AUDIT COMMITTEE

Tuesday 2 September 2003
(*Morning*)

Session 2

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AUDIT COMMITTEE
3rd Meeting 2003, Session 2

CONVENER

*Mr Brian Monteith (Mid Scotland and Fife) (Con)

DEPUTY CONVENER

*Mr Kenny MacAskill (Lothians) (SNP)

COMMITTEE MEMBERS

*Rhona Brankin (Midlothian) (Lab)
*Susan Deacon (Edinburgh East and Musselburgh) (Lab)
Robin Harper (Lothians) (Green)
*Margaret Jamieson (Kilmarnock and Loudoun) (Lab)
*George Lyon (Argyll and Bute) (LD)

*attended

THE FOLLOWING ALSO ATTENDED:

Mr Robert Black (Auditor General for Scotland)
Fergus Ewing (Inverness East, Nairn and Lochaber) (SNP)
Barbara Hurst (Audit Scotland)
Margo MacDonald (Lothians) (Ind)
David Pia (Audit Scotland)

CLERK TO THE COMMITTEE

Shelagh McKinlay

SENIOR ASSISTANT CLERK

Joanna Hardy

LOCATION

Committee Room 2

Scottish Parliament

Audit Committee

Tuesday 2 September 2003

(*Morning*)

[THE CONVENER *opened the meeting at 10:03*]

Items in Private

The Convener (Mr Brian Monteith): I declare this meeting open and welcome members of the public and the committee. Fergus Ewing has joined us, and we expect Margo MacDonald to join us at some point. I have received apologies from Robin Harper, but I have not received apologies from George Lyon, so I assume that he is on his way.

I ask members, the press and public to turn off their mobile phones and pagers so that they do not disturb us or interfere with our audio system.

I welcome George Lyon, who has just arrived.

Item 1 concerns items in private. I ask committee members to agree to take agenda items 6, 7 and 8 in private. It is our normal practice to receive reports from the Auditor General for Scotland and then later in the meeting to discuss them in private to plan the approach that we will take. Is it agreed that we will take those items in private?

Members *indicated agreement*.

The Convener: We will also discuss lines of questioning for our witnesses for our inquiry into individual learning accounts in private at our meeting on 16 September. Is that agreed?

Members *indicated agreement*.

Scottish Parliament Building Project

10:05

The Convener: Item 2 concerns the Scottish Parliament building project. I asked for this item to be put on the agenda so that the Auditor General for Scotland could update the committee on Audit Scotland's plans in connection with the project. As the summer recess is now over, more information might be available, and the Auditor General has kindly agreed to report to the committee on the stage that he has reached.

I welcome Margo MacDonald, who has just arrived. We have just got on to the item about the Holyrood project, Margo.

Margo MacDonald (Lothians) (Ind): The good bit.

The Convener: Yes.

I invite the Auditor General to address the committee and thank him for coming along.

Mr Robert Black (Auditor General for Scotland): Members will recall that, at the committee's meeting on 17 June, I indicated my intention to make a further report on the Holyrood project at some point. As the convener indicated, it might be helpful to the committee for me to provide a more detailed outline of my intentions.

I will examine and report on the management of the Holyrood project, using my wide statutory powers to access documents and make a report that will consider the economy, efficiency and effectiveness of the use of resources. That report will build on the earlier reports that I made in September 2000 and December 2002. I will also draw on the report that the previous Audit Committee made in December 2000 after it took evidence on the basis of my September 2000 report.

My current intention is to report in the summer of 2004 as, by that point, the project should be nearing completion and most of the expenditure will have been incurred. However, I will keep an open mind on the exact timing of my report, depending on how events unfold. Preliminary work will commence soon.

My examination, using my statutory powers, will include the following areas. First, there will be an updated assessment of the procurement strategy, together with an updated assessment of the project management, control and governance arrangements. Secondly, there will be a full and detailed audit of the contract management and controls and related value-for-money issues.

Thirdly, there will be an analysis of the delivery of contracts against the targets, and I will examine the reasons for the increases in the costs and for the delays. Finally, I hope to draw some general conclusions and highlight lessons that seem to me to be important for the future of public projects of the same kind.

My report will, of course, be made to Parliament in the normal way and will be made available to the public. It will then be appropriate for the committee to consider the report and decide whether it wishes to take evidence in due course.

I have discussed my intentions with Lord Fraser of Carmyllie, who is about to start an inquiry at the request of the First Minister and the Presiding Officer. I will use my statutory powers, as I have outlined, to report on contract management and value for money. Lord Fraser is in a position to examine matters that involve policy. I consider that, taken together, my three reports, along with the report that Lord Fraser will prepare, should present a full and accurate record of the costs and of what happened with the project, and that there should also be lessons for constructing public buildings in the future.

I would be happy to answer any questions that the committee might have for me.

The Convener: I invite committee members to ask any questions that they may have, after which I will come to other members who are attending, who may also wish to ask some questions.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): What impact will the proposed work have on the other work that Audit Scotland is scheduled to undertake in the coming year?

Mr Black: We will take the work on as a significant project in the coming year. To make room for it, we will be required to reschedule other projects. We are currently planning our forward work programme for next winter and we will take into account the need to revise our programme. We hope to plug the resource gap by other means—for example, by using consultants more than we would otherwise intend to—in an attempt to deliver the full programme to which we are committed.

It is too early to say what the overall cost will be, but we are minded to keep the cost to a minimum. To that end, we will use Audit Scotland's internal resources to the greatest extent. I envisage using consultancy support for some analytical work on the detail of the contracts although, at the moment, I intend to use Audit Scotland's resources for that. As the work progresses, I will keep the Parliament advised of the implications for our budget through the Scottish Commission for Public Audit.

Margaret Jamieson: When will you be in a position to advise us of the projected studies that will slip to allow your office to undertake the work?

Mr Black: I will be able to give the committee a general indication of the programme in the fairly near future. Certainly, by the early months of next year, I will welcome discussion with the committee of what our programme might look like through to the end of 2004 and beyond. The committee will have opportunities in the coming months to discuss with me the implications for the programme.

Susan Deacon (Edinburgh East and Musselburgh) (Lab): You said that the programme of work was being discussed with Lord Fraser of Carmyllie. I would like clarification on the relationship between his work and the work that your office will do. What work—if any—would you have undertaken in any event? To what extent has the catalyst been Lord Fraser's inquiry? To what extent will the substance, the processes and the reporting dates be dovetailed? Forgive me if that last point has been covered, but I would appreciate clarification.

Mr Black: You asked whether the work would have been undertaken in any event. The short answer is that I would have intended to report in the terms that I just outlined. Given the scale of the project and the related issues, it is appropriate for the Auditor General to report. However, as I said, Lord Fraser is much better placed than I am to consider policy matters, which are not appropriate for the Auditor General. He is also better placed than I am to examine events that occurred before devolution—before my office existed. However, I am not in a position to say in more detail what Lord Fraser will examine. That is a matter for him to determine.

In our preliminary discussions, we have agreed that there is complementarity between Lord Fraser's work and mine, in the terms that I outlined. We are committed to working closely together. The inquiry that he will run, which I understand will involve taking evidence in public, will be his inquiry, not mine. We will provide him with as much support as we can through access to our work, so that he is fully informed, and through helping him to understand our reports as a context for his work.

We are committed to dovetailing as effectively as possible. It is for Lord Fraser to determine the time scale against which he reports. I understand that he might report on a similar time scale to mine and certainly not sooner than I report. Matters that relate to his inquiry should properly be addressed to him rather than me.

10:15

Fergus Ewing (Inverness East, Nairn and Lochaber) (SNP): The Hutton inquiry has engendered a high expectation of your inquiry, coupled with Lord Fraser's inquiry, and a sense that the public would like to see the evidence for themselves, to find out for themselves what happened in relation to the Scottish Parliament and to get at the truth. Therefore, I will start by asking two questions about access and whether information will be made public.

As you know, I have taken a passing interest in the matter and have studied your reports of September 2000 and December 2002. Both reports stated conclusions, but many of the documents that were discussed in the major report and the Flour City report were not made public. That is unfortunate, unnecessary and not, perhaps, required by the law. What will your approach be to making public the documents that, of necessity, you will have access to and will study? Will they all be made public? If not, what criteria will you use to determine which will not be disclosed to the public?

Mr Black: I will answer that question by making a preliminary comment. My statutory duties are clearly prescribed in the Public Finance and Accountability (Scotland) Act 2000, which followed the Scotland Act 1998. There are things that I can do and things that I have no power to do. Strictly speaking, I have no duty to report to the public, although it is clear that making my reports public is in the public interest. I therefore need to take care over the material that I put into the public domain and to have regard to my statutory duties.

The second preliminary point is that my statutory role is to make reports to the Parliament. Through its standing orders, the Parliament has decreed that my reports will be considered primarily by the Audit Committee, which meets in public. Therefore, the Audit Committee has the power to question me thoroughly on my reports and to ask for further documentation that it feels is appropriate. In my reports—such as some of the detailed documents that are on the committee's agenda for today—I endeavour to present as full an analysis as possible of all the evidence and information that I gather, so that the committee has a full picture.

I will narrow my remarks to your question against that context of statutory powers and duties and the openness of the Audit Committee's work, which is important. I form professional judgments that are independent of the Parliament or any other party and are based on the information that I gather through the audit. That information comes from a wide variety of sources and I do not intend to publish them all, but I have regard to the public interest in making available as much as I can. The report represents my findings and conclusions, together with the significant evidence that I gather.

During an audit, we gather partial and incomplete information. I have a concern, which is recognised in the Freedom of Information (Scotland) Act 2002, that if taken out of context, that information could give rise to misleading conclusions. Sometimes, I need to obtain professional work to inform my judgment. In general, it is in the public interest that I judge which technical papers should and should not be made readily available.

Generally speaking, I take the view that if the Audit Committee sought access to papers in taking evidence from me on the basis of my report, I would do my best to accommodate that requirement. However, I cannot give an absolute guarantee that all papers will be made public, for the reasons that I outlined.

Very occasionally, commercial confidentiality might apply to audit papers, which makes it difficult to put them into the public domain. Having said that, I finish by saying that, in principle, I am committed to being as open as possible in communicating with the Parliament on these matters.

Fergus Ewing: I want to mention a particular example—the selection of the construction manager—of an area for which the public may wish to see the documentation. In the report that Sir Robert provided in September 2000, he said that four companies bid for the tender of the construction manager's position. Of those four bids, the second highest was submitted by Bovis. However, that bid was selected. The company that put in the lowest bid was, I believe, a company that had certain well-known connections with the Conservative party. That has already been made public in David Black's book and in other ways. However, in correspondence with your office, Sir Robert, I asked whether the amounts of each of the four bids could be made public. The tender process is over and, as in local government, there is a strong argument for saying that the public is entitled to know, once such a process is over, what bids were made. The public would certainly want a valid explanation, with the provision of documents, of why the lowest bid was not accepted. What was it about the second-highest bid that made it preferable? Your conclusion in the report was that the decision was based on quality, but how could quality be assessed at that stage? What led civil servants to assess quality?

I am not asking you to answer those substantive questions, Sir Robert, but I raise the issue as an example of an area in which the public would want to get at the truth. That can be achieved if everyone—in this room and outwith it—can see all the documents and draw their own conclusions.

What would be your approach to that?

The Convener: You may care to answer that question, Auditor General, but you are here to talk about the report that you are putting together and the evidence that you may then make available, so you do not have to justify previous reports.

Mr Black: Mr Ewing has given me an elevated status to which I am not entitled: I am but an ordinary citizen.

I will try to be helpful and answer Mr Ewing's question. The main point to make is that there will be an opportunity—on the basis of my next report together with the work of Lord Fraser—to revisit these issues. The points that Mr Ewing raises were touched on in my earlier report and I would refer him to particular paragraphs for a full understanding of my position. My report will be available to the committee when it takes evidence in future. At that stage, it may be appropriate to revisit some of these issues, if the committee is minded so to do.

I emphasise that matters that preceded devolution were not, strictly speaking, within my statutory powers, although I established a good understanding with the Scottish Executive that I could mention them. It is very possible that Lord Fraser will look into such matters in more detail than I was able to at the time.

The Convener: Are you finished, Fergus?

Fergus Ewing: I have different areas to cover, but may I ask just one further question?

The Convener: Just one, and then we must move on to Margo MacDonald.

Fergus Ewing: Thank you—and I apologise for ennobling Mr Black prematurely.

I want to raise an issue that arises from something that Lord Fraser said last night on "Politics Tonight", a programme in which I took part. I hope that I am not misquoting him. He said that work done in the process of the inquiry may lead to a reduction in costs. I welcome that and, in particular, I hope that the Flour City losses will be recovered from those responsible. Mr Black, do you share the view that the combined inquiries will lead to a reduction in costs? That view would suggest to me that your inquiry will allocate delictual responsibility. In other words, it will say that company A, B or C was negligent. I had understood that that would not be within the remit of your inquiry, or of Lord Fraser's inquiry. What does Lord Fraser think will lead to a reduction in costs? I welcome any such reduction but I am puzzled as to how this inquiry can examine an issue from the point of view of a court trying a negligence case.

Mr Black: As I am sure Mr Ewing will understand, I am not in a position to comment on opinions that Lord Fraser has ventilated on this matter or any other matters that relate to his inquiry.

In our own work, when conducting any audit we have to be mindful that commercial litigation issues may arise. Often, we are looking into cost overruns or poor value for money. In such instances, money may be recoverable through the courts. Therefore, I have to be careful about the terms in which I express my findings on the basis of Audit Scotland work. However, I have statutory powers to report objectively, using the audit process, on matters of fact. We clear those matters of fact quite carefully with the interested parties. It is then for other parties to determine whether information in my reports may be relevant to any further matters that may be pursued in the courts or in other ways.

The short answer is that there is no direct relationship between my work and the likely cost of the parliamentary building. However, some of the information that we produce will be relevant to that.

Margo MacDonald: Fergus Ewing's interpretation of Lord Fraser's words last night is also my interpretation. My impression is that there is likely to be a more transparent examination—not because people have suddenly become nicer but because we have been round the course before and recognise what has to be investigated and explained to the public.

I want to ask the Auditor General about his reference to the use of more consultancy services than he might ordinarily seek to use. Lord Fraser's inquiry arose out of a consultancy report that was not published. I asked whether it could be published so that I, on behalf of the public whom I represent, might better understand the processes that led to the Auditor General's report in 2000. At the time, Mr Black, you explained to me that you did not think it necessary to publish all the consultancy and expert reports. You have reiterated that view this morning. In light of public feeling about this project—and in light of the project's importance to the respect in which the Parliament is held—would you agree that MSPs who have shown a serious interest in the project might be taken more into your confidence than I was over that report? Regretfully, I was forced to make that report public after it had been leaked to me. That report led directly to this inquiry.

Mr Black: I note what Margo MacDonald says and will certainly take it into account in future work of this type. I determined that the particular report to which she refers was technical. I used its contents in the report that I made to the Audit Committee, which I considered to be appropriate. Lord Fraser will have access to the report if he so wishes. There will also be an opportunity for this

committee to consider the issues in the round when we consider the entire project at the end of the day. These matters will not go away and there will be opportunities to revisit them in due course.

Margo MacDonald: Will there be a bit more trust between the people who are intimately concerned with the project—either in its construction and management or in its monitoring—and people who may be outside that loop, such as me?

Mr Black: I am not sure that trust is the appropriate word to use in this context. I have statutory powers and duties to investigate through audit and to reach findings on matters of fact. It is inappropriate for me to place trust in people as part of that exercise. I consider matters objectively. The best thing that I can do is to build confidence in the committee that I will continue to analyse thoroughly and objectively all issues of concern, whether they relate to the Scottish Parliament building or to other matters, and report objectively on them to the Parliament. That is my commitment.

The Convener: If there are no follow-up questions from committee members, that draws the agenda item to a close. I hope that it has been of use to the guest members who came along. They are welcome to stay for the other agenda items if they wish.

"Supporting prescribing in general practice"

10:31

The Convener: Agenda item 3 is on general practice prescribing. I invite the Auditor General and members of his team to brief the committee on "Supporting prescribing in general practice—a progress report". Members may make comments and ask questions after that, but I remind the committee that we will discuss the report more fully later in the meeting.

Mr Black: I will introduce the report to the committee. I have with me colleagues from Audit Scotland who worked on the detail of the report, and who will answer any questions that members might have.

In 1999, I published a baseline report on prescribing in general practice, which made a number of recommendations that were aimed at improving the quality and efficiency of primary care prescribing. We invited trusts to take action on those recommendations and to use some of the indicators that we provided to improve the quality and efficiency of the service. The latest report considers progress against that baseline. The main report, which is a substantial document of more than 50 pages, considers three broad areas. The first involves factors that influence prescribing quality and cost, the second relates to prescribing quality and efficiency and the third covers issues that relate to achieving further improvements in prescribing. There is also a summary report, which members might find helpful.

The issue is a big one. The total prescribing expenditure for 2002-03 in Scotland was around £850 million, which is about 12.5 per cent of total national health service expenditure. Moreover, prescribing expenditure has been rising steadily each year, with a 13 per cent rise in 2002-03 compared with the previous year. Big resource issues are involved. The quality of prescribing has a direct impact on the quality of patient care, both in treating existing conditions and in preventing ill-health.

I am pleased to report to the committee that all trusts have improved prescribing quality significantly against the indicators in the baseline report. For example, there has been a significant increase in the prescribing of medicines such as angiotensin-converting enzyme inhibitors, low-dose aspirin and statins, which all treat, or help prevent, coronary heart disease. That significant development has taken place over the past few years.

Trusts have also achieved efficiency savings by taking action on issues such as generic prescribing and by reducing the use of medicines that are considered to be of limited value. The report identifies room to make further savings of around £14 million. Although that is a substantial saving and is worth achieving, we must recognise that it is a relatively small amount compared with the overall prescribing expenditure and that it will take some time to achieve.

Almost without doubt, those savings will be overshadowed by the rising cost of new drugs, of which the report gives some examples. To take one such example, there will be an increase of £28 million in the cost of prescribing for treatment of cardiovascular and central nervous system diseases alone. A number of evidence-based guidelines recommend the use of particular drugs to treat or prevent particular diseases, such as statins for coronary heart disease. Such drugs improve the quality of patient care, but they have significant cost implications. To stick with statins as an example, our report estimates that the annual cost to the health service in Scotland of providing statins is expected to grow to at least £95 million—the present figure is around £65 million—which is slightly less than 12 per cent of the total prescribing budget.

It is important that prescribing is targeted accurately and in line with the evidence so that extra spending achieves the greatest benefit. We also recommend that the cost of implementing the guidelines that I mentioned is calculated and made available to the health service so that the financial implications are understood fully. None of the drugs involved is cheap and each of them, if chosen for prescription, would entail significant cost to the health service. It is important that health boards consider implementing those guidelines along with other service developments. There are difficult choices to be made.

Further work is needed in a number of areas. As a result of our initial report, all primary care trusts now have prescribing strategies, but more needs to be done in developing health board-wide prescribing strategies and area-wide formularies, which are lists of selected drugs with guidance and protocols for their use. We have used commonly accepted indicators for prescribing quality and efficiency and we recommend that the health service should consider putting together a set of national prescribing indicators. That development, along with the sharing of good practice, would help trusts to benchmark their performance as they go along. There is also a need to link prescribing information with related information about the impact on patients, such as morbidity and diagnosis information, which is not possible at present. That situation makes our analysis rather difficult because we cannot relate prescribing interventions to patients' health.

The two other important areas in which improvements are required are in the development of universal and rigorous repeat prescribing systems and the further development of computerisation.

I invite Barbara Hurst to expand on one or two of the key points and to set them in the current context.

Barbara Hurst (Audit Scotland): The present report and the 1999 baseline report were both big pieces of work. We were careful about the choice of indicators because the issue is a clinical one and we had to work with experts in the field. We worked with prescribing advisers and used existing research to choose the indicators. Given the limitation that, at present we cannot link prescriptions with diagnosis, which the Auditor General outlined, we are confident that the indicators are the best available.

There is also the issue of the new general practitioner contract, which will have to build on those indicators. There will certainly be a closer link between pay and performance and some of the clinical indicators that are used in the contract will take into account such things as the prescription of ACE inhibitors. The report is early work in advance of the new contract.

One key area that the report picks up on is repeat prescribing, which is a huge issue and which accounts for around 75 per cent to 80 per cent of all GP prescribing. As a broad estimate, the annual wastage through drugs that are prescribed but not used is around £15 million. The report highlights that further action is required to ensure that peoples' prescriptions are reviewed regularly and that there is no over-prescribing.

We are pleased by the amount of work that the health service has done since the initial report and we give due credit for that. I am happy to take any questions.

Margaret Jamieson: The report mentions the waste in prescribing, which was also touched on in the baseline report. However, it does not really mention the work that has been undertaken in certain areas to try to minimise waste. The report indicates that there is a significant amount of waste through repeat prescribing. What discussions did you undertake to try to reduce that waste? I understand that, in Scotland alone, there are several million pounds-worth of unused drugs, which, because of some of the organisations involved, cannot be allowed back into the system. The fact that many drugs are now in bubble packs means that they could be reused, but we still seem to be unable to get over that barrier. What can we do to ensure that we recirculate drugs and thereby reduce the cost?

Barbara Hurst: A number of health boards have done quite a bit of work in that area. On the reuse of drugs that have been prescribed to other people, lack of knowledge of how the drugs have been stored presents a safety issue—we do not know whether they could be brought back into the system. That is why we have focused on repeat prescribing. Tackling the problem at the beginning of the process avoids having to worry about it so much at the end, but I accept the member's point.

I think that I am right in saying that, among other boards, Tayside NHS Board had done work in that area.

Margaret Jamieson: In future, I hope that people who are prescribed a new drug for their symptoms will be given the drug only for the trial period initially, as that will reduce the waste.

On clinical audit, Audit Scotland's report refers to cost-effectiveness. Did you mean cost-effectiveness in monetary terms or cost-effectiveness in its widest sense, which involves consideration of quality of life and the suitability of particular drugs for particular patients?

Barbara Hurst: We were speaking about cost-effectiveness in the widest sense, but I must add a caveat. We cannot tell whether people are being prescribed a drug for their diagnosis. It is a vicious circle. We must ensure that we can make that link and can consider the quality-of-life issues. NHS Quality Improvement Scotland will also have an interest in clinical audit issues and will pick up some of them.

Margaret Jamieson: The report mentions that transdermal oestrogen-only hormone replacement therapy patches are very expensive, but it does not expand on that comment in relation to patient compliance. Someone who uses a patch is more compliant than someone who takes pills once or twice a day. You do not comment on the cost-effectiveness of that.

Barbara Hurst: That is a crucial point. That is why we have been quite conservative with the savings. Patient compliance is an issue, and some patients definitely need the patches. We are not saying that the patches should not be prescribed to anyone, but there are people for whom their use is simply a convenience. The GP would need to make such a decision with the patient. In such areas, the saving is not 100 per cent.

Mr Black: The questions that we are being asked are highly relevant. When the committee decides whether to take evidence on the subject, it might want to bear in mind the fact that members of the health service are much better placed than we are to answer such questions.

I want to return to an issue that I mentioned earlier, which Barbara Hurst hinted at. Finding a way of linking prescribing to diagnosis and the condition of the patient would be one of the most significant developments in allowing the health service to demonstrate the effectiveness of prescribing policies. The committee might wish to give further consideration to that issue.

Mr Kenny MacAskill (Lothians) (SNP): My question is about computerisation. Government and agencies are attempting to make progress in that area, for example through digital Scotland and broadband Scotland and their application in the present context. What mechanism could break the logjam? Although we, like many agencies, discuss computerisation, there seems to be a lack of joined-up working between Government and agencies. Are there any specific developments—for example, in software or digital take-up—that would enable us to deliver more effectively? Would it be best to implement such developments through the health boards or would a more over-arching strategy, which might be being considered rather than actually implemented, be necessary?

10:45

Barbara Hurst: That would be a massive study in its own right, so I will give you a partial answer. On prescribing, we found that many pilots go on and on, but we are not learning the lessons from them. That is a great problem for the health service. Until we obtain some realistic time scales for those pilots and can assess whether they are worth rolling out, the health service will be in a difficult position. In relation to computerisation, we would push the Scottish Executive Health Department on that.

Susan Deacon: I found "Supporting prescribing in general practice—a progress report" interesting and informative, just as I found the baseline report interesting and informative in a previous life. I would like to probe some of the concerns that I share with my colleagues.

The Auditor General will know about my hobby-horse on implementation, as will members. I share Kenny MacAskill's concerns. Does the Auditor General's office have any plans to draw together some of the generic strands that come through in a number of reports—including the two that we are considering today—on the pace of implementation on computerisation in the NHS. I am enormously concerned about how far behind the NHS lags in making effective use of current technology. I would be interested to hear what further measures the Auditor General's office could take to accelerate the pace of change in that area.

I invite the Auditor General to comment on pharmacy. Although the report mentions community pharmacists several times, I was surprised that the issue was not given greater

emphasis, given that "The Right Medicine: A Strategy for Pharmaceutical Care in Scotland" dovetails neatly with the report and contains similar objectives. As Barbara Hurst indicated, much work is stuck in the loop of pilots and testing. For a number of years, it seems to have been well established that the linkages that have been made in trials and pilots between community pharmacists and GPs on repeat prescribing could deliver a step change in practice and in cost, if those initiatives were rolled out nationally.

I have two further questions, but I will pause for breath to allow my question on pharmacy to be dealt with.

The Convener: We will come back to those.

Mr Black: I will respond first to the point on whether we could do more work on the effectiveness of implementation. We should take that issue on board. I give the committee an undertaking that, when we think about our forward programme of studies—as the committee knows, we are committed for the next few months—we might consider doing more work in some of those areas. We are all conscious that there are major issues relating to information technology strategy, as Barbara Hurst mentioned. We must do some serious thinking about how we could engage more fully with that agenda in the coming months.

As Susan Deacon said, the report makes some mention of community pharmacists. I invite Barbara Hurst to give a fuller answer.

Barbara Hurst: I agree entirely with Susan Deacon. The link between community pharmacists and GPs is the way forward. That takes us back to computerisation, which would offer a link between community pharmacists and GPs. There are different views on whether community pharmacists should be able to have access to a patient's records. We feel that they would probably need such access as far as prescriptions are concerned, but that view might not be shared more generally.

Susan Deacon: I am grateful for that diplomatic response. I hope that we will have the opportunity to probe the matter further.

The first of my two final questions concerns the link with clinical audit, which has been mentioned. The Auditor General and Barbara Hurst have both referred to the parallel work that various bodies are carrying out; however, I wonder whether they will tell us a wee bit more about the connection between Audit Scotland's work and clinical audit. As Margaret Jamieson pointed out, it is important that the two should work in tandem.

I note an awful lot of emphasis on what trusts and, in turn, NHS boards should do. However, not so much has been said about what should be done to influence individual practitioner practice, which is the key to much if not all of this matter. I wonder whether Audit Scotland could comment on measures that could be taken in our medical schools during medical training to influence practitioner practice and prescribing.

Barbara Hurst: I will have a go at those questions.

As far as clinical audit is concerned, I should have mentioned in response to one of Margaret Jamieson's questions the role of prescribing advisers in the different health board areas. Although those advisers work closely with individual practitioner practices, they do different things—if you like, they offer a clinical audit, but in specific areas. That is good practice, and one of the reasons that we have published this weighty report is to highlight some of that good practice and ensure that it is shared more widely. Indeed, our report points out that there needs to be more of that kind of work.

As for our wider links with clinical audit and particularly with NHS Quality Improvement Scotland, we have been invited to sit on a group that is examining this issue with a view to taking it forward. We would certainly be able to feed our evidence into that group. Indeed, we try to do so whenever we can to ensure that no duplication occurs.

The challenge with influencing individual practitioners is that they are individuals, which is probably why we were so pleased to find such great improvement in this area. The matter is very difficult; after all, we are talking about individual GPs. However, the prescribing adviser's ability to work with individual practices is probably where their role has been most powerful at a local level. I am not sure that that has answered your question, but I think that it provides some background.

Susan Deacon: What about the question of training?

Barbara Hurst: The training of doctors has come up as an issue in a study that we have started on the use of medicines in hospitals. I think that you are right to highlight the issue as one that might need to be picked up.

George Lyon (Argyll and Bute) (LD): Given the report's recommendations on prescribing and extracting better value, the issue of implementation seems to be pretty critical. Is the roll-out of implementation being stopped by financial or IT barriers? As your comments have made clear, plenty of pilot projects have been introduced. Have they highlighted either that everyone cannot be linked or that there is a lack of incentives for independent GPs to take the technology on board?

Barbara Hurst: I am going to cop out, slightly, of answering that question until we do a bit more work. A lot of money is certainly going into the IT budget, but we need to examine where and how it is being spent. We will come back to you on that matter once we begin to examine the area.

The Convener: Okay?

George Lyon: That did not answer any of my questions.

Mr Black: I apologise for repeating what I said a moment ago, but I should point out that we must always operate within the boundaries of the evidence that we find and must not attempt to second-guess how the Scottish Executive Health Department might respond to such questions. Although we will always do our very best to answer questions as fully as possible, the committee ultimately can—and does—treat our documents as part of the evidence-taking. Some of the questions that have been addressed to Barbara Hurst and me this morning are critical, but it might be more appropriate to consider whether they should be put to the department if the committee has the opportunity.

The Convener: Obviously we can discuss the matter when it comes back on to the agenda.

Rhona Brankin (Midlothian) (Lab): I wanted to pursue the issue of sharing good practice, which links into the business of information and communication technology and how people access what is going on out there. However, I will probably need to find out about that matter during evidence-taking sessions, if we decide to take evidence.

Barbara Hurst: The committee could certainly explore that area. The situation is fairly ad hoc at the moment; for example, good practice might not be universally shared even within a single health board area. We were trying to push the message that we can learn from one another and that much good work is being done.

The Convener: I think that we have exhausted our questions, but we will discuss later how the committee will approach the matter. I thank Barbara Hurst for answering the committee's questions in detail.

"Outpatients count"

10:56

The Convener: We move on to the next item on the agenda. I ask the Auditor General to outline the results of Audit Scotland's census on out-patient activity.

Mr Black: I will briefly introduce the report and then invite Barbara Hurst and the team to give the committee a bit more detail.

In September 2001, we prepared a baseline report—rather like the GP prescribing report that we have just considered—that drew attention to some significant gaps in management information for out-patient services and recommended a whole-system approach to ensure an efficient and effective assessment of service delivery. Since that time, Audit Scotland has worked with the NHS and has provided all trusts with a self-assessment handbook—drawing on accepted best practice—on managing out-patient clinics. We felt that that was a way of supporting continuous improvement in an extremely important area.

The most recent report provides the results of a week-long census of out-patient clinics and shows that a range of health care professionals from consultants through to physiotherapists carry out an enormous amount of out-patient activity. We estimate that, in total, there are up to 10 million attendances a year. However, much of that activity is not recorded by national data collection schemes, which focus almost exclusively on consultant-led clinics.

With the introduction of new ways of working in the health service, patients no longer need to be admitted to hospital for a number of conditions and treatments; it is thought more appropriate that such patients should be seen by a health care professional who might not be a doctor. However, information systems have not kept up to speed with such developments; they are out of date and need to be overhauled to ensure that they inform and enlighten us about those new ways of working.

The committee might be interested in the finding that, overall, one in seven people did not turn up for their appointment. That rate is rather high and affects the time that other people have to wait for their appointments. As a result, non-attendance has a cost as far as the service that other people are denied is concerned. We suggest that trusts should examine their booking and communication systems to ensure that they are working properly and to minimise the rate of non-attendance. Trusts also need to consider introducing policies that deal

with the small minority of patients who repeatedly fail to attend without giving reasonable notice.

Very few clinics are cancelled; indeed, cancelled clinics affect less than 1 per cent of patients. However, although some cancellations are clearly unavoidable, more could be done to monitor the reasons for cancellations.

11:00

Finally, we found that very few clinics are held outside what we would call the traditional office working hours of 9 to 5, Monday to Friday, and that most take place in traditional health settings. We suggest that there is scope for the health service to consider the potential for meeting patients' needs in different ways, such as exploiting telemedicine and developing more outreach clinics.

We intend to produce a follow-up report on out-patient services. The census is just another snapshot of what is happening in the system. However, I welcome the fact that a great deal of work is going on within the health service on improving out-patient services. I suggest to the committee that my colleagues in Audit Scotland should have the opportunity to liaise with the Health Department about the most appropriate timing and approach for the follow-up work. The census report is a work in progress, in which we have highlighted a number of significant issues that we intend to revisit. I seek the committee's support for not suggesting an exact time scale for that follow-up work until we have had further communication with the Health Department on the subject. Perhaps Barbara Hurst would like to add a few comments.

Barbara Hurst: As the Auditor General said, we have tried to support continuous improvement in out-patient services for the past couple of years. This year, the Health Department issued an out-patient action plan that picked up on many of the issues that we raised in the census report and in the self-assessment handbook that we provided to trusts. Those issues are specifically around managing the demand for out-patient services, the queueing systems and capacity. I think that capacity will be the most challenging problem for trusts to tackle. Most of the actions in the action plan are due to be implemented by next March or April, which is why the Auditor General suggests that we wait until after that time before going back to assess progress.

Margaret Jamieson: Given the work that the Health Department has undertaken, I agree that we need to revisit the whole out-patient issue. I think that the "did not attend" rates—DNAs—have a huge impact on waiting times and waiting lists. Do you envisage undertaking further work to get underneath the issue of DNAs to find out, in the first instance, why people do not attend and what impact that might have on referral protocols? Are those protocols as robust as they should be? When we consider service redesign in local areas, one issue that is flagged up time and again is the variation in GP referral of patients. Some practices have higher referral rates than others. Will further work be done on the timing of clinics as well as on where clinics are held?

Barbara Hurst: Part of the reason for the census was that we had information about consultant clinics but no information about all the other clinics. In a sense, we wanted to get that baseline information so that we could decide what type of sample we would take of the clinics. We are particularly interested in the referral process—for example, how patients are kept informed of where they are in the system and whether they are contacted before their appointments. We are also interested in whether patients' test results are available when they turn up at a clinic. It would be a waste of patients' time if the results were not available, because patients would have to come back for them. We want to sample and consider such issues, but we also want to build in consideration of what the Health Department is doing to monitor the referral process. The sampling will be difficult because of the scale of the activity. However, I think that we should follow up on the areas to which I have referred.

Susan Deacon: You will be pleased to know that I have only three questions this time instead of five. My first question is specific. You recorded in the report that one in every 100 clinics was cancelled and that that affected less than 1 per cent of out-patients. Can you clarify that you are talking about the cancellation of total clinics as opposed to the cancellation of individual appointments? I think that the perception of many of us is that the cancellation of complete clinics might be relatively rare but that a substantial number of people are affected through their individual appointments being cancelled—sometimes repeatedly. I would be interested to know what the figure of 1 per cent represents in terms of the number of patients who are affected. I am sure that the figure is sizeable. Do you have any data on that?

Barbara Hurst: No. The analysis of that area is incredibly complicated. I can confirm that the figure in the report refers to the cancellation of clinics that had patients scheduled into them. The figure does not include clinics that were cancelled because they had no scheduled patients.

Collecting the report's relatively basic information was a difficult process. We have no information on the number of times that individuals' clinics might have been cancelled. It

would be nice—if we could do it—to sample individual patients at a clinic level to ascertain what is happening throughout their whole out-patient experience. That would be an ambitious project, but we have considered how we could do it through the follow-up work.

Susan Deacon: For the moment, rather than prolonging this line of questioning, I will simply make a comment. I echo what Margaret Jamieson said about the possibility of your doing a more in-depth piece of work on the level beneath the current analysis and on the management of appointment systems in general, which, of course, is linked to the earlier discussion about the use of information technology and so on. I acknowledge that it is the Auditor General's decision whether to do further work, but I believe that such work would be enormously valuable.

I have a further question. From your work in the area, can you indicate when we might expect data collection processes to be aligned with practice? You referred to that issue in the report and in your comments to us this morning. As politicians, we live in an almost dysfunctional world in that, when we debate issues, we have to use figures and reported data that lag substantially behind what might be happening in clinical practice, as you acknowledged. Can you give us a ballpark indication of when we might expect that alignment to happen nationally?

You might feel unable to comment on my final question, but I will ask it anyway. What do you think could or should be done to accelerate the pace of change in data collection at a local level? There has been much reference to work that the Health Department has done and is driving forward at that level, but some of the data that you identify in your report has traditionally not been collected at a local level. However, it would be reasonable to expect local management to take responsibility for collecting such data rather than being instructed to do so. If you feel able to comment on that, I would be grateful. If you do not feel able to do so, I would understand.

Barbara Hurst: I will have a stab at giving an answer. On your point about national data, the health service's information and statistics division has a data development project to realign activity on the ground with national recording systems. I do not know that project's time scale, but I could find out and get back to you.

On accelerating the pace of change in data collection at a local level, two key issues would need to be addressed. First, clinicians would have to be involved, because we should not try to force doctors, nurses and physiotherapists to collect data that are not valuable. Secondly, we should identify someone to manage the process. At the moment, that management is disparate in a number of trusts in that no one person is responsible for managing the clinics. Part of the difficulty that we faced in collecting the data was that were was no oversight of out-patient services. That is another area in which there could be movement. I noticed in the out-patient action plan that trusts are being asked to identify someone at executive director level to take responsibility for oversight of those services.

Rhona Brankin: I welcome the fact that patients' preferences are to be considered. I note from the report that there was a high number of repeat out-patient visits. Was that in comparison with initial out-patient visits?

Barbara Hurst: Yes.

Rhona Brankin: I thought that that was the case. Patient preferences are a big issue. In my experience, patient preferences are not taken into consideration when referrals are made for initial out-patient visits. People are given appointments almost out of the blue. However, when they attend clinics and make repeat visits, their preferences are taken into account because they make their appointments, subject to the constraints of when clinics are held. It is important that we consider not only extending clinics to non-traditional hours, but patient preferences—what patients are able to do and when they are able to access a car or get time off work.

Barbara Hurst: I agree. We are interested in that matter. One difficulty is that patients do not tend to complain.

Rhona Brankin: They complain to me.

Barbara Hurst: Surveys of health services and social care services suggest that people are less willing to complain in those areas, because they are grateful for what they get. We must try to think of ways around that problem. However, patient preferences are a real issue.

George Lyon: I would like you to explain further your answer to one of Susan Deacon's questions. You said that we should not expect the Health Department to force GPs and clinicians to capture information. I assume that they do not regard collecting information as a worthwhile exercise, because they work in a demand-driven service and the information is irrelevant to the overall need, which is to meet demand. Is that correct?

Barbara Hurst: I probably did not express myself very well. Clinicians must be involved with the development of a service, which takes place at every level—from demand and referral by GPs, through to planning of clinics and the exercise of patient preference. I was trying to make the point that we should not impose something on people, because that does not work.

George Lyon: Who is currently responsible for the clinics? Clearly, there is no managed service. Is the process driven by clinicians—consultants and practice nurses?

Barbara Hurst: Clinicians hold individual clinics and make bookings through their secretaries. That is a very traditional way of running the service. A GP will refer patients to a consultant. If referrals were managed more appropriately and were not made to individual consultants, that might help to reduce waiting times.

Mr MacAskill: I assume that you will be able to comment only very generally on the issue that I want to raise. Reference has been made to the number of people who fail to turn up for appointments and to the need for patients to be able to choose appointments outwith the normal hours of 9 to 5. Is there a perception that the increased costs of extending hours beyond 9 to 5—which would presumably involve time-and-a-half and double-time payment to staff—could be balanced with savings arising from the fact that people will be less likely to fail to turn up for an appointment that they find easier to keep? Is information too vague for that to be seen as a possibility at the moment?

Barbara Hurst: At the moment we do not have enough information on that issue. In the negotiations on the new consultants contract, there has been discussion of working different hours, which would have cost implications. However, I cannot answer the question in any more detail.

Mr MacAskill: Should we ensure that the issue is followed up and that attempts are made to work out roughly what percentage of patients would be more likely to keep an appointment if it were at a more suitable time, so that we maximise savings?

Barbara Hurst: Trusts are being asked to consider the ways in which they provide services. In our report, we say that a balance must be struck between costs and, if you like, the increase in patient preference. That is a key point, because a consultant's time is very expensive. To send a consultant to see two people at an outreach clinic is not cost-effective. You have touched on several important issues.

The Convener: That sounds like an opportunity for another pilot scheme. As there seem to be no further comments, we will bring discussion on that agenda item to an end.

"Dealing with offending by young people"

11:15

The Convener: Agenda item 5 is the Executive's response to "Dealing with offending by young people". Members have that response, together with the clerk's note on it, and I am interested to hear their comments. Margaret Jamieson and Rhona Brankin were members of the committee in the previous session and therefore have some experience of the issue. I would appreciate hearing their views before those of other members. Once we have discussed the issue, we can consider what action, if any, we wish to take on the Executive's response.

Margaret Jamieson: This was a complex area for the committee and some work has already been done on it. It will be an interesting area for new members to cut their teeth on.

We can use a lot of the work that has been done in Westminster to frame questions that we would wish to put to the Scottish Executive. Everybody, not only the Scottish Executive, can learn a lot of lessons. The concern has been expressed that, in Scotland, we were not in charge of what we should have been in charge of, because Westminster was leading on these issues. I am grateful for the briefing paper. It lets us see exactly what has happened in Westminster, which will influence me in the questions that I want to ask.

The Convener: We are actually considering the Executive's response.

Margaret Jamieson: I know, but the paper answers some of the points in that response.

Rhona Brankin: I am slightly confused: are we talking about the Executive's response to "Dealing with offending by young people"?

The Convener: Yes.

Rhona Brankin: Margaret is too subtle for me.

I want to ask about several areas. Paragraph 5 on page 2 of the clerk's paper talks about the Executive response. I welcome what is said about the inspection and review of adult services, which are issues that we felt very strongly about.

Turning to paragraph 9, I agree that our recommendation talked about promoting new services, as opposed to the new services themselves. Information on that was lacking and it would be useful to get more information.

Turning now to paragraph 12 on page 3, I agree that, when the Executive talks about the national work force planning group and about the increase

in the number of workers in local authority children and families teams, we have to be clear about where that increase is coming from. Is it an increase in qualified staff or other staff?

Margaret Jamieson: May I come back in, convener? I had jumped somewhat in the agenda.

Rhona Brankin: That is a relief.

Margaret Jamieson: I apologise for that.

The Convener: Apologies accepted.

Margaret Jamieson: It may all have been too much for us in our first meeting after the recess.

I share some of Rhona Brankin's concerns about the way in which we talk about qualified social workers. It is against the law for someone to call themselves a social worker unless they have undertaken the appropriate training. However, there are a number of other qualified staff in social work departments. Those people are qualified to different levels and we should find out more details on that. Work has been done on attracting social workers into certain areas.

The way in which Scottish Executive departments join up, or fail to do so, was an important aspect of the committee's inquiry. That is another area on which we need clarification. In certain areas, the Scottish Executive Education Department takes the lead, but in other areas the Scottish Executive Justice Department takes the lead. We need to explore that a wee bit further.

Susan Deacon: As a newcomer to the committee, I want clarification on where we go from here with a report of this nature. The Auditor General produced a report; the committee then investigated the issue and published a final report; and now we have an Executive response. Where might we go from here? We need to avoid simply going back over the same ground. We need to move forward in our analysis and ensure that change happens.

The Convener: My intention is to invite the Auditor General to make any further observations, and to add any further information, that he might have. Then, subject to the committee's agreement, it might be advisable to follow up on one or two points of clarification. I propose that, once we have had our discussion, I should write on the committee's behalf to the department responsible to seek clarification and raise the matters that members have highlighted.

We will hear from the Auditor General after Kenny MacAskill.

Mr MacAskill: I was struck by point 11 on page 3 of the clerk's paper. Having had previous employment in the criminal justice sphere, I recall that Edinburgh's only residential place for a child was in the likes of Birmingham or Barnet.

We all recognise that the size of our local authorities has caused the difficulty that they are unable to deal with many aspects of social work and care matters, but we need a bit more of a lead from the Executive. We all accept that cognisance must be taken of local authority autonomy and that the Parliament should not tread all over local authorities. However, that will not happen of its own volition; there will not be spontaneous combustion. Somebody needs to get a grip and ensure either that local authorities pool their resources to direct funds or that provision is made at a national level. The fact is that that has not happened since the Parliament commenced and it did not happen beforehand. One could argue that a lacuna has resulted from the demise of regional authorities—although even then, few special places were available.

If the Executive will not get a grip of the situation, nobody will. I do not mean this to be an overt criticism of the Executive, as I understand that it may have acted with the best of intentions with regard to local government democracy. However, the system is not working. There needs to be a clearer remit on how we are to deliver secure units and residential places in particular. In the main, the local authorities will not have the take-up. The structures for getting together are just not in place.

Rhona Brankin: That is a big issue for smaller local authorities, such as the local authority in my constituency. I agree that there are grave problems for local authorities of that size in finding the resource that is needed, albeit for a very small number of youngsters.

The Convener: Are there any other comments?

Susan Deacon: I do not want to reopen the discussion, which is partly why I sought clarification on the process, but there is a fundamental point on which I would like to comment. Paragraph 5 of the clerk's paper states the committee's support for the

"recommendation on the establishment of independent inspection",

and the comment is:

"This is a significant new commitment."

I stress that I say this in the absence of detailed prior knowledge of or involvement in the subject, but my instinct is to be concerned and to urge caution about directing yet more resources into yet more inspection. I am conscious of the fact that in this area, as in many other service areas, the Executive and this Parliament—sometimes with the best of intentions—have added to the pressures of dealing with day-to-day demands and delivering improvements in other areas by introducing further inspection. Would anyone care to comment on my anxiety on that front?

The Convener: There do not appear to be any volunteers at the moment, but we may want to hear more on that point. Does the Auditor General have any further information that he wishes to give us?

Mr Black: One of the lines that I occasionally have to use is that it is not appropriate for me to comment on policy matters. I have to say that that can be a great let-out from time to time. More seriously, the commitment to strengthening inspection is something that follows naturally from some of the recommendations in our report. Whether or not to take that step is a policy matter, and finding the resources for it is something that the Executive would have to determine with the Parliament.

More generally, with regard to the fundamental point about how such issues are followed through, I have two comments. We see youth justice as such a significant area of social policy in Scotland, involving huge sums of money and areas of major public concern, that we are committed to sustaining some kind of continuing programme of work in that area. We look forward to further discussion with the committee on that matter in due course.

In the meantime, we have one significant piece of work in the pipeline, looking specifically at the implementation of some of the issues and focusing mainly on the role of local government. On that point, I would like to bring in David Pia, to give an indication of the next stage in our work in that area. I think that that will help to assure the committee that we are not letting go of the issues.

The Convener: That would be helpful.

David Pia (Audit Scotland): We have two stages of follow-up work. The first is under way now and will report in October. It will focus mainly on the supervision of children who offend, which was an issue that we picked up in our main report as an area of risk. The evidence that we received, from a limited sample, was that there were gaps in services for the supervision of children who offend, so we have carried out a study looking at those services across the whole country and will report on that in October.

We will do a further follow-up in two to three years' time, which will consider the impact of the various initiatives that are under way in the whole field that is usually described as youth justice. As members will be aware, the Executive is carrying out an extensive action programme just now, and it has added a lot of resources to budgets in that area.

11:30

It is plain from the initial follow-up work that most of the issues that were identified in the report that we published at the end of last year are being addressed through the action programme. The follow-up work will assess the impact of those initiatives in addressing the policy objectives.

I would like to comment on a couple of the points to which members drew attention. With regard to the point about inspection, I would like to add to what the Auditor General said. Our report tried to draw attention to the fact that there is a clear gap in the inspection of services for young people in the community. There are inspection arrangements in relation to residential schools, prison care and the education system, but there is no means of checking the quality of services for young people in the community. We were particularly interested in that because those services were the ones in which the gaps in provision were apparent, so that was an area of risk.

Our follow-up studies look further at that area and, without prejudging our final conclusion, I think that it is safe to say that there are still questions about whether children who are placed in supervision by hearings are getting the service that the hearings say they need. Further questions arise about the extent to which councils and the Executive have arrangements in place to monitor the quality of those services. That explains the conclusion about inspection.

A question arose about the Executive's response to the point about the cost-effectiveness of residential and secure care. It is true that the Executive is committed to increasing the provision of secure care quite substantially, and a substantial increase is promised. Our report raised the issue of the knowledge that is available about the cost-effectiveness of that provision, because it is very expensive indeed. We also had questions about the cost-effectiveness of residential schools, which are also very expensive, providing non-secure care. The unit costs of those forms of provision are very high. It costs five or six times as much to look after children in those facilities as it does to support them on programmes in the community. That is not to say that the two types of provision are directly comparable, as they are addressing different needs, but the costs of those services are very high. There is still an absence of information about what we are getting for that money.

The Convener: Thank you. I found that information useful. It puts the inspection in a specific context and suggests that, in relation to some of the concerns that were raised by the committee, information will become available that might begin to orientate local authorities to work together at a policy level to fill in some of those gaps.

In summary, I would like to suggest to the committee that a number of points—specifically points 9, 11 and 12—are worth taking up, both for clarification to the Executive and for our own benefit. I would like to ask the clerk to draft a letter, which can be circulated for members' comments, and once we have some agreement on that we can submit it.

Rhona Brankin: It is also important to be clear about who is taking the lead in the various initiatives. As Margaret Jamieson said, it is notoriously difficult to work in a cross-cutting way. A lot of such work is happening, but it is important for us to have a clear view about where the lead is being taken by the Executive.

The Convener: It is noticeable that the response is signed by three people. That is indicative of the fact that, although people are working together, there is no clear and obvious focal point. It may be that different parts have a different focal point. Nevertheless, we should ask.

Mr MacAskill: In respect of recommendation 11, the questions seem to be why, where and how. Why are we doing this? Is it simply because there is public concern? Is this the best way to do it? Where would the places be? There is no point in putting residential accommodation in some areas if the need is in other areas. How would people get access to their kids? I know from my previous job as a practising agent that significant difficulties can be caused if families of the unemployed or low waged are required to visit their kids in Rossie School or other such places that are difficult to access. The final question is how places would be commissioned. Would it be left to individual authorities or would there be a national drive? Or would there be a conglomerate of local authorities?

The Convener: We will find a form of wording to express that. Do members have any other observations to make before we move into private session?

Rhona Brankin: The Executive has agreed with the establishment of independent inspection. Are we to assume that it agrees that the inspection should be multidisciplinary?

The Convener: I cannot answer that, but we can try to clarify that point in our letter. We will tease that out.

I thank the members of the public, the press and others who have attended the public part of the meeting. We will take a break and then move into private session. Members have five minutes or so to take any calls and wash their hands.

11:36

Meeting suspended until 11:51 and thereafter continued in private until 12:50.

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