The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

PUBLIC AUDIT COMMITTEE

Wednesday 14 March 2012

Session 4

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PUBLIC AUDIT COMMITTEE
4th Meeting 2012, Session 4

CONVENER

*Iain Gray (East Lothian) (Lab)

DEPUTY CONVENER

*Mary Scanlon (Highlands and Islands) (Con)

COMMITTEE MEMBERS

*George Adam (Paisley) (SNP)
*Colin Beattie (Midlothian North and Musselburgh) (SNP)
*Willie Coffey (Kilmarnock and Irvine Valley) (SNP)
*Mark Griffin (Central Scotland) (Lab)
*Colin Keir (Edinburgh Western) (SNP)
*Tavish Scott (Shetland Islands) (LD)
*Humza Yousaf (Glasgow) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

John Baillie (Accounts Commission)
Mr Robert Black (Auditor General for Scotland)
Barbara Hurst (Audit Scotland)
Cathy MacGregor (Audit Scotland)

CLERK TO THE COMMITTEE

Jane Williams

LOCATION

Committee Room 5

Scottish Parliament

Public Audit Committee

Wednesday 14 March 2012

[The Convener *opened the meeting at 10:00*]

Decision on Taking Business in Private

The Convener (Iain Gray): Good morning and welcome to this meeting of the Public Audit Committee. I ask members of the public, committee members and anyone else present to ensure that their mobile phones are switched off. We are joined by a photographer who is taking pictures for the Parliament's annual report; he will probably take a few shots at the start of the meeting and then leave us to it.

I welcome from Audit Scotland and the Accounts Commission Bob Black, John Baillie, Barbara Hurst and Cathy MacGregor, who will brief us on a section 23 report—"Commissioning social care"—and a couple of other agenda items.

First, I ask the committee to agree to take in private items 5 and 6, to allow us to decide how to take forward work on the "Commissioning social care" report. Are members agreed?

Members *indicated agreement.*

Mark Griffin (Central Scotland) (Lab): Before we carry on, convener, I should declare an interest as a member of North Lanarkshire Council.

The Convener: Thank you for that.

Mary Scanlon (Highlands and Islands) (Con): Convener, I would like to say something before we move to item 2. I appreciate that I am a very new member of the committee but I note that, last week, the Accounts Commission published a report on the Highlands and Islands Fire and Rescue Service that I think was the most critical I have ever seen. I had thought that the committee would get the report and look into the matter but I was quite shocked to find that the Parliament does not scrutinise Accounts Commission reports. I am not sure why that is—perhaps those who have been committee members for longer will say something about that—but I simply point out that the report criticised the leadership; said that 35 stations were not up to standard; and had things to say about investment in equipment and information technology. That is not new information, but worst of all the report said that firefighters on the front line—in other words, the people who put their lives on the line for us—were not fully trained or fully equipped.

As an MSP, I am shocked that the Parliament is not allowed to scrutinise or demonstrate any responsibility for one of our emergency services. I appreciate that many of the committee's members are councillors and that responsibility for the matter lies with local government. However, as far as I am aware, the fire service receives part—if not 50 per cent—of its funding from the Government; it is an emergency service but, despite the fact that this is the most critical report that I have seen in 13 years, it will receive no parliamentary scrutiny. I have received very helpful advice from the clerk but I simply repeat that I was shocked to find that we are not allowed to pursue the matter. I just wanted to get my comments on the record and to seek members' views.

The Convener: Thank you. Before I respond, does anyone wish to comment?

Colin Keir (Edinburgh Western) (SNP): Just as Mark Griffin declared his interest in a local authority, I should declare an interest as a member of the City of Edinburgh Council.

George Adam (Paisley) (SNP): I will have to do the same, then.

Colin Beattie (Midlothian North and Musselburgh) (SNP): I suppose that we had all better declare our interests.

The Convener: Indeed. When Mr Griffin was making his declaration, it crossed my mind that he might not be the only one who should do so.

Willie Coffey (Kilmarnock and Irvine Valley) (SNP): Can I respond to the issue raised by Mary Scanlon, convener?

The Convener: Yes, but we seem to be doing the declaration of interests first.

Willie Coffey: I, too, declare an interest in that respect.

I was taken by surprise by Mary Scanlon's comments. Where will anyone get an opportunity to carry out the scrutiny that she has suggested is required?

George Adam: Correct me if I am wrong but, as a previous member of Strathclyde Fire and Rescue board, I assume that scrutiny will be carried out by the local fire board members. I certainly know that, when I was part of the board, such issues were taken very seriously.

Mary Scanlon: Last week, I discussed this matter with members of the trade union, who were visiting Parliament. They said that they have been bringing these particular issues to the attention of the leadership of Highlands and Islands Fire and Rescue Service for five years now. I acknowledge George Adam's point but I am concerned that, despite their doing their level best to bring these

issues to management's attention, the unions have still been ignored. I realise that some measures have been put in place but the report is shocking and as a parliamentarian I regret that I have to say to the firefighters, "I'm sorry but I can't do anything about this except try to raise it at First Minister's questions".

The Convener: I thank Mary Scanlon for raising the issue and Willie Coffey and George Adam for their comments.

After Mary Scanlon expressed to me her concern that we would not look at the issue, I sought advice on the matter and was told that, given its remit, the committee cannot scrutinise Accounts Commission reports such as the best-value audit of Highlands and Islands Fire and Rescue Service. The report is neither laid in Parliament nor falls within the Auditor General for Scotland's remit. As the position is enshrined in statute, it is somewhat stronger than a convention. My layperson's understanding of that advice is that, in essence, the police and fire and rescue services are considered to be part of local government and therefore, as Mr Adam indicated, they are accountable to local government, the boards and joint boards and elected members.

That said, as someone who is even newer to the committee than Mary Scanlon, I, too, was quite astonished to see the report and realise that the Parliament's Public Audit Committee would not be able to consider it. Like her, I think that this is one of the worst best-value reports that I have ever seen. Although accountability might lie with the fire board, any reading of the report makes it clear that a great deal of the criticism is directed at that very board and its leadership. I guess that the additional scrutiny from the Accounts Commission is the issue at play.

Mr Coffey asked where scrutiny would take place. Having sought advice, I have no satisfactory answer to that. I imagine that the issue could be raised in Parliament by asking ministerial questions, or the Local Government and Regeneration Committee could find some way of considering it. However, none of that would be a formal part of the best-value scrutiny process. Given that some of the funding for Highlands and Islands Fire and Rescue Service—I do not know the exact figure, but it must be about 50 per cent—comes from central Government, I find it curious that, according to the advice that I have received, the committee cannot consider the report. I assume that the situation will change when the Police and Fire Reform (Scotland) Bill goes through and the single police service and fire and rescue service are created.

We have to leave the matter there, but I am grateful to Mary Scanlon for raising the issue and allowing us to clarify things.

Willie Coffey: We are now eight minutes into the meeting. I wonder whether, if such issues are to be brought to the committee's attention in future, it might be helpful to inform other members about them. I had no idea that Mary Scanlon was going to bring the matter to the table.

The Convener: Mrs Scanlon had asked for clarification, but I take the point.

Willie Coffey: That would be helpful.

The Convener: Let us now move back to our agenda.

Section 23 Report

"Commissioning social care"

10:09

The Convener: Item 2 is consideration of a section 23 report, "Commissioning social care". I invite Bob Black and John Baillie to present it.

Mr Robert Black (Auditor General for Scotland): Thank you very much, convener. As members will be aware, this is a joint report by Audit Scotland on behalf of the Accounts Commission and me as Auditor General. As chair of the commission, John Baillie is here to help with responses to members' questions.

Of the many performance audits that we have prepared over the years, this is one of the most significant. I say that for three reasons. First, as we are all aware, certain needs and demands in society are putting ever-increasing pressure on the social work and health services that are involved in social care. Secondly, although spending on these services has grown greatly over the past 10 years or so, we are now entering a period of significant cuts in public resources, the clear consequence of which is that current ways of delivering services are unlikely to be sustainable. Finally, to be frank, my particular concern, which is shared by colleagues, is that this is the latest of six reports that Audit Scotland has prepared in this general area since devolution, and they have all contained challenging findings about the commissioning and delivery of social and health care services and the efficiency and effectiveness of partnership working.

We began in 2001 by publishing a review of home care services in Scotland. In 2004 we produced a major report on the commissioning of community care services for older people, and a few years later—in 2008—we carried out a review of free personal and nursing care. That was followed in 2010 by a report on services for children in residential care. In 2011 we looked at transport for health and social care and also produced a major report—in the form of a performance audit—on community health partnerships.

All those reports over the years have commented on the poor quality of the data that is used to plan and deliver services; the shortcomings in the ways in which services are planned and commissioned; and the need for better partnership working. It is clear from the latest report that we still have some way to go in Scotland in that regard.

We produced a summary report with the main report—copies of which you all have today—and there is quite a lot of information on our website if committee members are interested. I will concentrate on the main report because it contains a lot of rich information that might be relevant as we proceed.

The report is divided into four parts. The first part describes the current system of social care in Scotland; the second part is concerned with issues around the commissioning of social care; the third part focuses on how care is delivered; and the final part of the report looks at the impact on service users and their carers and how their needs are taken into account by the agencies.

The first part starts with a description of the system of social care services in Scotland, which will be familiar to you. We outline in exhibit 1 on page 8 the range of organisations that are involved. Further to my earlier remark about spending in the past 10 years, there was a 46 per cent increase in spending in real terms on social care between 2002-03 and 2010-11, and the total spend by council social work departments in 2010 was about £3 billion.

On page 9 we outline the significant differences between social care services in different council areas. The data shows quite big variations throughout Scotland in the numbers receiving home care and the hours of care that are delivered. The total spending on social work per head of population—from the numbers that we have available—ranges from £534 in West Lothian to more than £900 in Glasgow, and even more in the island councils.

Many more people are being cared for in their own homes rather than in residential care settings. That applies not only to older people but to adults with learning difficulties and looked-after children. There has been a noticeable shift in the past decade, and we have captured that in exhibit 3 on page 10.

The final section of part 1 gives the clear message that the current approaches to delivering services are not sustainable. I need hardly remind committee members that the number of older people in Scotland is set to rise by more than 20 per cent in the next 10 years. The ratio of pensioners to people of working age will rise from 32 pensioners per 100 people of working age to 38 per 100 by 2035. Many more people will require care support, but there will be significantly fewer people around to deliver the services and fewer people paying the taxes that fund health and social care, which make the whole thing affordable.

The Scottish Government estimates that an extra £3.5 billion must be spent by 2031 if the systems for care services are to remain as they are now. As I noted a moment ago, social work

spending on care services is currently about £3 billion. I am not quite sure what is in that £3.5 billion, but that indicates the order of magnitude of the challenge from the Scottish Government's own projections.

In the second part of the report we conclude that most councils and national health service boards still have quite a way to go in the development of the strategic commissioning of care services.

10:15

What do we mean by strategic commissioning? It is a bit complex, but exhibit 5 on pages 12 and 13 attempts to capture what we mean by good strategic commissioning. We found commissioning strategies covering all social care services in only 11 of the 32 council areas, and most of those, unfortunately, did not have an analysis of local needs and costs or information on the capacity of providers to deliver, although that seems to be essential information for making decisions about where and how to invest resources in care services. The auditors found that skills for the good commissioning of care services continue to be inadequate, with staff needing training in straightforward but specialised issues such as the legalities of procurement and the particular skills involved in procuring personal care packages for local people on an individual basis.

On the subject of joint commissioning and collaborative working, the report found few examples of joint planning that were supported by a good understanding of the shared resources available to the organisations involved. An important finding was that councils seem to be targeting the resources towards people who need intensive support. That is perfectly understandable, particularly in view of resource constraints. However, it carries the implication that people who have less-intensive needs are not being offered the services that might avoid or at least delay the need for more intensive services. As we all know, people prefer to stay in their own home if they can. We have tried to capture that trend in relation to the home care hours example, in exhibit 8 on page 22 of the report. To return to my introductory comment, that is not a new trend, as it goes right back to the report on home care services that we produced in 2001. We could see it as an emerging issue at that time.

In the third part of the report, a key finding is that councils do not always involve voluntary and private sector providers in the planning work, although both those sectors deliver a great deal of social care in Scotland. Most councils do not understand sufficiently well the costs, capacity, quality and accessibility of the different providers—both the in-house providers and the providers in the voluntary and private sectors. That adds to the risk that, at a time when the pressures on budgets are severe, councils will tend to concentrate on reducing costs without taking adequate account of the true cost of delivering the range and quality of services that other providers offer or of the needs of individuals.

A further important issue in the commissioning of care services is the need to be aware of the risks associated with the financial health of provider organisations. We give examples in the report of some of the problems that have been encountered, and we suggest that more could be done by councils, with support from the Scottish Government and the regulators, to ensure that the specialist skills and analytical resources are available to councils to enable them to do the necessary checks. It seemed to be a tall order to expect every council in Scotland to be expert in the area at its own hand.

In the final part of the report, we address issues around the need for both councils and health boards to involve users and carers in decisions about social care. I am sure that I do not have to tell the committee that poor-quality commissioning of social and health care can have a significant impact on people, not least because it takes time for folk to build trusting relationships in those very personal services. It is also important to support the 500,000 or so carers who are looking after family members and friends in Scotland. Although councils have a duty to support carers, many of those who were consulted by Audit Scotland had not been offered support by their council or were not sure what support might be available. If we are going to address the challenges of population changes and resource constraints that I described a few minutes ago, support must be given to carers operating in family and social networks.

Towards the end of the report, there is an analysis of the implications of self-directed support, which is designed to give individuals more choice and control over the services that they receive. It seems clear that, if councils and other partners are to deliver self-directed support effectively, they will need support to develop the new commissioning skills that will be essential.

John Baillie will agree with me that this was one of our more challenging and important reports. He and I will do our best to answer the committee's questions, with support from Audit Scotland colleagues.

The Convener: Perhaps I could kick off with a general question. You made quite an important point when you said that this was one of the most significant reports that you had presented to the committee in a long—if you will forgive me—and distinguished career. Will you elaborate on why you think that it is so significant? Is it because of the growing challenges to the system, given the

increase in the number of older people, or is it because, as you indicated, there seems to be little progress in the integration of those services, although that is required for their delivery and has been an objective for a long time?

Mr Black: I would not want to give the impression that there is no improvement. The Audit Scotland team will be able to give more information about this, but I am conscious that there is a lot of activity going on in the area at the behest of Government.

As you implied, I have worked in this area for many years. I can go right back to my days as chief executive of Tayside Regional Council—before the most recent local government reorganisation—where I personally chaired the community care joint working group with the health board. I can remember speaking at conferences around the time of the reorganisation and saying that I understood the concerns about keeping water in public ownership and about effective strategic planning. However, I thought that one of the really big challenges facing the new local authority system was that of addressing the coming issues of care in the community. The challenge has been around a long time.

The issues and pressures are probably even greater now than they were back in 2000 when we started work on this area. As I think I mentioned, over the past 10 years there has been a substantial growth in resources, and there have been a number of initiatives, some of which we have prepared reports on over the years, but we still have a way to go to ensure that the partnerships work effectively.

There will not be an easy answer. It is something that the committee might want to reflect on; through its inquiries, it might be able to illuminate the area more fully.

The Convener: On the scale of the challenge that the report illustrates, paragraph 27 in the main report seems quite damning. You found that:

"Across the 32 councils, only 11 had commissioning strategies".

Only one of the strategies was long term and only four looked at basic population trends to project future needs, although those needs are growing rapidly, as demonstrated by some of the statistics in the first section of the report.

At the end of paragraph 27, you say that none of those strategies, where they exist,

"included information about the quality and cost of both in-house and external provision."

That begs the question how the system manages to deliver care at all, given how little planning there appears to be. You indicated that you would not like to say that there has been no progress. I am interested to know how the system delivers at all. If people do not have the information that one would think that they would need, are they making it up as they go along?

Mr Black: One important fact in the report is that the satisfaction of users of services in Scotland is very high. What we have out there are committed and able professionals delivering a good service in many ways. However, given the challenges that lie ahead, that will not be good enough.

The report is about commissioning social care. In the second half of last year, we brought you a report on community planning partnerships, using the example of economic development. The same message was in that report: partnerships seem to have been finding it difficult to understand their local markets, whether in the area of care or economic development. They appear to have found it difficult to come together and understand local needs and resources and to build shared strategies around that. I am sure that John Baillie wishes to add to that.

John Baillie (Accounts Commission): Yes—just briefly. The quality of care seems to be improving if we go by the work of Social Care and Social Work Improvement Scotland—the care inspectorate—which rates services on a six-point scale. In 2009, one in six councils were graded the top two points of "excellent" and "very good" for their work, which improved to one in four by the end of 2010. The impression that nothing is happening or improving is therefore wrong, because there are bright spots. Moreover, specific councils appear to be able to do better than other councils.

The Convener: It is encouraging to hear that the quality of care that is being provided is improving. That is certainly as we would hope. However, there is a bit of a contradiction with some of the findings in the report. For example, more care is being provided, but it is being provided to fewer people more intensively; if there is a squeeze, it is on lower-level support and preventative services. That rather runs counter to the accepted wisdom and the Government's policy of investing more in preventative strategies in this and other areas. Is that because what is being measured is the quality of what is being delivered, rather than its preventative effectiveness or what happens after the fact?

John Baillie: Yes. I think that there is something in your point. The emphasis on prevention is, for obvious reasons, one of our main concerns in the report. It is a matter of striking a balance between the extent to which money is invested in intervention and the extent to which it is spent on intensive caring.

Tavish Scott (Shetland Islands) (LD): In Mr Black's opening remarks, I think he said that there were few examples of long-term planning. Why is that?

Mr Black: Frankly, I think that that question needs to be addressed to the agencies involved. It is difficult to understand why it has proved so difficult and challenging for them to come together to prepare strategic plans at the local level, given that that challenge is not new and has been around for 12 years.

If I may, I will invite the team to offer comments on that. Do you have any sense of why it is so challenging?

Cathy MacGregor (Audit Scotland): We gave a case study example of why it had taken Fife Council quite a long time to produce a draft commissioning strategy. Those in the council felt that the goalposts were constantly moving and that policy, circumstances and budgets were changing. However, there was a point at which they recognised that it was necessary to draw a line and get the strategy, and then to update it, because otherwise they would constantly be waiting for the next change to happen.

It is worth pointing out that the Social Work Inspection Agency produced guidance on strategic commissioning in 2009, which specifically recommended long-term planning of between five and 10 years for commissioning strategies.

Tavish Scott: Do you think that it was fair to say that policy is always changing? Certainly, budgets are changing. Do you think that all those excuses are accurate and fair?

Cathy MacGregor: I do not think that it is up to me to say that. However, in that example a number of things were happening constantly while people were trying to prepare their strategy.

John Baillie: I will offer comment on a more general basis without shifting the argument. At this end of the table, we have all been going on for some time about the need for longer-term planning in local authorities. This is another example—it is the old issue of having to meet today's needs, with tomorrow's needs perhaps not being focused on as much as they ought to be.

Tavish Scott: May I try the question the other way round, in that case? I guess that we cannot quite understand the why without asking individual councils. However, the NHS is different from councils, in that its line of accountability is to the minister, whoever that may be. As the Auditor General said, the issue has been around since the beginning of the Parliament, so saying that the minister is in charge is not a political observation. One would have thought that longer-term planning, given all the demographics and so on to which your report rightly refers, should be easier in the NHS, because the minister demonstratively instructs health boards to follow the strategy. Is that your finding from the investigations? I am trying to tease out whether that is the case in contrast to the councils.

John Baillie: I will ask Bob Black to do that bit.

10:30

Mr Black: I return to the point that a lot of good things were happening—the report has the statistics. One of the tracer conditions for whether the system is operating better or worse is the rate of delayed discharge or bed blocking, which came down in recent years as a result of significant health service initiatives that were supported by local authorities. The numbers are much smaller now than they were a few years ago. There is an indication that perhaps there is an upturn again, so the issue must be monitored carefully.

Some of the issues can be addressed. However, I emphasise that there is always a risk that when a particular hot issue comes up—and I am not implying that this is firefighting—the initiative to address it does not look at the underlying systems of planning and delivery. The numbers in terms of population changes and resource constraints are so challenging that we must now really look at the systems on a joined-up basis, and partnership working must deliver significantly better performance over the next few years.

Tavish Scott: I take that point. Can you point us to something specific in your recommendations that demonstrates how partnership working could become more effective than—as your report clearly illustrates—it has been over the past 12 years?

Mr Black: The report contains an exhibit on what good strategic commissioning would look like. I do not want to take up too much of the committee's time, but I ask you to look at exhibit 5 on page 12. It says that the characteristics of good strategic commissioning involve issues of behaviours and culture, strategy and engagement, and performance and improvement. We indicate what those issues might look like when things are going well and when things are not going well. One needs to look at the total package around those, to get to a point where strategic commissioning is effective. It would be unfortunate to zone in on any one issue. There is a critical mass of behaviours and activity that must take place, and there must be good, strong leadership that is truly joined up between the local authority and the health board.

Tavish Scott: How does strong leadership between the local authority and the health board

get delivered? It seems implicit in your report that that has not happened over the past years.

Mr Black: That is a policy matter. We are getting close to the role of the Parliament, councils and ministers, and how that interacts strongly and effectively with executive teams in this area. Much of the challenge is to stop the old ways of doing things. That will require support from elected representatives to change the systems. We need an holistic approach to leadership on this issue.

The Convener: I have a supplementary to Mr Scott's question. In theory, one of the places where that leadership should be developed is the CHPs. I cannot find the paragraph, but I think that the report comments that CHPs seem to be predominantly part of the NHS leadership structure, rather than partnerships. Is that fair?

Mr Black: Yes. That was one of the key findings of our quite full report on CHPs, which came before the committee last year. For the most part, the health service was planning through CHPs as entities that were discrete from local government. That did not happen everywhere, but it tended to be the pattern.

Colin Beattie: Paragraph 12 on page 7 emphasises the real-term increases in spending: 46 per cent over the eight years from 2002-03 to 2010-11 and 68 per cent on adults with learning disabilities. Bullet point 5 on page 14 indicates a rise in spending of 105 per cent on providing personal care to people in their own homes. The next bullet point emphasises the very important point that public sector budgets are being reduced by 12.3 per cent in real terms.

Given what else is in the report, can we say that councils and so on will be able to handle such a transition without any assistance? There have been significant increases in the past, and there is no indication of a slowing down, although there will be less money. It will take fairly athletic work to deal with that. Can councils handle that on their own?

Mr Black: I am sure that John Baillie will have insights on that from an Accounts Commission perspective.

I have a contextual point. The numbers speak for themselves, and there is the issue of what one means by the word "handle". It is clear that councils, and health boards for that matter, have been very effective at controlling their budgets. We have reported in financial overviews—the Accounts Commission has reported on local government and the Auditor General has reported on the NHS—that they manage within their budgets, but we can see tell-tale signs, not least in the increasing concentration of resources on clients with more intense needs. Given that the Scottish Government and the Parliament are, vitally, emphasising and focusing on the importance of preventative spend, which I prefer to rebadge as services for people that matter at the early stages, it seems to me that the major risk is not that councils cannot handle the budget reductions, but that the range and quality of the services outside a core group of people with intensive needs will continue to be at risk of being diluted.

I am sure that John Baillie will have his own views on that.

John Baillie: Yes. The core of the problem is that the current position is simply not sustainable. We simply cannot go on delivering social care services in the way that we have for the money that is available. As Bob Black says, the quality and the quantity of services are diminishing as a consequence. A core point in the report is about finding new and better ways of working and working in partnership.

Barbara Hurst (Audit Scotland): Although we recognise that councils have a statutory duty, the thrust of the report is that health services also have a big role to play. It is no accident that some of the biggest successes around learning disabilities relate to finding different ways of funding that service. Traditionally, a long-stay hospital would be involved, and the money needed to move with people into the community. Through the report, we want to push the idea that there is joint responsibility. There is not only responsibility on councils to manage within reducing budgets; it is about looking at those budgets alongside the health budgets and considering how to deliver services differently. That is where the leadership issue comes in.

Colin Beattie: I suppose that I am concerned that there are many negatives in the report and that there does not seem to be the joined-up thinking that you identified coming through that would encourage us to think that, in the future, councils will be able to cope with the sort of transition that is on them now. That is an immediate issue.

Mr Black: Exhibit 7 on page 18 shows the guidance and support from the Government. There has been a lot of activity, but ultimately that guidance needs to be taken on board and used well through local partnership working and strong shared leadership at that level to drive things forward.

Colin Beattie: That leads me to the next point that I was going to make. Paragraph 41 talks about "difficulties in benchmarking" and data that cannot be properly compared. There is a lack of consistency, and councils cannot even tell the comparative costs of in-house and externally provided care services. That seems to me to be

very basic, given the current situation. Is there any sign of improvement in that respect?

I note that paragraph 43 refers to "underdeveloped information systems". That is a familiar theme, which has come through previously.

Mr Black: Yes, and it is one of the issues that have been around for many years. I would mention in particular our report in 2004 on the commissioning of community care services, in which we reported in very similar terms on the data shortcomings that led me to make my fairly forceful comments earlier about it being time for us to move on from that agenda and to make some progress.

Does Barbara Hurst want to add something about the vexed issue of data?

Barbara Hurst: Yes. There is certainly information that can be used to compare activity, but if you do not know the local needs you cannot really interpret it. The cost information is interesting. Previously, we tried to do some comparative costing of in-house provision against voluntary and private sector provision and it is possible to do that until the capital element is introduced, which means that it then becomes very different depending on which sector you are working in. As a basic point, I do not know how you can make a decision about cost-effectiveness without understanding some of that. We want to push this and say that with the introduction of self-directed support, an understanding of costs is essential. You will probably have to take money out of current services and out of fixed assets to put it into different types of services, so you need a much better grasp of that.

Colin Beattie: That leads on to paragraphs 60 and 61, which discuss the different types of contract. I am talking as somebody who was involved with the fallout at Midlothian Council, where we had difficulties with commissioning when a company collapsed within weeks of being appointed. Is there adequate understanding of the different types of contract and the mix of agreements among the councils and the people who are doing the commissioning?

John Baillie: I would say that there is limited understanding if we talk about councils as a whole, although there are some good examples. A particularly good example in our exhibit is Argyll and Bute Council—case study 4 on page 21—which merged its commissioning and procurement teams to try to get the benefit of both worlds. That seems to be moving, but it is an exception rather than the rule at the moment. Another aspect that we will no doubt discuss—you touched on this in your reference to Midlothian Council—is that due diligence should be properly carried out as part of the process of preparing contracts. It is also necessary to consider the whole area of monitoring financial health, which is another part of the input into setting a contract.

Colin Beattie: Obviously, a key element of the contract is pricing.

John Baillie: Yes.

Colin Beattie: Paragraph 66 talks about voluntary organisations reporting

"pay freezes, reduced staff numbers and changed ... terms and conditions".

At the moment, the staff are a soft target when it comes to cutting their salaries and trimming their benefits. That cuts the overall cost, but there is a limit to how far it can go. Is there any indication that the people who commission the services understand the knock-on effect in that regard?

John Baillie: I ask Cathy MacGregor to answer that.

Cathy MacGregor: I think that it would be unfair to say that councils do not know the costs of any of their in-house services. There are particular types of service—we have seen examples of this—in which it is possible to work that through. With home care services, for example, not a lot of capital investment is involved. Some councils are aware of the differences between their in-house costs and what they pay external providers. There is some understanding of some of the services, but that is not comprehensive and it is not being used to make strategic decisions about who should provide services.

You asked about the understanding of contracts. In large part, some of the issues—such as those with Midlothian and other councils—led to the production of specific guidance on procurement and social care. That guidance was produced jointly by the Government, the Convention of Scottish Local Authorities and the various parties involved. It has been relatively well received, although it has not been available for that long; it has been out for just over a year now. The guidance was developed in quite a collaborative way, so there is beginning to be a better understanding of contracts and what the options are. We flag up in our report, of course, that with the advent of self-directed support we expect that that will have to change again. Block contracts, for example, might have to be reconsidered.

10:45

Colin Beattie: With the budget cuts, it is clear that there will be greater pressure on pricing and more pressure on those who commission to take the cheapest rather than the best option.

I return to the fact that voluntary sector organisations are trimming back and cutting any fat—I almost said "cutting corners", but that is not what I meant. They must almost be at the point at which it is extremely difficult for them to cut prices further. In addition, it must be difficult for voluntary organisations to compare their reduced pricing with the pricing of an in-house service, to the extent that such a service may no longer be favoured and there may be pressure to appoint an outside provider that might not give the same levels of service. Have you seen any indication that that is recognised? Has a monitoring mechanism been put in place to ensure that service levels are maintained?

Cathy MacGregor: An element of that came through in the work that we did on working with providers. There is a section in our report on how councils and NHS boards are working with providers and the relationships that they develop. Some of the conversations that take place in those relationships are about what is possible, what can change and what the pressures are. Where there are good relationships between councils and providers, such discussions are taking place. There are one or two examples of cases in which longer-term contracts have been awarded. In one case, a council increased the amount that it was paying by 1 per cent across the board just to ease things a little. There are a few examples that there is some understanding of that.

However, the bigger point is that unless there is a broader understanding and a more rounded picture—not just of costs, but of the quality and the outcomes that services achieve for people—it is difficult to decide between in-house and external providers. A more strategic view needs to be taken of what is required to achieve good outcomes for people before costs are considered and a provider is chosen.

Mary Scanlon: I read the chapter that Colin Beattie was talking about. I hope that the Government's bill on self-directed support, which I think will be introduced to Parliament in a couple of months, will address many of those issues.

My point is about intensive care and preventative care. I begin by referring to exhibit 8. I notice that, between 2000 and 2011, the number of clients who received less than four hours of home care a week fell from 38,000 to around 23,000. Over the same period, the number of people who received 10 hours or more of home care doubled from 10,000 to 20,000. My point is not the same as the convener's point; it relates to one of the key messages on page 16, which mentions that councils are focusing on those who need more intensive support and that there are indications of

"tightening eligibility criteria and increasing charges."

That concerns me enormously, particularly given that paragraph 17—I am sorry; I am working my way backwards—says that the

"average number of hours provided weekly per person varies from 3.8 hours in Angus to 21.1 hours in Fife",

which represents a sevenfold disparity.

I am concerned by that because I remember that, when the bill to introduce free personal care went through, various leaflets were issued to people and clear criteria were provided. Do those criteria still exist or are councils interpreting them in different ways? The whole point of free personal care was that more people would receive four hours of free care at home a week, which would keep them out of hospital, where the cost of care was £3,500 a week. We seem to have gone in the opposite direction from what was intended in the Community Care and Health (Scotland) Act 2002.

Barbara Hurst: When we did the work on free personal and nursing care, we started to recognise that trend. At the time, we found that a lot of people did not understand what free personal care was and did not realise that it was less to do with things such as the shopping and the cleaning, which the traditional home help would have done, and much more to do with personal care—bathing and whatever.

After the implementation of the policy, resources were targeted on the people with the most intensive needs. I do not know whether that was a consequence of the policy introduction, but it certainly happened at that time. Now, because councils do less of the shopping and so on—with people having to make their own arrangements for that type of thing—resources are targeted on people at the personal care end of the spectrum.

We do not really know what people are purchasing outside of that, but the trend shows that formal resources are going to the intensive end; they are not going to what people might call the more preventative end at the earlier stages of need. Of course the care is preventative, in that it prevents some people from ending up in a long-stay ward in hospital or in a care home.

Mr Black: I do not want to be rude and take members away from their main area of concern, but I want to add to that by making a link to another piece of work. The message in the "Transport for health and social care" report that we produced last year is that issues around transport are also restricting access to key support services for people who are not looking for intense care, but who need to get to day centres, health clinics and so on. When people start looking at the total package of what is going on, concerns become even more intense.

Mary Scanlon: Constituents who come to see me say that they are not likely to get home care, because people have to be seriously ill with seriously complex needs to get it. I am concerned about the eligibility criteria point that was highlighted. There were clear eligibility criteria for free personal care. What happened to them? The report refers to councils "tightening eligibility criteria". Are the eligibility criteria being tightened to such an extent that the 2002 act no longer applies? Have councils made significant changes? I ask because the average number of home care hours provided weekly per person in Angus is 3.8 hours, which fits with the intention behind the 2002 act, but that does not seem to be happening in other areas that provide more than 10 hours or even more than 21 hours per person a week. Is there a disparity in relation to eligibility criteria?

Barbara Hurst: The issue is very complicated, and I have huge sympathy for people trying to manage their way through it.

When we did our work on free personal and nursing care, we found that eligibility criteria for services varied. We made some recommendations about that, but what happened was that with the introduction of free personal care some councils introduced or increased charges for other services. The position was not completely uniform across the country.

Social work directors and managers tell us that because they are still trying to manage within a similar resource, they are making the eligibility criteria tighter—so your constituents are quite right: in some places a person's need has to be greater. That is not a Scotland-specific thing; the picture is similar across the UK. It would be naive to say that it is an easy thing to get right, and I hope that we are not making it sound as though we think that it is. It is terribly difficult to get right. We do not think that councils will get it right on their own if they continue in the same way. There has to be a local area resource that starts from early days intervention and continues through to supporting people at home, if that is where they want to be, no matter how ill they are.

The eligibility criteria are a way of managing resources to try to do the best for the people who have the most intensive need. However, with that approach a lot of people will fall through the net and they will probably get to that situation quicker than they might otherwise do.

Mary Scanlon: In Angus, the average amount of home care provision is 3.8 hours per person per week. Would it be naive to assume that the eligibility criteria in Angus are as they should be, and that those who need low-level preventative care are getting it? Would it be equally naive to assume that in Fife the criteria are much stricter, given that the average home care provision is 21.1 hours per person per week? Does that show that one is concentrating on preventative care and the other is almost in crisis management? Does that show the different levels of eligibility criteria?

Barbara Hurst: That would possibly be the answer if you were to take home care in isolation, but you need to look at all the services that are available in Angus and Fife and consider the total package. Angus may provide that intensive support differently or it may label it differently. It would be dangerous to make that assumption based on those figures alone.

Mary Scanlon: Are the criteria different in different councils?

Barbara Hurst: They probably are, although I think that the criteria are more similar post free personal and nursing care.

Mark Griffin: Paragraph 26 states:

"We found little evidence in our audit of significant improvements and limited progress on joint commissioning by councils and NHS boards."

The report then flags up that one of the indicators that perhaps shows that partnerships are not working well together is the increase in delayed discharges. Coupled with the support being concentrated on people who have the most intensive needs and with the move away from preventative spend, we could see an increase in admissions to hospitals at the same time as an increase in delayed discharges, which are perhaps creeping up now that the budgets are under pressure.

Was there strong enough leadership in local authorities and NHS boards when budgets were increasing to break down the barriers between budgets and to merge budgets as much as was possible through the good years?

Mr Black: I am not sure that we are in a position to answer that question, although I recognise and respect that it is a perfectly reasonable question to put to us.

The report clearly demonstrates that truly effective partnership working that is centred on good strategic commissioning and a good knowledge of resources is nowhere near as far as advanced as it should be. I have mentioned the half dozen or so pieces of work that we have done over the past 10 years in the area, which keep on coming back to this.

A few years ago, Barbara Hurst examined the whole system in Tayside. That work was designed to help the health board and the councils to understand how the system operated. I thought that it was a useful contribution. I am not entirely sure how far that work was developed, but it would

be a good example to use to examine whether leadership is coming to terms with the issue.

Barbara Hurst: That was interesting work. We worked with the health board and with the councils in its area and we did modelling to establish, for example, whether increased community nursing support and home care and other work on rapid response teams were reducing demand on beds.

11:00

In a sense, the past is the past. Although bodies could have done things differently, they did not. There is now an absolute necessity to do things differently.

Delayed discharge is an interesting issue. In crude terms, the pie chart in exhibit 6 makes it look as though there is delay in placing people in care homes, but beneath the figures all sorts of things are going on to do with user choice and whether something else had happened.

In the delayed discharge work that we did years ago, we were pushing for planning for discharge to be started on the day that a person was admitted rather than there being a wait for a consultant to say that the patient is ready to go home. More effort could be made on such matters, which would turn the situation round, but the other side of the coin for councils is that a person who is in hospital is safe. A care package must be in place for when people come out of hospital—there cannot be a few days' wait after they have been discharged.

Mark Griffin: Also, from a council's perspective, people who are still in hospital are not only safe but are not costing it money.

I do not want to put words in your mouth, but do you feel that it would add value for the committee to ask local government and other partners of the NHS what they have done during the 10 years during which the intention has been that they work in partnership, and what they plan to do in the future?

Mr Black: It is clearly for the committee to determine its own work programme but I encourage it to take the matter seriously. I can think of no bigger policy issue in Scottish public service.

George Adam: Mr Black mentioned two important issues in his opening statement. First, this is one of the most important issues that we will address, because we are dealing with people's lives. Secondly, Audit Scotland's report last year on CHPs raised similar issues about the lack of leadership and the lack of desire to work in new ways and to look for ways to work together.

That worries me. I have always found NHS hospitals to be very reactive organisations: in effect, you become ill and you go to hospital. Social work seems to be more proactive, in that it works in the community and there is a focus on working together. It is important that, when we integrate health and social care, we get that right. From your experience over the years in producing the reports that you mentioned, what mechanisms can we use to ensure that we make partnership working happen? The matter is too important for us, as elected members, not to get it right.

Mr Black: I will look for assistance from the team on that question. I take you back to the exhibit on strategic commissioning. It may be dry language, but it involves people coming together round the table to understand the needs and priorities of the area and the systems of delivery that are in place. They must do the sort of things that Barbara Hurst reminded us of in the Tayside study, which are to look at the different forms of intervention and how they all relate to each other, and follow that through with involvement of users and carers.

We require a whole-system approach, with a focus on the needs of the user, and we must link that to a really good understanding of costs. If that was simple, it would have been done by now, but we certainly need to get to grips with it as quickly as possible.

John Baillie: I will supplement Bob Black's answer by stressing the need for medium and long-term thinking. It is inevitable that a lot of reactive thinking has to go on, because people get ill and have to be taken care of.

In addition to exhibit 5, I draw attention to exhibit 4 on page 11, which sets out how a commissioning process would and should happen. It looks simplistic, but that really is it. It is a matter of getting people to that stage. The transition between what there is now and what there has to be in the future, including self-directed support, is a very big bridge to build and cross, but it somehow has to be achieved.

Mr Black: I very much identify with John Baillie's point—we must not give the impression that nothing is going on. I ask Barbara Hurst to inform the committee a bit of our understanding of current activity.

Barbara Hurst: The drive towards the new health and social care partnerships as a replacement for the CHPs represents an opportunity to think differently. Far be it from me to tell elected members what to do, but the process gives local and national elected members a real chance to drive the agenda. It is about breaking down some of the barriers. As George Adam said, health and social work do not necessarily work in

the same way. In some respects, maybe they do not need to, but they need to have a shared vision and a shared understanding of where the resources can go to best help the people who need the services. There is a role for elected members in that.

George Adam: On a purely anecdotal level, some of the problems that I find as an elected councillor and MSP are about simple things such as communication between bodies. Sometimes, when an elderly person is waiting to get out of hospital, their partner will phone an elected member to ask what they can do to try to get care in place. The care can be made available, but there is an issue about getting the information. As I think was mentioned earlier in response to the convener's questioning, it is difficult for some individuals to go through everything and it can be daunting, especially for elderly people.

John Baillie: Others will know more about the detail of that, but one would hope that the drive towards self-directed care will start to address that issue, as long as the people who are then able to choose are properly advised and have somebody to speak up for them so that the care is directed properly. I suspect that, again, that is a medium to long-term solution.

Barbara Hurst: George Adam is absolutely right to raise that issue, because to the user of any of the services, it does not matter who provides it—and nor should it. Users should not be worried about having to communicate with different parts of the system. We need to get the whole system to work together so that the joins are invisible. Communication—between professionals and with the user—is key to that.

Mary Scanlon: NHS Highland and Highland Council have formed a lead agency model. My understanding is that the Highlands is about the furthest-forward area in Scotland, with NHS Highland taking over all the home carers from the council. I am supportive of that model, which has gained significantly from the Government's change fund. That will not truly begin for two more weeks, but it is an excellent model that tries to avoid working in silos and passing the buck. I just wanted to point out that some councils and NHS boards are fairly far down the road.

Barbara Hurst: We are interested in that model, so we will keep a close eye on what happens in Highland.

Colin Keir: Barbara Hurst said that the recipients of care do not care much about who the supplier of the care is. One thing that came up in 2009 in a consultation in Edinburgh was that, actually, people care quite a lot about who provides the service. One of the problems that was raised in the consultation process was that people were taken away from organisations that they knew. Perhaps Barbara Hurst would like to add to what she said.

Barbara Hurst: I am sorry: I did not mean to imply that the person who provides the care is not hugely important. That relationship is very important. I meant that, in terms of the service, the end user should not have to worry about communication between health and social care. That should be hidden, because it should be a given. The person who provides the care is hugely important. As you say, that became apparent in Edinburgh, because a number of users decided to go with direct payments rather than with what the council proposed.

That is part of the complexity of commissioning services. Procurement is not easy, but it is a technical issue and once we include people and their quality of life, it becomes a quite different issue. That is why we are saying in the report that the users are so important to the dialogue about the type of support that they are getting and that they should be central to the process as opposed to being passive recipients of that support.

Willie Coffey: I have picked out two points in the report. One is on the cost of adult care services, which, according to the report, is about £0.75 billion per year. The other issue is residential and secure care for children. which has been a feature of previous reports.

On the first point, Mr Black quite rightly mentions that this is the sixth time he has brought these matters to Parliament's attention since 2001. Despite a 46 per cent real-terms increase in spending over the past 10 years, we will still face these massive issues in the future. I want to pick Audit Scotland's and the Accounts Commission's brains about how we can influence and intervene on adult care services. Members will remember the recent situation with Southern Cross care homes. How do we intervene in a system such as this that costs us £0.75 billion per year. We were in a precarious position recently when we were unsure about the care needs of the elderly community, and it is such a high cost. Are we looking at a major redesign of the service or a rethinking during the next 20 years? As Mr Black said, the elderly population is going to increase to about 38 per cent in that time. It is a ticking time bomb and we have to get to grips with it. How can we do that in relation to adult care.

John Baillie: I will start, although I am sure that others will want to comment.

The first thing to say is that the—I am sorry. My mind has gone blank. What was your question?

Willie Coffey: It is about the £0.75 billion cost of adult care services. How do we intervene to

manage that when we know that it is likely to exceed £1 billion in the next five to 10 years?

John Baillie: I start with the general statement that, as we say in the report, there must be better ways found for future working. That is a general, almost facile, statement.

The current system is simply not sustainable, so we have to go from where we are to something that is much more effective but which costs less. Self-directed care is probably part of that, as is the communication that Mr Adam mentioned. We need to be far more specific about identifying user needs. It is interesting that the limited evidence that we have from England suggests that self-directed care can cost less than the more generic care that is being offered by councils.

That is my starter, if you like. I do not know if anyone else has anything to add.

Cathy MacGregor: You might be aware of the reshaping care for older people programme. It is designed to address how care is provided so that it will be possible to sustain it in the longer term. On the back of that, the change funds will help councils and NHS boards to lever in that change.

Mr Black: I agree with what has been said. I will comment on self-directed care first and then perhaps come back to Mr Coffey's wider question.

The way in which self-directed care is costed is really important. It tends to be costed around the individual care package, and it tends to mean support in the home. As Barbara Hurst mentioned earlier, the full range of services involves capital, such as buildings and equipment, so it is important that the understanding of costs gets to that level of detail so that we really know what is in the cost.

11:15

Taking a speculative jump, I imagine that one of the big challenges for strategic commissioners and councils is that the more people who move towards self-directed care, the fewer clients and users will be in the system using buildings and equipment. As a result, the unit cost of that system will increase and we will enter quite an unstable situation. The point is that we must not be in reactive crisis mode all the time: in that respect, I come back to the need for good forward planning in order to understand the cost mix and to anticipate where care packages are moving.

On Mr Coffey's wider question, I am sure that I speak for everyone in welcoming the fact that the Government, COSLA and the health service are quite rightly trying to ensure that a lot of Scottish public service redesign is driven by partnership working. The report comments that, with the Parliament's support, the Scottish Government and local partnerships, be they community planning partnerships or health partnerships, should get a good understanding of the key priorities in an area, relate them to the resources that are available and plan care accordingly. I welcome what might be described as a re-energising of the partnership framework. However, we must ensure that the initiative to introduce health and social care partnerships—which, as I understand it, might involve legislation—is well bedded in with the reinvigoration of CPPs. That is a big policy issue but, as Barbara Hurst suggested, it will be really important in ensuring that all care is properly joined up and not planned up and down two stovepipes, as it were.

Willie Coffey: Those are very important comments. Given that that is the biggest cost item in adult care, any initiative in that area will have to be a priority over the next few years.

In the past, Mr Black has highlighted the cost of residential care placements for children. Across all councils, it can cost on average £5,000 a week to keep a young person in some kind of residential care. The numbers might have fallen slightly over the past 10 years, but it is still a huge problem. My experience as a local councillor is that councils do not know the extent of the problem that they might face next year; the numbers could double.

Earlier, Cathy MacGregor touched on the difficulty that is faced by local authorities in planning in such matters and it seems to me that they need flexibility, assistance or a national initiative to deal with that. Indeed, case study 2 on page 20 addresses that very issue. If that kind of national approach to providing residential care and secure accommodation for children helps us not only to reduce costs but to deliver better outcomes for youngsters, we should prioritise it in our list of overall concerns. Does that kind of direction and treatment of residential care for youngsters represent the way forward?

Cathy MacGregor: Case study 2 is a particularly good example of how doing things at national level can make a difference. The service in question was very specialised and small-scale in terms of the number of children involved, and the approach in which people get together at national level has certainly been successful. A similar collaborative approach involving a number of councils and NHS boards is being considered in the west of Scotland for other children's services—in particular, foster care. There are clear examples of how such an approach can be successful and, as we have identified, specialised services that do not involve huge numbers have the most to gain from it.

John Baillie: I am sure that members have also seen case study 1 on page 19, in which that very point is made.

Willie Coffey: Members will know that when local authorities place youngsters in residential accommodation, they are never entirely certain what the outcome for the young person will be. That has somehow become a cost that has to be borne, and that is that.

More thought must be given to outcomes for those youngsters—Cathy MacGregor suggested that there is more work going on in that area. There must be a shift away from putting children in a residential care establishment without planning what the outcomes should be. That would surely be an advantage in the longer run.

Cathy MacGregor: In the report on residential childcare that we published a couple of years ago, we picked up on the issue of care planning and the need for it to be more regular and much more focused on outcomes, with an on-going process of considering what those outcomes should be.

Willie Coffey: Are you planning to expand the model that you highlighted in case study 2? Do you know whether there are plans to widen that approach across Scotland? I know that it does not cover all the kids who are in residential accommodation.

Cathy MacGregor: Absolutely we are. I am not aware of all that is happening as we have not looked across all the different types of services, but I know that some work is going on, particularly in foster care services.

Willie Coffey: There is scope for further work.

The Convener: A number of members' questions today can be summed up as asking the Accounts Commission and Audit Scotland what we should do to sort the situation.

Barbara Hurst gave two examples of where progress has been made—although in some respects only in the short term—which involved moving learning disability services to community care and targeting work to reduce delayed discharges. In both instances, it appears that the NHS and local authorities found a way to work together to deliver the outcomes.

Is it too harsh to say that that was because they both had an interest in those things? The local authorities had a statutory responsibility for the service users, and the NHS wanted those service users out of its area of responsibility. In both instances the service users were in hospitals and were therefore a cost to the NHS when they should have been in social care under local authorities. When they had a shared interest they seemed to be able to bang their heads together and make it work. Is that point reasonable or completely unfair?

Barbara Hurst: Health and social care certainly had shared interests in both those instances, but they have shared interests in a range of issues. Learning disabilities in particular was a big agenda that involved bridging finance and placing a real focus on shared interests. In a way, we are turning that around and saying that if one recognises the shared interest there, one must also recognise the shared interest among all the user groups. Perhaps the bridging finance will not be available to the same extent, but a more creative approach must be taken to funding to acknowledge that shared interest.

The Convener: Do you want to add anything, Mr Baillie?

John Baillie: No, I have nothing to add.

The Convener: I thank our colleagues from the Accounts Commission and Audit Scotland.

Section 22 Reports

"The 2010/11 audit of the National Library of Scotland"

11:25

The Convener: Item 3 concerns correspondence that relates to the section 22 report entitled "The 2010/11 Audit of the National Library of Scotland". The correspondence, which is from the Scottish Government, has been circulated to members. I will open the issue up for colleagues to comment.

Mary Scanlon: I have just read the letter from Peter Housden and I am a bit disappointed. Basically, he says that all the audits that were done at the National Library of Scotland were done according to UK auditing standards and Audit Scotland guidance. The briefing paper and report from the Auditor General states:

"The main samples tested during both years reviewed did not include any of the fraud related items".

On page 7, however, it says that

"it is unlikely that in this case the frauds would have been detected through this approach."

Paragraph 35 continues:

"Given the sophisticated nature of the fraud ... it would not have been reasonable to expect the external auditor to have detected the frauds".

I was looking for something a bit more robust—perhaps saying that lessons had been learned and that this was exceptional. The fraud that was discovered was of £500,000, which is not insignificant. I was hoping that the response would not be "We've done everything possible and it wouldn't have been reasonable to expect the auditor to detect the frauds before they were discovered." They were discovered only through the introduction of a new finance system in the National Library of Scotland.

My concern is that, if there are such issues in what is a small organisation by national standards, those issues might be prevalent elsewhere in the public sector. That is just my personal view.

The Convener: Do you have a suggestion for pursuing that?

Mary Scanlon: I hoped for something more robust from Mr Housden, saying that lessons had been learned, that something was being put in place to ensure that this would not happen again and that internal and external audits would be reviewed, or something like that.

The Convener: The letter says that the National Library of Scotland accepts the recommendations in the Audit Scotland report. Are you content that we are where we are, with the comment that you have made on the record?

Mary Scanlon: Yes.

Tavish Scott: If Mary Scanlon wishes to pursue the matter further, it may be worth noting the third paragraph of Peter Housden's letter, which comments on

"the Scottish Government's sponsoring directorate".

Its role in the matter is an issue that she may wish to pursue in other ways. I do not think that there is much that the committee can do about it, to be honest, but sponsoring departments and what they do is always an interesting area for investigation.

The Convener: Mary Scanlon has made her point on the record. The suggestion is that we note the correspondence. Is that agreed?

Members *indicated agreement.*

"The 2010/11 audit of Registers of Scotland"

"The 2010/11 audit of the Crown Office and Procurator Fiscal Service"

"The 2010/11 audit of Disclosure Scotland"

The Convener: Item 4 is correspondence relating to three section 22 reports, all of which identified problems with information technology contracts. The previous convener initiated the correspondence, the committee having noted similar problems in those three public bodies. As a result of the committee's consideration of the matter, the AGS has programmed a performance audit report in to the management of information and communication technology contracts in central Government, which will probably take place next year. Audit Scotland will look at the thematic issue.

Does anybody want to raise any issues about the correspondence?

11:30

Willie Coffey: There are some common threads in the three reports. We have seen that in reports in the past, particularly in relation to IT. One of the big messages is that there must be more planning in the early stages of project planning and in commissioning software. Is it too much to expect every organisation and public body in Scotland to have that level of sophistication in its IT services and so on? If it is too much to expect, the work still needs to be done by someone somewhere to assist those bodies to get IT solutions right before they spend the money on them and then discover that they do not work. I am pleased that the Auditor General will look at that in detail. More

work on IT systems must be done in the early planning stages before organisations buy them. They must see that systems are functional and can deliver users' requirements. They must be fit for purpose before public money is spent on commissioning and buying them.

The Convener: My suggestion is that we note the correspondence in the knowledge that there will be a more profound look at the common threads that run through the different reports, as Mr Coffey says. Is that agreed?

Members *indicated agreement.*

11:31

Meeting continued in private until 12:11.

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