

Section 23 Report "Community Health Partnerships"

11:04

The Convener: For the next item, Barbara Hurst will be joined by her colleagues Claire Sweeney and Carolyn Smith. I invite Barbara Hurst to make opening remarks.

Barbara Hurst: This is the first performance audit report that we have published since the election. It is fair to say that it was a difficult piece of work, largely because auditing partnerships is difficult. As well as having to look at different bodies, the softer issues around culture, leadership and the like made it a challenging report.

It is a joint report for the Auditor General for Scotland and the Accounts Commission. Clearly, in order for health services and councils to make the best use of their resources, they need to work well together, particularly around health and social care. I understand that the Christie commission report, which is published today, also looks at some of those issues. In that context, our report is topical.

Community health partnerships were introduced under the NHS (Reform) (Scotland) Act 2004 as statutory committees or sub-committees of health boards. The legislation requires every health board to have at least one CHP for the area of the board. The audit looked at the 36 CHPs that were in place when we started the audit. The number of CHPs seems to change by the day, so Carolyn Smith may well have a more up-to-date picture of how many there currently are.

I will highlight a number of key issues from the report. Since devolution, there have been a number of initiatives to improve partnership working between health and social care. We had general practitioner-led local health care co-operatives, which moved into joint future partnerships. We had the introduction of community planning and we have CHPs. However, those approaches have been incremental, and we found that there is a bit of a cluttered landscape around partnerships for health and social care, which we think needs tidying up because it looks like there is some duplication. Having different partnerships all doing the same things is possibly not the best way of working in partnership.

CHPs were introduced with a very challenging agenda in that they needed not only to improve the links between primary and community-based health services and the acute health services, but to bring together health and social care services so that people who use them can access them more easily. CHPs were expected to move care out of hospitals and into the community, and to improve quality of life for local people. Our report highlights that they have had varied success in meeting that agenda. However, it is fair to say that no one body could have done that on its own, anyway. That is why it is so important that all this joins up.

Essentially, there are two types of community health partnership: the health-only structure and an integrated health and social care structure. We found that, irrespective of the structure, effective partnership working depended on good local relationships, a shared commitment and clarity of purpose. A structural solution may therefore not be the answer, because lots of other issues need to be taken into account.

We recognised that partnership working can be difficult and that strong leadership is needed from both boards and councils for the effective joining up of health and social care. We found that the governance and accountability arrangements are complex and not always clear, particularly for those that are integrated structures.

Exhibit 1 in the key messages document sets out the key principles for successful partnership working that we believe all partners should apply. We certainly hope that boards and councils will find the principles useful in strengthening local arrangements. Around £13 billion was spent on health and social work in Scotland in 2009-10 and CHPs managed just over £3 billion of that, although that may well be an underestimate as it was quite difficult to pin down the resources.

We believe that boards and councils need a much better understanding of how they are using their combined resources—budgets and staff—so that they can continue to improve services. We know that the Government is leading a national project aimed at getting a much better handle on what shared resources go into services. We believe, though, that further work is needed to improve information at a local level on, for example, knowing your budget, your staffing and the outcomes for people. All that needs much more attention.

Not all CHPs have the strategic role that I outlined earlier. It is fair to say that few are able to influence the way in which resources are used across health and social care. There is also variation in the services and budgets that CHPs manage. It is important to note that we found that the level of engagement between CHPs and GPs and other clinicians needs to improve because the clinicians are the ones who are committing a lot of the resources.

CHPs have been given a key role in improving the health of local populations. We found many good local examples of that happening. However, there has been mixed progress in tackling some of the major challenges, and the Christie commission will be picking up on some of that in the report that it is publishing today.

Over the years—certainly since devolution—dramatic progress has been made in reducing the numbers of people delayed in hospital, but those numbers are beginning to rise again. The number of older people who are admitted to hospital a number of times is also going up. There are some issues around what needs to happen to make some of those indicators go in the right direction.

Joint working around health and social care is in the papers every day, so it is a matter of huge public interest and concern. The Christie commission's report will also address that, and I hope that our report will make a useful contribution to the discussion about how improvements might be made in that area. Everything that has happened, from the dreadful things taking place in care homes through to the care of older people on hospital wards, shows that the area is really important for public services and it cannot be taken lightly.

I will stop there. We are happy to answer any questions.

The Convener: You made a point about delayed discharges. Just this week, I have had another two inquiries from different constituents about elderly relatives being kept in hospital because funding is not available to allow them to be discharged into the community. It is a concern because of the finances involved, because it blocks valuable hospital facilities, and because of the anxiety and stress experienced by the elderly person and their family. It is also a concern because, when elderly people are ready to be discharged back into the community, it is not healthy for them to have a long-term stay in hospital. From family experience and from talking to others, I know that the level of service in care is not always what it should be. People are vulnerable to picking up all sorts of infections. Although our NHS performs miracles in keeping people alive in many circumstances, the long-term care of the elderly in our hospitals is not all that it should be. We really should be getting people back into the community.

The figures are now going in the wrong direction and it is a scandal. That is not too strong a word to use. Given what you have highlighted, do you see any evidence that some action will be taken to address that?

Barbara Hurst: Over the years, we have done a lot of work on services for older people. The problems are not new; they are almost systemic in the way in which some services are organised. The key issue for us is that, if serious action is not taken, there will be a real risk that, given their financial situation, organisations will retreat more into their silos because they will have to manage reduced budgets.

We were trying to look at examples of different organisations sharing their resources. We wanted examples of a much more sensible conversation about how resources were used, rather than examples in which, when one organisation was ready to send a person over to another, that other organisation responded: "We've got no money, so they'll have to wait there."

11:15

I do not have a crystal ball, so I do not know whether changes will happen, but we cannot afford for something not to happen. I agree that hospital is not a good place for people to be if they do not need to be there, although, of course, some people do need to be in hospital. We hope that our report highlights that, rather than institutions retreating into their silos, the sharing of resources must be addressed, because that would be one way to ensure that individuals received the most appropriate care.

The Convener: What you say in the report about community health partnerships is, to be frank, a damning indictment of inefficiency and ineffectiveness throughout Scotland. Although you point out some good practice, the picture is largely very bleak. It is also worrying, given the level of resources that are involved and the implications that you outlined. Is the community health partnership structure capable of being improved?

Barbara Hurst: We tried not to see the situation as a structural issue—although, clearly, that could be the answer—but more to consider how we make the structure work, given that it is in place. It can be made to work through a genuine commitment to services for individuals, rather than—I was going to say “parochial”, but that is the wrong word—protectionism.

Making it work needs a lot of different thinking about how resources are managed. We found that a lot of attention was paid to governance and accountability. Those are, of course, important—we are auditors, for goodness’ sake—but Bob Black would certainly say that they are second-order issues and the main issue is the service. If we want the service to be good, we can make things work. We can put in place the governance and accountability that would make it work, but we do not start there.

The Convener: Are bureaucrats hiding behind titles and structures, while the service to the people for whom they are supposed to care is secondary?

Barbara Hurst: I will not pick up too much on that. The report is challenging for the individuals on the ground, but there are some examples of good practice. Some CHPs are managing it. If we have that in some parts of the country, we can surely replicate it elsewhere.

Tavish Scott: Barbara, there is a career for you in the diplomatic service once you have finished what you are doing now; we heard you loud and clear.

Paragraph 33 of your key messages report says:

“We found only one genuine example of a pooled budget in Scotland.”

What did you find as to why that is?

Carolyn Smith (Audit Scotland): A few organisations gave us examples of pooled budgets that, when we started to examine them, we found to be aligned budgets or some other kind of financial mechanism.

I think that the reason why we found only one pooled budget is that they are difficult to set up and to get out of if the partnership wants to go its separate ways at a later date. There are also more detailed and complicated accounting requirements for pooled budgets. We found that a lot more use was made of them in England and in other parts of the world where resources are pooled. The pooling tended to be where partnerships were more mature and good working relationships had already been established. Services were already being pooled and that was just taken one step further.

Tavish Scott: Does Audit Scotland think that budgets should be pooled in order to drive success in the area?

Carolyn Smith: The report says that pooled budgets are just one way of jointly funding a service and may not always be appropriate. Aligned budgets could work equally well, depending on the situation and what is to be achieved by pooling services. We have examples of that. For instance, East Renfrewshire CHP, which does not have pooled budget arrangements, is achieving similar outcomes

to Clackmannanshire CHP, which does. Pooling budgets is a mechanism for bringing partners together and pooling resources, but it is not the only one.

Tavish Scott: The convener was very fair in saying that the general tone of your report is one of deep worry that the partnerships are not functioning as we all want them to function. Are pooled budgets not the key to making them operate in that way? With pooled budgets, a budget holder is in charge of delivering the objective, whether it is delayed discharges or some of the other things that you highlight in your report. Is that not how we can get the partnerships to work more effectively?

Carolyn Smith: Some service managers are in charge of an aligned budget. For instance, a single service manager could be jointly appointed and responsible for the day-to-day management of the social care and health care budgets. Those are aligned budgets, not pooled budgets. The person with day-to-day management responsibility may need to go up the line to get authorisation from the different organisations but, depending on that person's responsibilities, they could equally get on with pulling the services together through the use of an aligned budget.

Tavish Scott: You have looked at the issue in depth and have seen that the partnerships are clearly not working—that is what your report adequately illustrates to us. Do we not require a review of what financial mechanism drives success? You have not made a recommendation on pooled budgets—that idea is not mentioned in your recommendations. Are we not, therefore, destined to carry on with the same blancmange that we have at the moment, which is—as the convener rightly said—not delivering for the patients? They are the bottom line in this, not the bureaucrats sitting in their ivory towers.

Barbara Hurst: In a sense, pooled budgets are more symbolic—they are obviously symbolic, because there are so few of them. If there is trust and a genuine focus on the individual, it does not matter how it sits as long as there are mechanisms for shifting the money to where it is needed. What will not work is if the budgets for health and social care are kept so separate that no one can say that a better way of delivering the service would be to move a bit from this budget to that one to help a person to stay at home through more innovative services, rather than wait for them to go in and out of hospital because that is where the money is.

You are right that there must be a serious conversation about how those resources are managed for the individual rather than for the blocks of services. Pooled budgets would be one way of doing that, but there may be others. That is why we did not take the matter any further, especially as there is really only one genuine example. That felt a bit too risky. We were more concerned with the cultural issue. Financial mechanisms are needed to provide clear accountability for what is happening to the money, but the thinking could be turned around so that the focus is initially on the individual, rather than the money.

Tavish Scott: To echo Willie Coffey's point, in a year's time how will we know that the situation has got any better? Are you planning to come back to it? Is some review mechanism built in? I take your point that the Government is now trying to drive a process and so on and so forth, but how will the committee know, in a year's time, whether the situation has improved in any way whatever?

Barbara Hurst: Given how much is going on, I think that we would like to step back for the moment. It would simply not be helpful for us to go in and try to audit such a massive amount of change. We know of projects in NHS Highland that are piloting different ways of managing services and the committee might be interested in looking at the results of that type of approach. The area is too big for us not to come back to it in future, but at the moment it is right that we step back. Too much is happening and I am sure that the Parliament will have major discussions about it.

Humza Yousaf: Thank you for the report, which highlights a number of very serious governance issues that the convener and Tavish Scott, among others, have picked up on. When CHPs were first introduced in 2004, the Government felt—quite correctly at the time—that it did not want to be as hands-on as it perhaps should have been and successive Governments have followed the same model to ensure that they are not accused of being top-down and that they do not affect the partnerships' local nature. However, in your report's key messages and recommendations, you seem

to be suggesting that Government should be a lot more hands-on. Is there any danger that such an approach might lead to the loss of that local nature and accusations of interference or of being top-down, or do you think that it is essential in order to pick things up?

Barbara Hurst: You are absolutely right to point out that these services are delivered locally, which means that a local solution is required. However, we feel that Government can play a leadership role in supporting partnerships and ensuring, for example, that the approach to single outcome agreements is genuinely owned across the piece. That might well be one mechanism for getting a partnership to consider different ways of working. I must stress that we are not proposing some form of Stalinist centralisation—I seem to be going all over Europe in my responses—but we think that the Government has a role to play. After all, given how small Scotland is, the way in which these partnerships work is really important to the delivery of not just health and social care but a whole range of different services.

Murdo Fraser: Following on from some of Tavish Scott's questions on governance and accountability, which I feel is a crucial issue, I note Barbara Hurst's earlier comment that the governance and accountability arrangements were complex. Indeed, exhibit 7 on page 21 of the main report portrays what looks like a spider's web of relationships between the NHS, councils, CHPs and various other committees and bodies. The convener was right to call this report damning; given this complex set of arrangements, one has to draw the conclusion that if CHPs were not bound to fail they were at least bound to face very challenging times. What does Audit Scotland think needs to be done to simplify governance and accountability arrangements or is that a broader question that needs to be left to the likes of the Christie commission, which I believe is reporting on this right about now?

Claire Sweeney (Audit Scotland): You are right—this is part of a much bigger issue. One of our key recommendations is that there should be a review of all partnership arrangements in order to be very clear about their focus and purpose and the added value that they bring. Indeed, the report pulls out the distinction between the arrangements in some of the more urban and rural areas, particularly the island boards, where we have looked at the number of arrangements, how appropriate they are and how they work together. Exhibit 7 highlights quite nicely some of the complexities in that respect. It all brings us back to some of Barbara Hurst's earlier comments on being very clear about the added value of the arrangements and what they are trying to achieve.

The report also touches on performance management arrangements, the need to be clear about what success looks like and how to measure the impact of and the improvements made by such arrangements.

It is fair to say that the wide reach of the CHP agenda meant that the team found it difficult at times to think about the key areas that we would examine in determining what success for a CHP arrangement looks like. That is why we started to pull out some of the big health indicators such as delayed discharge and repeat admissions of older people as an emergency.

11:30

We try to get across the message that a clear approach to priorities is needed, that all parties need to be signed up and that strong leadership needs to drive that forward. We felt that the exhibits that explain the key principles that should underpin the partnership arrangements gave a flavour of what it would be fair for any successful partnership arrangement to reflect, whatever it was called and whatever the structure was. That is part of a much bigger issue, but we made recommendations about the need for a good look at all the arrangements that are in place and for reducing duplication.

Murdo Fraser: That answer is helpful. Did you get the sense from your investigations that the complexity of the governance and accountability arrangements consumed a huge amount of time? I often hear from people in local government and the health service the complaint that they spend much time in meetings. I am looking again at exhibit 7, which shows all the different forums, groups and committees. Hours in a week must be consumed by managers sitting down and talking to each other and to people in other groups when that time could be more usefully spent.

Case study 4, which is on the Western Isles, says:

"The CHP committee is large",

but most of its members

“are ... involved in other ... groups”

and attendance is poor. We have a huge waste of resource by employing people in important roles in local government, social care and the NHS who spend half their working week meeting one another. Surely that needs to be addressed.

Claire Sweeney: We tried to quantify some of the costs of such activity. It comes through in the report that doing that was incredibly complicated. Being clear about what success looks like is definitely an issue.

It is interesting that understanding each other's business emerged early as a potential stumbling block for partners. Often, they rushed ahead to an arrangement without sitting down or stepping back and considering how local authorities and NHS boards do business and without thinking about potential obstacles to a joint arrangement. Partners need to be very clear from the outset about the added value of entering into arrangements—that applies from the big scale right through to small-scale projects.

The Convener: Do any CHP members receive additional payments for serving on CHPs?

Claire Sweeney: I am not sure whether we examined particular payments.

Carolyn Smith: We did not particularly look at that. CHP members do not receive payments for serving as CHP members, but we did not examine whether they are paid by the NHS or other bodies for being a representative of a board.

The Convener: CHP members might be paid for being health board members, but do they receive additional payments from health boards or councils for serving on CHPs?

Carolyn Smith: Certainly not that we are aware of, but we did not specifically ask about that as part of the audit.

Barbara Hurst: If it would help the committee, we could ask some of our local auditors whether such payments are made.

The Convener: It would be interesting to know whether any additional payments are made. Murdo Fraser talked about the amount of time that is spent on the plethora of meetings and the cost that is involved in them. Are we adding unnecessary financial burdens? That might not be the case.

Willie Coffey: I see that this will be another great session for the committee. We have already had the whiff of scandal and a mention of Stalin, bayoneting the wounded and Teutonic maternity models, and the much-maligned turkeys have featured.

I will inject a wee positive note in defence of CHPs. Since they were established, the trend on delayed discharge has been down. We could argue over whether that is attributable to the existence of CHPs or to other activities, but exhibit 15 shows clearly that the trend since the establishment of CHPs has been down. Of course, we worry about the slight upturn in numbers again, and we need to understand the reason for that.

Barbara Hurst mentioned that the report says that CHPs have little or no influence over how money is spent. The report says that £13 billion is spent on health and community care, yet CHPs have no influence over how that is spent. How on earth could that have been the case from the outset? Was a deliberate choice made when CHPs were established that they were to have no say in how that money was to be spent? Given the amount of work that they do and the discharging that they are asked to carry out, we would surely expect them to have had some influence on spending from that point on. How did this situation come about?

Barbara Hurst: As we said earlier, it was originally intended that one of the tasks for the CHPs—I agree with Murdo Fraser that all the tasks were very challenging—was to shift money from the acute

health sector to the community health sector. However, CHPs are not really in the position in the structure to be able to influence that; it is up at a health board level. Although we now have clinics in the community and other such things, there has not been a massive shift of money. Perhaps it was unrealistic—I do not know—but, given the current position of the CHPs, shifting money out of the acute sector is a big thing for them to do.

We are saying that it is very difficult. We have not seen much evidence that CHPs have been instrumental in that way; much more of the attention has been on health and social care. Again, in terms of the structure, they sit within a health board, so they need very good trust and relationships with local authorities because there is an issue with regard to where the money is moving to. They have had a very difficult job to do. You may want to bring in some health boards and speak to them about how they decided where some of those choices would happen, because it is clear that they are happening at a higher level than the CHPs.

The Convener: Who would be responsible for the increase again in delayed discharges? Is it the CHP or the local authority?

Barbara Hurst: It is a joint responsibility.

The Convener: In every case?

Barbara Hurst: I suppose that I was speaking from a philosophical point of view. It has to be a joint responsibility because health boards cannot just discharge people if they need support at home and that is not in place. That would be irresponsible. A local authority that is struggling with its budgets will have to make difficult choices and, if someone is in hospital, at least they are safe.

Willie Coffey: Is the lack of aids and adaptations for people in the home part of the reason why people are not discharged early or on time? Perhaps the adaptation is not ready or available, or affordable, for a person who is going back home.

Barbara Hurst: Perhaps Claire Sweeney can remember the statistics on that.

Claire Sweeney: It tends to be to do with whether funding is in place.

Carolyn Smith: For the recent delayed discharge figures, we were looking at discharges that occurred after the report was published. The main reasons were that people were waiting for a care home placement or for a community care assessment. Waiting on funding accounted for only a couple of delayed discharges. The other issues have been more prevalent recently.

The Convener: What do you mean by “more prevalent”?

Carolyn Smith: The other issues were more the main reasons why people were waiting on being discharged from hospital—the delay was because of that.

The Convener: Because of what? I am not following you.

Carolyn Smith: Because people were waiting on a community care assessment, on support at home or on a care home placement.

The Convener: Yes, but is that not down to funding as well?

Carolyn Smith: The reasons are classified in four or five different ways: waiting on funding to get a care home placement or something else; waiting on a care home placement because there is not one available in the immediate area or in another appropriate area; and waiting on support to be put in place in the community.

Willie Coffey: This is probably too specific a point for the Audit Scotland team to mention, but it has certainly given me concern over the years, as a local councillor, when people have complained about

the lack of adaptations or the time taken to get adaptations or even assessments of needs by occupational therapists and so on. Is that in the mix and could we follow it up at some point?

Barbara Hurst: It probably is in the mix. I suppose that we go back to our telecare conversation earlier. Many years ago we did a report on community equipment, which we have not followed up, in which we found that there were significant delays in getting equipment and a bit of confusion about who was responsible for what type of equipment. All those things probably are in the mix, although I certainly hope that the situation is better than when we did the initial report.

Drew Smith: I am probably a little less underwhelmed by this than Willie Coffey is. I think that it is quite a damning report. As a new member, I find it difficult to think about the scale of your operations and how this report fits with other reports that you have done. How bad is the situation that it describes? It seems to be pretty appalling. The report states:

“Few CHP committees have a financial scrutiny role.”

It also states that few have been able to influence how resources are used across the system, that there is a lack of challenge at meetings and lack of influence over overall resource and that they are unable to demonstrate their specific contribution. Frankly, that is awful.

If CHPs do not do all the things that we might expect them to, what do they do? Their meetings do not sound like the kind that anyone would want to attend. I am interested in who attends the meetings and what they regard as their role. Is training provided to such people? What is their scrutiny role at meetings? I can understand why attendance is low. Why would anyone go to such meetings?

Barbara Hurst: I will pass to Claire Sweeney for the detail, but I will give the big picture. CHPs manage a range of services. All the community health services—for example, health visitors and district nurses—are likely to be managed through the CHPs. Many CHPs also have responsibility for mental health services and learning disability services. They are therefore functioning operational units as well. They must do all the partnership work in addition to the day-to-day management of services.

Claire Sweeney: There are a couple of issues within that. We are interested in issues to do with workforce capacity and skills, which are definitely a factor here. You will have seen that reflected in the proposed forward work programme. There are certainly issues to do with skills, training and the capacity to deal with difficult decisions. We have shown in the report that some areas have started to get to grips with that. The issue is investing in the CHP as the legitimate place to make decisions and do some more challenging work. CHPs operate in very different ways in different areas. In some areas, they are very strategic bodies but, in others, they are quite operational and oversee a lot of detail around particular services in primary and community care. There is certainly an issue there. Is the balance right? Are they doing as much strategic decision making as they can? Are they seen as weighty enough at board level, for example, and with the councils?

Again, there is the issue of the partnership arrangements between all the bodies and agencies. There are also the connections between the boards and councils. How do they fit with the CHP? Do the board and the council sit together and make strategic decisions, with the CHPs being seen as something more operational and functional? There are certainly issues there.

We do not know why people might not attend, as we did not ask them that question. However, I think that it comes back to issues to do with having a clear sense of priority and focus, knowing what success looks like and having everybody signed up to the general direction of travel, with commitment from all partners to start to move things forward. If the partners involved and the people sitting round the table have a problem understanding any of that, the meetings will be less attractive, there will be frustrations about lack of financial challenge and there might be a feeling that not enough information is available to allow them to make some of those decisions. The report covers all those issues, which are interlinked.

11:45

Drew Smith: I am not sure what is the chicken and what is the egg. Do CHPs have a lack of influence in their areas because they are dysfunctional, or are they dysfunctional because of their lack of ability to influence? I find it difficult to get to the crux of that.

If we were to investigate the issue, one of the problems would be who we should speak to, because the situation seems to be so different in different areas, with people interpreting the role of CHPs in such a different way. We could call witnesses and speak to people, but we will only ever find out about their experience of what is happening. Can you give me some guidance on how to gain a broader understanding?

Claire Sweeney: I think that that is right—we struggled with precisely that issue. What does the problem look like? What is the reason behind it? Is it a chicken-and-egg situation? The answer is that it will be down to a mixture of reasons. In some areas, CHPs may well have been set up and planned to be less strategic and more operational in their focus but, in others, they have just ended up having such a function. The situation will be different everywhere you look.

In the report, we tried to pull out examples that highlight some of the challenges that exist. We talked, for example, about the situations in Glasgow and the Western Isles, and the different arrangements that are in place in Ayrshire and Arran, and Argyll and Bute. There are some distinctly different models out there. It is an interesting area that involves a mix of issues.

Mark McDonald: Drew Smith makes an interesting point about the variations that exist. That struck me, too. The spirit of localism is about local authorities and health boards developing and devising their own solutions but, while areas such as Fife have a number of CHPs, Aberdeenshire, which is just as much of a sprawling, rural area as Fife, has only one CHP to cover the entire population. As far as population and geography are concerned, there seems to be neither rhyme nor reason when it comes to what the CHP model in an area should look like.

The Glasgow case study makes particularly depressing reading because it highlights one of the problems that exist when there are clear tensions between the NHS and the council. Sir John Arbuthnott was pulled in to find a way forward. He identified a way forward, which the parties agreed on, but then they discovered that they could not agree on it because of competing interests and conflicts. Frankly, that is extremely depressing. Is there a systemic issue that is to do with a tension between local authorities and the NHS that affects all CHPs, or does the problem exist only in certain areas?

Willie Coffey touched on the welcome downward trend in delayed discharges. The question to ask is whether CHPs have been integral or superfluous to that. I suspect, from reading the report, that the answer will be that it varies. Although the report raises a number of areas in which we are right to be extremely critical, it is worth noting that you identified some areas in which CHPs are working and delivering. The question that we must ask is whether there are local factors in the areas where they are not working that are causing that to happen, or whether we are talking about a problem with CHPs per se. If CHPs have been effective in some areas, can that good practice be transplanted to other areas to make their CHPs more effective, or are there stumbling blocks that are too difficult to overcome? Those are issues that we need to consider, and I would welcome your views on them.

Barbara Hurst: There was a lot in that question.

The situation in Glasgow was well heralded for a long time. When we did the audit, we felt that we had to try to understand what was happening there. We certainly knew that Glasgow was ambitious in what it was trying to do. Other CHPs were watching with interest because Glasgow was going for quite a big solution. It did not work for the range of reasons that we have outlined in the case study. There is a mixed picture of the ways in which health boards and local authorities work across the country. There are definitely places in which they are working well, but it is hard to know how to transfer that because they are working well partly because of their relationships, culture, leadership and so on. Those are the softer aspects of management. It is easy to transfer the management of a budget if you think of it as, "We do it this way by doing this, or by doing that," but it is more difficult to transfer those softer aspects.

It is interesting to note that a number of the councils around Glasgow are all following the East Renfrewshire model. Inverclyde and West Dunbartonshire are moving towards a more integrated model, so Glasgow's experience has not put everyone off.

Mark McDonald: Thank you.

Convener, I should say that, having made a note to declare an interest, I forgot to do so: I am a member of a local council.

George Adam: I agree with Willie Coffey on the issue of occupational therapists. In Renfrewshire, I have also had the specific problem of people queueing up to have their houses adapted.

I, too, agree that there are some CHP success stories out there. I always get concerned that, when we receive a report like this one, we all run for the hills, take cover and say, "It's broken. Let's try and find a way to fix it."

In general, is it not true that we need to be more proactive in social care to reduce spend at the other end? With the population getting older, we have to be cleverer. If we can get it to work, the CHP model looks like it could deliver that service. During the discussion, you mentioned strong leadership, whether that is political leadership in the local authority or leadership at the officer level in the various parts of the council and the NHS.

We need to break down the barriers between those organisations. We live in a world in which they are all going to have to work together. It is not just a case of us saying that we would like things to work; they are going to have to work. How do we get to that situation? There is such leadership in my area, but how do we transfer that into other areas? Do we provide guidelines to making the situation better, rather than requiring areas to reinvent the wheel?

Barbara Hurst: That is the million dollar question. Exhibit 1 sets out the key principles. I agree that there are some good success stories out there. The complexity, particularly for services for older people, is that in recent years, the emphasis has been on intensive home care support, which is highly laudable. However, in some ways, that has been done at the expense of some of the more preventive services at the lower level, such as cleaning, shopping and doing the laundry. That shift to home care support therefore has an impact on services.

The report is about CHPs, but it is quite difficult because it is also about the decisions that underpin what they are trying to do. All this takes us back to our earlier discussion about preventive spend as opposed to emergency spend. Of course we have to spend when there is an emergency, but we might be able to prevent some of that. The CHP is well placed to facilitate those discussions. Where CHPs are working well, they are working well, but where they are not, they are not. That is a truism but, because the picture is so mixed, it is difficult to describe.

The Convener: I will draw the discussion to a conclusion. It has been fairly comprehensive and we have covered a wide range of issues. I suspect that you have whetted members' appetites for the issue. Thank you for your contribution.

Barbara Hurst: Thank you, convener. I hope that that has reassured the new members of the committee that audit is not really boring.

The Convener: That sounded like a plea from the heart.

11:55

Meeting suspended.