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Pàrlamaid na h-Alba

Official Report

PUBLIC AUDIT COMMITTEE

Wednesday 9 May 2012

Session 4

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PUBLIC AUDIT COMMITTEE
7th 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:

Derek Feeley (Scottish Government)
Geoff Huggins (Scottish Government)
Brian Slater (Scottish Government)

CLERK TO THE COMMITTEE

Jane Williams

LOCATION

Committee Room 1

Scottish Parliament

Public Audit Committee

Wednesday 9 May 2012

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

Decision on Taking Business in Private

The Convener (Iain Gray): I welcome committee members and members of the press and public and ask everyone to ensure that their mobile phones are switched off.

Our first item is a decision on taking business in private. Does the committee agree to take items 6 and 7 in private?

Members *indicated agreement.*

Section 23 Report

"Commissioning social care"

10:00

The Convener: The next item is the committee's continuing consideration of the Audit Scotland section 23 report entitled "Commissioning social care", with evidence from a panel of Scottish Government witnesses. I welcome to the meeting Derek Feeley, who is director general for health and social care and chief executive of the national health service in Scotland; Geoff Huggins, who is head of the reshaping care and mental health division; and Brian Slater, who is policy manager in integration and service development. I thank you for attending.

I usually offer our witnesses the chance to make a statement, but I have had an indication that you do not want to do that. Is that right, Derek?

Derek Feeley (Scottish Government): Thank you for the opportunity, convener, but the letter that we sent to the committee in advance of the meeting says more or less what we would say in an opening statement. We are happy to proceed to questions.

The Convener: I appreciate that.

Perhaps I can kick off with a question that, I hope, goes to the heart of the report. When the Auditor General presented the report to the committee, he said that he felt that it was one of the most important reports he had published in his time as Auditor General, which is now coming to an end. He said that, first, because it examines an issue that will grow in importance, given the increasing proportion of older people in the population who need the kind of social care that we are discussing and, secondly, because he has, in his time as Auditor General, repeatedly presented to the committee reports that have made it clear that there had been little progress in pulling together health and social care to deliver the best services for those who need them.

The Auditor General still feels that there is little progress to report; for example, only 11 out of 32 local authorities have been able to demonstrate that they have a strategy for commissioning social care. I want to ask you what I asked the Convention of Scottish Local Authorities and care providers in previous evidence sessions: what has gone wrong and why, in so many years, has so little progress been made in pulling together health and social care?

Derek Feeley: That is a big question to begin with. First, I agree with Robert Black's assessment

of the issue's importance. How we will deal with it is one of the nation's biggest challenges.

Secondly, I recognise that progress has not been as rapid as any of us would have liked. Before I try to assess why that has been the case, however, it is important to point out that this has not been an entirely success-free zone—we have had some successes. For example, we are in a significantly better place with delayed discharges than we were 10 years ago, and that is down to better joint working between health boards and local authorities. That said, I agree with the report's assessment that things could be moving quicker, and that joint commissioning is one of the routes to faster integration.

Why has progress been slow? It is not through any lack of intent; after all, over the past 10 years, initiatives such as joint futures have been designed to move us forward. Progress has been hampered by the separation of budgets, by different governance and accountability routes, and by a set of incentives that have never really been well aligned to our purpose. In simple terms, I do not think that we have ever managed to make the right thing the easiest thing to do. That is where health and social care integration comes in. We now have a real chance to accelerate the agenda through the proposals for health and social care integration, which the cabinet secretary has been setting out. The legislative aspects are further described in the consultation that was published yesterday. That gives us a real opportunity to accelerate our progress in this area.

The Convener: There have been previous initiatives with the same or similar purposes—you mentioned joint futures, which goes back more than 10 years. We have a commitment again from the Government to move forward. Why will it be different this time?

Derek Feeley: A number of factors in the new arrangements will help us to accelerate the integration agenda. We are helped by the fact that there is a broad consensus on the need to do something in this territory. There is political consensus in the manifestos that preceded the 2011 Scottish Parliament elections, but there is also a consensus among the broad range of stakeholders that enough is enough and that we need to move the agenda forward.

Some of the arrangements that the cabinet secretary has set out in the consultation paper will help us to make progress more quickly. We will have a set of national outcomes to which everybody is signed up and towards which all partnerships will be required to make progress. We will have joint and equal accountability for delivery of those national outcomes, and integrated budgets with joint and equal accountability for how they are spent—again, that is a good connection to the joint commissioning aspect. There will be an enhanced role for professionals in the integration agenda which, again, will help us to move it forward.

The Convener: We pressed COSLA and representatives from local councils quite hard on why so few of our councils have managed to produce a commissioning strategy. I want to be careful about paraphrasing what they said, but they implied that local authorities had always found it extremely difficult to create joint funding for joint projects. In other words, they found it quite difficult to get the NHS to commit resources to such projects.

To be fair, the one exception that they mentioned—which you also mentioned—was delayed discharge. The implication was that there was a particular indirect benefit for the NHS—unblocking beds—and that in those circumstances, there was a willingness to share budgets. However, otherwise it was very hard to get the NHS to commit budgets to integrated projects. I ask you again: why will it be different this time?

Derek Feeley: It will be different because we will build on some of the early successes of the change fund, which has helped us to move the agenda forward. It is early days, but we are starting to see some promise from the change fund initiatives, which the health boards, their local authority partners and third sector organisations are coming together to agree. Emergency bed days for people aged 75 and over, which had been rising steadily over a number of years, first began to plateau and are now coming down.

In some local partnerships, we have things like reablement agreed between the partners; for example, there are preventative approaches in places including Stirling, which are reducing care needs by about 20 per cent. There are the green shoots of some genuine partnership working.

Now that we know the change for which the change fund is designed—health and social care integration—the process ought to move forward more quickly.

The Convener: The reablement projects are examples of partnership projects being funded by the change fund. Is the change fund funding institutional change in how we deliver services or is it simply an alternative pot of money to fund joint projects?

Derek Feeley: No. The change fund is about change; it is about redesign, shifting the balance of care and—to use the jargon—bending the spend.

The Convener: We heard some evidence—it was one of Audit Scotland's key

recommendations—on the role of Social Care and Social Work Improvement Scotland in ensuring that real progress is made and that commissioning strategies are effective and consistent across the country. In your written evidence, you essentially accept the recommendation that the care inspectorate should have such a role. Do you envisage a new and expanded role for the care inspectorate to ensure that what we want—you said that you are optimistic about this—will be delivered? Is that a correct reading of your written evidence?

Derek Feeley: Geoff Huggins might want to add something, but I think that there are three things we want the care inspectorate to do. First, it should have in its scrutiny programme a commissioning theme. Secondly, it should work with local authorities and health boards to help them to deliver the duty in section 100 of the Public Services Reform (Scotland) Act 2010 to learn from the care inspectorate's reports and to do more closing of the loop, if you like, from scrutiny through to action taken. Thirdly, it should work outwith the scrutiny process—there are already some encouraging signs in this regard—with partnerships to advise them on how they can improve their commissioning strategies and how they can evaluate their success. Those are the three things on which we would like to see the care inspectorate step up to the plate. The early signs are that it recognises the need to do that and that it wants to be involved.

Geoff Huggins (Scottish Government): I do not have much to add, other than that the care inspectorate identified that one of the priorities for 2012-13 will be to work, as part of the strategic work, with local government on better commissioning. The inspectorate has acknowledged that need because of the interaction between the strategic functions and the delivery of individual and local services. It is clearly on the agenda for 2012-13.

The Convener: Will the care inspectorate have the capacity to do that? There has been significant debate over recent months about its capacity to deliver on things that it has already been doing, and it will have important new responsibilities.

Geoff Huggins: In order for the cabinet secretary to be able to decide last summer on the size and structure of the care inspectorate, we went through a process to ensure that it would be capable of regulating the quality of individual care services and that it continued to deliver on the strategic functions. The budget has been maintained at a level that will enable it to do that, and will grow slightly over the next two years.

The Convener: The care inspectorate will identify areas in which there should be improvements.

You said that we have suffered in the past from dual lines—or more—of accountability. There has certainly not been a single line of accountability for delivery of services. In two, three or four years from now, when the committee looks at the issue again, will the single line of accountability be to you and will you answer then for delivery of care services across Scotland?

10:15

Derek Feeley: By that time, we will be in the territory of health and social care integration. It is intended that an accountable officer will be appointed jointly by the local authority and the health board. That person will be accountable directly to the chief executives of the local authority and the health board and will have responsibility for spending the integrated budget. They will also have responsibility for ensuring that there is joint and integrated commissioning. The consultation paper is pretty clear on what we require every health and social care partnership to do. Paragraph 5.19—which I say for the benefit of the *Official Report* staff is on page 32—says:

"Each Health and Social Care Partnership will be required to produce integrated strategic commissioning plans for use of the integrated budget over the medium and long-term."

As I said, there will be accountability from that joint accountable officer to the chief executives of the health board and the local authority. The consultation paper proposes that, thereafter, there be a joint holding to account by the cabinet secretary, the leader of the council and the chair of the health board, similar to current accountability reviews in the NHS.

The Convener: There will not be a single line of accountability for delivery of the services. When you say that there will be accountability to the chief executive of the health board and to the NHS, that means that one of the core problems that you have identified as being the reason for lack of progress will continue into the changed system.

Derek Feeley: No it will not, because the joint accountable officer is the person who is accountable.

The Convener: That joint accountable officer is accountable to two people: the chief executive of the council, who is not accountable to ministers or Parliament, and the chief executive of the health board, who is. That means that the split in accountability will remain.

Derek Feeley: There will be the joint commissioning strategy, an integrated budget, responsibility through the joint accountable officer, a partnership agreement that sets out exactly what both parties have agreed to, and significantly

enhanced transparency around all that. That represents a significant step forward.

The Convener: We are supposed to have joint commissioning strategies now. Audit Scotland can identify only 11 from 32 authorities, and it is not clear who is accountable for that failure. It seems to me that you are describing a system in which that will continue to be the case. If there is no single line of accountability, who will be responsible for ensuring that we have commissioning strategies throughout Scotland, instead of in less than half the country?

Derek Feeley: If the consultation paper becomes law, as we hope it will, the newly established health and social care partnerships will be responsible for the joint commissioning strategy, the integrated budget, delivery on the national outcomes, greater transparency, joint and shared accountability and so on.

Mary Scanlon (Highlands and Islands) (Con): The Auditor General, who has been in post for a significant time, presented us with the section 23 report, "Commissioning social care", which he described as

"the latest of six reports that Audit Scotland has prepared in this general area since devolution",

saying that it was one of the "most significant" that he had prepared in his time in office. He said that all of the six reports had

"contained challenging findings about the commissioning and delivery of social and health care services and the efficiency and effectiveness of partnership working."—[*Official Report, Public Audit Committee*, 14 March 2012; c 445.]

I do not want to misquote him, but I think that there is a frustration that nothing much has changed since 1999. Listening to what you have said this morning, I thought to myself that I have heard that on the Health Committee and the Health and Sport Committee for nine years.

A main thrust of the report is that insufficient resources, focus and priority have been given to preventive care services and the focus has been mostly on intensive care—more or less on crisis management. Paragraph 49 says that

"The number of people receiving home care of less than four hours a week ... decreased by 41 per cent"

in one year between 2008-09 and 2009-10. Within that year, the housing support figure went from 84 to 47 per cent.

The Auditor General says that there is not enough preventive care. There is no focus on reducing emergency hospital admissions, which the health secretary has often said is a target and which I support. You are moving more towards crisis management and intensive care and further from the preventive care that has been the focus since 1999. The way I see it is that things are getting worse rather than better.

Will you respond to the point that preventive care is not in place and that we have a system of crisis management and intensive care, which is a main criticism in the report?

Derek Feeley: We are investing in prevention—the change fund is designed to do that and to get people to redesign care in a way that shifts the balance towards care at home. Outwith the change fund, we are in the health service and in local government doing a range of things more generally on prevention that are about the shift towards care at home and away from institutional care.

It is true that the level of home care of less than four hours has dropped over time. You are right that we need to understand exactly why that has happened.

Mary Scanlon: You have had 13 years to understand the issue. Why is the situation getting worse rather than better? Why is it going in the opposite direction from that which the health secretary and all the rest of us seek?

Derek Feeley: What might be happening is that a different kind of care is being delivered to the group of people concerned. At the same time as the shift to which you refer has happened—on the other side of the balance sheet, if you like—a big growth has occurred in telecare, which I know Mary Scanlon has strongly advocated. We now have 111,000 people with telecare support. We need to understand the position a bit better because it is possible that some home care has been replaced by telecare. I suggest that if that is so, it is good, because it helps people to live independently.

The third sector runs a number of schemes—for example, befriending schemes—that might be replacing some of what was previously provided in home-care packages of relatively low intensity. A range of shifts are happening. We can quantify some of them, such as the advances in telecare and other measures, which we need to understand a bit better.

Mary Scanlon: Do you think that the Auditor General got it wrong and that you are concentrating on preventive care rather than tending to provide intensive support after hospital admissions? Was he, perhaps, unaware of befriending services and telecare?

Derek Feeley: I am not saying that the Auditor General "got it wrong". He reported a reduction in the amount of home care, which I do not dispute. All I am saying is that I would like to understand better exactly what is going on and what the relationships are between decisions that are made

about where to place the bar for access to services.

Mary Scanlon: Do befriending services and telecare account for the 41 per cent reduction in home care? Do you not think that that reduction is significant and that you should be concerned about it? Does it not go in the opposite direction from what was intended?

Derek Feeley: I am not saying that we should not be concerned about the reduction or that we should not look at exactly what is happening. All I am saying is that there are positive initiatives on the other side of the coin that may be contributing to that reduction.

Mary Scanlon: They may be, but you do not know.

Geoff Huggins: At this time of the year, we visit each health board and their local authority partners to talk about their work, particularly around mental health. This year, a key focus is on older people's mental health, and one of the really interesting phenomena that we have seen in our visits so far—particularly to Shetland and Grampian—has been the range of additional and new third sector and community services that are appearing as a consequence of the change fund. Those services are to do with older people's engagement, activity and participation.

That phenomenon has just begun to emerge at scale over the past six to nine months, and it is considerably more difficult to track. It does not sit within community care statistics at the moment, but local government and health boards are clearly becoming quite excited about it, because they see the downstream benefits of better mental health being maintained. The likelihood that people will be ill and will require additional support at home will be reduced, and they will be more able to continue to thrive in their communities. We want to promote that, and I have been quite surprised by the degree to which it has been pushed back across the table at us as something that is really happening out there. We are beginning to see quite a change.

The other key point is that, although the figures are changing, the challenge and the demographic are also changing. We are seeing a changing scale of challenge—the convener referred to that—at the beginning of the process. That means that, even if things look the same or different, they must be understood in the context of the scale of the change and how it is developing over time.

Mary Scanlon: I would like to think that people with mental health issues will one day be treated with the respect and dignity that they deserve. There is a long way to go on that.

My final question is about the eligibility criteria, on which I have previously lodged a parliamentary question. It seems odd that the average number of home-care hours a week in Angus is 3.8, whereas in Fife the average number is 21. I cannot imagine that people in one area are more ill than in the other, although that seems to be the explanation in the written answer to my parliamentary question. Could the difference in hours be because of a difference in the eligibility criteria in the areas? Is there a postcode lottery in respect of what people need in order to be eligible for care, or does Angus focus more on prevention than on intensive support? I do not know; I am looking for the answers. One figure is six times the other, and that disparity is not easy to explain away. Why is there such a considerable difference? It is highlighted in the Auditor General's report.

Derek Feeley: I am sure that my colleagues will want to add to what I say. We need to be sure that we are comparing like with like.

Mary Scanlon: Did not the Auditor General say that in his report?

Derek Feeley: I suspect that Fife is reflecting housing-related support, for example, which may not be reflected in the Angus numbers. I am not denying that there will still be a variation; I am simply saying that the variation might not be as extreme as Mary Scanlon might think. Some of the variation will be down to issues that we talked about earlier. Partnerships are at different places in their redesign programmes and in the shift in balance to the care-at-home sector. There may be a range of other issues.

10:30

Brian Slater (Scottish Government): I will let Geoff Huggins cover the eligibility question. On the question of the disparity, as Derek Feeley has said, we might not be counting like for like. Fife Council and Angus Council both submitted written evidence to the committee, and Fife Council tried to explain some of the disparity by saying that it was not counting like for like with Angus Council. I read that correspondence as saying that, if Fife Council were counting in the same way as Angus Council, the figure of 21 hours that is cited in the report would come down to nearer 10 hours, which is around the Scottish average.

The Convener: The disparity is still significant.

Brian Slater: It is still significant, but I think that Mary Scanlon said that the figure in Fife was nine times higher. The disparity is not quite at the level that she suggested. I am not saying that the report is wrong; I am just saying that the councils may not be counting like for like. Our analytical services people are looking at that to ensure that, when the

information is collected in the following year, we will count like for like.

Mary Scanlon: The truth is that, as things stand, we cannot adequately explain that discrepancy.

Brian Slater: We can only say that it is probably not as great as the discrepancy that you suggested.

The Convener: It is puzzling that, in the correspondence to which you have referred, Angus Council begins by saying,

"In applying the guidance"

and Fife Council begins,

"As per the Scottish Government guidance".

They then count in different ways, as you have said. Who is correct? Who is following your guidance and who is not?

Brian Slater: There has clearly been a difference in interpretation of the data that has been requested. As I said, our analytical services people are looking at that and seeking to clarify it in the guidance that will be issued for the following year's collection.

Colin Beattie (Midlothian North and Musselburgh) (SNP): I have raised the subject of funding before. Paragraph 12 of the report refers to the fact that local authorities' spending on social care has increased by 46 per cent in real terms over the past eight years. The final bullet point in paragraph 23, on page 14, states:

"Public sector budgets are expected to be reduced by 12.3 per cent in real terms between 2010/11 and 2014/15."

According to all the demographic information that we have seen, the likely demand for such care is not going to drop. We hear about all the strategies that are going to be put in place and the changes that are going to happen to enable us to manage that care better and more efficiently, but it is unlikely that there will be huge amounts of additional money available. I asked previous witnesses whether all those changes and strategies will hold us for the next five or 10 years, and the clear answer was no. To my mind, they will do for another three years or so. Do you agree with that? What stresses will that put on the NHS as it works in partnership with local authorities that are struggling to find the money? How will you cope with that?

Derek Feeley: That, at least in part, is what our health and social care integration proposals are designed to assist with. Geoff Huggins may want to talk about the reshaping care for older people work that he has been involved in. Having done that work, the one thing that we can say with absolute certainty is that doing more of the same is not the answer. That is why the work that is being done through the change funds is so important. It is about the redesign of the services that will be necessary for that group of people in the future. The health and social care integration work is important because it provides a more effective way of planning and commissioning those services and delivering against an agreed set of outcomes, which I described earlier.

The other thing that we need to bear in mind as we develop our thinking around these issues is that there is a tendency to look at what we might call the demographic burden, but that is the wrong approach to take. We need to figure out a better way to use the assets that will come with an ageing population. The number of older people aged 65 plus who provide more than 20 hours care per week is significantly more than the number who receive such care—a significant number are care providers rather than care recipients. An important part of what we need to do is to think through the change in the terms of engagement, from being about the demographic burden to being about how we use the demographic asset.

Colin Beattie: Again, you talk about using strategies to get us through the next few years. How long can that continue with a budget that, certainly for councils, is unlikely to increase and which might well decrease, as the report suggests? How will you cope with that?

Derek Feeley: It is hard to be certain about budgets beyond the period of the spending review. We will be able to make significant progress over the spending review period given the resources that we have. Given the additional resource that has gone into the change funds and the fact that the health budget has been protected, we will be able to make significant progress in the next three years. However, we recognise that that will need to prepare the ground for the medium and long term. We cannot use all the resources that we have in the next three years just to stand still; we must use them to rethink and redesign.

Geoff Huggins: The member has outlined a genuine challenge. Historically, modelling on the subject has been done on the presumption that we would continue to offer care home places and care at home to the same proportion of people. However, that will clearly not be the case. We are beginning to see change in the structure of how care is delivered. As Derek Feeley said, there is also increasing participation among older people in providing care and support. Our work on the dementia strategy has indicated that a broad group of people are looking to offer support to one another as well as to receive support from statutory services. We are beginning to see a change in how systems work and in people's expectations within the systems.

Much of the historical modelling on future costs was based on inflationary figures and presumptions about year-on-year inflation in wages that no longer apply. Therefore, we will probably want to consider in a different way some of the additional burden elements that are factored into projections. A range of things is changing. People are being healthy for longer and living healthier lives, and we are seeing the benefit of the smoking ban and policies on alcohol in Scotland. The nature of the challenge that we face is changing, and we are learning more about the interactions between physical and mental health, the ideas on participation and engagement and just how people will live different lives in future. That is a public policy challenge, but it is also a challenge to all of us as individuals.

Colin Beattie: You have highlighted some positive aspects but, if we look back at what happened previously, we find that there was a 46 per cent real-terms increase in council social work budgets. A proportion of the budget cuts must inevitably fall on local councils, which will create strains at that level. Under the present thinking at least, the NHS budget has a degree of ring fencing and a bit of security. How will one partner cope when another partner is struggling? You are counting on the fact that you will be able to make all the changes through partnership working to deal with the situation that is coming, but if some of the partners do not have the money, how will you do that?

Geoff Huggins: That will work out differently in different localities. One area that we are focusing on in our work on the in-patient estate is beds for old-age psychiatry. Across the country, the pattern of provision varies, with some areas having considerably more beds than others, and some having almost no beds. That reflects the degree to which some areas have already gone through a change process, reprovisioned and engaged in different relations with their local authority on services for older people with dementia, cognitive impairment or other illnesses. We will see more such change take place over the next two, three or four years as services across the piece are restructured. That is teaching us that looking simply at NHS mental health services, for example, does not work, because they are of a piece with local government services. There is probably not a national answer to your question, but there are probably 14 times 32 local answers. That takes us back to the discussion about integration and making provision work in a joined-up way locally.

Brian Slater: I take you back to the change fund, which we first started to think about prior to the last spending review, when we first saw the projections and anticipated that the health budget from Westminster would be protected and that social budgets would be cut. In England, they tried to cater for the smaller budget in social care by moving money out of health and over to the social work budget in local government. That was just plugging the budget gap and we did not do that in Scotland. We introduced the change fund, which had to be used on a partnership basis and had to be used to redesign services. There was an insistence that we had to do it differently. It was not about just moving a budget from the NHS to local government; it was about ensuring that the plans were signed off jointly and would redesign how we do things in the future.

Willie Coffey (Kilmarnock and Irvine Valley) (SNP): Good morning. I will continue on the same theme. The convener spoke about the strategic approach to commissioning and how services might look in the future. At our previous meeting, Councillor Douglas Yates told us that, in the next 20 years, there could be a £3.5 billion funding gap and that no amount of commissioning or fancy footwork would fix that.

In your comments, there was a glimpse into the future that was more encouraging. Could you tease out what that future might look like? What might commissioning be like? It sounds to me that it is about improvements in governance, accountability and joint this and joint that, but if provision still ends up costing the public purse the same as it does now—Geoff Huggins talked about that—the ticking time bomb will go off. I think that that is what the Auditor General was warning us about in his reports. How will the change to strategic commissioning bring about the positive outcomes that we need at an affordable price for the public purse?

Derek Feeley: We need to put commissioning in the broader context. Commissioning will help us to get to that better place, because it will help people to be clearer about what we want in terms of the needs of the population and the outcomes that we seek.

We have established a national steering group to help us think through exactly how joint commissioning will work. In the change fund guidance for this year, we included a requirement for partnerships to up their game. As I have said, if the proposals in the consultation paper become legislation, there will be a requirement to have commissioning. That will bring clarity locally about what it is that we will try to do together with our combined resources and it will be a move away from some of the fragmentation and separation to which the convener referred in his opening remarks. Everybody locally will be clear about what we are trying to do. They will be clear about that because they have engaged with their local populations in producing the plan.

The Convener: Sorry to interrupt you, but are you referring to the national learning framework?

Derek Feeley: The national learning framework is part of what the national steering group will try to develop. We are aware that that approach will require a set of capacities and skills that are probably not as well developed as they should be. People will have to understand how to do that work better.

We are starting to prepare the ground for that with the change fund. With the £80 million that is available for 2012-13, we are encouraging people to think about what they can do in advance of those changes and how they can make a difference locally. We want people to think about how they can reduce emergency admissions from care homes, how they can get people to be more comfortable living independently at home and how they can avoid emergency admissions to hospital. Work is going on locally in all those areas—I can give the committee some examples of that.

Another investment for the future that we are making with the change fund is that we are ensuring that at least 20 per cent of change fund resources go towards carers. We recognise that getting to a better place in the longer term is partly about developing and supporting carers in a more advanced manner. A huge amount of work is under way to ensure that we do not get to a position in which we have to pump more money into doing the same kind of things simply because we have not made the service change or done the redesign work that is necessary to meet those demographic and financial challenges.

10:45

Willie Coffey: How soon will we know whether we are being successful? We are acutely aware of what the Auditor General said. When will we get an indication of whether the current direction of travel is successful from the point of view of the public purse and affordability?

Derek Feeley: We are already starting to get an indication that we are making progress and moving in the right direction. I mentioned to the convener the reduction in the number of emergency admissions of over-75s, which had risen inexorably for 20 years. It is the first time that we have managed to reverse that trend.

Among the work that is being done locally is the admission-avoidance, hospital-at-home programme in North Lanarkshire, which has been found to keep out of hospital eight out of nine people who would otherwise be at risk of admission. Work that has been done in East Lothian on reablement has reduced the care-at-home requirements of the people on the programme by about 46 per cent. We can see the first signs of genuine progress.

The challenge for us will be to spread the learning from such local initiatives, to build the capacity that is required to do things differently and to prevent the not-invented-here approach, which has been a problem in the past. There is no magic bullet. It is not the case that if we do one thing differently, things will change. To meet a challenge of such a scale, we must embark on a complex, multidimensional programme of work and pursue it reliably.

Willie Coffey: You said that we will have to use the assets that an ageing population will bring. What does that mean?

Derek Feeley: It means doing some of the stuff that I mentioned earlier. We often overlook the fact that older people make up a large group of the people who provide care. Some of what we need to do is relatively simple stuff, such as giving people access to the information and support that they need so that they can do what they want to do, which is make a contribution.

In the NHS, we have been working extensively with people who have long-term conditions. We have worked with the Long Term Conditions Alliance Scotland on supported self-management programmes. The clear message from a lot of people who are managing their own condition or the condition of a family member is that they want to help. They want to be part of the process. Some simple tools and supports are all that they need to enable them to do that. Through the Long Term Conditions Alliance, we are trying to build that resilience and capacity.

There is a programme called ALISS—access to local information to support self-management. ALISS signposts people to where they can go to get support. If someone is looking for company because it will help them, for somewhere to go to walk their dog in a community, or for a community in their area that does exercise for people who are at their age and stage, ALISS will signpost them to that kind of thing. That is what I mean by using the individual assets of the person who wants to make the contribution, and better using the community's assets.

Willie Coffey: In my last question, I will shift to the issue of children in residential care. From my experience in local government, I know that it can be hugely expensive to provide residential accommodation for children in care, and it can have unpredictable impacts on a local authority. There could be a sudden requirement for £1 million in a year out of a local authority's budget. As part of the new approach to commissioning care generally, are we looking to try to manage that aspect better, in order to provide better

outcomes for children in residential care, while smoothing its impact on local authority budgets year on year? A local authority can be taken by surprise by the cost of residential care for children. That is a huge challenge and I hope that the Scottish Government pays attention to assisting local authorities in managing that process better.

Derek Feeley: I fully recognise what Willie Coffey says; it is an important issue. Our focus on joint commissioning and integration has been on older people, but that is only our initial focus. We recognise that we need to look wider, and some of the partnerships are already making progress on that. Highland has its lead commissioning model, which gives the local authority responsibility for all children's services. That is a novel approach that we will look at and learn lessons from. The issue is on our agenda and we recognise the need to make progress in that territory.

The Convener: Around here, Willie Coffey and I are the assets that ageing brings. The same cannot be said for Humza Yousaf, who is next.

Humza Yousaf (Glasgow) (SNP): Thank you, convener, but I should say that Mark Griffin is even younger than I am so he has a future. I feel like an oldie when I sit next to him.

Good morning, panel. It is fair to say that the uptake of direct payments has been relatively low. The Auditor General refers to that in his report. The nub of the problem seems to be that carers and service users are not involved enough in decisions about their own care. In your written response, you tell us that the Scottish Government plans to invest a further £39.5 million, but throwing money at the problem is not going to help entirely. Mechanisms have to be put in place to involve NHS boards. When the councils came before the committee, they took a fair bit of hammering for not having those structures in place. What are NHS boards doing to involve carers in the process? Carers primarily see the motives of councils and NHS boards as being simply to save money rather than to improve the services that people receive. Will the money help? Extra resources at times like this will always be welcome, but there must be some structural changes as well.

Derek Feeley: The money is largely for building capacity in third sector organisations and beyond. It is also for providing information about what is available. I suspect that you are right that there almost requires to be a cultural change if we are to make a broader success of self-directed support, not just direct payments, which are a relatively narrow bit of self-directed support.

Some of the stuff that we have done in the NHS has been helpful; indeed, a minute or two ago, I outlined what we have done around self-management. As an important first step in that work, the Scottish Government did not write the strategy but got the Long Term Conditions Alliance Scotland to do it. It called the strategy "Gaun yersel"; a less governmental title for a document one cannot imagine, but that is what the alliance wanted to call it and it is leading its implementation. Some of this is about handing over responsibility—

Humza Yousaf: Or is it simply passing the buck?

Derek Feeley: It is certainly not that. I am not sure whether you explored these issues with Ian Welsh when you took evidence from him, but I am reasonably confident that he, his chair and the board members of the alliance will not say that they feel that the buck has been passed to them. They will feel that they have been given some resources and autonomy to do the right thing for their members. They are closer to their members' needs than we are, so it is absolutely the right thing to do—it is a win-win. We get better outcomes for the people who get supported self-management and give that group a stronger voice.

Humza Yousaf: I do not know whether you saw the reports but, yesterday, various media channels were reporting carers' reservations about self-directed support. Why are people feeling hindered? Why are they being so hesitant in getting involved in the personalisation agenda?

Derek Feeley: I suspect that it is because self-directed support is not for everyone. The opportunity could be offered much more widely—indeed, it should be—but there will always be a proportion of the population who will say, "Thank you very much. I've had a look at that and it's not for me. I need a different kind of support."

It is not a case of people taking self-directed support or leaving it. There is a range of things that we could and should be doing in that middle ground to give people a voice. In fact, one of the reasons why the carers' parliament that we are holding later in the year is so important is that it will allow us to listen to carers' voices. Some of the early signs from the change fund evaluations are that carers are starting to feel a little bit less isolated and a little bit more involved. As I have said, we devoted a chunk of the fund to the carers agenda because we recognise that certain things need to be developed. That said, I cannot envisage a situation in which many people take up self-directed support; indeed, where it has been applied to a greater extent than we have applied it, it has not been massively taken up. It is just not for everyone.

The Convener: You said that resources were being provided to make self-directed support more available and that much of that was going towards

capacity building in the third sector and providers. However, in your written evidence, you refer to £23 million of "direct funding to ... councils". Will that money be ring fenced for this purpose?

Derek Feeley: The intention is that local authorities will use the money for the purposes that I have described.

The Convener: Lying behind Humza Yousaf's question was the concern that councils might see this change as a way of pulling back. What is the guarantee that that £23 million will not be used to plug a gap that councils perceive is there—and, in fact, might really be there—rather than to make the system work for those with anxieties about the shift to self-directed support?

Derek Feeley: Local authorities will not be able to deliver the change that they need to make in self-directed support if they take such actions.

11:00

The Convener: In its evidence, the City of Edinburgh Council mentioned the provision of web-based information on care alternatives to enable people to make choices. Will that allay the concerns of those who are anxious about self-directed support or will it put many of them off because they will feel that it is not for them? My elderly parents are at the stage of beginning to access care. I have to be honest and say that, if I told them that they had to navigate the web in order to find out what was possible, they would not be able to do that.

Derek Feeley: I think that there are a number of people in that situation. Web-based solutions have a role to play, but we should not rely entirely on that medium as the sole way in which to get information to people.

The Convener: You talked about signposting to services through ALISS. Is that a web-based system?

Derek Feeley: It is web based, but it operates in a different way, because people become members of that community. Members of the public and organisations have ALISS accounts and they undertake to share the information. At some point, information will be posted on ALISS, but you will also find folk in community groups sharing the information. They will say, "I got this from ALISS—you will want to know about it." It will be on library notice boards and all over the place. All that ALISS does is to provide a community of interest. People who want to share the information come together on ALISS, but they share it in a range of different ways.

Mary Scanlon: I have a question about something that I raised earlier. Given that more than £3 billion is spent on social care and that, according to the Auditor General's report, it is not sustainable to continue in the current way, I ask you to respond to what we were told by two previous witnesses. The first is Annie Gunner Logan from the Coalition of Care and Support Providers in Scotland, who told us:

> "In the current climate of public spending contraction, it seems ... increasingly difficult to account for the fact that councils under a duty of best value continue to sustain ... high-cost in-house services".

The second comment is similar. Ranald Mair from Scottish Care told us:

> "There is no level playing field around cost".

He questioned whether councils do provide best value and stated:

> "In some contexts it allows councils to adopt a protectionist approach".

The Coalition of Care and Support Providers in Scotland gave this example:

> "one council advised that its hourly rate for purchased care at home is capped at £10.43, whilst its equivalent in-house service costs £21 per hour".

I fully support what is happening in Highland with the NHS or the council acting as the lead agency.

What is likely to happen in future that will ensure that we get value for money and high-quality care, that the care inspectorate standards are taken into account, and that we do not pay double the rate for a council service, as the Coalition of Care and Support Providers in Scotland alleges happens in that case?

What plans do you have to address those issues and provide value-for-money, high-quality care from the voluntary sector, the independent sector and the public sector, with no protectionism?

Derek Feeley: Where to start?

Let me start with the guidance. It is clear that, in procuring care packages, people need to look at both quality and cost. That is right. We should not look at just one or the other. There is a misapprehension that lower cost always means lower quality, but we all know that that is not necessarily the case. We need to continue to be clear that, in procuring care, we are interested in both quality and cost.

We also need to continue to develop the integrated resource framework, which is potentially a hugely valuable tool for helping partnerships to gain a better understanding of exactly what the service costs and exactly what benefit they get from that investment. We will continue to develop that framework. We have recently been working on connecting it to the linked data at an individual level, so that it will be possible to look across the

piece at health and social care for a particular individual.

Those are two places where I would start. First, we need to make it abundantly clear that we are interested in both quality and cost and, secondly, we need to continue to give people the right tools to understand the matter better.

Geoff Huggins might want to add something.

Geoff Huggins: Mary Scanlon offered quotes from Ranald Mair and Annie Gunner Logan, but a different view has been expressed on the relative costs and value of council provision versus independent and private provision.

At times, it is easy to ascribe particular costs to particular services. Within councils, of course, additional on-costs will be notionally attached to them. Therefore, there is something of a dispute as to exactly where the truth lies nationally and locally.

Notwithstanding that, there has been a shift over time towards more provision of care home places and care services through the independent and voluntary sectors. Proportionally, they are the larger providers, and we can probably expect that shift to continue over time.

The process is clearly being crunched through at local level as people assess the best way to ensure value and quality for those within their areas. We anticipate that we will continue to see change in that over time.

Mary Scanlon: Annie Gunner Logan said that her evidence was based on a report by what was then the Scottish Commission for the Regulation of Care that, generally speaking, showed a disparity of about 20 points in quality of service. I think that the report was from 2011. According to the Coalition of Care and Support Providers in Scotland, the evidence exists.

I do not think that any of you have answered my question.

Derek Feeley: Brian Slater may be about to attempt to answer it.

Brian Slater: I will try. I simply wanted to say that that is why we are trying to improve commissioning skills.

Audit Scotland is absolutely right to say in its report that commissioning skills are not where they should be in Scotland. We fully accept that. Local government is probably further on in procurement skills.

Annie Gunner Logan made a good point about procurement versus commissioning. If a local council supplies frozen meals to its older people, it may get in contact with its neighbouring councils and ask whether, if they all linked together, they could provide frozen meals more cheaply. That is very much a procurement decision and councils are good at procurement. However, we need to develop skills in commissioning in general. A commissioner would ask whether that was the way that the council wanted to provide meals to older people or whether there would be alternative ways to do it. They would not consider only the cost of the service.

Mary Scanlon raises a valid point about the cost of different services. A commissioner needs to know the total resource that is available and the best way of providing the services, taking account of cost and quality. With integration, we are going down the line of having pooled budgets in future.

Willie Coffey: I thank Brian Slater for that explanation of the difference between procurement and commissioning. We got into a bit of a fankle at the previous meeting about the difference between the two, but he has explained it quite well.

I have a question about the social care market in general and the Southern Cross experience in particular. What, if anything, is the Scottish Government doing to help local councils avoid getting into the situation that we were in with Southern Cross? How do we assess the market and, if something like that were to happen again, how would we assist local councils?

Geoff Huggins: As you know, we have been working quite hard on that over the past 12 months. We had quite a busy year last year with the failure of Southern Cross, which required us to work closely with COSLA and individual local authorities to develop contingency plans to ensure that, were adverse events such as the closure of homes to take place, we would be able to make appropriate provision for the secure and safe care of older people.

That progress was given significant political leadership by Councillor Yates, who gave evidence to the committee, and the Cabinet Secretary for Health, Wellbeing and Cities Strategy in creating a framework for contingency planning, which continues to be in place. In addition, we have ensured that we stay close to the larger providers and that we understand what is going on in the market and how changes are taking place. We had good visibility of the recent changes with Four Seasons and Terra Firma. We were aware of what was going on and monitored it through both direct contact and contact with the Department of Health in England, which had regular week-to-week contact with Four Seasons about the changes that it was going through, so that we knew the degree of risk that was in place and were able to ensure that we could take any action that we might need to take.

In addition, we were aware of the concerns about quality during periods of change when providers might make changes in management. We also liaised with the care inspectorate, which has increased the frequency of inspections of homes that are subject to transfer. All Southern Cross homes were inspected considerably more during 2011 than those of other care home providers to ensure that there was no dip in quality and that the changes were not leading to individual adverse incidents.

Beyond that, we get into a broader set of questions. There was much focus on the financial structure of Southern Cross and the interaction with the lenders and the landlords, but there was also a broader set of issues, mostly south of the border, around lower occupancy rates, changes to individual councils' strategies in purchasing and the value of contracts.

In Scotland, we have of course the national contract, which gives a degree of stability to values in Scotland. That was what led us, in the context of the Health and Sport Committee's consideration of the regulation of care, to say that our approach would be to focus more on the overall financial stability of the market and the market's structure and take forward work on that, rather than try to build systems that looked at one particular element of the market, such as larger care home providers. They are part of a connected system that involves local government's commissioning strategy, wage inflation, landlord prices, lease prices, occupancy and changes in demographics. Simply looking at one component of that was not going to give us a good understanding of what the situation was likely to be over time.

We have therefore committed to taking work forward in that regard and will develop our understanding of the area in conjunction with COSLA and other partners. However, we will also be interested to hear what this committee has to say about the area and we will weave that into our work.

George Adam (Paisley) (SNP): I will go back to some of the things that the convener raised about how Mr Feeley views future services and particularly the accountable officer. In my time as a councillor, I brought up the point that access to services was extremely difficult for some individuals. When they went to a local elected member about that, it was just as difficult to go through the health board to get the individuals access to services.

You said that the accountable officer would be accountable to the leader of the council, Mr Feeley, but I assume that you meant the fully elected local authority body. If the individual is so accountable, what would the reporting structure be like and how do you envisage it working? That is important, because there seems to be a communication problem in getting from the local level to the health board level. Nine times out of 10 on the social care side it is the local authority that delivers a service. Will the accountable officer decrease the size of the communication gap in that regard?

11:15

Derek Feeley: The proposals are out for consultation just now, so my comments should be viewed in that context. However, the accountable officer arrangement should help considerably.

In effect, we are replacing the community health partnerships—which are, by and large, sub-committees of NHS boards—with health and social care partnerships, which are bodies corporate that sit jointly between the NHS boards and the local authorities. They provide a single route for a constituent who wants to access information about their whole health and social care package. The jointly accountable officer will be responsible for everything that the integrated budget pays for, overseeing the moneys that would otherwise be predominantly the responsibility of the health board or the local authority. As I described earlier to the convener—albeit not to his full satisfaction—there will be clearer lines of accountability between the accountable officer and the leaders of the executives of the two joint bodies and the council and the health board non-executives. The aim of what we are trying to do is to improve the outcomes for your constituents. If they do not get improved outcomes, the way in which they get remedy will need to improve.

George Adam: We must get that part right because that is where the process falls down at present. The $64,000 question is how we get that right—that is extremely important. We must ensure that there is a directly democratic process as well because the public just want the service to be provided.

I have been involved with the ALISS project for a wee while. It held a training session in Paisley two or three years ago. Where are we with the ALISS project? It has been talked about for a long time. It was a web-based directory, which its members were supposed to be able to access including in libraries. Is that all that it is?

Derek Feeley: That is what the ALISS search engine is—it is a web-based directory—but it is how people use ALISS that is different. Where are we with it? It is growing locally. It is not the kind of thing that we would impose on people; rather, we bring it to people's attention and invite them to use it in a way that suits them. Although it is a web-

based search engine—to non-experts like me, it is a bit like Google—it is what it enables members of ALISS to do that is important.

George Adam: I am very supportive of ALISS, but we talked about what we were going to do with it two or three years ago. We had an open day involving the third sector and the local authority, and everybody came up with ideas about how we could promote ALISS and ensure that people knew about it. It is a good idea, but the only place that I have heard ALISS mentioned since that seminar is here. That is why I ask where we are with it at the moment.

Derek Feeley: It is spreading gradually. I could provide the committee with information about where it is being actively used if that would be of value to you.

The Convener: That would be helpful.

George Adam: You talked about working with the Long Term Conditions Alliance Scotland. Last week, it was multiple sclerosis week and I was involved in a members' business debate on the subject. We are constantly told that there is a problem with fluctuating care throughout Scotland, especially for people with multiple sclerosis. One of the biggest issues is direct payments. The problem is not so much that people will not or cannot apply for direct payments; it is in getting access to direct payments. As you said, one of the benefits of carers is the fact that they are normally family members. However, a lot of local authorities cannot make direct payments to family members—I think that that is statutory. We need to look at that situation because it makes life difficult for families that are dealing with long-term conditions.

Derek Feeley: I confess that I do not know the legal position.

The Convener: Scottish Government guidance allows such payments, but some local authorities are reluctant to provide them. It also depends on whether the family member lives with the person who receives the care.

Derek Feeley: I am happy to write to the committee to clarify the point—unless either of my colleagues knows about it—because I am not sure exactly what the supporting rules are.

George Adam: My concern is that we are talking about the strategic level, but the issue affects people day to day. To get things right, we must think about the people who are behind all the situations that we deal with. It is important to have the answers at all levels.

The Convener: If you would rather write to us, that would be helpful.

Derek Feeley: I am happy to do that.

The Convener: The report that we are discussing refers to a watershed to which the committee has paid no attention yet—that is our fault—and to which Geoff Huggins referred obliquely. I do not think that anybody would be surprised that exhibit 1 says that

"around 88% of care home places"

are provided not directly by local authorities but by the voluntary and private sectors. The exhibit also says, however, that

"around 51% of home care hours"

are provided by voluntary and private sector services. This is the moment when councils have moved away from being the main providers of home care.

Geoff Huggins implied that that trend would continue. Is that just because you think that that will happen or because the Scottish Government's policy is to move in that direction?

Geoff Huggins: There are a number of reasons why that change is likely to happen. Care is becoming significantly more complex and is being provided in a broader range of ways. One of those ways, which we have discussed, is the use of technology—through the web, telehealth, telephone support or devices such as motion sensors. Greater individualisation of care is taking place. That suggests that, over time, we will have a larger number of smaller services rather than a smaller number of larger services. That is also the story behind self-directed support and direct payments. There are natural effects within that.

The Scottish Government's policy is that our objective is to deliver high-quality care at a good cost for the people of Scotland and to facilitate the change that will take that forward. That will be a good result, whether it is delivered through councils, the private sector or the voluntary sector.

The Convener: So Government policy has no preference for how care is delivered.

Geoff Huggins: I do not believe that we have stated a preference.

I will offer a clarification. I said that the intention to take forward the expert review of the market was in response to a Health and Sport Committee report, but it was in response to the Auditor General's report.

The Convener: I appreciate that.

As none of the witnesses has anything to add, I draw the session to a close. I thank Brian Slater, Geoff Huggins and Derek Feeley for their evidence.

11:23

Meeting suspended.

11:31

On resuming—

Public Audit Committee Report

"An overview of Scotland's criminal justice system"

The Convener: Agenda item two and a half is the convener's apologies for not noting apologies at the start of the meeting. We have apologies from Tavish Scott, and from Mary Scanlon for being late—which she was only momentarily.

Item 3 is "An overview of Scotland's criminal justice system". We are indebted to our clerks, who have looked at and collated into a summary the responses to the committee's report that have been received from the Scottish Government and the Crown Office and Procurator Fiscal Service. We have to consider the responses and decide how to take things forward. I open the discussion up for colleagues to comment.

Humza Yousaf: The Justice Committee, which Colin Keir and I sit on, received an identical response from the Government. That committee's convener, Christine Grahame, is writing to the cabinet secretary for clarification. It might be worth discussing that with the clerks to avoid duplication. There were a number of identical responses to the recommendations, and there will be a long letter from the Justice Committee's convener to the cabinet secretary, seeking clarifications and updates.

The Convener: We can certainly discuss that, but it is incumbent on us to decide whether we want to seek further clarification, which is one of our options.

Mark Griffin (Central Scotland) (Lab): I would be interested in more information about the pilot project, which has run in a number of courts, including that in Airdrie. We have a meeting next week—

The Convener: We do indeed—a visit to the Crown Office on Wednesday at 9 o'clock.

Mark Griffin: I am happy to take up the matter with the Crown Office then.

The Convener: That is certainly a possibility.

Willie Coffey: I was pleased to read the response on community justice authorities and to find out about the plan to provide some kind of framework for assessing their performance. That is encouraging, because such a framework has been missing over the CJAs' lifespan to date.

Mark Griffin mentioned the pilot scheme in Airdrie. That is helpful because, as members will recall, in some circumstances it is not known that prisoners are already in detention when they are called to court for another case. I am surprised that that situation has existed for so long, but it is good to know that the issue will shortly be ironed out.

I have looked at the response from the Crown Office and Procurator Fiscal Service on the victim and offender journeys, but I am not entirely clear that victims of crime are always informed about progress and outcomes at every stage. I can perhaps take that up as an individual member. My understanding is that victims are not routinely informed of outcomes, although I know that that has happened in several cases.

The Convener: We can certainly ask about that on the visit to the Crown Office.

Willie Coffey: Yes—I will probably pick that up. That is the one issue that I was unclear about in the response, which was a good and substantial one.

The Convener: One option that is open to us, which is a relatively new idea, is to identify issues that we would like to be included in the progress reports that the committee will receive. The next progress report is due a year from now, in 2013, which seems some way off, although I guess that some of the issues will not be addressed overnight.

It might be a reasonable approach for the committee to identify matters on which we would like to receive a progress report a year from now. One of them could well be how the victim journey is dealt with; another could be what progress there has been on the intermediate outcomes framework. That is just a suggestion for how we proceed.

Humza Yousaf: That is a good idea. A lot is going on in the making justice work programme and frameworks are being developed, so that would be a good way to proceed.

The Convener: Another point to note is that the Auditor General has programmed in a report on reducing reoffending, which obviously is relevant. As part of our work programme, we will consider the issues further.

Can members suggest any other items that we could or should ask to be included in the progress report?

Colin Beattie: To return to reoffending, one point that has arisen is that the reoffending rate in Scotland is significantly higher than the rate in England, although I believe that the gap has closed a little over the years. I am not sure whether we have ever really found out whether there is an underlying reason for that. Is there something that we are not doing or something that

we are doing differently or wrongly? Are there lessons that we can learn?

The Convener: Is there a way in which you would like that issue to be taken forward?

Colin Beattie: I suppose that the only people who would know about it would be the Scottish Prison Service and perhaps the Cabinet Secretary for Justice.

The Convener: We could write and ask.

Colin Beattie: It would be interesting to know.

The Convener: Well, let us write and ask them about that.

Would members like any other things to be included in the progress report?

Willie Coffey: We should keep a watching brief on the CJAs.

The Convener: That is covered in the draft outcomes framework, is it not?

Willie Coffey: Yes.

The Convener: I think that the same applies to the pilot project that you mentioned.

Humza Yousaf: Another issue that we might want to keep an eye on is the reintegration of offenders. The CJAs will want to develop integration pathways, so it is worth keeping an eye on that.

The Convener: We could ask for that to be included in the progress report, too.

Humza Yousaf: That is what I would like. Many of the issues will come out in the second phase of the reducing reoffending programme.

The Convener: That relates to the shared-needs screening tool that feeds into a community integration plan for each prisoner. We could ask for information on that to be included in the progress report.

Humza Yousaf: Yes. These programmes have really sexy titles.

The Convener: Absolutely.

Aside from asking that the various aspects that members have highlighted be covered in the next progress report, sending a letter to the Scottish Government on Mr Beattie's point and contacting the Justice Committee about the further information that it seeks, is the committee content to note the responses?

Members *indicated agreement.*

Section 23 Report

"Overview of the NHS in Scotland's performance 2010/11"

11:40

The Convener: The next item is consideration of a response by Derek Feeley to correspondence from the committee on the section 23 report, "Overview of the NHS in Scotland's performance 2010/11". We have had a relatively extended correspondence on the health improvement, efficiency, access and treatment—or HEAT—targets, and Mr Feeley's response has been circulated to members. Do members have any comments? I know that Mary Scanlon has been pursuing the matter.

Mary Scanlon: Indeed. At one of my first Public Audit Committee meetings, I raised the issue of HEAT targets that had not been met and were suddenly dropped. I have read the explanation provided. Instead of our having to ask why certain HEAT targets have been mysteriously dropped—for example, the target for reducing the increase in prescriptions for antidepressants has been changed to faster access to psychological therapies—I would welcome a bit more transparency at the time of the change.

I am no longer a member of the Health and Sport Committee but, as far as I am aware, the HEAT target to reduce increases in prescribing antidepressants has not been met. Of course, I welcome the fact that more psychological therapies are available, such as cognitive behavioural therapy by telephone via NHS 24, but I do not know whether one makes up for the other. I hope that after we have used these means to ask for such explanations HEAT targets will be stated in future and reasons why any targets have been dropped will be given when they are dropped.

Willie Coffey: I am probably the only committee member who remembers the big discussion that the committee had on antidepressant prescribing, but the fact is that these things were not at all clear. Perhaps we should have kept Derek Feeley behind to answer the questions, because his response specifically refers to the change from reducing antidepressant prescribing to access to psychological therapies that Mary Scanlon has just highlighted. The rise in prescribing antidepressants was huge—

Mary Scanlon: It was.

Willie Coffey: It was not at all clear why there was a sudden shift to the other target. Mary Scanlon makes a fair point, in that we need to know why the service shifts between targets, recommendations and so on. To be honest, I do

not think that I understood from Derek Feeley's response why such shifts happen. I really am not clear about that.

Mary Scanlon: It is not clear.

The Convener: I am at a disadvantage, because I was not part of the initial discussion. We have written twice on the matter now and it is up to members who want to pursue it further to suggest how we do so.

Willie Coffey: We have probably done enough in raising the issue.

The Convener: The concerns are certainly on the record.

11:45

Humza Yousaf: There are two things to highlight in Mr Feeley's response. First, he says that targets that are not met by a clear end date are revised, and why the targets were not met is analysed. Secondly, he says that some targets, such as that for antidepressant prescribing, are superseded by others. Perhaps we should reiterate that if a target is dropped or superseded that should be brought to the attention of a committee or parliamentarians instead of its simply sliding surreptitiously off the scales.

Mary Scanlon: So that we do not drag the whole thing out.

Humza Yousaf: Indeed.

The Convener: Are members proposing that we write back to Mr Feeley, noting the response but suggesting that, for the sake of transparency, any changes to targets should be notified—to the Health and Sport Committee, I guess, rather than us?

Mary Scanlon: That is fair.

The Convener: The targets are published, but we are asking that attention be drawn to any changes.

Mary Scanlon: They are published but they can be dropped suddenly. The other target that I mentioned in the initial discussion—reducing the NHS sickness absence rate to 4 per cent—was dropped because it was not achieved, but I am happy to concentrate on the antidepressant prescribing target. Overall, it would be helpful to have more transparency in the HEAT targets.

The Convener: I suggest that we note the correspondence but write to Derek Feeley, thanking him for his response and asking whether instead of simply publishing targets there could be a mechanism for notifying or drawing attention to any HEAT targets that are changed or dropped.

Mary Scanlon: It is also reasonable to include analysis and the reasons why targets have been dropped or changed.

The Convener: Are members agreed?

Members *indicated agreement.*

Public Audit Committee Report

"Major Capital Projects"

11:46

The Convener: Item 5 is consideration of correspondence from the permanent secretary on our report, "Major Capital Projects". The committee asked for additional information to be included in the six-monthly report that we receive, and Mr Housden's response has been circulated to members. The response is very positive; essentially, he says that the information will be provided. I do not think that we can say fairer than that and I suggest that we note the response and look out for the information in the next report. Are members agreed?

Members *indicated agreement.*

The Convener: That brings us to item 6. The committee will now move into private session and I ask any members of the public or press to leave the room.

11:47

Meeting continued in private until 12:19.

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