OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 15 November 2016

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 15 November 2016

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HEALTH AND SPORT COMMITTEE

11th Meeting 2016, Session 5

CONVENER

*Neil Findlay (Lothian) (Lab)

DEPUTY CONVENER

*Clare Haughey (Rutherglen) (SNP)

COMMITTEE MEMBERS

*Tom Arthur (Renfrewshire South) (SNP)
*Miles Briggs (Lothian) (Con)
*Donald Cameron (Highlands and Islands) (Con)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
*Alison Johnstone (Lothian) (Green)
*Richard Lyle (Uddingston and Bellshill) (SNP)
*Ivan McKee (Glasgow Provan) (SNP)
*Colin Smyth (South Scotland) (Lab)
*Maree Todd (Highlands and Islands) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Sir Harry Burns (Targets and Indicators Review)
Tracey Gillies (NHS Forth Valley)
Geoff Huggins (Scottish Government)
Jackie Irvine (Social Work Scotland)
Paula McLeay (Convention of Scottish Local Authorities)
Barry Syme (Association of Scottish Principal Educational Psychologists)
Lorna Wiggin (NHS Tayside)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 15 November 2016

[The Convener opened the meeting at 10:10]

Mental Health

The Convener (Neil Findlay): Good morning, everyone, and welcome to the 11th meeting in session 5 of the Health and Sport Committee.

I ask everyone in the room to ensure that their mobile phones are on silent. It is acceptable to use them for social media purposes, but please do not take photographs or film proceedings.

Agenda item 1 is an evidence session on mental health. We will focus on children and adolescent mental health services.

I welcome to the committee Lorna Wiggin, chief operating officer, NHS Tayside; Tracey Gillies, medical director, NHS Forth Valley; Jackie Irvine, children and families committee, Social Work Scotland; and Barry Syme, chair of the Association of Scottish Principal Educational Psychologists and principal educational psychologist, Glasgow psychological service.

We will move straight to questions, as we have less than an hour for the session.

Alex Cole-Hamilton (Edinburgh Western) (LD): Good morning, panel. Thank you very much for coming to see us today.

Everyone in this room is aware that the mental health strategy expired at the end of last year and that we are still awaiting a new one. Given that, as we learned during the summer, some children in parts of the country are waiting as long as two years for treatment by CAMHS and that CAMHS in-patient beds are sometimes rendered unavailable because staff are not there to service them, will panel members reflect on what they hope will be in the next mental health strategy? I ask that they focus on CAMHS and whether it should have its own strategy that underpins the overall mental health strategy.

Jackie Irvine (Social Work Scotland): In our submission, we make the point that looking at CAMHS in isolation will not solve the problem. We need to look at the continuum, from the lower-level tier 1 to tier 2 services through to the tier 3 and tier 4 services. We know, because it happened often in the past and is possibly still happening, that children are referred to CAMHS when there could be other services that they could get earlier in their journey of mental wellbeing. We know that that creates a bottleneck into CAMHS. The mental health strategy needs to look across that variety of provision and make those connections helpfully.

Tracey Gillies (NHS Forth Valley): It might be helpful for me to say something about NHS Forth Valley's waiting times, because they were particularly low in the recent NHS Scotland Information Services Division reported figures. I assure the committee that we have taken the matter extremely seriously and have put a lot of time and effort into working with CAMHS. I am very pleased that the number of children who were seen within our 18-week referral-to-treatment waiting time has increased from 74 per cent in September to 87 per cent in October. There has been a significant turnaround in the waiting times.

Alex Cole-Hamilton might have been referring to our very low waiting times in June. Those low waiting times were influenced partly by our ensuring that children who have been waiting a very long time are seen. Obviously, having those children come through the service has a negative impact on the overall RTT time that is reported, but it is still important that children are seen and prioritised appropriately.

Lorna Wiggin (NHS Tayside): Looking at the whole-life continuum, I would like to see much more emphasis on how care pathways are provided from birth right through to adulthood; on building up tier 1, to support the resilience not only of families but of individual young people and children; and on continuing to develop tier 3 and tier 4, to ensure that we can provide as comprehensive a service as possible for the young people and children who need that level of service.

It is imperative that we work across agencies and with the voluntary sector, the third sector, families and young people to get that right, and I would like to think that there will be an emphasis on that in the next strategy.

10:15

Alex Cole-Hamilton: On my question about the lack of availability of tier 4 beds, in the summer, we put in a freedom of information request, and the numbers that came back on kids who were referred to tier 4 beds but were turned away because the beds were not available—not because they were full, but because there were no staff to man them—were quite astonishing. Would you like there to be further investment, particularly given that we have no tier 4 beds north of Dundee? That is a natural gap in our provision in Scotland.

Lorna Wiggin: Currently, we have all 12 beds open in our facility, which serves the north. The issue is not always just to do with staff; it can be to do with the young people who are in the unit at the particular point in time and our clinical and multidisciplinary team's risk assessment of what it is safe for the facility to look after.

I would like more emphasis to be put on keeping children and young people out of in-patient facilities. We can do that—we have seen good, intensive support-at-home models emerging. For example, we have a programme called MacX, which puts in very intensive multi-agency and multidisciplinary support to keep children in their family home and in education.

It is a combination of both things. It is not just about the beds; it is also about putting all the infrastructure into the community services.

Alex Cole-Hamilton: But is there a gap? I accept what you have said, which certainly chimes with a lot of what we have heard about giving people care in the community, which is absolutely laudable. However, are all the needs being met? If people are referred to tier 4 beds and are turned away, are they getting the support at home that you have described?

Lorna Wiggin: Some of them will; some will need admission, so obviously we would seek a bed elsewhere for them that was suitable for their needs.

Through work that we have done in our eating disorder pathway and the more intensive family behaviour and cognitive support that we have put in, our admissions have gone down. It is not simply a matter of keeping on putting more beds into the system; it is a matter of considering what support the individual child or young person requires. Obviously, there should be intervention at an early stage if possible, as that stops deterioration. However, if the in-patient option is required, we must be sure that it is the right one.

I honestly have not seen any data from a whole-system risk assessment that would tell us how many beds would be the right number.

Jackie Irvine: On the point about trying to keep children and young people supported in the community, from my experience in greater Glasgow and Clyde, I think that managing a person's transition from being an in-patient to going out to the community is probably also an issue. My team has done a piece of work on that. I am responsible for children's social work services and health services, and I have a responsibility for community CAMHS. We have ensured that we have transition guidance, as young people can sometimes get stuck as in-patients, and there will be a level of anxiety in the family and among the professionals around them about their coming back into the community.

There are advantages and disadvantages. Obviously, a short stay is preferable, but we have some very complex cases that mean that people will stay in longer.

We have probably all experienced variations in availability across the country. At one point, our 12-bed unit was full, but I understand that we currently have vacancies. However, that is very difficult to anticipate.

Similarly, I am not aware of any whole-system look at indicative needs for in-patient beds.

Alison Johnstone (Lothian) (Green): Many submissions have highlighted the increasing number of referrals to CAMHS. Some people thought that that reflected growing need and were concerned about the number of rejected referrals.

Last week, we heard from the Scottish Association for Mental Health, which called for a wider review of how people are referred. It also wanted to understand better what is happening at tier 1.

Jackie Irvine said that some young people are referred to CAMHS when they could be referred to other services.

The latest ISD figures show that 18.7 per cent of referrals were rejected in 2015-16, and West Lothian Council, for example, has called for an urgent review because it is concerned that some children and young people are missing out on help that they may urgently need.

Jackie Irvine: I cannot comment specifically on the position in West Lothian, but we recognise that some children who are referred to tier 3 of CAMHS could be dealt with appropriately at tier 1 or 2, for example through school counselling. There is a demand that is not being addressed as early as it could be. We have worked in partnership across the country to build tier 2 services, but they are funded in a variety of ways. Some of the funding comes from councils, some from health boards and some from council education services, and some will be in the third sector. The variation across Scotland probably reflects the variation in what sits around CAMHS. I know what is in my area and I have heard from colleagues about what is in their areas, but some areas will be short of such support.

Even at tier 1, there is a need to support the development and confidence of staff who work with children in communities, whether in nurseries, primary schools or secondary schools, so that they do not become overly anxious and are able to deal with the children. At times, we are managing professional anxieties around children, and that does not help the children and certainly does not help to provide things when they need them, there and then, and for as long as they need them. Some children might be escalated to CAMHS when they could have been managed and helped to recover within tier 1.

Quite often, children have adverse experiences in family relationships. We are seeing a slight growth in functional family therapy in CAMHS tiers 1 and 2, but it is variable throughout the country and quite costly. In West Dunbartonshire and Glasgow, we have invested in functional family therapy for children aged 11 upwards, but the feeling is that signs of difficulty in children's behaviour start to appear much earlier than that, from the transition from nursery into primary 1. Difficulties can appear even earlier, but they are certainly evident in the early primary years.

There is a package of options. Sometimes we try to fit the child into the services that we have as opposed to asking what service the child needs, if it is not available.

Alison Johnstone: In last week's evidence session, the view was expressed that better training for teachers and so on would enable them to help young people instead of feeling that they had to refer them on because they did not have the capacity themselves. How is a rejected referral experienced by a young person? Do they go along to a tier 3 or 4 service?

Lorna Wiggin: I can tell you what happens in NHS Tayside. A referral could come through various routes—from a teacher, a general practitioner or a school nurse—and is considered by a disciplinary team against all the information that they have available to them. If they require more information, they will seek it. Once they have considered the referral, they decide whether it fits into tier 3 and the young person requires to be seen by a specialist or whether there is an alternative that they should access.

The referrer will always be contacted, which allows them to say why they are not suitable to deal with the issue, and they will be told what other options are available and signposted to other services that might be appropriate. They are also given some information and advice tools that might be beneficial. It is not a matter of the young person having to come along and then being told that there is no need for them to be there.

I do not know whether practice is similar elsewhere.

Jackie Irvine *indicated agreement.*

Tracey Gillies: That matches our experience. We have done a lot of work with GPs and other primary healthcare services on our referral criteria to ensure that they are well understood and agreed by all. We provide information if a referral does not progress following a multidisciplinary discussion such as Lorna Wiggin has described. We also have an advice-only email referral service and a professional-to-professional advice line. There are ways in which people can discuss referrals or receive further information about services.

The Convener: Is that your experience as a practitioner, Barry?

Barry Syme (Association of Scottish Principal Educational Psychologists): It depends on how people get into CAMHS. In Glasgow and other authorities, we try to follow getting it right for every child, with a multi-agency meeting. We are trying to push for referrals—I hate the word "referral" because it implies that we are putting the matter somewhere else. However, we would see ownership remaining within the school establishment and that a referral to CAMHS should go through that multi-agency group, whether it is called a joint support team or a joint assessment team. The advantage of that is having people around the table from social work, health and education giving advice about the appropriateness of the referral. We know that the majority of referrals come through GPs, but there is a piece of work to be done with them about how they link GIRFEC into their practice so that the most appropriate referrals go to CAMHS.

If that is not deemed appropriate, the question is what other supports are there? There are lots of supports around, but getting them is often a postcode lottery. Even in a large city such as Glasgow, certain parts of the city will have certain resources but others will not, and it is about having local knowledge. In Glasgow, we have 28 joint support teams and we are working towards using the GIRFEC model so that referrals go through the joint support team. That will mean that the most appropriate referrals will go to CAMHS, but it also means that if a referral is not going to CAMHS, or if one comes back from CAMHS—or if there is a lack of other support available—it should go back to the joint support team.

Jackie Irvine: Another issue is the quality of the referral when it gets to CAMHS. If it has the most pertinent information, that quickly gives CAMHS a much clearer idea of whether it is an appropriate referral for which they have to provide assistance. In West Dunbartonshire, we had a pilot involving GPs and education colleagues in sharing information around GIRFEC, which was widely reported to Government ministers. One of the outcomes very early doors was our finding that, quite often, schools knew the child and the family much better than the GP did, because they would know the parents and the siblings and have that background knowledge.

Therefore, we moved towards encouraging educational psychology services, when they think that a referral is required, to convey that to the GP. It is not that educational psychologists are not allowed to make referrals, so we are encouraging them to say to GPs, “We could do the referral. We agree with what you and mum are saying; we think that a referral is required, too. If you have not done the referral yet, we could complete it.” As everyone around the table has said, if a referral does not seem appropriate, there is a response to the referrer on why that is so, but we are encouraging people to have telephone conversations about referrals in the first instance. If that does not happen, there should be a telephone conversation when the referral is not accepted.

Clare Haughey (Rutherglen) (SNP): I want to move on from what we have been saying about referrals and expand the discussion a bit. At last week’s committee meeting, some of the panel, and some of the written evidence, talked about different referral criteria for different services and the need for national guidance on referrals. I am interested in the panel’s views on that.

Lorna Wiggin: There is definitely variation across health boards in the referral criteria and even in the tiers at which patients will be seen. It would be advantageous to have some national guidance that would at least allow a young person, child or family member to understand what type of service will be provided and how that will be done. There is no doubt that there is variation at the moment.

Clare Haughey: Does anyone else want to comment?

Barry Syme: I agree with Lorna Wiggin that there is variation, even across neighbouring authorities and health boards—we find that in Glasgow. My particular area in the south of the city borders three other areas, and the variation between them causes problems for parents. I had an example of that a couple of weeks ago when a parent was told that their child required an educational assessment by an educational psychologist. That was then the parent’s expectation and we were contacted because the case was in our geographical area, but our threshold is different. There is a piece of work to be done on that situation.

Clare Haughey: Would differences in referral criteria explain why there is such a variation in the rate of referrals to your services that are accepted? Are you getting lots of inappropriate referrals sent to you that do not meet the criteria? If so, that would seem to me to be quite a waste of your time and that of healthcare professionals. It would also set up expectations by families and young people about the service that they will receive, which then turns out to be inappropriate for them.

10:30

Tracey Gillies: Some of the variation is more in the availability of what other support is available. I suppose that I would look at it more from a health perspective, although what my colleagues have said is appropriate. We are seeing quite a lot of pressure on primary care resources, and a lot of GPs are working as locums in different areas. The fragmentation of primary care services and the difficulties with GP recruitment that we are all experiencing sometimes mean that people are less aware of what is available locally, particularly with third sector or local authority services, which might be called different things. There is a need for better signposting to make people aware of what is available.

We have not really touched on some of the administration processes that sit behind all the services. When referrals are not received electronically, sometimes they just do not contain enough demographic information or all the pieces of information that would be useful. That can lead to a request for more information and for the referral to be sent again. The referral might not necessarily be inappropriate; perhaps it just did not have all the right information to start with. Those cases are counted in the ISD numbers. It is important to separate out the cases that are administratively incomplete from those that do not meet the referral criteria.

Clare Haughey: What are the health boards doing to address the issues that you are picking up?

Tracey Gillies: We have put in place a way to ensure that we receive as much information as possible electronically and we work with our local authority and third sector colleagues to provide electronic information about what support services are available, which can be kept up to date and passed on to the young people. There is also a push system, with an advice sheet that goes back out to referrers at the point of referral to let them know what other support is available.

Lorna Wiggin: We use the information and the data that we get to create a dashboard for the service and for clinicians, which lets them look at themes. If we see that there is a particular issue in a school or a cluster of GP practices, we can go back in and do further education and try to understand why the issues are arising. There is a mixture of trying to ensure that the information is easily accessible, trying to ensure that people are up to date on what is available—because things change—and ensuring that, if there is an issue, we identify it quickly and try to do something about it.

The Convener: You might have addressed this and I have not picked up on it, but what happens after a referral is rejected?

Lorna Wiggin: In Tayside, the referrer is contacted and told why the child or young person has not met the criteria and what other services would be more appropriate. There is signposting to any other support, information or advice or any tools that might be helpful for the individual. There is always contact with the referrer, whoever they are—it is not always a GP; it could be a school nurse, teacher or whatever.

The Convener: Is that then tracked?

Lorna Wiggin: No. Once the person is referred back, they are discharged from the service at that point.

The Convener: So they are referred back and then there is no follow-up to see whether the action that was suggested was successful. We do not know whether the rejections result in people coming back through the system.

Lorna Wiggin: No—we would monitor that.

The Convener: How do you monitor it?

Lorna Wiggin: For readmissions, everybody has a community health index number, so—

The Convener: I am not necessarily talking about readmission. How do you monitor—

Lorna Wiggin: If someone is re-referred to out-patients or—

The Convener: No. How do you monitor what happens after a referral has been rejected?

Jackie Irvine: If the referral was from a named person, such as an education professional or health visitor, or from a lead professional, which is predominantly those in social work services, they would maintain responsibility for the child. Barry Syme mentioned that the word “referral” feels a bit like talking about something being moved from one place to another. That is why, in GIRFEC terminology, we have moved to talking about requests for assistance.

The originating referrer, if you want to put it that way, or the lead professional or named person would maintain responsibility for the child and that case. Obviously, the lead professional or named person might do a variety of things. They might go back to CAMHS and have further dialogue about why the request was not accepted, but they would certainly go back to the team around the child to look at what other service could be put in place for the child. That is obviously more difficult if there are fewer alternatives, but from our knowledge and the growing implementation of GIRFEC it is certainly helping to keep an eye on that child and to make sure that they do not just drop off the plate.

The Convener: Do you collect data on that? Is there a standard reporting system?

Jackie Irvine: No. Nationally we are not in a position to do that because there are different information systems across social work services, education authorities and health authorities.

The Convener: Do you therefore know how many referrals have been rejected and then come back?

Jackie Irvine: No. I can honestly tell you that I do not have that information. However, from the point of view of being head of children’s health and care, I would know if we had an issue in my area.

The Convener: Would any of the witnesses be able to know that?

Jackie Irvine: No.

Maree Todd (Highlands and Islands) (SNP): We have heard about the transition from child and adolescent services up to adult services, and last week we heard that there are different cut-off points in different parts of the country—some relate to full-time education, some are 16 and some are 18. We also heard from the representatives of the Scottish Youth Parliament and SAMH that they would prefer there to be a bespoke service for children between the ages of 16 and 24 that would see them through vital periods of transition in their lives so that any damaging consequences from their having been severely ill are limited. For example, if somebody has had to come out of education because of their illness, they will still have a team that can support them to get back into education even though they might be 17 and a half. Would you support that? Do you have any thoughts about that particular variation in the service?

Tracey Gillies: Our services go up to age 18. It is difficult to make one size fit all. I agree that some individuals would benefit from a clearly staged, gradual transition and the holistic team approach being maintained for a longer period. Equally, some people at the age of 16, 17 or 18 clearly wish to mark that they feel ready to move to adult services and would prefer to be managed in adult services. Maybe we should be making those opportunities more available when they are appropriate.

Lorna Wiggin: If young people are telling us that that would the best pathway of care for them, we should be listening. We need to look at what we have currently and the steps that we would need to take for those who would benefit from such an approach. Some young people will definitively opt to move to adult services; that might be because, having experienced a young person’s unit in which the age group can be quite young, they feel that that is not the right place for them. You are right to say that there is an age at which they fit in neither one nor the other, and we need to find what the pathway looks like for each individual.

Maree Todd: Clare Haughey mentioned that last week. We were talking about referrals at the other end of the age scale, where there used to be a cut-off age of 65. Perhaps specifying a number is not useful and it would be more useful to base services on an individual's needs. That is what you guys are saying.

It might just be me who does not understand how the other thing that I want to ask about works, so please excuse me. How does educational psychology fit in with CAMHS? How do the services work together? I imagine that somebody who has autism spectrum disorder or attention deficit hyperactivity disorder is more likely to need a lead professional who is an educational psychologist rather than a psychiatrist, whereas some people will need a psychiatrist to be their lead professional. How do the two systems work together to provide care?

Barry Syme: In the past 20 years, the role of the educational psychologist who works in mental health has certainly increased. Last year, ASPEP undertook an audit of all 32 services in Scotland and we did event sampling for a week to look at how much time we spent on mental health. It came out that 29 per cent of our time was spent on mental health work, which ranged from direct work with young people and children to advice and so on.

Across Scotland, services will vary, depending on their size. It is a question of capacity—there are places with two psychologists and places with 40 psychologists. We are talking about economy of scale. At the most recent count, there were about 20 different interventions in mental health that educational psychology offers, including cognitive behavioural therapy, eye movement desensitisation and reprocessing, and video interactive guidance.

We have developed a skill set, and we need to identify how we fit in with the tier model. It has taken a long time for educational psychologists to get their heads round the working of the tier model. We are now trying to target our interventions at a tiered level. We are focusing on tier 1 and tier 2, because that is where we know that the gap is. In fact, we are taking an even broader outlook; we are looking at tier zero, which is about promoting universal resilience. As educational psychologists, we are pretty good at that.

We target our interventions and focus on evidence-based interventions at tier 1 and tier 2. A prime example is safeTALK. My authority really pushes safeTALK, which is suicide awareness training. Every establishment has a member of staff who is safeTALK trained, and we are now rolling out safeTALK to S5 and S6 pupils. That is being done by educational psychology alongside health and social work services.

You mentioned autism spectrum disorder and asked how we work with CAMHS. The diagnosis would come either from the Scottish centre for autism or from the local CAMHS team, depending on the set-up, but that is just the diagnosis. That is fine as a medical diagnosis, but the issue is what to do with that diagnosis. We are working with CAMHS on what the implications of that are and what a child in that position needs help with. The child will have to go to school and be educated, so consideration needs to be given to his sensory issues. If he cannot cope with loud noises or with the dinner hall, we need to think about how we can we make environmental changes to his curriculum so that he can go to his local school. That is where the partnership working comes in.

The situation is improving, although there is further work to be done. Discussion is on-going in greater Glasgow and Clyde CAMHS, particularly in clinical psychology, about how we can formalise that in a better way so that we know exactly what we are doing.

Maree Todd: Much of our focus has been on CAMHS. When we look at CAMHS, are we capturing that activity?

Barry Syme: I do not think that we are; it is an untapped resource. All educational psychologists are Health and Care Professions Council registered, so we have to conform to those guidelines. We have the skills, because there are similarities between the training for educational psychology and the training for clinical psychology. We must distinguish between clinical psychology and CAMHS, which are two separate things.

I do not think that that activity is being captured. It is a resource that could be used more widely.

Ivan McKee (Glasgow Provan) (SNP): I want to explore how you measure the performance of the system as a whole. There is a target in place for the waiting time at tier 3, which seems to be the main indicator that is used. Is that the right thing to measure? Should other things be measured as well? Are there unintended consequences of using that indicator to measure performance?

Jackie Irvine: From Social Work Scotland's point of view, nationally there is a view—which I concur with—that measuring just the waiting times as a hard outcome is of fairly limited use, although it does give an indication of when people are not getting a service. I am aware that many health boards, including Greater Glasgow and Clyde NHS Board, have moved to the choice and partnership approach—CAPA—model, which allows them to look more at general outcomes for the family and the child. Collating that information on a local area or a health board basis can be difficult, but we are looking more at outcomes to do with reintegration back into education and communities. A CAMHS service on its own would be a bit limited in its ability to assess whether that approach was working or was right.

The other aspect comes back to the transition back into education and communities. Even if a child has not been in an in-patient bed, it is a case of helping the professionals around that child to continue to provide support and to understand what has made a difference.

There is a real issue for communication. That is why the partnership approach is providing a more holistic approach: it is not a case of starting CAMHS, ending CAMHS and then getting back to life. It is a case of starting CAMHS and educating other people about what needs to happen for that young person.

Practice is variable rather than consistent across areas. There are teams within CAMHS in West Dunbartonshire, such as the young people in mind service; in other areas, they work with carers, such as foster carers, residential carers or families, to help them to understand the behaviour that might be exhibited by their young person so that they can understand the premise and therefore how to respond better. That also provides good outcomes.

10:45

Ivan McKee: Do you measure that?

Jackie Irvine: We measure it on an individual child basis, and that is the difficulty that we have with any outcome approach. We have been discussing that with colleagues in the Care Inspectorate. Aggregating from one child up to the population is very difficult.

Ivan McKee: Why is it difficult? You measure whether the outcome, if you want to call it that, for that child was successful and then you aggregate all those individuals.

Jackie Irvine: I suppose that it is because the question whether the outcome is right is subjective. The best person to give the view on that would be the child and parent, whereas the professional might say, “Yes, we’ve achieved an outcome.”

We measure population information in relation to numbers of referrals, the number of children who are looked after and the number of children who are referred to the Scottish Children’s Reporter Administration. Measuring whether outcomes are improving for children who present with very different circumstances is different. We measure that individually, but aggregating it is more challenging, particularly nationally.

Lorna Wiggin: We do not have good systems, as the committee heard earlier. Health, social work and education have different systems. Doing that work takes a lot of effort and hours. That takes away from the time available to provide services, so there is a balance.

Access to services is important, but it is only one indicator. We would all agree that some more qualitative outcomes should also be measured, both for children and families, and for how we are using the resource, so that we can understand the variation better and know whether it is right. Sometimes the variation is right, but sometimes it is not.

Ivan McKee: The question was about performance measurement of the system. You are telling me that it is difficult to measure the performance of the system so we do not do it.

Lorna Wiggin: No; we measure. We have a whole dashboard of different measures that are agreed with our clinicians and multidisciplinary teams.

Ivan McKee: The headline number is the waiting time target at tier 3. The question was what other measures we should use, and whether there are unintended consequences of having the primary measure as the waiting time target at tier 3.

Jackie Irvine: I cannot answer that question.

Barry Syme: From an education perspective, we monitor not by looking at waiting times but by looking at outcomes and how they are tracked over time. As a number of other services do, if we are doing a direct piece of work, we use standardised assessments or core measures before and after. To some extent that is a pretty dumb way of doing it, and the better way is to specify from the outset what is being looked for.

The fundamental point about referral to CAMHS is what is wanted from that referral or piece of work. If a piece of work comes to educational psychologists, the first thing we ask is what the referrer wants us to do. Then we do it, or not, and measure the outcome to ask whether all agree with the intended goal and the result.

The outcome also has to be measured over time. You could do a piece of video interactive guidance or parenting work with a family, and the parents could say that they are a lot happier. The case is then effectively discharged and inactivated. Down the line, however, is that child still in mainstream education? That is what we need to be better at, and we are starting to do that in education.

Ivan McKee: Are you doing that?

Barry Syme: Yes, we are. We are starting to measure, certainly. That is being driven by Education Scotland as part of its inspection process. We are slightly smaller: it would be more difficult to do that nationally across CAMHS.

Ivan McKee: Is that a better headline measure than the waiting time target at tier 3?

Barry Syme: I think that it is. Ultimately, if you are going to keep on forcing that waiting time target, that is where you will put your money.

Ivan McKee: Yes. That is what I am trying to get to. The problem that you have is, if people are saying that the waiting time target is not a good target, what can you put in its place? I am not hearing about anything that is measurable—or rather, I am hearing something from Barry Syme. You are right in saying that what you measure gets done. If you are not measuring the right thing, it will not get done. I am a bit disappointed that people are not saying what they want to measure. It all sounds a bit vague, to be fair.

The Convener: That was a statement rather than a question. Tom Arthur is next.

Tom Arthur (Renfrewshire South) (SNP): I have a quick question for Jackie Irvine. When the convener asked what happens when CAMHS referrals are rejected, you said that the data that is required to answer that question is not available nationally. Is more data sharing between services needed?

Jackie Irvine: I meant that how a rejection is dealt with probably varies somewhat across the country. I can speak only about my health board area, although I am here to speak on behalf of Social Work Scotland. The mental health strategy might want to reinforce the management of that process and the information that goes back.

I think that it is standard for information always to go back to the referrer about the reason for the rejection and about what other service might be preferable or more appropriate for the child. I am not quite sure exactly what you want me to answer.

Tom Arthur: Given the range of services, is data sharing between services seamless enough?

Jackie Irvine: I do not think so; there is still work to do on that. We involved GPs in our pilot, which went well locally, but we are still looking to roll that out from one area of our patch to the next. West Dunbartonshire is very small.

Data sharing happens only with consent. If families are presenting to their GP or to a school with difficulties, it is much easier for the pastoral care teacher, for example, to speak to the GP and do the referral on their behalf or with them. GPs are always notified of whether a child has been accepted into CAMHS, even if they are not the referrers. It helps them to have that up-to-date information.

There is the general communication issue about what people are experiencing in a local area depending on the demand at the time. We need to make sure that the information is communicated to all services so that they can address issues in a solution-focused way. We do that through our community planning partnership children's services strategy work, which we make sure focuses on children's mental health and wellbeing. The work is reported up to the community planning partnership. If we were having significant difficulties in managing or accessing services, we would report those difficulties up. The difficulties could be to do with resource, a spike in demand or a lack of appropriate services at lower levels.

Tom Arthur: Would any other panel members like to comment on the data-sharing issue? It seems that data sharing in some areas might be insufficient. Is the lack of data sharing potentially a barrier to better outcomes for service users?

Tracey Gillies: In general, we all have data-sharing agreements and protocols that specify what we can share, the levels of consent and the information that goes back. Having the principles and protocols set out is different from having systems that speak to each other easily on a daily basis—that is probably where the need is greater.

Jackie Irvine: The issue is not just that education services as a whole have a different system from social work as a whole. In social work, there are different information systems across the 32 local authorities for client-held records. Those systems do not speak to each other. In health services, there are different levels of recording for client-held information. It is not just three systems that lack connectivity—there are variations in those systems. That is why addressing the issue is so complex.

Lorna Wiggin: The teams that work with children share information and work well together, but the information technology systems do not enable that information sharing to work seamlessly and smoothly in real time. We are embarking on using a product that will enable our social work, health and other colleagues to see on a single system all the information that it is appropriate for them to see about a child or young person. That product is being rolled out.

The information sharing is there. Any child who comes before us will have a single plan to support them that has been developed by the voluntary sector in a multidisciplinary and multi-agency way. With a paper-based system, however, an individual who goes into a family will not always have access to all the information at that time. We are working on a solution to enable that to happen and to ensure that the information is there when it is needed.

The Convener: If we had more time, I would get you to explain functional family therapy, but I can probably guess what it is.

In its submission, Social Work Scotland talks about the need for a "much more holistic approach" and "early intervention" and says:

> "the best way to deal with mental ill health is through a social model".

I do not disagree with a word of that; indeed, I totally endorse it. After all, much of this is about poverty, inequality, poor housing, poor environment and the rest of it.

In a previous inquiry into looked-after children in which I was involved, a number of people talked about the need for social workers—or what previously were called social work assistants or, as some called them, the home makers from years ago—to go in, do fairly basic work with families, get them into a routine and deal with systems of behaviour, boundaries and all that kind of stuff. That is desperately needed, but how can it be done in the current climate when local government budgets are under such pressure? Following on from that, do you have the human resources—the people on the ground—to deliver not only that but the range of other services that are involved in CAHMS?

Jackie Irvine: Your question is obviously very sensitive. We still have a model of what we would call home helpers or family support assistants, but that is a precarious service to keep afloat in the current financial climate. As someone who is responsible for social work services in my area, I can say that we have to make some difficult decisions.

The Convener: Which area is that?

Jackie Irvine: West Dunbartonshire. The situation there is no different from that anywhere else in the country.

The Convener: How many people are delivering the service on the ground in West Dunbartonshire?

Jackie Irvine: About 48 to 50 social workers who are qualified in fieldwork are out in the communities.

The Convener: In the inquiry that we had, social workers told us that, given the pressures that they are under, that element of their work has largely gone and they do not do much of it these days.

Jackie Irvine: The 21st century social work review recognised that professionals should be doing what they are trained to do, as in any profession, and that there was a need for social work assistants or family support workers to do more of the hands-on work that you talked about—setting boundaries, helping people to get into a routine and to understand what children need to keep them healthy and well behaved, and managing families' stress and chaos at times. I am sure that, if a study were to be carried out, it would find that staff have been lost in those areas, and that leaves social workers possibly having to do a wider range of tasks, because they have not had that earlier support.

Families find such workers—we would call them paraprofessionals—much less stigmatising. Instead of a social worker coming to their door, they have people who can take them out into the community and do things with them, such as getting them used to shopping. Because our area is very small, the people in the community know the social workers, and there is a huge stigma in that respect. Our health visiting service has young family support workers who are, helpfully, funded by education services, as are the outreach workers that we have from nurseries. They work really well with lower-level families where the concern is not with immediate risk but with helping families who are struggling with poverty or other difficulties.

I suppose that the level varies, and we are experiencing many more complex cases. I should say that that observation is anecdotal and relates to what I have seen in West Dunbartonshire; it is not made on behalf of Social Work Scotland.

11:00

The Convener: What do the other witnesses think about resourcing? Across the field, how many workers short are we? Is there an oversupply in anyone's area?

Tracey Gillies: Are you talking about staff who work in child and adolescent mental health services or the type of workers that you referred to earlier?

The Convener: I am thinking of child and adolescent mental health services, but the aspects are associated.

Tracey Gillies: We have seen a significant increase in the number of staff as a result of our investment in and redesign of the service. That work was done partly to address the waiting times issue that has been highlighted and partly to ensure that we have good provision not only at tiers 1 and 2 but at the tier zero level that Barry Syme mentioned, which I think comes back to your question about the community support that is available. We are just about to finalise the recruitment of extra nursing staff, which will leave us where we were at establishment.

Lorna Wiggin: The position is the same for Tayside. At the start of 2015, we invested in nursing, psychology, professional leadership from medicine and nursing, further work on enhancing the support that is available at tier 1 to do education and training, and support for families.

Our biggest issue is recruiting to consultant psychiatrist posts. We have 2.7 whole-time-equivalent vacancies in out-patients and a 0.5 vacancy in in-patients, and the shortage of individuals to take up those posts has been quite a long-standing issue. That has given rise to challenges with regard to the resources that are available.

Moreover, NHS Tayside has only one university output to recruit from. We recruit very small numbers from elsewhere, so we really rely on the students who are trained by the University of Dundee and Abertay University, and that can sometimes restrict the number of registered mental health nurses who are available. However, we have managed to recruit some additional staff.

I do not know whether that helps.

The Convener: So we have a panel of people who are saying that they do not need additional resources. That is a first.

Lorna Wiggin: I am sorry—I am not saying that. As far as additional investment is concerned, it is recognised that referral rates are increasing. Last year, we took a big look at our demand to ensure that we had the right resources, hence the investment that we have just embarked on. There will be another round to look again at the issue in the knowledge that our referral rates have gone up, in order to understand why that has happened, what the issue is and what areas we need to think about for the future. I am not saying that we have reached a position where we do not need more investment in CAHMS.

We know that our hard-to-reach populations probably do not seek services, and I am sure that children and young people are no different from the rest of society. I am therefore not complacent, and I do not think that we will not need further investment.

The Convener: Before I bring in Miles Briggs, I should say that the submissions that I have been reading refer to looked-after children—particularly those who are in residential care. I will not comment on that, but we should put on record the concerns that have been expressed about that group of young people.

Miles Briggs (Lothian) (Con): My question is about disparities in the referral system. To what extent does your experience show that potential referrals are more successful if they come from a GP rather than from a named person or a school?

Given that we are holding you captive for a wee bit longer this morning, do you want to identify any priorities and important issues that, from your experience, should be included in the next mental health strategy?

Jackie Irvine: I highlight the disparities in referral data. I cannot with confidence say that one group refers better or more appropriately than other groups, but I certainly know that what has helped locally—colleagues have mentioned this—is education work with GPs and referrers to make clear to them what we can achieve in CAHMS or what social workers are looking for in that respect. What also helps is being clear about the other services that are available prior to tier 3 to ensure that people get referrals in early.

That is the gist of my response, although I should point out that, as we have mentioned, the specific criteria for getting into CAHMS might vary. We want to eradicate that variation, because the criteria need to be standard across Scotland to ensure that families and professionals understand and are talking about the same thing.

As for the mental health strategy, I go back to my earlier point that I—and certainly Social Work Scotland—want an emphasis on tiers 1 and 2. If those services are not there, some children will be escalated into CAHMS inappropriately, or they might have to wait so long that they do not get the service that they need when and for the length of time that they need it. That sort of thing is variable, and the variability comes down to funding. As we have discussed, such services are funded by the voluntary sector, and some CPPs put in money in various ways, but we are picking up a significant gap there.

Aside from asking for extra money for CAHMS—notwithstanding the fact that demand for CAHMS has gone up, particularly in relation to autism spectrum disorder and ADHD, the assessments and diagnoses of which take some time and a lot of work—I want an emphasis on ensuring that every CPP has a view about what it has on the pathway all the way from what my colleague has helpfully termed tier zero, so that people understand how children are routed into the appropriate service at the appropriate point. In the main, we identify children quite early, but it is not unknown for a child to reach secondary school and to be struggling with a lot of the transition by mid-secondary school. That is when their mental health rapidly deteriorates.

We need to strike a balance because, as we have discussed, if we focus on only one area, such as waiting times for CAHMS, we will miss out on doing a lot of the preventative work that we could be doing to keep children and young people from needing such services and, indeed, adult mental health services in the future. We need to take what could almost be called a spend-to-save approach.

The Convener: We will have to stop there. We could say a lot more on the issue, and I am sure that we will do so in the future.

I thank the panel very much, and I suspend briefly for a changeover of witnesses.

11:07

Meeting suspended.

11:11

On resuming—

Targets

The Convener: The second item on the agenda is an evidence session on targets and, specifically, on the Scottish Government's review of targets. We have received apologies from Colin Smyth.

I welcome to the committee Harry Burns, chair of the targets and indicators review; Geoff Huggins, director of health and social care integration at the Scottish Government; and Paula McLeay, chief policy officer for health and social care at the Convention of Scottish Local Authorities. I invite witnesses to make an opening statement.

Sir Harry Burns (Targets and Indicators Review): When I was asked to lead the review, my discussions with ministers were along the lines of, "Let's have a fresh look, let's decide what we want out of the complex health and social care system and let's have indicators of progress that are based on the principle of information for improvement, not for judgment." My experience over the years during which we carried out the Scottish patient safety programme, the early years collaborative and so on was that, if you give front-line staff the freedom to solve the problems that they encounter and the opportunity to test solutions, they will learn and the system will improve. As a result, in Scottish hospitals we have had huge reductions in mortality, in infection rates and in infant mortality and stillbirth rates—reductions of a level that no other system has achieved.

It seemed to me that we needed to approach the review with this in mind: targets and indicators should lead us in the direction of a change that we want. The change that we want is improved health and wellbeing across the Scottish population, which is based on people being in control of their own health and wellbeing and their own lives, and on the ways in which we support people who are in difficulty to find ways out of that and to become more engaged in the pursuit of wellbeing themselves.

I am standing back and looking at the whole system. Having said that, I expect that the public will expect some reassurance on waiting times and so on. We have made huge progress on waiting times in Scotland over the past few years and certainly since I was a surgeon at the Glasgow royal infirmary, when it was routine for people to wait two or three years for elective surgery.

We want to keep some of the things that are working, but we want to find new ways to move the system towards a more holistic approach to wellbeing. That is how we are describing what we are setting out to do.

11:15

Ivan McKee: I am glad to see that Harry Burns is leading this initiative. I do not have a background in health, but I have a background in performance measurement from 30 years in business. When I started looking at performance management from a health point of view, I was confused by the terminology. On planet NHS, words such as “outcomes” and “targets” seem to have different meanings from those that they have in the rest of the world. There is a very well-established process for doing performance management, but the health service seems to have gone off at a tangent and is looking at it in a completely upside-down, back-to-front way.

At the end of the day, you figure out what your strategy is—that seems to be called “outcomes” in the health world. You then figure out what you want to measure, which are your indicators. An indicator has an outcome—a result—and a target. Those things are parts of a coherent measurement system, but in the health world it seems that outcomes are completely different from targets. In my mind, they are all part of the same coherent structure that you need to have in place to understand where you are going and how you are getting there. Having that structure is the first step to drive performance improvement, as you say, because you need to be able to break performance down to different levels to understand it.

What are panellists’ thoughts on that process? Have I got a correct understanding of the mix-up that we have managed to get into?

Harry Burns: You are absolutely right. We have inherited a certain process. From memory, the target culture came from the horror stories that came predominately from London, where people were lying on trolleys for 48 hours before being seen in accident and emergency departments and so on—absolutely unacceptable situations. Targets such as waiting time targets were imposed on the system without any real understanding of how they would influence the broader suite of activities. I remember the discussion around treatment time guarantees for people who were suspected of having cancer when I was lead clinician for cancer in the 90s. Sixty-two days seemed a reasonable time for people to be seen and get that reassurance. A lot of targets were imposed without due consideration for the broader system. We need to step back and see what the broader system is telling us.

We had an interesting comment from the emergency medicine community at our first meeting. They said that the accident and emergency department is a barometer for what is happening outside in the community. If there are stresses and strains in the community, you see different patterns of problems presented. That was an insightful comment. We cannot judge performance in accident and emergency departments without consideration of the broader context in which they are working.

For example, a lot of stuff is said about breaching four-hour waiting time targets. When I worked in A and E departments, which was some years ago, we did not have computed tomography scanners or magnetic resonance imaging scanners. A and E departments were triage places. If someone came in with a broken bone, they went to the plaster room; if they had a cut, they went off and got it stitched; if they had a sore tummy, they went to a surgical ward; if they had a chest pain, they went to a medical ward; and so on. Now all that investigation takes place in most A and E departments. Treatment starts in the A and E department—if someone is having a heart attack, very often the treatment will start in the ambulance. However, we are still acting as if people are hanging around on trolleys. They are on trolleys being investigated and treated, so we need to rethink that four-hour target. It is important that people do not lie about on trolleys not being treated, but as soon as they start treatment, they are no longer just lying around on a trolley.

We are not thinking about the broad system and there is no appreciation of the complexity of modern healthcare. Over the next few months, I want to come up with some suggestions, get them out in the system for testing, get the opinion of front-line staff on how those suggestions helped them achieve better outcomes for patients, then move on from there. Industrial process control is probably not the right way to describe it, but we want to start a different way of thinking about performance in health and social care.

Ivan McKee: I am delighted to hear that. Targets are essential: the trick is to figure out how to measure the right things. That is the hard bit.

I have a couple of other quick comments. First, do you envisage that this would be aligned to the national performance framework? Secondly, I had a look at the 25 or so people on your expert group. The all seemed to be health professionals. If you were building a hospital, you would call in an architect and a civil engineer and not just have clinicians involved. We are building a performance measurement system: would it not be a good idea to bring in people who have done that in other walks of life?

Harry Burns: We have patient representatives and health and social care representatives and a back up of people involved in the redesign of services. In another piece of work I have been doing recently, we brought together all the modern theorists and I am writing that up so that we can feed that thinking in.

The Convener: I have to pick Harry Burns up on one thing. You said that we did this on the back of the things that happened in London. Many of those things also happened in Scotland. I would not like us to rewrite history at the very start of this. We all have constituents who have experienced similar things, up to the present day.

Harry Burns: The four-hour target was initiated in England by NHS England on the back of a number of scandals. I am not saying that we were perfect. Interestingly, we have looked at performance in other countries. Very few outside the United Kingdom impose targets on A and E departments, but in comparison to those other countries we do pretty well.

Donald Cameron (Highlands and Islands) (Con): I will ask two questions, one specific and one general. The specific one is about the sense of enshrining targets in law. The treatment time guarantee is enshrined in the Patient Rights (Scotland) Act 2011. I looked at the legislation this morning. If there is a breach of the guarantee, the health board must make arrangements to ensure that someone is treated early or at the next available opportunity, give an explanation to the patient and give support and feedback. My provisional view is that that does not provide any substantial pressure to the health board. I would like you to consider in your review the logic of enshrining the targets in statute. There does not seem to be much point in doing that.

Harry Burns: I would like information to be used for improvement. If you set a target, that is as good as you are ever going to get. It might be that we are looking at exceeding and doing better than those targets. It might be that we would find ways of improving way beyond the existing guarantees, but while there is a target, particularly one that is enshrined by law, that is as good as you are going to get. Folk are not going to have any reason to go any further.

I have an open mind just now. I think that, by the time that we sit down and engage with front-line staff and patients, we might well come up with a set of ideas that leads to better performance than that currently enshrined in statute. Enshrining things in law is for you guys to decide, but it does ossify the process once you do that.

Geoff Huggins (Scottish Government): Some of the early feedback that we have had, and one of the reasons why we are having the review, is the perspective that those targets that were enshrined in law have so much more force within the system than other issues such as the provision of services in the community or broader population health gain.

The challenge that Mr Cameron is presenting is that targets do not have enough force, but quite a lot of the feedback that we are getting is that they have too much force and distort the system. That is one of the issues that we need to tease out through the review.

Donald Cameron: My second, general question picks up on what Ivan McKee was asking, and is the fundamental question of what we should be measuring. We need some kind of benchmark for performance. Patient outcome is talked about a lot. It would be sensible to have a measure of efficiency of some sort.

The four-hour A and E target is a good example, because it matters to a member of the public how long it takes them to get through A and E. They will walk out of a hospital either having been seen quite quickly, or the experience having taken ages. They will make a judgment about whether that was a good experience.

Harry Burns: You are right and I accept that. However, what we see and, in part, what is being presented to me is the idea that, in the four and a half hours that a person spends in the A and E department, two hours of that time might be spent being treated or investigated. In days gone by, that would have required an admission to the ward and an overnight stay. We need to collect data to see what is actually happening within the four-hour target and we need a rational way of meeting patient expectations for a timely encounter with the health service. At the same time, we need a way to allow the patient to get rational investigation and treatment and, if that should happen in the A and E department, so be it.

Donald Cameron: I think that you realise that it is a much more nuanced picture than simply measuring a timeframe. We have all heard from hospital staff who say that the A and E target is useful, because it shows how quickly people move through the hospital and how the hospital is working. On the other hand, I spoke to a doctor who said that, if the primary care system is working well, a lot of people are seen in primary care by their GP and most do not get to A and E. Only the hardest cases get to A and E and, because they take longer, they breach the target.

Harry Burns: We have encountered an interesting Australian study in which the four-hour waiting time target was reviewed in 59 hospitals. It found that patient mortality increases the closer that they are to the four-hour target. In the paper, they have not come up with a rational explanation for that, but it seems to me that those are the sickest patients. They are the patients who come in, who are being worked on, who are having things done and who are being resuscitated, therefore mortality is higher. We have to understand the processes that are at work in A and E departments and come up with a rational way of supporting them to support patients.

Alex Cole-Hamilton: I welcome and thank the panel for coming to see us. Thank you, in particular, to Sir Harry Burns for his elucidating opening remarks and subsequent answers on the multidimensionality and nuances of the targets that we measure at the moment, particularly with regard to A and E waiting times, which was a point well made.

Waiting targets are fresh in the mind of committee members, not least because we cross-examined the cabinet secretary last week about the Audit Scotland report, “NHS in Scotland 2016”, which was very uncomfortable reading for the Government. Of the eight targets that had been set, only one was met, two were nearly met and the performance on the rest was pretty poor. In that session, it was suggested to the committee that the targets that Audit Scotland was assessing are some of the hardest and most challenging in the world. Is that accurate? Is it a good thing? If the targets do not capture the multidimensionality that Sir Harry Burns describes—which might offer some mitigation of the binary, black-and-white, pass-fail report that was given to us—how might they be improved?

Harry Burns: The four UK healthcare systems have broadly similar targets. The healthcare systems of the Republic of Ireland, Australia and New Zealand are the others that we looked at that have attempted the target approach. We think that some European countries have targets for some bits of their healthcare system, but we cannot find consistent publication of data. The Republic of Ireland, Australia and New Zealand targets are far laxer than ours. For example, off the top of my head, the Republic of Ireland’s admission waiting time target is something like 25 per cent of patients admitted within two months and 100 per cent within a year, whereas our target is much shorter than that.

11:30

We have set ourselves pretty robust targets, and, where we fail, my bet would be that a number of the failures will be underpinned by robust and sensible explanations. The problem with the data up until now is that those explanations have not been sought. All the management evidence that I read shows that where we have targets, management effort is put into ticking the box. I would like to understand what is going on out there. If 90 per cent of people meet the target and 10 per cent do not, you need to learn from the 90 per cent in order to help the 10 per cent. If all you are concerned about is ticking a box, you do not learn. We can improve way beyond what we are doing, but we have to make that effort and destigmatise the process in the interim.

I have been looking at data from one of Scotland’s largest health boards that says that the number of patients attending A and E departments has declined significantly over the past few years, which kind of suggests that primary care may well be doing the right thing. That did not come out in the Audit Scotland report, so there is stuff happening out there that we need to know a lot more about. The next three or four months is our effort to understand what is happening and reshape it.

The primary target should be about improving the health of the public in Scotland and what we need to do to achieve that through the healthcare system, the social care system, the criminal justice system and the education system. I am not sure whether the Scottish Government knew what it was getting when it asked me to do this, but I am looking at the whole system.

Alex Cole-Hamilton: I agree with everything that you say. My response is possibly the knee-jerk, visceral reaction of any Opposition member reacting with some scepticism when the Government, having failed to meet a set of targets, commissions a review as to whether they should be setting the targets in the first place. It might be incumbent on us to react like that. I want to go where you are taking us, but I also want to be confident that we are not just giving the Government a pass.

Harry Burns: Absolutely. I do not hold the knee-jerk reaction against you.

Alison Johnstone: I was heartened to hear Sir Harry speak about a much more holistic approach to Scotland’s health and wellbeing. It is obvious that targets affect budgets: we spend money to meet them. Is that having an impact? Is there what some of us might perceive to be a lack of intervention and a lack of a more preventative approach because we are obsessed with targets?

Harry Burns: I am sure that Paula McLeay will have some comment to make on that. You are absolutely right—at the moment, budgets are in silos. Despite all the efforts to get integration, people are accountable for different bits of the budget, so although money can be saved in acute care, for example, investing it in primary care and social care is different. There has to be an effort to bring the money together, to ensure that it flows to the correct place. There are tools for doing that but, at the moment, different accountability streams make it difficult for that money to come together.

I have been looking at stuff on the way in which front-line staff engage with people. Some studies from England show substantial reductions in costs in criminal justice and healthcare when we get things such as housing right. We need to think broadly.

Alison Johnstone: I ask you to address another point. GPs at the deep end have produced research that argues that the way in which we allocate NHS resources, particularly under the Scottish resource allocation formula, does not do enough to tackle health inequalities.

Harry Burns: I have some sympathy with that. I return to the point that health inequalities will not be fixed simply by healthcare and that, when people looked at one major set of interventions in the north of England, they found that the most important public sector worker in fixing a lot of things was the housing officer. Helping people to get out of difficulties with their housing seemed to have a big impact on their health and wellbeing, on reducing domestic violence and on stresses and strains. That is difficult to quantify.

Alison Johnstone: Could we have NHS targets on reducing poverty?

Harry Burns: NHS targets on reducing poverty?

Alison Johnstone: We know of income maximisation schemes such as healthier, wealthier children in Glasgow, where health visitors and midwives help families who are on low incomes to access benefits.

Harry Burns: Such work is already happening. Our early years collaborative found that health visitors in Lanarkshire who were doing 30-month assessments were referring people to money matters centres. That is what happens when the front line is empowered. When we tell those who are on the front line to solve the problem, they come up with innovative solutions and get on and do it. That is part of the culture that we want to engender.

Paula McLeay (Convention of Scottish Local Authorities): The value of bringing the review of NHS targets and the review of health and wellbeing indicators together is that we are asking whether the whole system is pulling in the same direction. That question is really important.

We know that targets fundamentally drive behaviours. We need to focus our attention on whether the answer to an A and E target is to invest in A and E or to invest in the preventative services that keep people out of A and E. How do we ensure that we have the right targets and indicators to shift the behaviours to deliver the outcomes that collectively we agree need to be achieved for people? Fundamentally, that is the task that has been set.

Geoff Huggins: We are beginning to see the integration authorities, which have the resource for A and E and the resource for unscheduled care bed days, looking at what they can do upstream. Some people say that targets drive money too much. Sometimes, however, people say that they do not drive it enough, in that the better solution to what is going on in the hospital sector is better preventative and anticipatory care.

The challenge is that we now have the organisations—although in some places we have had them only for seven or eight months—that have the pooled budgets and can look across the system and offer different solutions from those that we have had historically. We are beginning to see that happen.

Of the health and wellbeing outcomes to support integration, the fifth is a requirement on partnerships to address health inequalities. Within that, we are seeing exactly the sort of projects and work that Alison Johnstone identified. The integration authorities will be required to report annually on what they have done to address health inequalities within their responsibilities, which go beyond healthcare systems.

Harry Burns: One process that we introduced in the patient safety programme and the early years collaborative involved encouraging people to collect data daily—for example, how many people you saw today, how many people you gave debt advice to, how many people took up the debt advice and how many people have come back and said that they were better off as a result.

Having annual reports is one thing, but what keeps the front-line staff trying new things is seeing the run charts on the wall. The classic example that I use in my lectures is of bedtime stories for children under the early years collaborative. We know that bedtime stories enhance cognitive ability. The nurseries just asked the kids whether they got a bedtime story. Nurseries did things, and gradually the number went from 60 per cent to 90 per cent of children, because the nurseries followed that up daily.

When we implemented specific infection-control programmes in the patient safety programme, the more there was compliance with the programme, the lower the infection rate was. That is tremendously motivating to front-line staff. They see change happening and they want to make it happen.

A key is the methods that we use to implement those high-level objectives. I suggest that annual reports are not sensitive enough and that we need the day-to-day flow of information.

The Convener: At the beginning, you listed successes on infection control, mortality rates and so on. How many of those successes were driven by targets? If we were meeting the targets, would we be reviewing them?

Harry Burns: The patient safety programme and the early years collaborative set their own objectives. When that is done, people get the system together and say, "What do you want to achieve?" In the early years collaborative, the aim was to make Scotland the best place in the world for children to grow up in. How would we know that we had got there? The aims were to reduce infant mortality levels by 15 per cent by the end of 2015, to reduce the stillbirth rate by 15 per cent by 2015, to improve developmental progress to 85 per cent by the age of three and so on. Front-line staff set those aims then set about trying things to achieve them. We made the 15 per cent reduction in infant mortality, we overperformed on the stillbirth rate—it was an 18 per cent reduction—and we will know at the end of this year about the other aims.

If someone from outside comes in and imposes something on the front-line staff, with the staff having no say in whether the objective is credible, the staff are perhaps not as engaged. If the staff set the objective, it will be more challenging. Not for a second did I think that we would reduce infant mortality levels by 15 per cent—I cannot find any other country in the world that has done that over the past three years—but we did it.

That approach is different from the external setting of targets. The system sets the target and tests ways of achieving that target, so we know from the start that staff are engaged with it. We might come up with that in the review, but we might not. We might have a mix that includes externally imposed targets.

The Convener: If we were meeting the targets, would we be reviewing them?

Geoff Huggins: There is a wider context to the work that is going on in Scotland. At its ministerial meeting early next year, the Organisation for Economic Co-operation and Development will look at how advanced healthcare systems around the world consider issues that are to do with quality and performance. The expectation is that systems will increasingly move towards patient-reported outcomes, so the question will be not, "How did the system, as a machine, operate?" but, "What was your experience of health and care? Did you feel safe and listened to? Did you feel that you had control over what happened?" There is a wider context to our understanding of what healthcare systems are for.

Michael Porter's work on value-based healthcare is about moving beyond the approach of simply asking how fast something happened or how much it cost to looking at the degree to which it produces greater health or greater satisfaction. That is about how people understand their relationship to the healthcare system.

The challenge with such things is that, because they become increasingly related to people's expectations and experiences in a complex distributed system, they are probably even more difficult to achieve than mechanical targets. It is probably even more difficult to offer satisfaction to a population of 5 million people on their experience each time they cross the threshold of the GP surgery than it is on how quickly they were seen. The challenge is about opening up a space in which we are likely to require not only different forms of data collection but different ways of understanding the benefit that people receive. Such things are not necessarily easier to do.

Members have to understand that there will still be things on efficiency and sustainability and that people will expect a predictable healthcare system that is well managed. However, what has been set out regarding people's experience of their own health and wellbeing and the degree to which a health gain is produced is quite a big ask. Please do not underestimate the ambition of the work.

The Convener: It is only a few years since the push came for the 12-week target. I do not know how long Mr Huggins, his predecessor or other people in the directorate have been in post, but did people encourage or discourage the Government from going down the route of targets? Are the same people who advised on that still in post but now saying, "Actually, we need to move away from something that we were involved in implementing"? I am trying to get to the bottom of how the decision was made in the first place and whether some of the people who pushed for it are in the same place and now saying, "Actually, we were wrong on that."

There is nothing wrong with people saying that they were wrong and that they had the wrong approach. I have spoken to stakeholders who have been involved. I recently went to a Royal College of Nursing Scotland seminar at which people said, "At the time, we were all involved in it—there was a bit of an atmosphere and everybody just went along with it. Maybe we shouldn't have."

I am playing the devil's advocate, which is part of the committee's role. Are some people saying, "This is the kind of mood and atmosphere now. Maybe we should just go along with it"? In the same way as before, they might regret that in a number of years.

11:45

Geoff Huggins: I cannot entirely understand the different motivations that a range of people might have had for saying different things and for saying what they said when they said it. Our challenge is that people often say that they want us to review targets because the targets are wrong or too specific. They often ask for targets that relate to their specialism or professional interest. People say different things for different reasons.

The broader context in which we understand targets, performance, outcomes and indicators moves on. If we go back even three or four years, the work on the indicators is a good illustration of that. The first nine indicators that support the nine health and care outcomes were largely derived from information from the Scottish health survey, in which we asked qualitative questions of the population. At that time, that was the best methodology for understanding people's experience of healthcare, such as their sense of safety and control.

However, for the reason that Sir Harry Burns outlined, we need real-time day-to-day information that gives feedback loops and engages people in the service that they deliver. One reason why we are reviewing the indicators is that we need faster access to knowledge about people's experience of healthcare. The methodology that is used to get that information has moved on, as has our understanding of the change process. We are looking to develop systems that enable partnerships to know about people's experience this week—not 18 months ago when the survey was done, after it has been collated and published, as such information does not give partnerships any ability to act.

The broad themes will continue, but the methodology by which we get to them may differ. The example of the four-hour target was given and was discussed at the first meeting of the expert group; different people have different views on that and have had different views over time. It is a good indicator of overall sustainability and the system's ability to run effectively. How we understand that as part of a broader objective of producing health gain and the wider benefits of the health and care system will probably change over time, but we will still need something to carry out that function in the system.

The Convener: Richard Lyle has a question.

Richard Lyle (Uddingston and Bellshill) (SNP): My question has been partly answered. I have the greatest respect for Sir Harry Burns and I am sure that he will do a good job. My question is for Geoff Huggins. Boards are diverting resources to meet targets. Disproportionate amounts of money have been spent to manipulate targets by, for example, bringing in surgeons and other people to work overtime. The charge that will be made against you and the Scottish Government is that you have not met the targets so you are changing the system.

You have partly answered my question but, in all honesty, do you agree that over the years we have built up many targets and ways of doing things and had many political parties attacking the health service and attacking people such as you? You have brought in the targets and are responsible. What are we going to do about that? How are we going to ensure that people like me—and others—do not say to you that you are going to manipulate things again? How are we going to have clear, concise targets that are meaningful to people and which everyone respects?

I would like you to answer rather than Sir Harry Burns—he has spoken for most of the session and I have listened to him intently. How will we get the right targets in place that are respected by all political parties and the public?

Geoff Huggins: As Sir Harry Burns outlined, we have a process to seek a wide range of views. We are able to draw on expert advice. We are able to test the ideas that come from the review process, and we will do that. The challenge is that we are doing something that is complex and will need to operate on a number of levels. The process needs to take us to the situation where we can produce better health—that is the intention of the health and care system—and where we can demonstrate that the system is running effectively and give confidence to those who hold us accountable that the stewardship of the system is being discharged effectively.

That is a range of slightly different ideas. I guess that the challenge in the review of targets is that people will tend to load all their expectations on to it as the mechanism whereby we will fix a range of ills, when it will be only one part of the solution that we need to bring forward.

Richard Lyle: I know that Sir Harry Burns will respond to this question. Are you under any pressure at all to deliver certain targets, or will the Government fully accept what your group comes up with?

Harry Burns: You know me well enough to know that I am pretty good at withstanding pressure and that I would never put my name to something that I did not fundamentally believe in.

Richard Lyle: I know that only too well.

Harry Burns: In discussions with ministers, I have said that I want to stand back and take an overall view of the system. However, I recognise that the public have expectations of guarantees about how they will be treated. I will do my best to ensure that we bring all the competing priorities together and come up with something that is credible and insightful and does something for the wellbeing of the people of Scotland. That is the fundamental thing that is in my head: the question is not how fast someone goes through a bit of the system but how well people are and whether we can move them to a better place.

On Geoff Huggins's answer to you, we are where we are because, when targets were brought in, that was what people did—that was the notion in people's heads about how to move a system, and we have learned from that. We will come up with an insightful way forward but, five years from now, other insights might well have emerged that will lead us to tweak the system even further. We can never say that there is a gold-standard set of targets.

Now that I am a free agent, as an academic, I am going all round the world telling people about the changes that Scotland has made. People are asking me to help them to set up an early years collaborative, as we did here, and they want to know what our thinking is about health inequalities and so on. Scotland is getting a lot of attention because of what we have achieved.

Now we are in the next phase, but I am not fooling myself into thinking that in the process we will not learn even more and find even better ways of doing things. That is how systems change.

Paula McLeay: The convener asked whether we would still be doing the review if all the targets had been met. I certainly hope so, because how well we are doing on the current targets is no indication of whether our system is fit for the future that we want to achieve and can drive the changes that we want in models of care, which are about shifting the balance of care, providing more care in communities, investing in social care and supporting people's outcomes.

At the moment, what we have is siloed and operational. It is not that such things do not have a place, but they are unlikely to get us to where we want to be in the future. Regardless of what the performance indicators are telling us about the system right now, we certainly need the current review so that we can ascertain whether the whole system can drive and support the change that we want.

Miles Briggs: To what extent do you think that there is manipulation and massaging of figures around targets? The Audit Scotland report maybe did not point towards that, but I have met professionals—I do not say this to criticise them—who are not putting people on the system because they know that if they do they will not meet their targets. I have seen that happening and I know that it is happening in CAMHS and in alcohol and drug partnerships. What is your view, given the work that you have done? My concern is that whatever we put in place, such manipulation will happen all over again.

Secondly, where does the realistic medicine agenda fit into all this?

Harry Burns: That was certainly an issue that I raised with the emergency medicine people at the first meeting of the expert group. They said that if that is happening, it is happening in a very small number of cases. The people whom I spoke to said that they are just working hard to achieve the four-hour target.

As far as the CAHMS people are concerned, I do not know. I have not specifically asked them and it is not something of which I have any direct experience. Perhaps Geoff Huggins can comment.

Geoff Huggins: We did a review about three years ago—following the challenges that we had in NHS Lothian—to assure ourselves that what we had seen there was not happening elsewhere. At the time, we were satisfied with the outcome of the review.

If Miles Briggs has information that suggests that there are things that we should look at, we would be very happy to look at them. Our experience, however, is that the value that clinicians take from targets is in seeing them as something that gives them influence in relation to securing resource. To artificially present a better position than the one that they are in is not always seen as the best way forward. If you have such information I would be very happy to see it.

Harry Burns: Part of the improvement process is to allow front-line staff to try to do things differently and to see whether that produces a better result. I say to them that if it works they should tell everyone about it, and that if it does not work they should tell everyone about that, too. The only shame in failure is in not telling people about it, because they therefore do not learn that that intervention does not work.

If there is a sense out there that the situation is punitive, that is not good. Information should be used for improvement: if there has been a failure, we should ask why it happened and what we can do next time to ensure that failure does not happen. If we create that kind of climate, the whole system will gradually improve.

The Convener: The issue in Lothian was that manipulation of the system was happening and no one was being told about it.

Miles Briggs: What about realistic medicine?

Harry Burns: I think that what is happening is entirely compatible with the chief medical officer's approach to realistic medicine. The medical system is part of the broader health system, which is part of the broader social system, and the broader social system needs to change in order to achieve the wellbeing agenda for Scotland. Realistic medicine fits in very nicely and offers a way of conceptualising the healthcare contribution to that. I will be having conversations with the chief medical officer to make sure that we are all on the same page.

The Convener: Finally, what is the timescale and what happens next? What is going to happen with the system that you have implemented?

Harry Burns: We are developing workstreams around understanding the data, we are gathering evidence from what has happened elsewhere on what might make the improvements and we are developing understanding of how they might be applied in Scotland and of the method that might be used to drive the changes.

I hope to have an initial report ready for ministers by the end of March or in April, and I hope that it will include proposals for testing things out to ensure that they do not create perverse incentives or unanticipated effects within the system. If they do not, we will adopt a continual-improvement approach to delivery of services. In the course of that process we will want to engage with the public in a number of ways. Members of the committee are obviously a key link to constituents and so on, so we will want to hear your views.

The Convener: When is the report likely to be in the public domain?

Harry Burns: It will be in the public domain at the end of March.

The Convener: Okay. I thank the panel very much for their attendance this morning.

11:59

Meeting suspended.

12:00

On resuming—

Petition

NHS Centre for Integrative Care (PE1568)

The Convener: The third item on the agenda is a petition that has been referred to the committee by the Public Petitions Committee. This is our first look at petition PE1568. I ask members for comments—including on how they wish to proceed with the petition.

Miles Briggs: We should keep the petition open. Other work is on-going on public consultation and due process around that; we await the outcomes of that work. It would also be helpful if the committee were to write to the Scottish Health Council for its views.

Alex Cole-Hamilton: I have been impressed by the fervour with which the petition has been presented to Parliament: there is a demonstration outside at lunchtime. The supporters of the service are to be commended. We are listening.

Alison Johnstone: We have all received a great deal of correspondence on the petition, and many of the centre’s patients feel that the in-patient component of treatment is invaluable and important for their recovery. Without it, the offering would not be the same. The centre helps people with chronic pain and chronic fatigue syndrome, so the issue of travel is important because the effort of getting there might negate the benefits that they receive. I agree that we should keep the petition open.

Ivan McKee: I would echo that. A huge amount of work has gone into the petition. I commend the group behind it for bringing it to the committee’s attention. Our writing to the Scottish Health Council to understand its approach would make a lot of sense; it will keep the petition live and we will take the matter from there.

The Convener: I hope that we will invite the Scottish Health Council to speak to the committee, in due course.

All committee members have had correspondence, and a number of us have made representations to the health board and others. We all have personal views on the issue, but the committee agrees to keep the petition open and let the process take place. Thank you.

12:03

Meeting continued in private until 12:45.

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