems, and we have good will and a changing culture, we should effect corporate change together. Our starting point should not be simply beating a drum and saying that we need more resources.

I can give a practical illustration of working together on the enormously sensitive issue of delayed discharge. Through the good will of Angus

Council, Perth and Kinross Council, Dundee City Council and Tayside NHS Board, we have combined expertise and knowledge to develop an integrated information system that provides all the agencies with access to the same information from a variety of different settings. As the chairman of Tayside NHS board, I believe that if we can do that for delayed discharge, we should be able to do it for other things.

I do not think that that will be enough in itself. My view, as a non-executive member, is that there are likely to be occasions when additional funding from the Executive to local government and health to target community planning and promote well-being will be required and helpful. However, the starting point for me is that we should consider what we are currently doing and how we can jointly improve the performance and the value of the public pound that we spend.

The Convener: We will have to start to watch our time at this point, so I ask members to keep their questions a bit sharper and crisper.

Mary Scanlon: You mentioned the glossy document that will be published once a year. However, I am concerned that that glossy document might be published without any measurement of health inequalities. The only advice that is given about the document in the policy memorandum, at paragraph 49, relates to how equal opportunities can be promoted as part of the process. Do you think that there should be a more prescriptive form of measuring community planning?

Your submission says:

"The Bill makes it a duty on a local authority to report performance to the public for its functions. This appears to ignore the need to have joint reporting by community planning partners on joint issues."

What exactly are you suggesting by that?

Peter Bates: The question that you asked Tom Divers was enormously pertinent. I hope that my answer to your question does not come across as impertinent.

This committee could usefully ask the Scottish Executive a searching question about auditing. What planning requirements exist? I do not want to minimise the importance of the community plan, the children's plan and so on. I know that they involve a huge amount of work, but we should ask how many of them might usefully become part of the community planning process. From a management perspective, I have always adhered to the view that, when you introduce a new procedure, you should think about stopping another procedure to ensure that you do not simply add burdens on to hard-worked staff who might feel that the new procedure is just another imposition. When the glossy document appears, they might just ask, "What does this mean for me?"

In health and local government, we are required to produce many plans. We must ask whether the community plan might serve as a vehicle for auditing that and recognise that we might be able to stop producing the plans and leave the responsibility for meeting those requirements within the community planning process.

Mary Scanlon: Are you implying that local authorities need not publish a report on their performance and that that could be subsumed into some community plan? Does that not threaten the accountability of local government and other bodies? If all the responsibilities are merged, how would the public agencies be accountable?

Peter Bates: I am not implying that and I would not venture to comment on that aspect of local government's role. As Tom Divers said, the NHS, through its performance assessment framework, which is in the public domain, and local government, through its democratic processes, will maintain their forms of accountability, and rightly so. The point that I was making related to the huge amount of time and energy that the NHS and local government staff put into the production of a wide variety of planning processes. The community planning process gives us the opportunity to revisit that system and, rather than fudging accountability, sharpen up the process and lessen the time that is spent producing all of the plans.

It is clear to me that the NHS will remain accountable to ministers and the Parliament and that local government will remain accountable to the electorate. The community planning process will not change that. However, we think that the community planning process should result in the NHS and local government, through joint stewardship, telling the public what they have achieved together and saying that that is what they are prepared to be judged by. In any event, the joint futures agenda and other agendas that will be sucked up through the community planning process will require local government and the NHS board to do that.

Councillor Presswood: I can provide members with three specific examples. Although each agency retains accountability in the conventional way and is required to publish performance information, there are a number of issues that can be addressed realistically only through community planning. It would be wrong to expect any one agency on Tayside to be held accountable for achieving targets for a reduction in drug and alcohol abuse, for accident prevention or for a reduction in crime. In all those areas, a genuine partnership approach is required. I would like community plans to produce figures on how we are performing in key areas. That requires the

collaboration of all agencies. People are interested in seeing what we, as community partners, achieve in the key areas.

We were asked whether more prescription from the centre is required. My instinct is to oppose that. In our written submission we emphasise the need for more support from the Scottish Executive in streamlining the current planning procedures. Increased prescription from the centre would not be helpful. In our written submission we also emphasised the need for community planning partners, rather than just individual agencies, to report on the joint issues that I have identified.

Mary Scanlon: I have a final question about measurement. You mentioned crime, accidents and so on. Under community planning, different organisations will measure different things. Tom Divers listed health, safety, education, employment, transport and the environment. I worry that, because there is no guidance, every association will have different headings. Bodies may pick out whatever has been positive and has had good outcomes, in order to produce a glossy document. I would like to think that community planning would have a substantial positive effect, but I cannot get a grip on what we are measuring and how we are doing that.

Peter Bates: That is an important, challenging question. I can speak only from the perspective of the national health service. We need to strike a balance. We do not want to come under more pressure to tick certain boxes, but we recognise that the Parliament and communities have the right to ask what community planning has achieved and what difference it has made. One size does not fit all. The approach that we take in Angus is likely to be quite different from the approach that we take in Dundee, and rightly so.

As part of the community planning partnership, we will be involved in ensuring scrutiny and transparency of planning within Angus, Dundee and Perth and Kinross—as well as across boundaries, where that is in the interests of efficiency. Fife, too, may be included. We should make very clear what we are saying we will achieve and be held accountable for that. If we fail to achieve what we have set out to do, we should be honest enough to admit that. We should also be realistic. I am sure that we will not be able to achieve quickly some of the things that we want to achieve.

I understand where Mary Scanlon is coming from. However, if there were a list of 20 things that everyone had to do, people could become obsessed with doing all 20 things. It might be much better for them to consider local geographical needs and to concentrate on the three or four issues that are really pertinent to them, instead of ensuring that they are able to tick boxes.

Mr McAllion: Robin Presswood was right to say that no one agency should be held responsible for failing to meet health targets. However, the danger is that no one will be held accountable. This morning we heard Heather Knox and Fiona Lees from Ayrshire say that they do not think that community planning partnerships should be able to incorporate legally, so that there is a clear line of accountability. Tom Divers thinks that they should be able to incorporate. What view do you take on that issue?

Peter Bates: I take the middle ground.

The Convener: Cheers.

Mr McAllion: There is no middle ground; you are either for it or against it.

Peter Bates: I realise that there is not. I was not being flippant.

The Convener: We were looking for you to be the golden goal.

Peter Bates: I will draw on my other experiences to answer that question. John McAllion's question clearly was a difficult one, because Tom Divers thought for some time before he answered it. We can see from the way in which the joint futures agenda is starting to unfold throughout Scotland that it is bringing to the table some difficult issues. Do we have pooled budgets? Do we have aligned budgets? Do we have a single manager? If we do, to whom does that manager report? Who will hire and fire that manager and discipline them if something goes wrong? Who will hold them accountable?

The joint futures agenda is starting to put on the table all over Scotland those issues and questions, and rightly so. It sounds as if I am fudging the answer, but there are different forms of accountability. Chief executives in the national health service—and I see myself as accountable to ministers through the performance assessment framework—are clearly accountable for certain things. If we do not do them, as we know only too well in Tayside, we are held publicly to account.

11:30

Mr McAllion: The problem is that you are accountable through the minister to Parliament, but the chief executive of Dundee City Council is accountable to the council. That is the difference. His accountability is different from yours. Should there not be one clear line of accountability for community partnerships?

Councillor Presswood: Perhaps I can come in. My perspective is that the bill is clear that leadership in the community planning process rests with the local authority. The democratic

mandate that local authorities are given means that they are the correct bodies with which accountability should rest. A direct consequence is that the electorate will start judging us not just on the services that we provide directly, but on the services that other public sector agencies provide within Tayside's three individual local authority areas, and on what we can achieve collectively through community planning. That may sound controversial, but the electorate already judges the council on areas in which there is an overlap.

Mr McAllion: Does that mean that the three chief executives of the three local authorities can override Peter Bates in the health improvement committee?

Councillor Presswood: I think it means that they can challenge Peter Bates if he and NHS Tayside are not delivering on key objectives that have been jointly signed up to. If NHS Tayside fails to deliver, it is absolutely correct for Dundee City Council to turn round and say, "Why haven't you achieved these targets?"

Mr McAllion: But Peter Bates will turn round to the three chief executives and say, "I am not accountable to you. I am not accountable to your electorate. I am accountable to the minister through Parliament. He has given me different priorities." That is the problem.

Peter Bates: But the test I always apply—perhaps it is a particularly challenging test—is, in the event that something goes wrong and somebody has to be held accountable, where do the lines go? Not the dotted lines, the straight lines. Tom Divers made it clear that the national health service and local government retain legal accountability for performing certain duties. You are right that chief executives have accountabilities within their bodies. It would not be right for the national health service and local government to find themselves in the confrontational situation that John McAllion presented.

As I see it, the community planning process is an attempt to drive, through co-operative partnerships, local government and health services working together. That is what the joint future agenda is about.

It is interesting that in respect of the joint future agenda the Parliament has taken reserve powers. It said to local government and health services, "Here's what we want you to do. Demonstrate you can do it, but by the way, we've got reserve powers, and if you don't we might do something else." That is right. If the community planning process simply becomes a stick, it will not achieve what it needs to achieve, which is to create a spirit that enables local government and health to bring different things to the table—different experiences and different responsibilities. I would not like the community planning process to give that sort of power to an individual, because that is not what the community planning process is designed to do. But clearly, as Robin Presswood said, the primary duty rests with local government. The NHS, as I understand it, is comfortable with that.

Mr McAllion: But in every health board area you are dealing with three or four local authorities, and sometimes more than that.

Peter Bates: Yes.

Mr McAllion: They all have different priorities, so how do you bring them together? The three chief executives of the three local authorities in Tayside may have completely different views on something, and they are accountable through different streams. Should there not be a corporate body that is accountable for implementing community planning, so that people can say, "If you have failed, they are to blame"? As it is, Dundee can blame Angus, Angus can blame Perth and Perth can blame Dundee.

Peter Bates: First, there are 32 councils. They are separate entities that fiercely, understandably and properly regard their own sovereignty as important. That is the way that Scotland is organised.

Mr McAllion: Unfortunately.

Peter Bates: I will not comment on that.

The Convener: Oh, go on.

Peter Bates: The national health service has to respond to that. Even if we went down the road of having a single accountable person—

Mr McAllion: A single body, not a single person.

Peter Bates: Let us take Angus Council, which is particularly interesting. The health service responds to Angus Council, but within the council area, there are a number of localities and communities that fiercely regard their own identity as important. Arbroath, Montrose and Brechin see their identities, rightly, as seriously important. Angus Council has to relate to a number of localities. The health service has to relate to Angus Council and also to a number of localities. The NHS is pretty good at recognising that one size does not fit all. That is why I hesitate to say that the solution is to make a person accountable and that will fix it. I do not think that it will.

The Convener: We have to bring the discussion to a close at that point. Thanks for coming along this morning and for your written evidence.

Peter Bates: Thank you for asking us.

The Convener: Before I conclude the public business of the committee this morning, as this is

the last meeting before the recess I put on the record my thanks to the committee clerks and to committee colleagues for all their hard work. I also thank all the witnesses from whom we have taken evidence, and the people who have assisted us on our trips from Edinburgh to Inverness and Glasgow in the past few weeks and months.

I wish you all a good summer recess. That concludes the public part of this morning's business.

11:36

Meeting continued in private until 12:05.

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