The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

PUBLIC AUDIT COMMITTEE

Wednesday 30 April 2014

Session 4

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PUBLIC AUDIT COMMITTEE
9th Meeting 2014, Session 4

CONVENER

*Hugh Henry (Renfrewshire South) (Lab)

DEPUTY CONVENER

*Mary Scanlon (Highlands and Islands) (Con)

COMMITTEE MEMBERS

*Colin Beattie (Midlothian North and Musselburgh) (SNP)
*Willie Coffey (Kilmarnock and Irvine Valley) (SNP)
*Bob Doris (Glasgow) (SNP)
*James Dornan (Glasgow Cathcart) (SNP)
*Colin Keir (Edinburgh Western) (SNP)
*Ken Macintosh (Eastwood) (Lab)
Tavish Scott (Shetland Islands) (LD)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Gillian Barclay (Scottish Government)
Paul Gray (Scottish Government)
Dr Anne Hendry (Joint Improvement Team)
Fiona Hodgkiss (Scottish Government)
Liam McArthur (Orkney Islands) (LD) (Committee Substitute)
Gerry Power (Joint Improvement Team)

CLERK TO THE COMMITTEE

Jane Williams

LOCATION

The David Livingstone Room (CR6)

Scottish Parliament

Public Audit Committee

Wednesday 30 April 2014

[The Convener *opened the meeting at 10:03*]

Decision on Taking Business in Private

The Convener (Hugh Henry): Good morning and welcome to the ninth meeting in 2013 of the Public Audit Committee. I ask members, witnesses and others to switch all electronic devices to flight mode so that they do not interfere with the recording equipment.

We have apologies from Tavish Scott. Liam McArthur will attend the meeting at some point.

Under agenda item 1, does the committee agree to take in private item 3?

Members *indicated agreement.*

Section 23 Report

"Reshaping care for older people"

10:04

The Convener: Agenda item 2 is consideration of the section 23 report, "Reshaping care for older people". The witnesses before us today include, from the Scottish Government, Paul Gray, who is director general of health and social care and chief executive of NHS Scotland—try getting all that on a business card; Gillian Barclay, head of unit, integration and reshaping care; and Fiona Hodgkiss, principal researcher, health analytical services. From the joint improvement team, we have Dr Anne Hendry, clinical lead for integrated care; Pete Knight, programme lead for partnership information; and Gerry Power, national lead for co-production and community capacity. Welcome.

I believe that Paul Gray and Dr Hendry would like to make opening statements.

Paul Gray (Scottish Government): Thank you. Dr Hendry will follow directly on from me.

I am pleased to be invited to the committee to respond on the reshaping care for older people programme report. We have already said that we accept the recommendations in the report, and we hope to set out today where we are already making good progress on them, in what is a 10-year programme.

There is no doubt that services are under pressure, and we are working hard to find better ways of finding and delivering savings where possible. However, we believe that we can achieve high-quality outcomes through new, more sustainable ways of delivering services that will meet older peoples' needs. Generally, there is a positive consensus around the need to reshape care for older people and, indeed, to integrate health and social care to meet current and future demands—Parliament has passed legislation to that end. There is agreement that we need to avoid as far as possible expensive crisis interventions that involve acute hospital care when we have evidence that a planned approach can ensure that people can be better cared for at home.

We also need to ensure that new accommodation that is commissioned conforms to current best practice. Yesterday, I went to see some accommodation that does conform, and I am happy to speak about it in due course. Such accommodation helps people to get the best quality of life.

We also need to help people take control of and manage their conditions, so that they do not have

to be constantly dependent on repeat visits to health and other facilities. Our self-directed support programme, which local authorities are implementing, is an important component of that.

We would like to help the committee, if it considers it appropriate, with information on important national strategies. For example, the dementia strategy was not touched on in any detail in Audit Scotland's consideration. We believe that that strategy forms an important component of what we do, and there has been substantial progress there.

Our focus on outcomes and activity has been shaped by older people themselves, so there ought to be as much attention on the suite of core measures that was developed in consultation with older people as there is on the commitments that are set out in exhibit 11 in the report.

The approach has moved on since the reshaping care for older people commitments were set. Although those commitments remain useful, we are moving to a whole-system approach, for which we have a coherent framework.

If the committee would find it helpful, I would be happy to speak about how the change fund moneys were spent. The joint improvement team report provides some detail on that, and colleagues from the team can assist me with that. We asked partnerships to submit their reshaping care for older people plans, which were subject to scrutiny, and we assured ourselves about the governance arrangements. It was also important that partners were directed to work with the third sector and anticipatory care colleagues as part of that process.

Audit Scotland helpfully acknowledged that the 10-year reshaping care for older people programme was complex and transformational.

Before I take questions from the committee, I invite Anne Hendry to give a brief opening statement.

Dr Anne Hendry (Joint Improvement Team): Good morning. On behalf of the joint improvement team I thank the committee for inviting us to give oral evidence on the reshaping care report, which was published by the Auditor General for Scotland and the Accounts Commission.

The committee might find it helpful if I briefly describe the joint improvement team's role. The team is a strategic improvement partnership between the Scottish Government, NHS Scotland, the Convention of Scottish Local Authorities and the third, independent and housing sectors. Membership of the team is mainly drawn from people with experience in the health, social care or housing sectors, and our main purpose is to challenge and provide critical support to help local partnerships deliver improved outcomes.

We are working with all 32 local partnerships to implement the reshaping care for older people programme and to use the change fund to develop and test new models of care and support that are based on greater collaboration and integrated working. We encourage the spread of good practice through our national learning events, sharing case studies and specific benchmarking activities. Scaling up those improvements to deliver sustainable change is a longer-term ambition that is being addressed primarily through our national development programme for joint strategic commissioning and integrated resourcing. I am sure that we will explore that issue this morning.

On behalf of the national partners, we have published a series of progress reports on reshaping care since the inception of the change fund. Many of the examples in our November 2013 report have spread beyond those tests of change and are being embedded in practice. We are seeing evidence of partnerships joining up those interventions to amplify their impact and provide more comprehensive, coherent and co-ordinated services in a locality to support older people to remain at home.

To tailor our improvement support to the areas that are most in need of that support, we keep sighted on the various trend data that are available nationally. For example, we track monthly the performance by all partnerships against the health improvement, efficiency and governance, access and treatment target for emergency bed days, which is the sentinel measure for reshaping care for older people.

We are very happy to explore further our activity in response to the committee's questions.

The Convener: Mr Gray, you referred to exhibit 11 in the report. I seek clarification on commitment 7, which says:

"We will ensure older people are not admitted directly to long-term institutional care from an acute hospital."

What happens when an older person who is in an acute hospital is not capable of returning home? Where do they go?

Paul Gray: First of all, to be completely transparent with the committee, I mention that in some instances, older people are being admitted directly to long-term institutional care. I spoke to colleagues in South Lanarkshire Council's social work department about that yesterday, because we share concerns about the matter. With the commitment, we are trying to prevent any notion of an automatic move into long-term institutional care from acute settings where many alternatives,

including step-down care, equipment and adaptations in people's homes, a care package or a combination of those features, can often help.

Dr Hendry will be able to speak about—I prompt her to do so—what we are doing to head in that direction. Commitment 7 will be hard to keep in every single case—I am not going to back away from saying that.

The Convener: What you have said is entirely reasonable and sensible—it is absolutely right to seek alternatives where at all possible. However, I cannot understand why that commitment is so specific. Why is it not couched in the language that you have used—that we would seek to avoid admitting older people directly to long-term institutional care from an acute hospital unless no alternative exists? That is not what the commitment says. What you have said is eminently sensible, but the commitment is very clear:

"We will ensure older people are not admitted directly to long-term institutional care".

Why say that when you know that the practicalities are different?

10:15

Paul Gray: Were I to write the commitment today, I think that I would insert some qualifying words in it.

The Convener: But why was it put down in that way? We can say about any report that we will rewrite it. I presume that the great, the good and the intelligent sat down and came up with a series of commitments that had been thought about very carefully. However, you are saying very directly today that what is in commitment 7 is really not what you are committing to and that it should not be written in that way.

Paul Gray: The other point to make before I bring in Dr Hendry is that it is, of course, a 10-year programme, and by the end of it our ambition would still be not to admit older people directly into long-term care from acute hospitals. That means that a set of alternatives would have to be available. They are not available yet, but they may come within the scope of the 10-year programme that we have in hand.

The Convener: Whether it is a 10-year programme, a 20-year programme or a 30-year programme, you still suggest that there is an aspiration for that commitment to happen, although we know that some people are not capable of living on their own. The logic of what you say suggests that no one should be in long-term institutional care. If we are going to have long-term institutional care, why would it not be available to older people who should no longer be in an acute hospital?

Paul Gray: A better outcome for an older person who is in an acute hospital could be to go through an assessment facility into long-term institutional care. One of the issues that we face is that acute wards are not always the best setting in which to assess older people's care requirements. That is what we are trying to avoid. It would be better to have step-down assessment facilities. In the course of the 10-year programme, we may be able to achieve that. I am grateful to you, convener, for acknowledging that I am simply seeking to say to the committee that we are not at that point today.

The Convener: I accept that. I am just puzzled by the commitment. Even your suggestion of not doing the assessment in an acute hospital and possibly having a step-down facility for that would be hugely problematic for an older person. Both my mother and father—God rest them—were in hospital for significant periods. Taking older people like them from one institution to a second one merely so that they can have an assessment before they go to a third institution would be physically, mentally and emotionally damaging.

If we truly believe that we are seeking to minimise the pressure on an older person who we accept needs care, why do we not get the facilities to do the assessment properly into the hospital, rather than uproot them? Sometimes older people cannot understand why they are in a particular environment and it takes them time to settle into a new environment. Under what you suggest, no sooner would they be in a new environment for assessment than they would be on their way again. That is a surefire way to shorten a person's life, as opposed to putting in place the care that they need.

My criticism here is not about failure, because I know that the commitments are all about aspirations. However, I just cannot understand the logic of commitment 7 and why it has been written in that way. You have already said that it probably should not have been written in that way, but why was it written like that in the first place? I also question the logic of what you say about taking older people into intermediate settings if we accept that they need long-term care. Do you want to come in on that, Dr Hendry?

Dr Hendry: As Paul Gray stated, that is part of the ambition of the 10-year commitment. Our response to engagement with older people and the clinical profession is that a hospital setting is not the best setting in which to make a life-changing decision about giving up home and moving into long-term care.

It is not just about assessment; it is also about an opportunity for enablement and recovering confidence and independence. An admission to hospital often happens when there has been a crisis, not just in the individual's health, but in the confidence of carers. Commitment 7 is about an opportunity to give people time and space to recover that confidence and independence and to look at the possibilities. It is not in any sense about depriving somebody of their right to have institutional care, if that is the right outcome for that individual.

The Convener: I know that. I think that, in most cases, if we can achieve that, it is the right thing to do. I have been through it with my family. The last thing that you want for elderly family members is for them to be in a hospital long term. The best place for them is to be at home, with their family and network of support around them. I accept all of that, but if an assessment needs to be done, why is it not done before someone is moved? Why put them into yet another environment as a stepping stone to somewhere else? You are right that the best solution is for someone to be independent, in their own home and in the community, but if it is obvious to medical and social work professionals that that person will not cope in an independent environment, why pile on more agony by taking them into another setting, simply to do another assessment?

Paul Gray: I can offer a statistic on that, if I may. In an assessment that was done in 2009, 33 per cent—one third—of people in residential care did not need to be there.

The Convener: But that is a different issue—that is about looking at the issue after the event. We are talking about a commitment for future practice that is about the move from hospital to institutional care. We are not talking about people who are in institutional care now who should not be there. We are talking about trying to influence our future practice.

Paul Gray: Indeed, but I am explaining one of the reasons for the genesis of the target.

I will bring Dr Hendry in on this, but there is another point—I discussed it yesterday—which is perhaps germane. Clinicians, particularly nurses, advise me that when an older person is in an acute setting there can be a loss of confidence, as Dr Hendry said. That could have happened before they came in. The ability to assess their suitability to return home is diminished by the fact that, to put it simply, they are in hospital and therefore unwell.

I accept entirely what you say about the bad effect of multiple moves. Nevertheless, assessing someone in an environment that is more home-like gives us a better understanding of their likely suitability to return home. What partly lies behind that commitment is our recognition that a lot of people have gone from hospital into care settings when they did not need to and that there was a better way to assess suitability. I accept your point about multiple moves; it is an important point. However, I think that, in this case, there was some genuine clinical evidence behind the decision. At other meetings of the committee you have been fair with me about the difficulty of having absolute targets.

The Convener: Yes, but you have also accepted that the commitment is not as it is written—that some older people will go directly from an acute hospital to long-term, institutional care, if that is appropriate.

Paul Gray: I would like to think that, in seven years' time or more, we might not have got there 100 per cent but we will be very close to it.

The Convener: But should it not be down to the needs of the individual rather than some bureaucratic target?

Paul Gray: It should be, but our evidence suggests that the needs of the individual are generally better met if they are assessed in a more robust and realistic way.

The Convener: Are there any other questions on that before I move to Willie Coffey and the issue of delayed discharge?

Bob Doris (Glasgow) (SNP): I will be very brief, convener.

I hear what you are saying, Mr Gray, but I think that had commitment 7 said, "We will ensure that older people are not inappropriately admitted directly to long-term institutional care", you could have explained what you meant by "inappropriate" and fleshed things out. The commitment is a strong one, and the convener has put on record some of the caveats that I think you accept are accounted for in normal practice.

I am asking a supplementary, convener, because I thought that you would have asked about the progress on commitment 7, about which it is said, "National data is not available." The obvious question for the Public Audit Committee is what is being done to collect that national data, because unless that happens we cannot see whether things are getting better or worse.

Paul Gray: As the report says, we have evidence that the rate of long-stay residence in care homes has decreased over time. Dr Hendry can say something more about that.

Dr Hendry: Local partnerships are collecting that information. For example, the submission from Glasgow City Council's social work services, which can be found on page 13 of the additional information paper, describes the experience of

implementing the model in Glasgow. The initial expectation was that up to perhaps a quarter of the people who get an opportunity to have that convalescence recovery space might go home, but the council is already finding that significantly more than that have been able to return home or that people who have to move on to long-term care are moving on to long-term residential care rather than nursing care. Partnerships are tracking the matter at a local level.

Bob Doris: They might well be. However, I note that the issue of health and social care integration is coming up in a series of health boards. I speak from experience. A family member of mine was in hospital for two weeks, a support package was put in place and he returned home. That would be one of the success stories, but how are such cases being audited nationwide? Instead of tying up the committee's time on the matter, I ask our panellists to reflect on how we audit the national picture. I understand that, given the integration of health and social care, it might be this time next year before you are able to map out how best to audit the issue, but do you intend to carry out a national audit of what is happening locally to allow the Public Audit Committee or the Health and Sport Committee to examine the matter in future?

Paul Gray: It is important that I put on record the fact that one of the things that the report has made me think about is to check, without making any assumptions, whether we have struck the right balance between national and local reporting. We do not want to diminish the way in which we have commissioned local partnerships by turning them into bureaucratic reporting machines but, as the accountable officer, I want to assure myself that I have sufficient national information to be able to provide assurance to committees such as this one. The report has certainly made me reflect on that point.

Willie Coffey (Kilmarnock and Irvine Valley) (SNP): I just wanted to come in on that point, convener. I certainly acknowledge the points that Dr Hendry and Mr Gray have made about the question whether it is better to assess a person while they are still in hospital or when they are moved elsewhere. From my own family's experience, I recollect that it was very helpful for the assessment not to have been carried out in hospital. People are simply too stressed out because their family member is in hospital and because they hope that their stay will come to a positive end; it is better to discuss further destinations or outcomes after that. I realise that that is perhaps the opposite of what you found, convener, but I have to say that I found it more helpful for the assessment not to be carried out in hospital. In any case, it was not possible, because every day we went to the hospital we hoped for a better outcome to permit a different direction of travel. I fully understand the points that have been made in that respect and why such an approach works for some families.

The Convener: Mary Scanlon has a number of general questions, after which I will come to the issue of delayed discharge.

10:30

Mary Scanlon (Highlands and Islands) (Con): I want to stay with exhibit 11 and pursue a line of questioning that I have pursued previously. First of all, though, I have to say that I find Dr Hendry's statement that we are only now getting evidence of joined-up partnership quite depressing and put on record that some of us have been waiting for this for 15 years. Progress on the matter has undoubtedly been very slow.

On exhibit 11, we are now four years into a 10-year programme of eight commitments but, given that you have achieved only three of them, your record card is not so good there. On commitment 1, which says that you will

"double the proportion of the ... budget",

you have actually reduced the proportion from 9.2 to 8 per cent. On commitment 3, which relates to the change fund, there is no evidence available. On commitment 5, we are a long way from getting a measurement, given that the Scottish Government has no definition of "waste" or "unnecessary variation". On commitment 7, there is, as the convener and other members have pointed out, no "National data ... available", which means that we have no way of measuring it. Finally, on commitment 8,

"There is no centrally available information".

Are you deliberately not conforming to data, information, definition and measurement requirements that allow Audit Scotland to do its work and which are essential if the committee is to carry out its task? Are you deliberately not providing the data? In six years' time, when the programme is over, will we still be asking the same questions? Can you give us a good reason why you are hampering measurement, which in turn hampers Audit Scotland and people like me?

Paul Gray: I never withhold anything deliberately from the Public Audit Committee, and if I do so inadvertently, I try to put things right.

Mary Scanlon: Well, it is all in Audit Scotland's report. I have quoted from exhibit 11, which makes it clear that the information is not there.

Paul Gray: I have acknowledged that, Ms Scanlon. We are less than halfway through the programme, and I have already told the committee that the report has caused me to reflect on whether we ought to be gathering more

information centrally. However, if we are serious about local partnerships, we also have to be serious about delegating responsibility and authority to them if they are to deliver in ways that are meaningful to the communities they serve.

With regard to commitment 5, you have drawn attention to the comment in the report that

"The Scottish Government has not defined what it means by 'waste' and 'unnecessary variation'"

in practice and performance. One of the purposes of the joint improvement team is to enable us to discover and share best practice. Where we see good practice, we seek to share it, and where we see practice that is less so, we seek to draw that partnership's attention to better opportunities elsewhere. Moreover, a national definition of waste might not be applicable locally, but if the committee wants me to reflect on whether it is possible to produce such a definition, I will be more than happy to do so. However, I simply point out that we might end up producing a national definition that is not helpful to the local partnerships to which we have delegated these things.

Again, I want to record in response to Ms Scanlon that there is no point at which I would deliberately withhold information from a committee of the Parliament.

The Convener: Did you just say that you would consider whether you could define "waste" and "unnecessary variation"?

Paul Gray: That is correct.

The Convener: But if you are not sure whether you should or could define those phrases and if you do not know what they mean, why have you said that you

"will improve quality ... through reducing waste and unnecessary variation"?

Paul Gray: What I am saying is that it will be different in different localities.

The Convener: Yes, but you do not know what it means. How can you improve quality and productivity if you do not know what your commitment means?

Paul Gray: It will mean different things in different localities. That is the point. If I produce a national definition that is singular and linear, that might inhibit the development of systems that are appropriate to different localities. For example, it might be an unnecessary variation in an urban area to have certain practices in relation to admissions or whatever, but it might be an entirely appropriate variation in a rural area, because the set of circumstances is different. If I created a national definition of that, I would simply be saying that everything had to be the same everywhere. That is precisely the opposite of what we want to achieve.

The Convener: Does each locality then have its own target for reducing waste and unnecessary variation in practice and performance?

Paul Gray: As I have said, I am thoughtful about how we could test—

The Convener: I am not asking about whether you are thoughtful; I am asking about what you have just said about there being no national definition. Are there local definitions?

Paul Gray: There will be. Dr Hendry will be able to say a little about that.

Dr Hendry: It is a reality of life that there is variation in how services are used by people and in how services are provided and delivered. The improvement team is working with partnerships to help them to understand their local data and the variation and to ask what is happening in that regard. As Paul Gray has said, a partnership must determine whether there is a variation in admission rates or the use of a particular service across localities within the partnership and determine what the reasons for that are. It must ask whether the variation is justified on the basis of demography or equity and, if not, say what it is doing to try to smooth out that variation.

Mary Scanlon: Well, after those answers, I am not confident that we will have those measurements in two, three or even six years' time, but I will move on.

Commitment 1 says that you will

"double the proportion of the total health and social care budget",

but it has been reduced. Why has that happened, given that there is an increase in the number of over-65s of up to 22 per cent and that that number has been increasing for decades? Why did you promise to double the budget and then reduce it?

Paul Gray: Well, the budgets are set in the Parliament, of course.

Mary Scanlon: So why did the Scottish Government promise to double the budget and then reduce it?

Paul Gray: Ministers take a range of decisions in relation to setting the budget. Again, we are only part of the way into a 10-year programme. I entirely accept the figures, but there is a range of other factors that come into determining how much of the health and care budget for older people is spent on care at home for older people over the life of the plan.

The figures concern a proportion of the budget that is spent on care at home. The amount—9.2 per cent—of the total health and social care

spending on people who are aged 65 or over that is spent on home care has reduced slightly, but that does not mean that it cannot go up again.

The Convener: You state that you will double the proportion. For the record, can you state what the percentage will be before it is doubled and what it will be afterwards? What are you doubling it from and to?

Paul Gray: I cannot do that at this point. I will have to check the exact numbers. I do not want to give inaccurate or misleading information to the committee, but I am happy to come back to the committee with that information.

The Convener: I understand that. However, you are clearly saying that you have a baseline figure, which means that you know what the figure will be when it is doubled. Those figures exist.

Paul Gray: They should do, but I do not have them in my head. The figures also include third sector spend in this area, and that is not represented in the integrated resource framework data, so I would want to answer your question in writing later.

The Convener: Is the baseline figure somewhere around 8 or 9 per cent? Do you hope to double that to 16 or 18 per cent?

Paul Gray: That is my understanding, but I would like to give you an accurate response.

The Convener: So you will revert to the committee in writing on that.

Mary Scanlon: I understand that that money is for care at home. I do not want to repeat the questions that the convener, Willie Coffey and Bob Doris asked in the first half hour of the meeting, but it is my understanding that the budget for care at home was to be doubled because you wanted to avoid elderly people languishing in acute beds, delayed discharge and long-term institutional care. That explains the commitment that has been in place since 1999, which is clearly stated in the report. That was reflected in the convener's initial questions about the fact that more of the focus will be on preventive care and care at home, yet expenditure on that is reducing.

I want to move on to an issue that is raised by some additional figures that we received from Audit Scotland, which is reflected in paragraph 36 of the report. In the most recent financial year, four out of the 32 local authorities increased the funding that they provide for home care and social care. I will not go through all the additional information that we received, but if we look at spending on home care as a percentage of the total healthcare budget, we see figures of 2 per cent for West Dunbartonshire and 12 per cent for North Lanarkshire. If we look at the average number of home care hours provided, we see that it was 4.2 hours in Angus and 16.4 hours—in other words, four times greater—in South Ayrshire. If we look at the number of home care clients as a percentage of the population, we see that in Highland the figure was 3.9 per cent, whereas in West Dunbartonshire it was 9 per cent.

Why are there such huge disparities between council areas in the number of clients, the number of hours of home care provided and the percentage of the budget that is spent? You say that, where best practice exists, it will be rolled out, so are some councils better at that than others? Are you monitoring what the information that we got from Auditor General suggests is going on? Are you auditing what is happening in local authorities? Are you pulling up those that are not meeting best practice?

Paul Gray: I emphasise again that the delivery of care in a rural setting will be different from the delivery of care in an urban setting, and that its delivery in an inner city will be different from its delivery in smaller townships. I will ask Gillian Barclay to give you some background on the degree of variation that exists.

Before I do so, I will answer your fair question on what we are doing. We are asking the joint improvement team to point out to the local partnerships the variations that exist. Some of those variations can be explained, but if they cannot be explained by evidence and data, we want to know what is to be done to resolve matters.

The Convener: Just before we hear from Gillian Barclay, regardless of the variations in the percentages, which you say are down to local circumstances, can you confirm that the commitment means that all councils will be expected to double what they provide?

Paul Gray: No, I would not say that, convener.

To return to exhibit 11, we say that we will

"double the proportion of the total health and social care budget for older people that is spent on care at home over the life of this plan."

I will not say that every authority or partnership will exactly double the sum that it allocates to care at home. In some areas, the figure might be slightly lower and, in others, it might be slightly higher. If a partnership was already demonstrating excellent practice and its expenditure was at the right level, I would not force it to do more just for the sake of making it do more.

Mary Scanlon: As a member of the Parliament for the Highlands and Islands, I keep a close eye on spending in remote and rural areas. I do not accept that that is the reason for the disparities that exist. I put it on record that, when it comes to spending on home care for older people as a

percentage of the total healthcare budget by council area, West Dunbartonshire Council has the lowest figure, 2 per cent, and North Lanarkshire Council has the highest, 12.6 per cent, which is six times greater. I come from Inverness, and I do not think that either of those areas could be considered to be remote, rural or island areas.

10:45

Gillian Barclay (Scottish Government): I will explain some of the variations. There are undoubtedly big variations in the way in which local authorities have commissioned and provided care for older people. Some years ago, because a previous committee highlighted the issue, we looked at the differences, for example, between Angus and Dundee, which are close in terms of geography. Because of that, one would think that the services would be similar, but we found that, in Angus, more care was being categorised as home support rather than care at home. That was to do with how the local authorities accounted for and measured the spend.

At that time, Angus Council had developed its housing with care a lot more than Dundee City Council had—although since then there has probably been a levelling out on that—so a lot of the spend was on housing rather than social care. The issue was just how the service was described. Even with that explanation, I am sure that there are big variations in how local authorities and their partners have commissioned support for people in their homes, but how it has been categorised has not been helpful.

Mary Scanlon: Well, I can say how it has been categorised—the source is Audit Scotland's analysis of the integrated resource framework data from 2011-12. If you have not found that helpful, we can discuss that with Audit Scotland.

Paul Gray: For clarification, Gillian Barclay is not saying that the Audit Scotland report is unhelpful; she is talking about how local authorities initially classified the information that they gave. That is one area of variation that we would like to remove so that, when we talk about a set of numbers, we are talking about the same baseline and attribution of spend. I can understand why the committee finds the issue difficult—so do we, and that is one of the things that we want to sort.

The Convener: We will move on. I have questions on delayed discharge, but I will allow Willie Coffey to come in on that first.

Willie Coffey: Delayed discharge is one of the themes that were discussed when we considered the report previously. On page 36 of the Auditor General's main report, she indicates that good progress has been made on the issue since 2007 but, nevertheless, the figures are still high. One statistic is that the level of delayed discharge is equivalent to 837 hospital beds being occupied for a year by patients who are clinically ready to leave hospital. What progress are we making on delayed discharge? I know that there are reasons why it occurs, but the picture as submitted by Audit Scotland for this meeting, which is on pages 29 and 30 of paper 2, shows a variation in the way in which the issue is treated in health boards across Scotland.

I have to remind myself that we are the Public Audit Committee and that we are looking for any opportunities to make savings, where they can be made. What is happening at the moment? Is the picture improving and what are we doing to get standardised practice across the health boards?

Paul Gray: The situation on delayed discharge remains an issue. As you rightly say, there has been a reduction since January 2007, when 793 patients were delayed for longer than four weeks, down to the latest data that I have, which shows that the figure is 254, which is a reduction of 68 per cent. However, I say on the record that that is still not good enough. The issue is being raised at chief executive and chair level in the NHS Scotland boards. For example, the chief executives of NHS Lothian and the City of Edinburgh Council now meet weekly to discuss what more can be done in the areas they serve to reduce delayed discharge even more.

More than 70 per cent of the delays of more than four weeks are in a non-acute setting such as a community hospital, care home or general hospital ward. I mention that because, in my view, the real impact on patients is from being delayed in an acute ward. We ought to fix it all, but if I was prioritising something, it would be delays in acute wards. Tackling delayed discharge is one of the main reasons—although not the only one—why the Government legislated to integrate health and social care. We believe that that integration is an important component of our approach to providing better outcomes for patients.

The joint improvement team and the Care Inspectorate are working with NHS boards and local authorities to drive up the quality of care in the community to ensure that there are good places for patients to go when they are discharged from hospital. Anne Hendry might want to say more about what we are doing on delayed discharge.

Dr Hendry: We have for some time held delayed discharge learning events for staff from health and social care who are involved in planning discharge and pathways home for people. We have built up a level of good practice that is being shared nationally, some of which is

now being woven through the unscheduled care programme so that people further up stream in the hospital understand what they need to do to promote good discharge practice.

A number of partnerships have commissioned and now operate discharge hubs, which are an integrated single point of contact and pull together the health and social care equipment and adaptations processes to help people to get home quickly.

We are working with partnerships at present to help them to understand the revised guidance on choice, including how to apply guidance under the Adults with Incapacity (Scotland) Act 2000 on choosing a care home when someone has lost the capacity to make decisions. We are supporting all the boards to train their staff in applying that refreshed guidance.

We are also working with colleagues in justice and mental health on the guidance and processes to go through when somebody has issues with capacity and might require a guardianship or intervention order.

That is just a flavour of some of the practical work that we are doing with partnerships. As Paul Gray said with regard to Lothian, Edinburgh and Aberdeen are recognised as facing very specific challenges in recruitment to the care sector. That issue is tied into a bigger community planning agenda involving the economic situation in those areas and the average wage that people are paid in other occupations and sectors.

Willie Coffey: I was going to ask about that specifically. Exhibit 1 on page 29 in the additional papers shows that the number of bed days that are lost in Orkney—Liam McArthur's constituency—is as low as 239, whereas in East Lothian it is more than 1,600. That is an incredible difference. Is it all attributable to an inability to recruit care sector staff to deal with discharge provision? That is surely not the case.

Dr Hendry: The delayed discharge expert group report from 2012, which is still extant, sets out the common issues that influence those figures. There is often a mixture of issues that relate to practice and to the ability to recruit to the care sector and to move people on to care home placements. In some areas, the resilience and stability of the care home sector is an issue, so we are working on that with the Care Inspectorate and with our policy colleagues in the residential care task force.

Willie Coffey: One would imagine that it would be less of a problem in East Lothian than it would be in Orkney in terms of the options that are available for people locally.

Dr Hendry: The cost of independent sector care homes in the Lothians is extremely high, and well above the national care home contract rate.

Willie Coffey: So people just stay in hospital longer in East Lothian because care homes are too expensive.

Dr Hendry: As Paul Gray said, the issue is being tackled at a very high level by health and local authority chief executives. In fact, NHS Lothian and the Edinburgh city partnership had a high-level meeting at the beginning of this month to examine some of the transformational and ambitious models that need to be implemented in order to design a way out of that situation.

Gillian Barclay: There are no private sector care homes in Orkney; unfortunately, there is no market there. Some of the issues in Lothian, such as the recruitment and retention of staff, are quite deep rooted and will take time to resolve. There have been issues with poor quality, as Anne Hendry said, and we hope to address those in partnership with the Care Inspectorate, Healthcare Improvement Scotland and the private providers themselves.

Willie Coffey: When will we see progress? If we look at this in a year's time, will we see a much improved picture?

Paul Gray: I hope that we will. An enormous amount of effort is going into addressing the issues but, as Gillian Barclay said, the circumstances in the Lothians, for example, are deep rooted and of long standing. We cannot alter the economic context in which services are delivered—as colleagues have said, there is better remunerated work available very close at hand in some areas, which is a key issue.

Overall, 30 per cent of people who were delayed for more than four weeks were waiting for a suitable care home place, and 25 per cent were waiting for a care package to enable them to go home. I mention those figures only to show that we are not just approaching the issue in the round but looking at the specifics area by area. The answer in Edinburgh and the Lothians is not necessarily the answer elsewhere.

The delayed discharge figure has gone up to 254, which is higher than it was previously. I would like the trend to start coming down, but I am not going to say that the figure will be zero in a year's time, because I do not think that it will be.

Liam McArthur (Orkney Islands) (LD): Willie Coffey referred to Orkney as an exemplar, which had me looking back at the figures. I am conscious that there are caveats to any type of statistical analysis, and that Orkney's population size is always problematic.

I wonder how the figures on bed-blocking to which Willie Coffey referred correlate with the figures that Mary Scanlon discussed previously with regard to the percentage of older populations in hospital and social care services. The number of older people in hospital in Orkney—as day cases, in-patients or emergency admissions—seems to be far higher than the average. There are no home care clients identified, and there is a lower than average proportion of residents in care homes. How does that tally with the figure on delayed discharge, which looks heroically successful?

Paul Gray: Can you tell me what page you are looking at?

Liam McArthur: I am looking at two different documents. Exhibit 1 is on page 29 in the additional information from Audit Scotland, and exhibit 10 is on page 24 of the main Audit Scotland report.

Paul Gray: I am not sure that I have that additional information.

The Convener: We will provide it.

Paul Gray: I have it now. What is the page number?

Liam McArthur: It is exhibit 1 on page 29 in the additional information. Willie Coffey referred to the figure for Orkney, which is at the far right end of the graph, and the one for East Lothian, which is at the other end.

Exhibit 10 in the Audit Scotland report seems to show that Orkney has no home care clients, precious few residents in care home settings and everybody else in hospital, whereas the delayed discharge rate in exhibit 1 in the additional information—which should be an aspiration for all, by the look of it—shows a different picture.

11:00

Paul Gray: Yes. The question is how, therefore, such a high percentage of the population is apparently using hospital services while delayed discharge does not present a problem. That is to do with the system in Orkney, which Is a good example of a system that is highly integrated between health and local government. It is also because, as Gillian Barclay said, provision of care home places is effectively controlled by the public sector and no market for private care exists. It is that combination of factors that matters.

We are seeking to tackle system integration. In order to do that, Tim Davison from the national health service and Sue Bruce from local government are considering how to integrate better the systems in Edinburgh to ensure a speed of flow that is beneficial to patients.

The Convener: I have a couple of questions on delayed discharge, on which I seek clarification. You said that, since 2007, the figures have fallen from 793 to 254.

Paul Gray: That is correct.

The Convener: Those figures were for delays that were longer than four weeks. Has that four-week definition always applied or has it changed at any point?

Paul Gray: That definition has always applied, as far as I know.

Dr Hendry: We have always recorded delays in relation to the number of weeks. In 2001, the original target was to reduce the number of delays that were over six weeks. At that time, there were 2,162 delays over six weeks with an average delay of 153 days; in 2013, that figure had dropped to 100 delays over six weeks with an average duration of 22 days.

We are trying to increase incrementally the scale of ambition, so the target has dropped to four weeks and we are working towards a target of two weeks. Many of the partnerships that I support are looking to turn around delays in 72 hours or less. In Scotland, there is no sense that anyone is complacent about the target.

The Convener: No—and those challenging targets are commendable.

How are circumstances impacting on delivery? Over the years, we have introduced more rigorous inspections and standards for private care homes. That is quite right; those of us who have loved ones in care homes want to know that they are being properly supported. From time to time, we see horrendous examples of poor care—we have seen that in the past few days in England, and it happens here, too.

Allied to the legitimate demand for higher standards, we also have an understandable and legitimate reduction in hospital beds. In the past few years, I think that the number of beds has been reduced by 6,000. Delayed discharge falls between them. We are reducing the number of hospital beds, but we have people blocking those fewer beds because no care home places are available.

We have problems in some parts of the Lothians. Edinburgh is an example; 25 per cent—I do not have a precise figure, but it is around that—of care home beds are not available because of inspection concerns. Given what you have said to Willie Coffey about the Lothians, that you have explained all the financial pressures and that you cannot get staff to work in homes or in home care jobs, added to which is the removal of something like 25 per cent of home care beds in Edinburgh,

what is happening? A crisis is clearly developing in Edinburgh and the Lothians.

I am not seeking to apportion blame because I would not for one minute want the standards of inspection to be reduced; that would absolutely not be the right thing to do. What happens, however, when you have this perfect storm of not being able to recruit staff because of a more vibrant economic market, 25 per cent of home care beds being removed because of the inspection regime, and there is pressure on hospital beds, which have been reduced by about 6,000? What is happening with this crisis in Edinburgh and the Lothians?

Paul Gray: I will invite my colleagues to come in on that in a second. The convener has rightly drawn attention to the complexity of the situation. The other thing that we are trying to do is reduce the number of admissions because if fewer people come in, fewer need to go out again.

The Convener: I am sorry: admissions to where?

Paul Gray: I mean admissions of older people to hospital. We are working hard to achieve that and I have seen evidence in one small area—not Edinburgh—of a reduction in the number of admissions of older people by 50 per cent, which is very welcome.

Dr Hendry alluded briefly to the fact that we are working with local authority inspection regimes and the private care providers to overcome the issues that have caused staff to put a moratorium on accepting more people. Dr Hendry might want to say a bit more.

Dr Hendry: We are working with the Care Inspectorate, Scottish Care and local partnerships to take a deeper dive into examples of moratoriums being applied to admissions for good reasons. We want to work out what could have been done by the partnership earlier to get early warning that that was going to happen, and what the partnership could have done to address the issues before the situation got to that point and, if quality issues emerged, what could have been done to improve quality jointly across the independent sector, health and the council. The learning from some of those deep dives with a number of partnerships in NHS Forth Valley and the Lothians will be transferred to other partnerships.

Similar work is being done in NHS Highland with the improving quality approach that it is taking with the integrated authority and the independent providers.

Obviously, quality of care has to be paramount, but we are increasingly placing at the heart of joint commissioning this question: what is the menu of services that we desire in a locality? The joint strategic commissioning programme is working with every partnership in Scotland to look at their joint commissioning plans and at the model of care that we want to commission. Is it care home, hospital, care at home, or are there other models? In particular, what is the role of housing in care? As recently as the beginning of April, some ambitious and exciting concepts came up in Edinburgh around a care village or care campus to replace some of the existing facilities.

The Convener: Is there a problem at the moment in Edinburgh and the Lothians?

Dr Hendry: We around this table have just discussed the fact that there are issues in Edinburgh and the Lothians. That is recognised at a very high level, and work is under way to tackle it sustainably.

The Convener: Okay. Ken Macintosh will ask about the change fund.

Ken Macintosh (Eastwood) (Lab): Central to the whole agenda is the idea that we should shift budgets from the acute sector to community care and care at home. It is certainly the focus of the eight reshaping care commitments—in fact, it is in commitments 1 and 3. However, the Auditor General has pointed out that rather than shifting resources, we are going In exactly the opposite direction; funding of acute care is going up and funding in community care and in local government is going down. Why?

Paul Gray: The process of shifting the balance of care is complex and takes time. An area in which you would see expenditure rising in the acute sector would be capital investment—for example, in Glasgow. It nevertheless remains our ambition to shift the balance over time, which is why we are doing what we are doing. The joint improvement team provided evidence in its written submission on how the change fund has changed how funding is assigned to different aspects. If it is helpful, I can ask Dr Hendry to give you some insight into that. I am not ignoring your core point, however. I want to be clear that a decisive shift from acute care to non-acute care is still work in progress.

Ken Macintosh: So, all you are saying is that the shift is not happening because it is difficult and complex.

Paul Gray: Redesigning a health and social care system is a complex task. For the integration of health and social care, we are bringing together parts of what is delivered by the health service, parts of what is delivered by local government and parts of what is delivered by the third sector. That is complex and it takes time. I am not saying that because it is difficult, we are giving up; I am saying that it is difficult because it is complex.

Ken Macintosh: The Auditor General points out in paragraph 23 of her report:

"Between 2002/03 and 2009/10, council spending on social care ... increased by ... 40 per cent".

So it is possible to do it, because it increased by 40 per cent over that period. Interestingly, the reshaping care for older people strategy came in during 2010. Since then, though, the spending has declined. I just do not understand that. We had a 40 per cent increase in spending on social care before the reshaping care strategy, but since then spending by local authorities on social care has declined while spending in the acute sector has continued to increase. The situation was clearly as complex previously as it is now. What is impeding the process? Shifting the balance of care is the number 1 and the number 3 commitments in the reshaping care strategy, but it is not happening. What is happening and why?

Paul Gray: I think that Dr Hendry will be better placed to give you the detail. However, expenditure on free personal care and nursing care would partly explain the change in the trend that you have drawn attention to.

Dr Hendry: Gillian Barclay is probably best placed to reflect on the free personal care trends. I will follow on after that on some of the issues around the demand for acute care.

Gillian Barclay: Mr Macintosh highlighted an increase in expenditure between periods. I am sorry, but what were they?

Ken Macintosh: It was the period between 2002-03 and 2009-10.

Gillian Barclay: Yes. We increased the budget for local authority social work spend to match the increase in demand from the introduction of free personal care in 2003. I guess that that accounts for quite a large part of the expenditure. The number of people who receive free personal care is still growing, but the expenditure per head is perhaps levelling off. The amount of the social care budget that is sucked up by free personal care has increased over time. The difference in spend between local authorities is quite stark. Some local authorities spend a fair amount more on social work than others do.

Ken Macintosh: Yes—but before we go on to the variation among local authorities, I am talking about the national picture across all local authorities. Local authority spending on social care since the reshaping care strategy commitments were brought in has declined. In other words, at the very point when in theory the strategy becomes the political priority and the healthcare priority, exactly the reverse of what is supposed to happen is happening.

The explanation of why the figures apparently rose between 2002 and 2009 is helpful, but it does not explain why they have stopped rising. They should have continued to rise. The demand is increasing. Why are the figures not continuing to rise?

Is it the joint improvement team that is taking the decisions? Who is taking the decisions that are leading to a decline in one budget and to an increase in another?

11:15

Paul Gray: The decisions on what local authorities spend are taken by local authorities, not by me—if I have understood your question, Mr Macintosh.

Ken Macintosh: I am trying to work out why this is the case. We are trying to audit the spend of a major Government programme that is trying to shift things. As you say, it is a complex process. It was having some success—we could argue about how successful it was—between 2002 and 2009. Instead of that success being built on, we are going into reverse—we are going in the opposite direction. I am trying to work out why. What has changed? What decisions are being taken? Who is taking those decisions?

Paul Gray: As I said, local authorities take the decisions on what local authorities spend. One of the issues in the way in which we are approaching integration of health and social care is that there are better ways of doing things. Services do not all need to cost more money; indeed, some of them can cost less. For example, we have better approaches to the prescribing of medicines, which—

Ken Macintosh: I am sorry. I am reluctant to stop you, because I agree with what you are saying—but the point is that it is a very specific aim of the Government to increase the budget. I assume that it is also the aim to get better value and to produce better care—in fact, I know it is. Are you saying that the key reason is that local authorities are not spending enough money on social care.

Paul Gray: No. I was answering your question as factually as I could. Who makes the decisions? It is the local authorities.

Ken Macintosh: Are local authorities part of the process? They are part of the joint improvement team, are they not?

Dr Hendry: At strategic level, COSLA is one of the national partners on the joint improvement team. At local level, the local authority is absolutely part of the local partnership that it is taking forward the reshaping care strategy. At local level, however, the partnerships are also

recognising that the change fund is 1 per cent to 1.5 per cent of the total budget for older people. The real issue is how they spend the 100 per cent. That is to do with the partnerships' integrated resource framework—and that is exactly what they are considering as part of joint commissioning. The legislation around integration will give us some additional leverage in treating the resource as a joint budget and in making best use of the public pound.

Ken Macintosh: Why has the change fund not produced an increase in spending in social care?

Dr Hendry: I find it difficult to understand how the change fund, which is 1 per cent to 1.5 per cent of the total budget, could exercise that level of leverage. It has been a catalyst for a different way of working and for new relationships across partners, and it includes greater use of third sector partners. I do not know whether it would be helpful to explore any of that.

Ken Macintosh: That is fine. I want to keep this at a high level at the moment.

We heard evidence from witnesses on 2 April. Catriona Renfrew in particular was clear on this point. She said that reshaping care might be a priority but, when it comes to health budgets, the priority is actually acute access, drug budgets and addressing waiting times. She said that very clearly. She said that those, and not reshaping care, are the drivers when it comes to allocating the acute budgets. Was she accurate in saying that?

Paul Gray: I am sure that Catriona Renfrew was accurate in giving her view of things. I need to look at things in the round. You were talking to the director of strategy at NHS Greater Glasgow and Clyde, I think—that is Catriona's role, if I have got it right. What she was telling you was accurate, I am sure, in so far as she represented it.

Since December, when I came in, I have chaired a number of discussions with NHS chief executives—Dr Hendry has attended at least one of those meetings. I have been clear about the importance that we attach to the overall integration programme. The cabinet secretary has been clear with the chairs about the importance that he attaches to seeing a commitment to that shift in future local delivery plans. At my level, I am clear about the commitment to that shift. Further, I have acknowledged and you have accepted, Mr Macintosh—for which I am grateful—that it is difficult and complex.

Ken Macintosh: I do not think that any of us wishes to berate anybody on this panel or in the health service as a whole, because you have a clear focus on a target.

The First Minister is fond of using the expression "Follow the money." If waiting times, acute access and medicines are political priorities, and the money is going into acute care and not into local government services and older people's care, there is very little that you can do. You are trying to take decisions while the money is going elsewhere. Am I right or wrong in that assessment?

Paul Gray: My responsibility is to work within the budgetary framework set by the Parliament and to account to this committee and others about how I manage that. However, I am clear that we have set out a strategy and priorities for the boards, and we are asking them, in future local delivery plans, to come forward with their proposals for how they will achieve that.

Ken Macintosh: Commitment 3 in the reshaping care for older people agenda says that by stimulating

"shifts in the totality of the budget from institutional care to home"

you will

"enable subsequent decommissioning of acute sector provision."

Two weeks ago, Ranald Mair was very clear that you will not be closing hospitals, yet that seems to be a very specific aim. Is commitment 3 accurate?

Paul Gray: One of the things that NHS Lothian mentioned as an opportunity was the transformation of what had been provision for acute service delivery into provision for a step-down facility or, as Dr Hendry said, a care village. I would say that there are opportunities, which chief executives are actively pursuing.

Ken Macintosh: So you expect some hospitals to close. Can you tell me which ones?

Paul Gray: Well—

Ken Macintosh: It is quite important, is it not?

Paul Gray: Dr Hendry will give you the detail, but Lothian has identified acute settings that are now available for transformation.

Dr Hendry: We have heard some personal stories this morning, so I will give you mine. I am a geriatrician and I normally provide specialist support for rehabilitation in hospital. However, the ward is no longer required because the cohort of older people who would normally have gone there is being supported directly at home or in more of a community or homely setting. The reality is that that is happening. It is an incremental, emergent process rather than a big bang, but the shift is happening.

The Convener: Colin Beattie is up next.

Colin Beattie (Midlothian North and Musselburgh) (SNP): Thank you, convener.

Colin Keir (Edinburgh Western) (SNP): I have a supplementary to that last question.

The Convener: Colin Beattie's question is on the same issue.

Colin Beattie: Before I touch on one or two of the issues that Ken Macintosh has mentioned, I would like first to say that one thing that stands out in the Attorney General's report is the huge number of areas where there is a lack of good data. That affects this committee's ability to take conclusions from the report. Paragraph 70 says that

"there is a lack of information on the need for care at home."

It goes on to say that the home care figures

"do not includee people who use direct payments to buy homecare."

On primary care, paragraph 70 says that

"national data on primary care services is limited."

That must cause enormous difficulties for anyone who is trying to extract trend analysis from the report or look at how services will develop in future. It must be—I hope that it is—very much a priority to try to get good data out on which to base decisions in future.

Paragraph 38 covers the use of intensive home care, which Ken Macintosh mentioned, as a criterion. Its use is increasing, whereas the number of people who receive it has fallen. Is there any evidence that that indicates that councils are raising the bar to try to deal with people in more acute situations, whereas the people at the bottom, who may have slightly less need, are falling out?

Dr Hendry: I wonder whether Gerry Power should answer that.

Paul Gray: I am happy to pick up the question first and give colleagues a chance to contemplate what they want to say.

On Mr Beattie's first point, which was about data, I have already said to the committee that one of the things that the report has made me do is reflect on the adequacy of data and the level at which it ought to be collected. I make that point again. I hope that it was not the Attorney General who wrote the report, or I am in more trouble than I thought. [*Laughter*.]

Colin Beattie: I keep using that term, unfortunately.

Paul Gray: On paragraph 38, the problem is that, with measures that are proxies of other things, it is not always simple to determine what the reality is. I think that you are pointing to the second last sentence in the paragraph, which states:

"Census figures indicate that the percentage of homecare clients receiving intensive homecare has increased from 24 per cent in 2005 to 32 per cent in 2013. However, the numbers of people receiving homecare have fallen over this period."

Is that the distinction that you are drawing out for us?

Colin Beattie: Correct.

Paul Gray: Some of the home care that people receive is delivered through the third sector, so it is not recorded in the same way that it would have been recorded in 2005, because the voluntary sector is providing more than it did then. That is one explanation. The other is to do with the way in which people receive home care. There is now greater dependence on kinship care or care by relatives. Factors such as that come in, but we do not record that care in the same way. I say to the committee that I am not about to start a national data collection exercise around that, or we would be in real difficulty.

Colin Beattie: Looking at the figures in paragraph 38, I would have thought that it is reasonable to assume that the number of people who receive home care has dropped. However, that relates only to council provision. You are saying that there is another figure out there somewhere for those who receive home care through the third sector, but that provision is not captured in the figures that we have, so the arguments that we are making could be entirely wrong.

Paul Gray: No, I would not say that they were entirely wrong; I am simply saying that there has been a shift in the way in which care is delivered, and that is one factor that will play a part.

The Convener: Mary Scanlon has made a point to me. Do councils not commission home care, irrespective of the fact that it may be delivered by independent providers? Councils would therefore have the information.

Paul Gray: They might. Of course, some individuals receive care through self-directed support, which is a different—

The Convener: That is a recent phenomenon. I presume that, when the report was produced, it was all done through local authorities.

Paul Gray: I accept that, but there are also some people who commission their own home care support as a matter of—

The Convener: Yes, but we are not talking about that. That is not the focus of the report.

Paul Gray: I ask Gerry Power whether he wants to say something about the way in which the third sector is engaged in this work, and also whether he can help the committee on the extent to which information is recorded about how the third sector is commissioned. I think that that would be useful.

Gerry Power (Joint Improvement Team): It is true to say that certain third sector organisations are commissioned by statutory organisations to provide formal support to individuals. It is equally true that a vast amount of voluntary and charitable work in Scotland is undertaken with no funding from the statutory sector, which has been going on for—

11:30

The Convener: Can I stop you for a moment? That is not what we are talking about in this report.

Gerry Power: Okay. If I understand what is being said, the question is whether the care packages that are being delivered by statutory agencies for those who require 10 hours of care or more per week have led to a reduction in the number of those who require less care. I was asked to comment on the voluntary sector's input to that. Have I misunderstood the question?

The Convener: I think that paid voluntary sector input was referred to.

Colin Beattie: I understood from what was being said that that piece had been missed out from the process—that was all that I was saying about that. My original question was whether there was evidence of councils raising the bar and whether that has resulted in more people receiving intensive care, but fewer receiving—

The Convener: In addition, the reference that we make to the third sector—we took evidence from witnesses on this—is about paid-for services, not charitable or unpaid work. We are talking about commissioned care, which is the focus of Audit Scotland's report. We know from the report and from listening to other witnesses that not all paid-for services are delivered by the local authority. Some are delivered by the private sector and some are delivered by the third sector—by voluntary or charitable organisations.

That is the focus, not the charitable or voluntary activity that people give of their own free will for no reward.

Paul Gray: I take that point entirely. My point, which perhaps misled Gerry Power slightly, was that one of the reasons why the number of people receiving home care appears to have fallen could be that more use is being made of the unpaid and voluntary sector work that does not go through statutory commissioning. That is the point that I was making.

The Convener: Where does that feature in the Audit Scotland report?

Paul Gray: It does not feature in it, but it is part of my explanation.

The Convener: Does Colin Beattie have anything else to ask before others come in?

Colin Beattie: Is there any evidence of councils raising the bar?

Gillian Barclay: In 2010-11, we required local authorities to start recording risk categories of individual clients who were assessed as needing free personal nursing care. The eligibility criteria were categorised as low, moderate, substantial and critical.

We have monitored the statistics over time. Eighty per cent of people who meet the substantial and critical risk levels have been getting services within about two weeks. Much more support has been developed for those with moderate and low needs, with services such as community alarms, telecare and others that are not necessarily recorded as home care; they are recorded as a different type of care.

Colin Beattie is right to raise the question and I understand exactly what he is getting at when he asks whether councils are raising the bar in terms of the moderate, substantial and critical categories. Some councils are prioritising those whose risk category is critical or substantial above those whose risk category is moderate or low. However, those councils do not ignore the groups whose risk categories are moderate or low; they are developing services of a different nature for those clients.

I hope that answers some of the question.

Colin Beattie: The final sentence of paragraph 23 says that there seems to be a problem with trend information, because the information is about specialities and services rather than age groups. Perhaps it would be more relevant to gather information on age groups. What is the impact of not having that information?

Paul Gray: How the NHS records its expenditure is as stated in the report. We can assume that certain specialties will see a high proportion of older people, but there is not a direct correlation.

For example, one might assume that dementia—I know that that is a condition, but I use it by way of an example—is largely connected with older people but, sadly, a few younger people come within its scope. In that sense, we do not record or publish by age. It is fairly clear what paediatrics will be about and what being seen by a geriatrician is likely to be about. However, if

somebody is seen for cardiac issues, that does not put them into a particular age group.

The Convener: Colin Keir is next.

Colin Keir: Thank you, convener.

I am sorry, but I want to take us back to the difficulties that NHS Lothian is facing, because I want to nail down a couple of points. Some of the problems have been partially mentioned, but they have come up in more general terms. The Royal Victoria hospital was meant to be closed down about 10 years ago, and it will in effect become part of the proposed care village. Improvements are needed to Edinburgh royal infirmary and changes are to be made to the Astley Ainslie hospital and Liberton hospital. Corstorphine hospital is way past its best—the four wards there that are classified as a hospital will probably have to close simply because they are way out of date. All that comes along with the pretty commonly known fact that Edinburgh royal infirmary was built too small for demand and with some of the problems that we are having with private care homes. Given all that, are we hitting the perfect storm? Major changes are happening that make the Lothian picture look worse than I like to think it is.

Paul Gray: Lothian is of course performing well in some areas—

Colin Keir: I agree. The issue is just all the stuff that has to happen.

Paul Gray: Indeed—the convener made a similar point. Given the extent of your question, if you and the convener are content, I would like to ask NHS Lothian to provide a note to the committee on what it is doing on that set of issues. Otherwise, I will give a partial or incomplete answer, and it would be more helpful to the committee to have a complete answer. Are you content with that, convener?

The Convener: Yes—that would be helpful.

Colin Keir: It would be helpful. We have spent a bit of time on the issue, but the discussion was generalised. Although NHS Lothian is doing some things well, there are many pressures on it. There are many changes, with capital expenditure going on in many different places, along with the fairly well-known problems in nursing homes. It would be helpful to have information so that we can nail down how Lothian is doing and how that feeds through into the figures in which we compare the local with the national.

Bob Doris: I will ask about the change fund in a second, but first I want to refer to Mary Scanlon's telling contribution on home care budgets for older people for 2011-12 and the lack of quality baseline data. There is a tension between allowing local flexibility and having a national picture. I understand the bureaucracy that can be created around that. I have a specific request relating to one example that Ms Scanlon gave. She rightly pointed out the distinction between the spend in North Lanarkshire, which was 12.6 per cent of the budget, and the spend in West Dunbartonshire, which was 2 per cent. I understand that, for many years, North Lanarkshire has had a personalised budgets policy for older people. The spend is significant and may or may not be accounted for in the budgets for care at home for older people, but the situation in West Dunbartonshire might be very different. That is one explanation, although it might be completely false.

Mr Gray, could we ask you to come back to the committee with some more detailed information on that quite dramatic difference between those two local authorities? That would allow the committee to understand and get beneath the numbers. Would you be able to do that?

Paul Gray: We can ask the partnerships do that for us, yes.

Bob Doris: Thank you; that is useful.

Ms Scanlon raised the issue of the change fund, which is worth £300 million over four years. At our last evidence session, I suggested that the strength of the change fund lies in the fact that, while some initiatives will be highly successful and others will not, the successful initiatives can be mainstreamed—and rolled out across other health board areas—and those that are not successful can be ditched. How will the mainstreaming and rolling out of change fund initiatives be monitored and audited?

Paul Gray: The importance that we attach to spreading successful initiatives and making them sustainable is evidenced by the fact that that is pretty much core to what the joint improvement team does. Dr Hendry will tell the committee a little about how we ensure that that happens.

Dr Hendry: As part of the joint improvement team report that was published in November, which looked at the midway point of the four-year change fund, we asked partnerships to assess how far they had spread each of the specific areas of improvement or intervention that are part of the reshaping care pathway. That information is provided in our submission.

That was a self-assessment exercise, but it was done in partnership with a member of the joint improvement team who is walking that journey with the partnership. There is therefore an element of validity within the assessment. We are working with the partnerships to turn that self-assessment into an action plan to complete the spread and mainstreaming of good practices.

Bob Doris: The final year of the change fund is 2014-15. When can we expect to see a final overview report saying that X per cent of projects were not continued—that is fine; that is the whole point of the change fund—Y per cent were mainstreamed, and here is the strategy for rolling them out?

Dr Hendry: I probably should not give you a date, because that would raise expectations. However, I can give you the commitment that that is part of our core business. We will produce a further report as part of our iterative process of national and local support. That will be complemented by our on-going work to support partnerships to embed those approaches as part of our joint commissioning plan for older people.

Bob Doris: That will be important for this committee or a subsequent committee. Our scrutiny must be more than a snapshot; we must follow it through.

I have a two-part question on health and social care. First, apart from NHS Highland, which uses the body corporate model for health and social care integration for older people, are we looking at a new set of baseline figures for spend for the first time?

Secondly, I will give examples of two local organisations to get a flavour of how they will be impacted. The good morning service in north Glasgow has £50,000 from the change fund. I hope that that organisation can be mainstreamed following the integration of health and social care. Another local project—the alive and kicking project—gets about £130,000 from Glasgow City Council. It is doing a lot of preventative spend work in the community around Red Road. Is that the kind of project through which we can expect to see the health board share the positive burden of preventative spend for older people into the future? More important, will the committee be able to audit that properly once we have health and social care integration?

Dr Hendry: I suppose that my reflection is that that resonates with the earlier conversation about the balance of local accountability versus national accountability, or the proportionality of what we look at nationally versus what we look at locally, while getting assurance that local scrutiny is in place.

11:45

Bob Doris: What about the baseline figures?

Dr Hendry: All health boards and councils have integrated resource framework mapping data. I suggest that we ask Fiona Hodgkiss to speak about that issue.

Fiona Hodgkiss (Scottish Government): The report acknowledges that quite a lot of work has gone into understanding local cost, activity and variation. That is being done at a national level and locally, at an aggregate level. Increasingly, it is also being done at an individual level, and we are able to consider activity and spend in relation to sub-populations such as people with dementia. We are also able to examine sub-geographic levels and we can consider the activity and cost around services in general practice. There is a lot of work to try to understand activity and cost around integration.

Paul Gray: You want to know whether there will be budgets and whether they will be baselined. Is that the question?

Bob Doris: I am keen to ensure that, when the budgets emerge, we are comparing apples with apples when we compare, for example, North Lanarkshire and West Dunbartonshire. Obviously, we would not compare West Dunbartonshire with the Highlands, because the demographics are different, but we could reasonably compare West Dunbartonshire with North Lanarkshire once the budgets are created. Will the data allow us to compare baselines? We cannot do that just now.

Paul Gray: I would expect that there will be baseline budgets. I take your point about comparability. I will follow up on that.

The Convener: Could I have some clarification on definitions? When you talk about mainstreaming, are you talking about successful projects being integrated into the mainstream activity of local authorities and health? Are you talking about taking the amount of money that is available under the change fund and ensuring that it is still available, not for specific projects but given to the relevant agencies, which will determine how best to deliver their services? Will the money continue to be available, mainstreamed into the budgets, or will it be withdrawn and the services absorbed into the activities?

Paul Gray: The change fund is limited. In other words, it is there for a period of time. It is not being continued. That is the explicit answer to your question.

The Convener: There will be no financial mainstreaming. The services will be mainstreamed or absorbed, but the financial responsibility will then fall to the local health service and the local authority.

Paul Gray: There is an innovation fund that replaces the change fund, but I do not want to mislead the committee in any way: the change fund is time limited. The principle behind a change fund is that it funds the change and, once the change has been embedded, it should displace

other things that are not as good. That is the way in which it operates.

The Convener: I understand that. It is important to have that clarification. I remember much of the debate about the end to the ring fencing of local authority funding and the mainstreaming of some of that ring-fenced funding. That funding was put into the local authority budgets so that the local authorities could decide how best to deliver the services. However, what we are talking about here is the disappearance of a fund. It is not as if it will be absorbed into a future increase. It will, as you say, disappear.

Paul Gray: It is time limited.

James Dornan (Glasgow Cathcart) (SNP): Earlier, Kenneth Macintosh talked about Ranald Mair's comments. I remember Ranald Mair saying that reshaping care was not about giving us the ability to close hospitals and that, rather, the new way of working was about ensuring that we did not have to build any more. Does that ring a bell with you, Dr Hendry? You talked about freeing up services in order to bring them out into the community instead of keeping them in hospitals. Do you accept that that is a more accurate summary of the situation than the suggestion that we introduced this policy in the hope of closing hospitals? Of course, I accept that some buildings will be used for other things or might not be used at all.

Paul Gray: That is reasonable. The fact is that some facilities are being reused for other purposes. There is the major project in Glasgow to build a new hospital, which will result in other facilities being released and replaced. I say to both Mr Dornan and Mr Macintosh that I am somewhat reluctant to say what will happen in 10 years' time, hence my hesitancy.

James Dornan: That is fine. I just wanted to clarify what I thought that Mr Mair had said.

I have a couple of questions around identifying and sharing good practice and the role of the Scottish Government and the joint improvement team in that regard; that has already been discussed a wee bit today. Does the issue of best practice explain why there is a different percentage of spend in different areas across the country?

Paul Gray: Absolutely. Anne, do you want to say something on that?

Dr Hendry: The rates of admission and the lengths of stay in acute care are big drivers for spend. As we know from the integrated resource framework, the biggest proportion of the health and social care budget spend on older people is on in-hospital care, particularly care as the result of an emergency admission. We are working with partnerships and are very focused on the emergency bed day target. The published data show that emergency bed days in Scotland for the over-75s have fallen by 359, which means that there are 359 fewer occupied beds today than there were at the beginning of the 2009-10 baseline. That is a very real shift. Until and unless we can make some difference in the emergency bed day rate, we recognise that we will not be able to reinvest the resources associated with that into more anticipatory, preventative care and care and support at home. That is very much the focus of the work that we are doing with partnerships.

Those figures were for the over-75s. There were 491 fewer over-65s in hospital at April 2013—that is the most recent published national data—than there were for the process baseline of 2008-09. That is very tangible.

James Dornan: Would joint working allow uniformity of the categorisations that we talked about earlier? Is that one of its other benefits? Again, I take into consideration the local flexibility that you talked about, but for auditing purposes the more that things are categorised, the better.

Dr Hendry: That is a very real challenge and we are working with the Information Services Division on how we code and classify some of the activity, because the models are changing and some of our coding and data have to change to keep pace with that. For example, hospital-at-home services are special services that are now delivering in the community, in people's homes, care that was previously delivered in hospital. There is not an easy diagnostic coding for that activity, so it is easy for it to be invisible. We are actively working with the ISD on how we might code and capture that data so that we can track the growth and spread of such care across Scotland.

James Dornan: Would that include the likes of recording the different types of home care?

Dr Hendry: Yes.

James Dornan: Would it also include the third sector? When Mr Power was trying to make a contribution earlier, we talked about it not really being germane to the report. However, it is right to say that numbers might have dropped because there is another service that can be used. Is there a means of finding out how many people are using another service rather than the statutory services?

Gerry Power: If I have understood the question correctly, it is about the third sector in general. Certainly, the third sector has had significant involvement in both the planning and the delivery of services. As I said earlier, third sector organisations have had a significant input across the board for decades, but with the change fund—as we have seen and as is mentioned in the report—the third sector certainly feels that it has

had much more of an influence in how services are designed and delivered. If we look at the projects that have been funded through the change fund, we can find a lot of data on the number of individuals to whom those services are being delivered.

We are talking about a different way of working. It is not simply a case of replacing a statutory service with a non-statutory service—we want to connect communities in such a way that we signpost people to different ways of using services. That links to self-directed support. We are talking about a fundamental shift in the way in which we provide and think about services. We want to empower individuals and to enable families and communities to support themselves better rather than simply rely on statutory services. There are figures that demonstrate how the change fund projects for third sector organisations have engaged with and supported people. Those figures will be available from the partnerships.

James Dornan: Further to Bob Doris's comments, will information on what is being done with the third sector, how the change fund has been used and what has been done to carry on that work come back to the committee in one form or another?

Dr Hendry: I am sure that we would welcome the opportunity to bring back such information to the committee at a future date.

James Dornan: That is great. Given what has just been said about the third sector adopting a new and innovative way of doing things that involves the use of shared practice, do you think that the third sector could teach others about the best way to proceed? Is that something that could come out of the reshaping care for older people work?

Gerry Power: Absolutely. I think that, as well as changing the way in which the third sector is involved, that work is starting to reshape the way in which our workforce development takes place. As a result of the integration agenda, workforce development is very much focused on co-productive partnership working between the statutory sector, the user of the service and third sector providers. It is starting to reshape the way in which statutory services think; they can learn a lot from the third sector.

James Dornan: That is good. Once the health and social care body comes into being, will the third sector still have a meaningful role? Will it have a part to play in the decision-making process?

Gerry Power: When I have engaged with partnerships—they are probably sick of hearing me do this—I have referred them to the policy memorandum under the Public Bodies (Joint Working) (Scotland) Act 2014. I cannot cite the precise paragraphs, but it is very clear from that policy memorandum that there is an expectation that we must not lose the gains that we have made through reshaping care for older people as far as third sector involvement is concerned. We must ensure that that is embedded in the integration agenda.

The third and independent sectors might not be seen as part of the formal melding of health and social care, but it is very clear that the intent of the legislation is that those sectors should be full partners in the decision-making process and the design and delivery process. I continually bang the drum on that. When the statutory regulations come out, they will make it clear to statutory organisations what the expectations are as regards involvement with the third sector.

Ken Macintosh: I have a brief follow-up. You said that there is evidence that the voluntary or third sector is playing an increasingly important role but, in her evidence to the committee, Annie Gunner Logan highlighted the fact that, under the joint working legislation, that sector is not a statutory partner. According to paragraph 62 of the Auditor General's report,

"The JIT reviewed NHS board and councils' work with communities and concluded that it is very difficult to measure any impact that these initiatives have had."

That is quite worrying for us, because although most of the MSPs around the table are very keen to promote community-based initiatives and recognise the strength and resilience that they build in communities, if we cannot follow the audit trail or audit them, it will be very difficult to give them a political priority. Do you have any evidence that supports their impact? The Auditor General was not able to highlight any, and it would be helpful to have that.

12:00

Dr Hendry: It is complex—

Ken Macintosh: I think that we heard that one earlier.

Dr Hendry: "Complex" is probably the word that I would use because the relationship between the input from a community or voluntary sector support and the outcome is not a linear one. We are working with Evaluation Support Scotland and the a stitch in time? project on contribution analysis and logic modelling to map the impact of these interventions. The issue is difficult, but the difficulty lies in the fact that it is a complex multidimensional intervention rather than with gathering data.

Ken Macintosh: The classic example would be a lunch club that ends up being cut as part of a

budget saving even though it costs very little to a local authority, is an incredibly important investment and creates the kind of strength in the community that we are actually missing. If you have any evidence, please bring it to the committee.

The Convener: Coming back to Mr Power's comments about his discussions with other providers, I think that everything that we have heard today and in the previous evidence session suggests that to ensure that people are not inappropriately placed in acute services or kept there longer than necessary, we need to provide appropriate and flexible care wherever they need it, whether that be in their own home or in some other community support facility such as that described by Ken Macintosh. A lot of this discussion centres on the home care service that the local authority or the third sector delivers or some of the specialist individual services that are available, but the key thing about keeping people in the community is ensuring that they have access to a well-designed and appropriate home. Sometimes the house that they live in is perhaps not the best if they are to stay in the community, and they will need to move into some of the fantastic new housing that I and I am sure other members have seen and which is provided sometimes by local authorities but more often than not by housing associations. Some of that will be better-designed and better-built mainstream housing, but often it will be sheltered and very sheltered housing.

We need to consider the demographics involved in the issues that we have been discussing and the huge increase in the number of older people. Although we can adapt some existing homes to people's needs—and I am sure that every one of us has had to get local authority adaptations for their relatives—the fact is that, as Ken Macintosh pointed out in relation to lunch clubs, local authority budgets are under pressure and, as a result, adaptations budgets are being squeezed, to say the least, and cannot keep up with demand.

In any case, those budgets are limited, and what we need is more new-build sheltered and very sheltered housing. What discussions are taking place on increasing the provision of such housing as part of the planning for this policy? Given that we are now talking about shifting resources away from acute care to preventative and community care, how much of an increase can we expect to see in the budgets for constructing sheltered and very sheltered housing over the next five to 10 years?

Gerry Power: Convener, I do not think that I am the best person to answer that question. I certainly do not have an immediate answer to your question on the investment that we can expect in that regard.

The Convener: Mr Gray?

Paul Gray: I can tell you that there is a housing co-ordinating group, convener, but I hope that you will accept that I am not going to be drawn on what ministers might decide on future housing budgets. Nevertheless, I take your point about the importance of properly adapted or newly built accommodation.

The Convener: Let us leave aside political debates about what this or any future Administration might spend on housing. Surely if you are talking about reshaping your current budgets to allow people to stay at home, that discussion has to cover not only individual home care support, specialist services and aids and adaptations but the provision of suitable housing. Does that not feature in your decisions and in whether you use some of your budget to ensure that such housing is provided and people are not kept in hospital?

Paul Gray: It certainly features in our discussions. I have already said that I am not going to pre-empt any decisions that might be made by this or a future Government, but—

The Convener: In that case, can you tell us how much additional money you have put into sheltered and very sheltered housing over the current period and the past few years through your discussions on reshaping services for older people?

Paul Gray: As far as I know, the health budget has not been used to fund housing, if that is what you are asking me.

The Convener: It is partly that. I know that there is a separate housing budget, but if you are talking about using your budget to ensure that people are not hospitalised unnecessarily or that, once they are in hospital, they are allowed to go back into the community, where is the integration that a number of contributors have talked about? What about the need to identify and provide more sheltered and very sheltered housing to allow more people to be supported in their own homes at a time of need?

Paul Gray: At the moment, capital expenditure is not coming out of health for housing.

The Convener: I presume that the integration that we are talking about is not just between local authorities and the health service but between health and housing within the Scottish Government. What discussions have there been on integrated social policy planning to provide more financial support for the construction of the sheltered and very sheltered housing that is fundamental to keeping people in the community?

Paul Gray: Dr Hendry can tell the committee a little more about what is discussed at the housing co-ordinating group. That might be a starting point.

Dr Hendry: Our housing partners are key partners in the reshaping care work not only at a strategic level in the national housing co-ordinating group, in which the housing and health leads work together, but at a local level. I would say that all partnerships have brought housing into the reshaping care discussions on the change plan and the joint commissioning plan; housing is wired into the joint commissioning work; and we are also working very closely with the Chartered Institute of Housing and the Scottish Federation of Housing Associations on a housing learning network and housing innovation. Next week, in fact, we are holding events in Edinburgh and Inverness with our housing partners, including registered social landlords, to consider how we maximise their contribution. The residential care task force has been a key building block in our work with housing partners.

The Convener: Yes, but if we are talking about doubling home care budgets, we are surely not talking about doubling the budgets to keep people in inadequate and expensive-to-adapt homes. As part of that process, we will need to provide new sheltered or very sheltered housing that is specially suited to the needs of that older population. Where in your work to reshape services for older people are you having discussions about the amount of capital resources that must be provided to meet the increased need and demand for such housing?

Gillian Barclay: I cannot respond with regard to the budget for RSLs, which is obviously a separate budget stream, but I can tell you that we have been working closely on future developments with existing RSLs that have a combination of care homes and very sheltered housing. I know that a number of very successful change fund projects have focused on providing more social care in existing housing.

I realise, however, that your question was about how we get more of that housing in future. We are having a dialogue with the banking sector on independent sector provision of housing, and a number of quite exciting models such as care villages and supported housing are coming up. That said, we do not hold the purse strings for that; all we can do is encourage that type of development.

The Convener: I understand that, and it is good that that discussion is taking place with the banks, financial providers and so on. However, there is a Government budget for housing, and given that we are talking about integrating and co-ordinating care, can you point to where discussions and planning for the provision of more sheltered and very sheltered housing are being co-ordinated and to decisions that are being taken on shaping resources, whether they be from health, housing or other areas, to provide more money in that respect? If you do not do that, you will, as you are planning to do, simply spend more money from a budget that is very much under pressure on keeping people in houses that are often expensive to adapt and which might not be best suited to their needs. Who is doing that work and making those decisions?

Paul Gray: Well, ministers make the decisions about where the budgets lie.

The Convener: Yes, but you have talked about integration, co-ordination and planning. Leaving ministers aside, can you tell me where, at the co-ordination and planning level, housing fits into your discussions on reshaping services for older people?

Paul Gray: The housing co-ordinating group has been mentioned, and we are holding housing innovation learning events. We are seeking to ensure that when private providers or indeed local authorities make new provision it conforms to the highest standard, and our planning and building control regulations are also aimed at ensuring that, once built, houses do not have to be adapted to accommodate older people. That is the direction of travel. I understand the question that you are asking me, but the best answer that I can give is that I cannot pre-empt ministers' decisions about where future budgets should lie.

The Convener: I will leave it at that. Thank you very much. We have had a very full discussion, and we look forward to receiving some of the additional information that you have offered. Clearly, this will be a major issue for this and future Parliaments.

Paul Gray: Thank you, convener.

The Convener: We now move into private session for item 3 on the agenda.

12:13

Meeting continued in private until 12:42.

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