The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

WELFARE REFORM COMMITTEE

Tuesday 13 May 2014

Session 4

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WELFARE REFORM COMMITTEE
8th Meeting 2014, Session 4

CONVENER

*Michael McMahon (Uddingston and Bellshill) (Lab)

DEPUTY CONVENER

*Jamie Hepburn (Cumbernauld and Kilsyth) (SNP)

COMMITTEE MEMBERS

*Annabelle Ewing (Mid Scotland and Fife) (SNP)
*Linda Fabiani (East Kilbride) (SNP)
*Alex Johnstone (North East Scotland) (Con)
*Ken Macintosh (Eastwood) (Lab)
*Kevin Stewart (Aberdeen Central) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Mark Kennedy (Salus)
Kenny Small (NHS Lanarkshire)

CLERK TO THE COMMITTEE

Simon Watkins

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Welfare Reform Committee

Tuesday 13 May 2014

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

Decision on Taking Business in Private

The Convener (Michael McMahon): Good morning and welcome to the eighth meeting in 2014 of the Welfare Reform Committee. I ask everyone to ensure that mobile phones and other electronic equipment are switched off.

It will, of course, depend on how many questions we have for our witnesses, but I think that our meeting today will be slightly shorter than usual. The publication of the Heriot-Watt University evaluation of the Scottish welfare fund has been delayed, so we cannot take that evidence as we had planned.

The first item of business is to decide whether to take in private item 5, which is consideration of the committee's work programme, and whether to take consideration of draft reports on food banks and sanctions in private at all future meetings. Do members agree?

Members *indicated agreement.*

Personal Independence Payments

10:01

The Convener: The second item of business is our first evidence-taking session for some time on personal independence payments. As with work capability assessments, Atos Healthcare holds the contract for undertaking PIP assessments, but in much of Scotland that work has been subcontracted to Salus, which—as I and other Lanarkshire members know—is NHS Lanarkshire's occupational health arm.

I welcome Mark Kennedy, who is the general manager of Salus, and Kenny Small, who is the director of human resources at NHS Lanarkshire. Members might recall that, last year, we invited both men to come before the committee to set out how they intended to implement the contract. We have waited until now to hear again from them in order to give the contract a chance to run for a number of months, and to give our witnesses a chance to put together some concrete evidence. They have now provided that evidence, and I thank them very much for their written submission.

I understand that you also wish to make opening comments. I do not know whether you are both going to say something. I will start with Kenny Small.

Kenny Small (NHS Lanarkshire): Thank you very much, convener. We appreciate this opportunity to update the Welfare Reform Committee on the PIP contract that Salus holds.

We believe that the story is a positive one and, in a minute or two, Mark Kennedy will talk you through our submission and give you some statistics on, and evidence of, our performance in delivering this contract. As you would expect with such a complex contract, we had some teething problems in the very early stages. We now believe that we have got beyond those problems, the vast majority of which were not of our own making, and that the contract will pick up and run in a favourable way.

With those brief introductory comments, I hand over to Mark Kennedy to talk you through our paper, after which we will, I hope, take questions from the committee.

Mark Kennedy (Salus): We have submitted to the committee a high-level report that contains some statistics starting from when the contract commenced in July. The contract has been running for nine months now and, to date, we have led face-to-face consultations with about 7,000 claimants at eight venues, mainly in the west of Scotland and Edinburgh city, and have had only

five complaints from claimants going through the process.

Members might remember from our previous appearance that the consultation time was under review. Things have now settled down as a result of a number of information technology problems being solved and as a result of increased familiarity on the part of the assessors; the consultation itself now takes 90 minutes or so. At the moment, each assessor can comfortably provide about four consultations a day; we feel that to do more than that would be detrimental to claimants, in respect of the duration of the assessment.

We expect that, by the end of the calendar year, 30,000 or 31,000 consultations will have been offered. Our workforce currently comprises 26 or so national health service based practitioners, but we hope that, at our peak in August and September, we will be employing about 37. At that point, we will be at full capacity and offering around 3,000 PIP assessment slots per month.

As members will recall, we were determined to take the initiative forward with the ethos and compassion of the NHS at the centre of it. We have invited disability groups across Scotland to consult with us and we have put on an open day, which included seven representatives from those groups. Last November, I made a presentation to the Scottish social security consortium that set out in a transparent way how Salus intended to work with claimants from day 1 of their claim.

We feel that we are delivering a high-quality service. We have received informal feedback from Atos and the Department for Work and Pensions that the quality of our report writing is among the highest in the United Kingdom and to date we have not—touch wood—had many complaints from members of the general public who are going through the process. Things seem to be settling down and, in my opinion, are working well.

The Convener: Thank you very much. We will move to questions.

You said that 7,000 assessments have been carried out so far and that 30,000 or 31,000 could be carried out by the end of the year. Is that where you expected to be, or are you ahead of or behind schedule? Have you been set targets, and if so, are you meeting them?

Mark Kennedy: At present, we are on our way to where we want to be. As Kenny Small suggested in his opening remarks, at the start of the process the volumes with regard to the flow of claimants to the service were a bit inaccurate, so Atos and the DWP have been required to do a bit of catching up.

The way it works is that we provide appointment slots a month in advance to Atos, which fills them on our behalf. We say to Atos that we will provide it with 3,000 slots a month, which is the maximum we can do, and we are now just about at our maximum capacity.

As far as overall performance is concerned, I think that there is still a bit of catching up to do—and not, I have to say, by Salus. The need to catch up flows from the figures that Atos and the DWP have put together.

I do not know whether I have explained that correctly.

The Convener: You were set a target. My understanding is that the DWP wanted a reduction in the amount of money that was being claimed by the overall number of people going through the system. Is that right?

Mark Kennedy: That is not right, from Salus's perspective. There is no target setting as far as Salus is concerned. We deliver an assessment that the DWP has endorsed and we have no quota for the number of people who should pass or fail it.

Kenny Small: The target that Salus exclusively works to relates to the number of available assessment slots and the production of assessments. What happens thereafter is neither our responsibility nor part of our contractual liability.

The Convener: The statistics will begin to show whether this is true, but when we have met organisations across Scotland to discuss the new changes we have picked up anecdotal concerns about the criteria for PIP. We heard the same concerns about the work capability assessment criteria, and we and other people have proved that they do not provide any evidence on whether people are fit to work. In most cases, the criteria are very unfair and serve very little purpose in assessing people for fitness for work. Do you believe that the assessment criteria that you have been given are fair and provide you with something that you feel comfortable assessing in determining whether people are entitled to the new PIP?

Mark Kennedy: I absolutely think that the criteria are fair. You have mentioned that Salus's background is in occupational health; we have been assessing people's functionality for decades now.

I can state clearly that NHS Lanarkshire would not be involved in this if we did not think that the process is fair. I have not picked up in the numbers that we have put through any anecdotal evidence of people's unhappiness with the assessment, but I also accept that we have not—to my knowledge—received any formal report on

PIP from the DWP. I think that we are delivering a fair assessment in a compassionate manner.

The Convener: Perhaps I can give you an example to illustrate why I am asking about fairness. In one of the meetings that we had, it was brought to my attention that a person who was being assessed had been asked whether they could walk a certain distance. The person said that on some occasions they might be able to do so, but would find it difficult. That individual felt that the test was set up to make them fail. They were required to walk from the car park into the assessment centre, which was a distance greater than the distance of the test. In making it from the car park into the assessment centre, that person in effect proved that they were not entitled to the benefit, which they thought was inherently unfair. Someone who is keyed up to go in for an assessment wants to get there, but walking that distance does not actually measure their normal ability to walk a certain distance. It is that type of unfairness that has been brought to our attention. Will you comment on that?

Mark Kennedy: I can categorically say that that is not happening in Salus-led provision. We do not take such assumptions into consideration. Our assessment starts when the individual presents themselves at reception in the building. I have heard such stories before, and I am not sure what company they relate to, but they certainly do not relate to NHS Lanarkshire's approach.

I have heard bits and pieces about where certain bus stops are, but I can categorically go on record as saying that what you describe is not the case as far as we are concerned. As soon as the individual presents within the facility on our premises, the assessor will meet the individual at the desk and escort them to a consultation room. That room could be 10m away or 50m away. No such assumptions are ever made.

Kenny Small: It is important to recognise that the initial estimate of how long an assessment will take and our current experience are very different. Our current experience is that assessment of an individual takes between 90 and 110 minutes. It is not a short assessment, and it does not involve any snap judgments. It is very much an opportunity—a relaxed opportunity, we believe—for an individual to tell us their story and for us to use a set of prompting questions for people to tell us what effect their disability has on their normal everyday life. That is what the assessment process does: it allows people a relaxed opportunity to walk us through the implications of their disability in relation to their everyday life. That informs the process for the assessment that we then submit. As Mark Kennedy said, there are no assumptions made beforehand, and there are no tricks.

The Convener: I know from conversations that I have had with Kenny Small and from evidence that we took from Atos previously that there was a dialogue between the companies that are carrying out the assessments and the DWP. Atos said that some criteria had been changed, and it had raised some issues about the work capability assessment and about some modifications that had been made to the criteria or to the assessment process. Has that happened with you? What has the response been, if you have had to go back to the DWP to discuss issues of that sort?

Kenny Small: We have not done that, have we?

Mark Kennedy: No—we have not been asked to alter, or to consider alterations to, the assessment tool. There have been IT changes that have made it a bit easier for the health practitioner to go through things in a more timely fashion, but we have not been asked to implement any major changes, at all.

Kenny Small: Right at the very beginning, the clinical director of Salus, Dr Imran Ghafur, was heavily involved with Atos and the DWP and made comments around the clinical governance aspects of the original assessment. Some tweaks were made at that time. I was going to say that that was during the early stages—in fact, Atos and the DWP were using some experienced clinical professionals to road test the assessment process before we even launched it. Since we launched it, however, the assessment process has been what it is now.

The Convener: Atos went to great lengths to try and assure us that it had been in a constant dialogue with the DWP to get some of the assessment changes made. Atos was picking up from practice things that it was concerned about, and it raised them with the DWP. Was that your experience?

Mark Kennedy: That conversation might be around the process, rather than the actual assessment. Atos had significant problems with IT at the start. That was one of the things that it was actively discussing with the DWP.

The Convener: I now open up the discussion to committee members, starting with the deputy convener.

Jamie Hepburn (Cumbernauld and Kilsyth) (SNP): Welcome, gentlemen. Mr Small, the last time you were at the committee, you said that your

"overt intention is to seek to add the value that we believe an appropriately recruited and selected and then trained and supported NHS workforce can bring to the assessment and reassessment process for DWP PIP."—[*Official Report, Welfare Reform Committee*, 22 January 2013; c 488.]

Mr Kennedy talked about putting the ethos of the national health service at the heart of your work. Can you set out how you are going about doing that?

10:15

Kenny Small: I am a director of human resources, so the jobs aspect of this discussion is very close to my heart. As Mark Kennedy has said, we have recruited about 26 whole-time equivalents, and we anticipate that that figure will go up to 37 whole-time equivalents. Those are new jobs. We have used those posts in Lanarkshire and with other health board partners. As you know, we have centres that go way beyond Lanarkshire, in the west of Scotland and in the city of Edinburgh.

We have recruited the individuals from a combination of sources. Some of them come from the external market and some of them are from our own redeployment register, on which are staff who have been affected by organisational change and find themselves in temporary roles or roles that are not as fulfilling as others. We use those opportunities.

We also use opportunities to offer alternatives for staff who find themselves unable to undertake other substantial roles within the NHS for reasons of fitness to practise. Our experience—the evidence is there to be seen—is that delivery against the aspiration to add substantive income and roles to the NHS in Scotland has been successful. It will continue to be increasingly successful as we flex the workforce to meet the demands of the number of assessments as that number grows.

Reputationally, from the perspective of Salus and its link with NHS Lanarkshire, the role that we are fulfilling—given the evidence that we are getting back from Atos and the DWP's analysis of our performance—stands testing against anyone in the UK. The complaints that Mark Kennedy mentioned account for something like 0.0007 per cent of activity. The majority of the complaints have been about people not being able properly to read the map telling them where to go to get the assessments, so those are, arguably, not even complaints about the quality of the interaction around the assessment anyway. However, you can be confident that we are doing something about making those maps better.

From the perspective of the ethos of the NHS and adding value, we are delivering that. As you would imagine, we are keen to ensure that that continues.

Mark Kennedy: The whole structure within Salus has been set up to mirror the NHS. There is no concierge at our sites, and there is no security—they run like out-patients departments. In general, judging from the feedback that I am getting from Atos and the DWP, people are respectful of that and are happy with that.

When our nurses and practitioners are trained, they are constantly reminded that they are working for the NHS; they are performing a public service. The people whom they are assessing are the same as the people who come through the door of the general practice or wherever practitioners had their previous jobs, and they should be treated with equal respect.

It is hard not to go into the nitty-gritty stuff. We are trying to instil a caring ethos around what we are doing. We accept that it cannot be easy for individuals to present themselves for disability assessments, so it is our job to make it as painless as possible for them. We believe that we are doing that to a high degree. I do not have any alarm bells ringing as far as complaints are concerned.

Jamie Hepburn: That is helpful, Mr Kennedy. Thank you.

In your paper, you say that

"the consultation duration is determined by the claimant. The claimant should be satisfied that they have had enough time to provide an accurate account of their position."

How does that work in practice? No one can be told, "Your time's up. Go now." Is that correct?

Mark Kennedy: Yes—that is the case at the moment. Our average appointment time is about 90 to 110 minutes. On any given day, some people might need to be there only for an hour, while others might require two hours. At the moment, our challenge is to manage that flux as best we can while respecting the needs of the individual.

We do not close people down. As you know, the health practitioners are trained to ask probing questions. If a person is going off track or off at a tangent, the practitioners are trained to bring the discussion back to the person's functionality and how they are performing. As Kenny Small said, the whole approach is fairly simplistic. The person sits down and tells us what happens, from the moment they open their eyes in the morning until they go back to bed, during their average day and what happens during their most difficult day. However long that takes is how long it takes to deliver the assessment.

Jamie Hepburn: You have said a couple of times that the average appointment time is 90 to 110 minutes. I take on board your point that that allows for a fairly comprehensive assessment.

On the flip side, I note that the Scottish social security consortium expressed concern to you that the duration can be too long for some disabled

people. How do you square that circle? I know that it is not an easy thing to do.

Mark Kennedy: We are trying to instil in our staff the need to make a judgment. If people become repetitive, we can intervene and say, "Have you anything to add that you have not said, or do you want to stress any point?"

Interestingly, when the consultation came up we went through the whole journey for the individual—including the assessment process—in detail. I have to agree that it is a lot to ask of someone to come and sit in front of us and explain their day for two hours, so we try to keep appointments under two hours. We are very much aware that the process must be driven by the individual; we do not want accusations about people not being allowed to tell their story fully. We manage the process at present within our appointments system. If one person takes a long time, we live in hope that someone else will not, so that we can shuffle things.

A lot of the changes post Atos and the consultation process have been about the efficiency of the process with regard to IT. Those have given us an extra 15 or 20 minutes that we did not have in the early days of the programme.

There have not been many episodes in which the process has gone over two hours—at least, not that I have been told about. The vast majority of assessments last about an hour and a half. We are not actively seeking to push the duration lower because that is about the optimum length.

Kenny Small: That brings us back to the potential added value from the NHS. The NHS health professionals are trained to speak to people in a language that they understand and to test and search people during communication without appearing to do so. That is where we genuinely add value. The core element of a health professional's training is about communicating and engaging with people in a meaningful way. Although we have added to that training, the core training has been really important in the success of our experience to date.

Jamie Hepburn: That begets another question, which occurred to me earlier when you answered my first question. There could be another advantage, given that the process takes place in the NHS environment. Do your professionals who undertake the assessments pick up on other issues, and are they able to refer individuals to other parts of the NHS?

Mark Kennedy: Yes. As part of the NHS, we are unique in that we still have a duty of care to any individual who presents in front of us. We ask anyone with suicidal ideation or any chronic complaint that we think requires further examination, for example, to contact their general practitioner immediately. We function in the same way that any other out-patient department of the NHS would.

Jamie Hepburn: That is helpful. I have one final question. We have heard that you have had few complaints and you said that you have so far not been sanctioned with any penalty credits. I do not know how much you want to tell us about that, although it is obviously good for Salus. What are the arrangements and circumstances in which those credits can be applied? How does all that work?

Mark Kennedy: The contractual agreement with Salus involves service credits—or penalty credits—around quality measures. For example, if someone waits more than 30 minutes, there will be a charge—or a reduction in payment—to Salus. They are performance drivers; none of them affects the duration of the assessment.

Some of them relate to the quality of the reporting. We submit reports to the DWP that are banded as either A, B or C. An A is a fabulous report that gives the DWP all the detail that it requires; a B is a report that, with some fine tuning, could be better and of more value; and a C is what the DWP determines to be a failed report, with something fundamental in the assessment that needs to be changed.

We have threshold levels on those measures. If more than 5 per cent of the reports that we submit are band C reports, there is a penalty. The penalty credits are key performance indicators, and to date we have not invoked any.

Linda Fabiani (East Kilbride) (SNP): I want to go back to a point that the convener raised at the start of the meeting. Mark Kennedy said that Salus had not received any formal reporting back from the DWP. What is the system for that formal reporting? Is it based on a timescale, with the DWP reporting back every so often, or does the DWP report back after a certain number of assessments? What form will the reporting back take and what do you expect to get from it?

Mark Kennedy: That is a good question. We are interested in that as well, because such reports might help us with regard to quality, depending on what is in them. At the moment, there is a contractual arrangement between Atos and the DWP for reporting—there is no direct mechanism between the DWP and Salus for that. However, I hope that the DWP will soon be reporting early findings on PIP in the public arena, which we could perhaps drill into, as our work will represent a percentage of that.

We get informal reports from Atos on the claimant journey and satisfaction as well as management information about the number of slots and stuff like that. We do not yet get any

qualitative evidence from Atos, but we are saying up front that, as a public sector body, we would appreciate such evidence.

Linda Fabiani: So you do not get back, for example, statistics on the decisions that are taken and other things relating to your assessments. Would you expect that to happen in future?

Mark Kennedy: No, not within our contractual agreement but, obviously, it is something that we are interested in. To my knowledge, there has not been a formal report on that, although members around the table may know more about that than I do. I have not had anything other than informal rhetoric from the DWP.

Linda Fabiani: Would it be useful to have that information?

Mark Kennedy: I would like to know. I am not quite sure what we would do with just a flat statistical report, but yes, it would be good to know how many decisions are made in relation to our reports.

Kenny Small: As Mark Kennedy described earlier, the feedback that we get in relation to the qualitative measurement of the assessment process is very useful, because we have a system in place that allows us to track things right down to the individual health professional who is undertaking those assessments. Obviously, if there is a need to order further development training for an individual to improve their assessment process, we would want to know right away so that we could take immediate action in that respect. In terms of the quality of the input, some of the feedback that we are getting is very helpful indeed.

Linda Fabiani: On another tack, I was really pleased about the consultation that you undertook at the start of the process with the disability groups and so on. It seems as though that has been fairly successful. Do you intend to undertake such consultations regularly—or, indeed, irregularly—to find out what the perception is of your work?

Mark Kennedy: Yes. I intend to have a further event in September and to hold at least one workshop annually on what the process involves. It would be good for us because, at the moment, we are reliant on customer feedback from the contractor and it is a wide sample. We know that word of mouth and local working are valuable. By September, the organisations that we consulted should have engaged with a lot of people who will have been through PIP and who will have either had a decision or not, so the workshop in September will probably be to find out what people are telling the organisations. There is a learning issue for us in that regard.

I am very interested in people's experiences when entering and leaving Salus premises. We will not have any influence over changing any element of the assessment, but I am interested in people's experience when they come through the door. I have to ensure that that experience is as good as it can be. We will invite people back annually and will probably do so in September this year.

Ken Macintosh (Eastwood) (Lab): Sorry if I am going back to basics, but I want to confirm that although you assess claimants, the decision on how an assessment affects their benefits is made by Atos or by the DWP. Do they share any of that information with you? Do you know at all which parts of the assessments that you carry out trigger changes in benefit assessment?

Mark Kennedy: We do all the assessments. The DWP makes the decisions. Atos does not make the decisions. In an assessment, we talk through the client's normal day and we agree on the best descriptor of the opportunity that they have—whether they are eating, sleeping and walking, for example. The descriptors are scored. I assume that the DWP adds up those scores at the end of the day and makes a decision based on the score and on the qualitative information that is provided. We do not encourage our staff to look at numbers at all—we just train them. The purpose of their role is to ensure that the best descriptor is chosen. We do not get any feedback on the decision making, which is all done by the DWP. Although we have put 7,000 people through the assessment process, I currently have no knowledge even of how many of them have had a decision.

10:30

Ken Macintosh: You try to ensure that each of the assessors is conducting assessments according to the same criteria each time and that they are scoring in a suitable way compared with one another for each claimant. You have no knowledge about how the information is used. Will you be told at some point? There is clearly a big dilemma involved in being a caring service and a gatekeeper. Will you be given information about how the scores trigger claimant—

Mark Kennedy: No. We have a contractual commercial arrangement. Like anybody else, we will have access to information when the DWP reports it. I will never get a report back—nor should I, you might argue—stating that, out of the so many thousand people whom we have assessed, X have been successful in their claims.

Ken Macintosh: You have received a very low number of complaints about your service, which must be very gratifying. Whereas that is simply an

assessment of the professionalism and care that you are providing, the individual concerned might still be extremely unhappy with the decision that they face. Their complaint about that would go to the DWP or Atos, not to you. Is that right?

Mark Kennedy: That would go to the DWP. I imagine that it would have to report—as it has done previously for work capability assessments—how many of the negative decisions went to appeal, how many were upheld and so on.

Ken Macintosh: When the patients—do you call them patients or claimants?

Mark Kennedy: We call them patients, but that is because we are the NHS.

Ken Macintosh: When patients come to see you, do they view your assessment as an interrogation? Do they know how much it matters for their benefit claim?

Mark Kennedy: They know how much it matters to their benefit claim. The importance of their visit is not lost on them. There is obviously a degree of anxiety on the part of anybody undergoing an assessment. That is the whole idea behind using the NHS ethos and quality NHS staff. It is our job to try to relax people and to make the assessment as non-threatening as possible, so that we can do a good assessment. That is what we aim to do. People are not naive when they come to the assessment centres.

Ken Macintosh: It is a very difficult thing to capture, but the idea is that you are a fair, impartial assessor. You are neither the setter of the criteria nor the judge and jury. You are simply carrying out a process that will be fair and will treat all claimants in the same way.

Mark Kennedy: Yes.

Ken Macintosh: Do you think that you have put that across well?

Mark Kennedy: Yes. As Kenny Small says, when we start to submit assessment reports, problematic reports are flagged up to us. It is very easy to identify whether one of our assessors is struggling with the individuals in front of them or with how to proceed. They will get more intensive training and support in order to improve. We have some quality measures that give us enough reassurance to know whether we are doing a good job.

Ken Macintosh: Are you aware whether any of the delays that have beset the larger programme concern your part of it? Do you simply provide slots, which are filled?

Mark Kennedy: I am aware that there is a backlog—although that is not from our perspective. There is a significant period of time for the patients between submitting their claim to the DWP and getting to Salus. We do not control or influence that. We provide our appointments a month in advance. We rely on Atos filling the appointments. We do not influence how quickly the paper trail comes through the DWP to Atos to us.

Ken Macintosh: Are people allowed to bring somebody with them?

Mark Kennedy: Yes. They are encouraged to do so.

Annabelle Ewing (Mid Scotland and Fife) (SNP): Good morning, gentlemen. I have a few questions. Do you have a rough estimate of the total number of claimants or patients in Scotland who are currently covered by the Salus contract? Do you have any idea how the Salus component fits in with respect to the rest, which is Atos?

Mark Kennedy: I am told that about 55 or 56 per cent of the total is covered by Salus.

Annabelle Ewing: We have heard already that you are not aware of the outcomes for the individual. How do the outcomes for Salus compare with the Atos outcomes, in terms of both the result and how long it takes to get to see somebody? I have a constituent in Fife—to whom I referred on a confidential basis in a debate in the Parliament the other week—who waited four and a half to five months to get an assessment from Atos, notwithstanding that they had had major surgical intervention. I hope that the situation is not the same on the Salus side of things.

Mark Kennedy: I would not know, to be perfectly honest, because a case has to be processed through Atos prior to coming to me. I suspect that the people who come to Salus wait for a degree of time before their appointment. However, they are written to probably about a month before their appointment with Salus—that is the only bit that I can influence. Maybe my submission does not mention that we have a do not attend rate of around a fifth, so one person in five does not appear on the day and needs to have their appointment rescheduled. The waiting time from a person's original submission is too long.

Annabelle Ewing: Is there a possibility of a home visit if the circumstances require that?

Mark Kennedy: Yes. I should clarify that Salus provides only face-to-face assessments at the venues mentioned, but there are two other processes for assessment. One is to do with a very quick turnaround for people with critical illness and terminal illness, for whom Atos does a paper referral. Also, Atos deals with anybody whom it assesses as requiring a domiciliary assessment.

Annabelle Ewing: On the part of the process that you are engaged in, you referred to the descriptor approach and to the fact that qualitative information is also included. Can you provide a wee bit more information? In an average case, when you see a patient for their assessment, to what extent would additional written information be provided in relation to a descriptor? Our confidence in the descriptor approach, at least in the case of the work capability assessment, is not very high, because it does not seem to allow you to give additional relevant information.

Mark Kennedy: There are two aspects. There is the choice of the descriptor, which is a process in itself. The health practitioner then has to justify why that descriptor has been chosen. If we submit C level—unsatisfactory—reports, Atos and the DWP returns them to us saying that the justification did not meet the choice. We have to put a bit of work in to say, "We have chosen this descriptor—this is the rationale for why we have done so." The health practitioner will write things such as, "The client has, on two occasions or frequently, stated, 'Blah, blah, blah'." The health practitioner has to justify their choice. There are a number of descriptors and, at the end of the assessment, the practitioner also has to summarise all the descriptors. There is therefore a second test—if you like—in the write-up, as it has to marry the small summary with the descriptors.

I think that Atos and the DWP might be looking at the second summary, which is like a short essay on why all the descriptors have been chosen, with a view to refining it somewhat. We have to provide more evidence than just ticking a box to say, "This is the descriptor chosen." The health practitioner has to demonstrate why they chose it. The DWP then assesses the decision on the descriptor to see whether the descriptor is relevant and feeds back to us directly if it is not, so there is a check.

Annabelle Ewing: I have one last question at this point. In the case of the work capability assessment, which we have been trying to get to the bottom of, the more hard-and-fast medical information—stricto sensu—is enclosed with the application, the better the applicant seems to fare. How does that work with respect to Salus, given that it is an arm of the NHS in Scotland?

Mark Kennedy: The same opportunity is given to the patient when they attend. They are invited by the DWP to submit further medical evidence of their claim to the DWP and, if they have a further submission, to bring it to Salus. Patients arrive with poly bags full of evidence, of varying sophistication. We are duty bound—and contractually bound, although we would do it anyway—to review every piece of evidence that comes in. That has been an issue affecting the duration of assessments. If someone arrives for an assessment with 40 pieces of evidence, we have to log and consider that evidence.

We are encouraging the DWP, or Atos, via a number of partners, to try to give more detail to claimants on what would be regarded as priority evidence. People can arrive with something as simple as a receipt from a taxi, saying, "I need to use a taxi to get to places," or they might have a two-page letter from a GP that contains strong advice—people bring everything. We are asking the DWP to give a wee bit more advice to people about what would help their claim. The evidence has to be assessed and is part of the assessment.

Kevin Stewart (Aberdeen Central) (SNP): We have information that the administration cost for disability living allowance was £49 per claim, compared with £182 per claim for PIP, and that the average decision time on a new claim for DLA was 37 days whereas for PIP it is 74 days. In your response to Mr Macintosh, you said that the timescales are mostly out of your hands and are governed by the DWP and Atos. Does that reflect on Salus? Do folk come into your office and moan about the bureaucracy around the new process and how long they have had to wait?

Mark Kennedy: We have occasionally—more than occasionally—had individuals come to reception and say, "I'm so glad to be here, because it's taken so long to get here." That is why I said that the wait is too long. It would not be acceptable in the NHS; why is it acceptable in this process? You are right that I have no control over how that works, given the arrangement that we have.

Kevin Stewart: Do you go back to Atos and the DWP to tell them what folks have said?

Mark Kennedy: Yes.

Kevin Stewart: You do. You said that folks would not have to wait as long for an NHS appointment. You are an offshoot of the NHS. How do folks react to that? They sometimes do not get that there is a difference.

Mark Kennedy: I can say anecdotally that more patients or claimants come through our doors saying that they are happy that we are doing the assessment and not someone else. There is an acceptance of us and—I think rightly—a degree of trust about how the NHS will perform.

On whether the wait could be shorter, because the work is commercially contracted via the DWP we can only make recommendations. We feed back our major concerns to Atos monthly, and a concern that people consistently mention is the length of and delays in the process. I should say that I have no idea how long it takes for a decision

maker to process a case once Salus has assessed the individual.

We are in an unusual position, in that, if we owned the process end to end, we would actively look to make it more efficient—

Kevin Stewart: If you owned it end to end, do you think that the average waiting time for a claim would not have doubled?

Mark Kennedy: I would like to think so.

Kevin Stewart: That is extremely useful. I think that it was Mr Small who said at the start of the meeting—I paraphrase—that NHS officials are trained to deal with patients and have the right level of communication. Sessions that we have had with Atos and the DWP have led us to conclude that communication is a major failing in relation to the assessments. Have you indicated to Atos and the DWP the differences between your style and theirs in order to bring others up to the standards that you seem to have in this regard?

10:45

Kenny Small: In the conversations that I have had with Atos and with Mark Kennedy and his colleagues, we have looked at the issue almost from the other end of the telescope. I think that Atos acknowledges the added value that the NHS brings. It certainly seems to recognise Salus's performance on communication and delivery relative to performance elsewhere in the UK. In conversation with Atos we have discussed how it might prefer to run the entire contract throughout the UK, or indeed throughout Scotland. However, for the NHS or the public sector to become more involved in this work would require either a change in approach or a change in interest.

Kevin Stewart: I will be a bit naughty here—I know that Mr Small may not be able to answer this. Are you describing a situation that would be best dealt with by the NHS rather than through private contracts?

Kenny Small: I would not necessarily go as far as that. However, as we have seen it from the outset, and as we articulated when we first came before the committee, the NHS is in a very strong position because of our training and skills—as you have described them—and the ability of our staff to get the best out of people when they are in the pressurised situation that Mark Kennedy described of giving the information on which we create the assessment. We do not treat this as a business; we treat it as a patient contact. That is part of the reason why it takes so long. It is also part of the reason why we get the quality feedback on the key performance indicators that we do. It almost could not be better.

Kevin Stewart: Mr Kennedy, you talked about logging individual pieces of information that folks bring. One of the things that I have been told—I am sure that colleagues are the same—is that those bits of paper that folks think prove that they have certain difficulties are often disregarded. Have you suggested to colleagues in Atos and the DWP that that logging process should become the norm?

Mark Kennedy: It should already be the norm. We are under contract to record every piece of evidence that comes with the client.

To return to my previous response on that issue, I was suggesting that there is a vast range of information, some of which carries more weight than others. We asked Atos why we could not put that out in the public realm. A letter or substantial report from a healthcare professional will carry a lot of weight in this process. A note from a neighbour to say that they have seen the individual struggle to put their bin out would not carry the same weight, although you could argue that that is a vital piece of information. We are trying to get some clarity about the best form of evidence that someone can present with their claim. I have fed that back to Atos. I am unsure what Atos, via the DWP, has done on that.

Kevin Stewart: Mark Kennedy said that the NHS has a duty of care. Do you feel that other contractors and decision makers in the DWP have a duty of care? If so, do they adhere to it?

Mark Kennedy: To skirt round the question, I would ask you to ask them. We perform a duty of care in this programme.

In relation to your earlier comment, I would love to see our performance relative to that of the other companies throughout the UK. I would welcome that. Whether I will see that, I am not sure.

To add to Kenny Small's response to your earlier question, I remember the discussions at Lanarkshire NHS Board when this process was brought to the table. Most of the discussion centred on the question of what makes us better at doing this than anybody else. I reiterate that the NHS deals with disability every minute of every day. Our view was that no one was better placed to deliver the service in Scotland.

Kevin Stewart: Thank you. That was useful.

Alex Johnstone (North East Scotland) (Con): I have a couple of brief questions that might differ slightly from the others. Will you confirm that you work as subcontractors to Atos?

Mark Kennedy: Yes.

Alex Johnstone: Atos has made it clear that it does not want its contract with the DWP to be

extended. Does that affect your longer-term contractual position?

Mark Kennedy: No. The withdrawal of Atos from work capability assessments involves an entirely different contract.

Alex Johnstone: Given the indication from Atos, have you found anything in the model that you have operated that could be extended to the other areas in which Atos currently works?

Mark Kennedy: I have limited knowledge of the work capability assessment, because we do not have anything to do with it. However, I think that Atos is learning about taking a different approach to the process with the claimant. The process does not need to be as harrowing as it sometimes is.

Atos has commented on bits and pieces. It was surprised that we had no security on site. As I said, we took the view that such individuals access the NHS, so why would we have security? We have several claimants or patients who have been through the work capability assessment process and are now applying for PIP and who have said that the experiences are as different as night and day.

Culturally, Atos or other providers could learn something. The committee will accept that it is not my job to teach them, but it would be nice for a summary to be provided. As the committee knows, Atos will not be involved in work capability assessments in the future, but I am not sure about the rest of its welfare portfolio or its involvement in PIP.

Alex Johnstone: My final question will partly repeat a question that I have asked before. Could an organisation such as Salus be involved in things such as work capability assessments in the future?

Mark Kennedy: To be honest, I am unsure how to answer that. I have said on the record that nobody is better placed to look at an individual's functionality than the NHS. From a clinical point of view, there is no reason why that should not be the case in assessing whether somebody is fit for work. However, like the committee—although maybe not everybody round the table—we are reticent about the current work capability assessment structure. We are making no moves to enter that market at this point.

Kenny Small: The immediate answer to the question, which Mark Kennedy is perhaps embarrassed to give, is that a core part of Salus's job for the staff of NHS Lanarkshire involves workplace capability assessment. Salus is experienced, diligent and successful at conducting that role for NHS Lanarkshire and other employers across Scotland and beyond as part of an occupational health service.

Alex Johnstone: I will ask the same question once more in different words. If Atos was not involved and the contract was up for grabs, could you do the job better?

Kenny Small: I do not think that we can answer that.

Alex Johnstone: I keep trying.

The Convener: I have one more question about the process. I want to compare how Salus operates with how Atos does work capability assessments. It took us a long time to get clarification on the differential between the work that Atos assessment centres do and the work of the decision makers at the DWP. Part of the confusion centred on Atos's reports being sent to claimants, which means that they know the conclusion of the Atos assessments although no decisions have been made. The decisions are made by the decision makers, who can add points to an assessment on the basis of further information.

There was a lot of confusion, because people received reports from Atos that indicated the points that were awarded at their assessment, but that was not the decision—the decision was made later, on the basis of the assessment. Do you have to undertake the same process? Do the claimants that come before Salus receive a report, with or without points attached, based on your assessment?

Mark Kennedy: To the best of my knowledge, they get a report. That report will be provided via the DWP, and I believe that it accompanies the decision making. I might be being naive, but I am not aware of claimants receiving a report prior to a decision being made.

Kenny Small: They do not get one from us.

Mark Kennedy: That is correct—they do not get one from Salus.

The Convener: There was a lot of confusion on that. People told us that they were made aware that Atos had given them certain points. Atos said that it does not make the decision, but that people assumed that it made the decision. It said that it was actually—

Mark Kennedy: I see your point. All that I can say is that, fundamentally, Salus does not provide anyone who has been assessed with a report. I am uncertain what Atos does with the report, but I cannot see any reason to provide someone with a scored report without a yes or no decision accompanying it.

The Convener: I asked that question just in case any of the same confusion was occurring in

relation to the PIP assessments. I wondered whether you had identified any of the same problems.

Mark Kennedy: If you do not mind, I will clarify that and get back to you later.

The Convener: It would be helpful if you could do that. As I said, it took us a long time to pin down exactly why the confusion was occurring. People told us that Atos had decided that they were not to receive the benefit, but Atos did not make the decision. People were being given their reports, which indicated what the Atos assessment had concluded in terms of points. However, that was not necessarily what the DWP decision makers had decided. That created quite a bit of confusion, and a lot of claimants had difficulty coming to terms with the difference between the report that they received and the final decision.

Mark Kennedy: I suppose that the detail of that would be in the contract between Atos and the DWP. I am not aware of Atos having that behaviour with regard to PIP, but I will clarify whether that is the case.

The Convener: Just to clarify, the confusion led to Atos being blamed for many decisions that had, in fact, been made by the DWP. I am concerned to ensure that the responsibility for the assessments lies with those who make the decisions. It is the DWP that is responsible, not Salus, as a subcontractor for Atos, or Atos itself. It is vital that we ensure that people are aware that the decisions are made by the DWP and that it is the assessments of the DWP that are in operation.

Mark Kennedy: Our health assessors feed back that point to the patient when they arrive, in order to put their mind at rest by letting them know that it will not be the individual who is in front of them who will make a judgment. We explain that it is done by the DWP.

The Convener: Do you have any other comments that you would like to make? Is there anything that we have not covered that you would like to make us aware of?

Mark Kennedy: There is only the fact that the natural reassessment of the DLA is due to commence around October. At that point, individuals who are currently in receipt of benefit will come for assessment. I want to put on record that the importance of that is not lost on us. That will be a difficult time for the claimants and possibly for Salus in doing our job to objectively assess people. However, I am told that that does not come into play until October.

The Convener: We will watch out for that. You might find yourself being invited to come back to tell us how things are progressing. We certainly want to keep on top of the matter. Officials from the DWP and representatives from Atos have appeared before us a number of times to give us updates. If things are going well with the application of the process by Salus, that is all well and good. However, the committee wants to make sure that that continues. If you want to come back to us with good news, we will give you the opportunity to do so at some point in the future.

Kenny Small: The only thing that I would add is to repeat the invitation to MSPs to visit any of the sites. One or two of your colleagues have come to Glasgow and have found that useful. The only difficulty is that, although you can see the site and how it operates, you cannot necessarily speak to the clients or patients unless they are prepared to speak to you.

The Convener: That is helpful and we will probably take you up on that. We have gone out to all the other centres and have made sure that we are as aware of the process as we can be, so that our deliberations are as informed as we can make them.

I thank you both for taking the time to come to the committee this morning—we appreciate it.

10:59

Meeting suspended.

11:03

On resuming—

Food Banks (Scotland Week 2014 Visits)

The Convener: We move to agenda item 3. As members will recall, Linda Fabiani was going to North America, so we gave her a mission—which she chose to accept before the recording self-destructed—to see how food banks work over there. I ask her to report back, after which I will give colleagues the opportunity to discuss what she discovered.

Linda Fabiani: I was out in North America in April during Scotland week, so I took the opportunity to visit the New York City human resources administration/department of social services and, when I was in Toronto, the Ontario Association of Food Banks.

In New York, I met the team of Cecile Noel, who is the executive deputy commissioner with emergency and intervention services. I will cover the main points that came out of that meeting. The department provides adult protective services and is a cover-all, which means that food provision and domestic violence are dealt with by the same department. The department has what it calls emergency feeding services, which are interesting; they provide 500 programmes of food bank support in New York City, or about 50 per cent of the support in the city.

The services receive state and federal funding amounting to the equivalent of £8.3 million for the food banks. Most of that goes on providing food pantries; 25 per cent of it is used to provide soup kitchens as we imagine them to be—that is, specific places where people turn up to be fed. Recently, there has been a fairly sharp increase in families using the services whereas, in the past, single people have always been the main client group.

The services also operate a food stamp scheme, and they have introduced a debit card scheme that they hope will cut down on the corruption that has existed—mainly, I should say, on the part of the retail outlets rather than the individuals receiving the food stamps. In the scheme, a supplement is put on to a debit card, which can be used at any store. However, the services are already finding that some malpractice is occurring.

More than 1.5 million New Yorkers receive food stamps. Income-based eligibility criteria are applied to the debit card scheme, which is used by 1.8 million people. The maximum amount is $189 per month, per person; the amount depends on the size of the client's household, their expenses and their income. People can use both the debit card and food banks. Food banks are non-judgmental: people just turn up and no questions are asked about whether they are in receipt of anything else.

The services have also started a food stamp nutrition outreach programme to try to educate people about food. They work closely with supermarkets and other food companies to increase donations of healthy, nutritious food, and they have also started cooking classes and workshops. All of that is run under an umbrella organisation called Food Bank For New York City, and there is a formal arrangement with supermarkets to offload surplus food.

What really struck me about the New York City experience was that that kind of food provision is just part of the fabric of what happens; it is part of what seems to be a social service. There was no real strategic approach to it, just a reliance on the voluntary sector to plug the gaps and an expectation that that would happen because it has been ever thus.

Toronto was a bit different. The Ontario Association of Food Banks, which was set up in 1992, is voluntary; it receives no Government funding and is completely autonomous. Individual food banks affiliate to it. It struck me that our own experience—limited though it is—suggests that the Trussell Trust is moving towards the same model.

The association has 127 food banks as members and 1,100 affiliates for hunger relief programmes, with agencies across the province. The association's approach is more holistic than the approach that I found in New York City. It is trying to address the root causes of hunger; like others, it talks about sustainable solutions, and it wants to make food bank use unnecessary. The first Canadian food bank started in 1982 and the association told me that, since then, food banks have gone from being a temporary solution to being a need.

The association grew from the grass roots and, like so many of these things, was born out of the church system. People can go to a food bank once a month and receive three to four days' food, which is intended to get them to the end of the month. Although the association is not judgmental, it does have a limit on how many visits someone can make to a food bank.

The association said that there were particular issues in rural areas. In an earlier evidence session, the committee heard about similar issues in rural areas of Scotland with regard to stigma and the loss of dignity associated with everyone knowing that a person is using a food bank.

The association does not do food stamps or vouchers. The food banks themselves serve 2.8 per cent of the population in Toronto; there has been a big increase in their use, with households coming for the first time. The primary source of income for 69 per cent of clients is social assistance and disability support. The association said that most recipients are rental tenants, who spend 71 per cent of their income on housing. I thought that that statistic was really high. I know that house rents in Ontario can cover utilities and some furniture, but we tend not to include those things in rents here and we had no breakdown to enable us to make a comparison.

The association has a varied clientele. The average food bank user uses the service for one year to 18 months, and the association reckons that less than 5 per cent of their users are long term. As for what has driven demand since 2008, I note that food bank use increased by 28 per cent between 2008 and 2009, and it has not fallen since. I guess that the association was suggesting that the impact of the recession led to the increase, but the fact is that the recession was relatively mild in Canada compared with other places. The current politics of those in control in Ontario might also account for some of that increase.

As I said earlier, the Ontario Association of Food Banks takes a holistic approach; for example, it campaigns on these issues because it sees the use of food banks as a symptom of poverty. It is trying to create community hubs to address the wider issues; it is also focusing on promoting healthy food, and it works with Canada's five major grocery chains.

The conclusion was that food banks are plugging the gaps in state provision. Although the association felt that there was a danger of food banks becoming institutionalised mainstream support, it also recognised that, given that the use of food banks has done nothing but increase since they began in 1982, they might already have become mainstream support and are becoming institutionalised, despite the fact that neither local nor national Government gives them direct support.

The association also told us that people automatically give to food banks. Having visited my family over there, which I do quite often, I have picked up the same thing. It is just something that is done; because people see it as one of their responsibilities, it just happens. Moreover, under the Ontario Local Food Act, 2013, farmers can claim a 25 per cent tax credit based on the fair market value of the food that they donate to food banks and other charitable meal programmes. As a result, farmers are supplying food banks directly.

The Ontario Association of Food Banks thought that we should get firm information to monitor trends in use, the characteristics of food bank users and so on. The association has started to do that comparatively recently, and it has been surprised at the findings. We have already heard evidence of that kind of work being done. The association also thought that we should set standards for use. For example, people should be fed on the basis of need, not on any other criteria, and there should be a code of conduct to ensure that people are treated decently.

I will conclude my report with my own views. I found some of what I discovered quite depressing because of the evidence that we have heard about what is happening here in Scotland. When I looked at the situation, I almost found myself thinking that, unless some very big change happens here, that is the road down which we are heading.

From what I could see, the big difference between New York City and Ontario was that people in New York City, even at official level, did not really get what I was saying about our worries about food bank use becoming mainstream and institutionalised. I suppose that it has always been that way for them, and they did not really understand the distinction. It was very telling that the Ontario Association of Food Banks absolutely got what I was saying, and that it was frustrated that it had suffered from provision creep and that food bank use had become institutionalised without anybody noticing.

That is the big warning for us. If we do not want that sort of thing in our society, we have to get a big warning out there, and we should fight very hard against getting pulled into an attitude of "This is just the way things are," or "This is just what happens."

11:15

The Convener: That sounds very interesting, Linda. I have an observation, rather than a question. With regard to your final comments, I was reading an article a little while ago that discussed people's different views of the system. We take great pride in having a welfare system, and we provide a lot of things because we believe that that is what society should do. We take great pride in the benefits system, free school meals and the various other things that are provided. However, there is always a sense that those who are in receipt of the benefits and who have to make the claims feel stigmatised and do not want to be in that position; indeed, there is a sense of shame that we need food banks. In other parts of the world, however, there is a sense of pride in their provision. It is a cultural thing. Is that what you picked up? Contained in all of that, of course,

is the danger that food bank use becomes institutionalised.

Linda Fabiani: You are absolutely right, convener. Please excuse my personalising the issues, but I discussed the matter seriously with some of my Canadian relatives, who, through their local church, are very supportive of food banks. I tried to put across the points that you have highlighted, but they are proud of the fact that their church does so much and that their children automatically help in the same way that they do. As we talked about the issue further, they realised that they had made food bank use normal, and that there were people who were relying on charitable handouts. That made them think a bit. The danger is that we get into the same culture.

I am proud of the fact that Loaves & Fishes, which is run by Denis and Cathy Curran, and some of the local churches do such great work. However, the reality is that there will always be people who, for whatever reason, need that kind of provision for a short time or perhaps for longer. Denis Curran told us that the client group had changed, and that is what we must guard against. Basically, we should be saying that no families or children should be going hungry in our towns, cities or rural areas. We must guard against institutionalising that. What I have called food bank creep has happened in Ontario and perhaps other parts of Canada, and it is certainly not something that I want to see here.

Ken Macintosh: You made it clear that the biggest recent rise in the use of food banks in Canada happened as a result of the recession. It is rather unfair to ask you this—you were just visiting the areas in question, and you would not have been able to do any research on the matter—but are you aware of any welfare changes in the Canadian system? There is evidence from Germany, for example, that the welfare changes there have driven a huge increase in food bank use.

Linda Fabiani: I have talked about what I heard directly from the officers of the Ontario Association of Food Banks; I cannot speak from the basis of research that has been carried out on such matters. Anecdotally, I can tell you that there have been changes over the past few years, certainly to the Ontario welfare system. I know that some of them have been driven at a federal level down to the provinces, but I do not have the knowledge to comment on whether that has had a direct effect.

Ken Macintosh: It is very interesting to consider the interaction between the state and voluntary programmes, as well as the danger of what you have called food bank creep and whether we wish to support that actively or to go in a different direction.

Alex Johnstone: I have been interested in what Linda Fabiani has had to say about the Canadian experience in particular, and the suggestion that the recession might have caused the increase in demand. It worries me that the effect of the creep that she has described is that, when there is pressure from increased demand, demand increases but, when that pressure ceases, demand does not reduce proportionally. I wonder whether we can find examples of countries where demand has been significantly managed down at any time.

The Convener: We have a helpful briefing on food banks from the Scottish Parliament information centre. If SPICe continues to monitor the situation, we will welcome any evidence that it comes up with. I will speak to SPICe and see whether more work can be done, but, as I have said, I have found its briefing on food banks quite helpful. The SPICe documents guided me to other articles, and I am sure that SPICe will keep an eye on the issue and let us have any relevant information.

Ken Macintosh: I believe that we were going to talk about that in an informal session, because SPICe is not at the table just now to give us evidence. My own thoughts are that the evidence from Germany shows that, on the face of it, welfare change had a lot to do with the increase in food bank use, and Linda Fabiani alluded to anecdotal evidence about the effect of welfare changes in Canada that accompanied the recession.

Perhaps we should discuss this in private session, but it might be worth carrying out a literature review, because it could be important for our own report on food banks, particularly the relationship between the rise in food banks, the recession and welfare changes. There seem to be parallels here. The American situation might be slightly different, but the Canadian and German examples certainly seem to have useful information that we could share.

The Convener: We can take that up when we look at our report on food banks and at information that can assist us.

Annual Report

11:21

The Convener: Agenda item 4 is consideration of our annual report. The process itself is very standardised; there is a format for creating the report every year. Now that we have had a chance to see the report, I ask members whether they are happy with its content.

Jamie Hepburn: I am entirely happy with the content of the report. My only thought was that we could add a little more to the engagement and innovation section to reflect the number of informal visits that we have undertaken over the year. For example, convener, Ken Macintosh and I visited Deafblind Scotland in Lenzie, I visited New Horizons Borders in Galashiels, you and Annabelle Ewing visited the Glasgow Disability Alliance and a number of us went to food banks in our own constituencies. Perhaps our report would benefit from reflecting that activity.

The Convener: I think that the clerks would be happy to do that.

Alex Johnstone: The only thing that I would ask is that the report note my objection, as previously mentioned, to the use of the term “bedroom tax”.

The Convener: We will work that in as usual.

If there are no further comments, we will now, as agreed at the start of the meeting, move into private session.

11:23

Meeting continued in private until 11:40.

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