HEALTH AND SPORT COMMITTEE

Wednesday 1 April 2009

Session 3

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HEALTH AND SPORT COMMITTEE
11th Meeting 2009, Session 3

CONVENER

*Christine Grahame (South of Scotland) (SNP)

DEPUTY CONVENER

*Ross Finnie (West of Scotland) (LD)

COMMITTEE MEMBERS

*Jackie Baillie (Dumbarton) (Lab)
*Helen Eadie (Dunfermline East) (Lab)
*Michael Matheson (Falkirk West) (SNP)
*Ian McKee (Lothians) (SNP)
*Mary Scanlon (Highlands and Islands) (Con)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)

COMMITTEE SUBSTITUTES

Joe FitzPatrick (Dundee West) (SNP)
Mr Frank McAveety (Glasgow Shettleston) (Lab)
Jamie McGrigor (Highlands and Islands) (Con)
Jamie Stone (Caithness, Sutherland and Easter Ross) (LD)

*attended

THE FOLLOWING GAVE EVIDENCE:

Jan Baird (NHS Highland)
Carol Fisher (NHS Ayrshire and Arran)
Professor Alex McMahon (NHS Lothian)
Julie Metcalfe (NHS Greater Glasgow and Clyde)
Jennifer Milligan (NHS Dumfries and Galloway)
Nicola Sturgeon (Deputy First Minister and Cabinet Secretary for Health and Wellbeing)

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SENIOR ASSISTANT CLERK

Douglas Thornton

ASSISTANT CLERK

David Slater

LOCATION

Committee Room 2

Scottish Parliament

Health and Sport Committee

Wednesday 1 April 2009

[THE CONVENER *opened the meeting at 10:05*]

Child and Adolescent Mental Health Services Inquiry

The Convener (Christine Grahame): Good morning. I welcome everyone to the 11th meeting in 2009 of the Health and Sport Committee and remind members and witnesses to switch off their mobile phones and other electronic equipment. No apologies have been received.

Under agenda item 1, the committee will take oral evidence in our child and adolescent mental health services—CAMHS—inquiry. I welcome our first panel of witnesses. Carol Fisher is health care manager at NHS Ayrshire and Arran; Jan Baird is director of community care at NHS Highland; and Professor Alex McMahon—I hope that I said his name properly—is deputy director of strategic planning and modernisation at NHS Lothian.

I ask members to launch off with questions. The witnesses should indicate to me if they wish to answer a question.

Michael Matheson (Falkirk West) (SNP): "The Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care", which was produced in 2005, obviously came off the back of the Scottish needs assessment programme—SNAP—report on child and adolescent mental health.

The Convener: Do the witnesses have a copy of that document in front of them? I am passing a copy of it down to them in case they do not have it. I am sorry that I stopped you, Michael.

Michael Matheson: Key principles from the SNAP report were contained in the framework. What have you started to change in the services that you provide as a result of the framework?

Jan Baird (NHS Highland): In NHS Highland, with our partners in Argyll and Bute Council and Highland Council, we specifically started to look at our specialist services in the department of child and family psychiatry and the services from it into the community. It was recognised where the gaps were, and an implementation plan that spans eight to 10 years and mirrors the framework's requirements was produced. The process has been on-going, with both our council partners. The need to work with partners to deliver has been recognised.

Having redesigned the specialist services end of CAMHS, we considered how to develop work with our tier 1 and 2 services in primary care and the development of the primary mental health worker, whom the written evidence showed is instrumental in delivery. That role, which has been in place for some time, is being reviewed, and we are looking to expand it to meet some of the framework's requirements.

Professor Alex McMahon (NHS Lothian): I joined NHS Lothian in September last year, so a lot of the work that we are talking about pre-dates my coming into my post.

It is reasonable to say that all of the principles that are set out in the framework have been incorporated into our work plans in NHS Lothian. To pick up on what Jan Baird said about the tiers of service that we offer, a lot of work is based in the community in primary care, but a lot is also done on promotion and prevention, in particular in specialist services, as well as on tackling ill health.

We are undertaking a review of our CAMHS within new Scottish Government policy guidance, particularly on the Government's waiting time commitment on child and adolescent mental health, to ensure that the principles and the other work that we currently deliver are fit for purpose for the future.

Carol Fisher (NHS Ayrshire and Arran): I came into post only at the beginning of January, so much of the work has happened—

The Convener: I am sure that this is not a plot—it is just coincidence that a couple of you only recently came into post.

Carole Fisher: Yes. CAMHS are obviously an integral part of what we have been doing in NHS Ayrshire and Arran in our full review of mental health services. We continue to work closely with partners on that, and a group was set up with input from CAMHS and other partners. It is headed by one of our public health consultants and focuses on the framework's implementation.

The outcome of our strategic review of mental health services produced many recommendations that we are in the process of implementing, including restructuring how our CAMHS are delivered and developing primary care mental health link workers in schools.

Michael Matheson: A number of different service elements and activities are identified with lead partners in different sections of the framework. What percentage of the service elements and activities would you say that you have fully implemented?

Professor McMahon: I would not be able to give you an answer to that question just now. I would have to come back to you on that.

The Convener: It would be helpful if you can write to the committee with that.

Jan Baird: Can I ask Mr Matheson for the references from the document?

Michael Matheson: Yes. For example, page 33 of the framework document is headed "Service elements and activities", although I was not specifically referring to that one. The service elements and so on appear throughout the document in different sections. Areas are clearly identified for action, so it would be helpful to know where you are at in each of them.

Jan Baird: We certainly have an implementation plan across NHS Highland that covers all those actions. I would be happy to share that with you because it would give you the detail that you want.

Michael Matheson: Yes, but can you give us the detail on how far along you have got with your implementation plan?

Jan Baird: For every element?

Michael Matheson: Yes.

The Convener: If it is not possible to do that just now—although you might be able to touch on some elements today—we will be happy to have that supplementary evidence in writing. What can you tell us today and what can you provide us with later?

Jan Baird: I can go through the detail of some of the elements on which we have done quite a bit of work. The first one is on the involvement of children and young people. We have done significant work with the Highland users group, which represents users of mental health services and recognises the need to address children's and young people's mental health. It is looking to develop a young people's Highland users group. The group did a review so that, before we went into the redesign, we could capture young people's views about what services they want and what they feel about existing services. That was a significant piece of work, and such a policy review would be helpful for the committee.

On the provision of training and consultation for teaching and non-teaching staff, we have some developments that involve working with staff specifically. We are developing policies; for example, just about ready for implementation is a policy that has guidelines on responding to emotional distress in integrated community schools. That is intended to help staff working with young people who suffer from emotional distress. We are also using some of the heads up Scotland materials and working on attachment resilience and emotional wellbeing training. Quite a lot of training is being developed that will allow us to have a training programme that we will incorporate in our integrated children's services plan, which is "For Highland's Children 3". Again, we recognise the need to support staff.

That covers some of the links with the elements in the framework document.

The Convener: Does somebody else want to comment? I appreciate that the framework refers to quite a few elements.

10:15

Michael Matheson: I want the witnesses to be aware of what I am trying to get at. The document is more than three years old. It has a range of helpful headings under which the lead partners are identified and the action points that are meant to be taken are given. I want to understand exactly how far along the line you are—as service providers and others who are responsible for the implementation of the framework—in implementation in each area that is set out in the framework. Your response to that will give me an understanding of what you have achieved over the past three years and what you have still to achieve. I am not looking for information on implementation plans; I am looking for what you have done.

Jan Baird: That was what I was trying to explain. We have a 10-year plan in which we address the issues, recognising that implementation has to be incremental. I explained our actions around young people and mental health, and we have worked on a review of our primary mental health worker service. Our education and social work partners and families welcome that service, which is very successful. It is important to keep young people in the area through early intervention and support work—that is very important in an area such as Highland. The review of our primary mental health worker service is informing the framework. We are also reviewing our wider children's services, which incorporates CAMHS. Paediatricians play a key role in services for young people with mental health problems.

That is a flavour of some of the things that we are doing, if that is helpful.

The Convener: Does any other witness want to come in at this point, or would you rather provide evidence at a later stage?

Carol Fisher: I will provide evidence at a later stage.

Professor McMahon: I would rather provide it after the meeting.

The Convener: Written evidence?

Professor McMahon: Yes.

Mary Scanlon (Highlands and Islands) (Con): I echo Michael Matheson's point. In the foreword to the framework, the two ministers say:

"We now look to our partners in the NHS and local government to ensure that it is delivered."

The document is, in fact, four years old. About a month ago, a new bill—the Education (Additional Support for Learning) (Scotland) Bill—was lodged. That prompts the question that Michael Matheson put: how much of the framework has been implemented?

I turn to page 26 of the document, which is on early years. My main concern in that regard is early identification—an issue on which witnesses have expressed concern at committee. Last week, the committee heard Dr Philip Wilson of the University of Glasgow express serious concerns: he spoke of an absence of health visitors and highlighted Highland as possibly the worst such example. I live in Inverness and have family experience of the issue—after my granddaughter's 15-month health check, my son was told that the health visitor did not need to see my granddaughter again until she was five. I asked friends who work in nurseries in the area about contact between the nursery and health visitors. The answer was that there is none. In evidence last week, Dr Wilson said that, if a child development opportunity is missed, it is missed for ever.

I am concerned about the lack of early intervention and diagnosis. Parents have to battle to get anything. The parents of children at Drummond school are an example: last week, I received information on a parent survey that showed that some parents have had to wait 10 years to get occupational therapy for their children. It is heartbreaking for MSPs to have to write to health boards and schools on these matters.

I have heard about an implementation plan for Highland and that NHS Highland is asking people what they think about services. My question is this: are children being identified at the earliest possible age? Are children being identified so that they and their parents can be given support, advice, treatment and so forth? In my experience, that is not happening.

Let me also welcome Professor McMahon to the meeting.

Jan Baird: The points are valid ones. Early intervention is key, and the role of midwives, health visitors and school nurses is vital in the delivery of mental health services for young people.

We have a number of parenting programmes—the Webster-Stratton and Pippin programmes, for example—that many of our health visitors have been trained in. It is known through evidence that baby massage develops mother-and-child bonding and relationships. We have also done training with our midwives on recognising the importance of bonding in the early days and on how that can contribute to the emotional wellbeing of young children and prevent issues later on. All of those things will be part of our training programme, which I hope will become a rolling programme and will be evidenced through "For Highland's Children 3".

Mary Scanlon: Obviously, baby massage is important, but I am talking about potentially vulnerable children who go three years and nine months with no health checks and no health visitor. There have been examples of that recently; the Brandon Muir case and others have been in the press. I am seriously concerned about the matter, particularly after the very poor report on child protection that Moray Council received.

What is being done to pick up vulnerable children with mental health issues at that stage? Baby massage is welcome, but we are talking about more than baby massage; we are talking about potential mental health problems that can be identified and treated in childhood so that they do not become a huge issue in adulthood.

The Convener: I think that Mary Scanlon is talking about the mental and emotional wellbeing of children at that age rather than diagnosed mental illnesses. We are looking at the early stages. I am looking to my medical colleagues, who are nodding, so I seem to have got things right.

Will the witnesses address the role of health visitors in particular? The evidence that we have received is that health visitors are key before a crisis happens and social workers become involved, and that a carer or mother would perhaps see a health visitor coming to their home as a positive experience, whereas people would be on the defensive if a social worker came to their home and would see their work as a bit of policing. There is a different attitude to health visitors, so will you address the health visitor's role and our concerns?

Jan Baird: Absolutely. I cannot comment on the lack of health visitors because that is not my understanding. Health visitors have a key role: under the getting it right for every child programme, health visitors in universal services are individuals who co-ordinate and help to progress the care of people and identify any early issues. They are therefore seen as having a key role.

Mary Scanlon: How can they do that if they do not see a child for four years?

Jan Baird: I do not understand why they do not do so. I would have to look into that.

The Convener: So that is not within your ken at the moment.

Professor McMahon: Mary Scanlon is right about the need to identify the needs of particular children between zero and three years—particularly children in households in which either parent or both parents may have substance misuse, drugs or alcohol problems—in order to ensure that children are protected and that support is given to the families. Parenting skills are incredibly important at that stage, as is the need to ensure that there is developmental support for the child physically, psychologically and intellectually to achieve attainment.

Fortuitously, only yesterday I was at an event in West Lothian that considered the life stages model and the work that needs to be done between zero and three. We considered the need to ensure that educational attainment for pre-school children and schoolchildren is supported and that the right investment is made in health, local authority and voluntary sector services to ensure that the maximum support exists.

Perhaps the issue of stigmatisation is being alluded to. There is a perception that a health visitor might be acceptable to families while social workers might not. We probably have a role to play in destigmatising and ensuring that the appropriate interventions support families at the right time.

The Convener: Ms Fisher, do you wish to say anything? You do not need to if you do not want to.

Carol Fisher: I cannot make any specific comments about health visitors and how often they see children, but I agree that we are doing a lot of CAMHS work in early years interventions, supporting staff to identify where there are problems.

The Convener: How do you do that? How do you identify problems in very young children?

Carol Fisher: CAMHS in Ayrshire and Arran are refocusing into locality teams and working with partners. That is the next step. CAMHS and their partners will work to support the health care staff who actually see children.

I cannot comment on how often health visitors see children, but a health visitor works within the CAMHS team, and that provides a link.

Jan Baird: I can add some further assurance. In our submission we alluded to the development of an infant mental health best-practice pathway between a clinical psychologist and our special care baby unit in Raigmore hospital. That provides the earliest possible intervention and support to parents. The people who meet up with very young babies and children work in universal services, but we need to develop their competence and their confidence to deal with mental health and wellbeing. That is what the pathway will address.

Mary Scanlon: Although the framework appears to be an excellent document, much of it seems to be simply getting ignored, despite the fact that it is about five years old. Sorry—I mean four years old. That possibly justifies the fact that a bill had to be introduced to address the issues. I have found the evidence—apart from that given by Professor McMahon—quite disappointing.

The Convener: You are making it older by the day—that is how I feel.

Mary Scanlon: The framework is from 2005—it is four years old.

Michael Matheson: It was October.

Mary Scanlon: 2005.

The Convener: Please: members should speak through the chair, not across the table.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I have three short questions, and I will split them up. The first is a very simple one: who audits the implementation of the SNAP report and holds the health boards to account?

Professor McMahon: From my short time at NHS Lothian, I am not aware that the SNAP report has been on the agenda, for example when the minister or cabinet secretary has come to do an annual accountability review. I guess that, through the health improvement, efficiency, access and treatment—HEAT—targets and the single outcome agreements that we now have in place, there will be greater scrutiny around implementation.

To pick up Mary Scanlon's point, the issue is not so much around implementation—a lot of the work is being implemented—but around outcomes and whether or not we have evaluated the things that we have done to find out whether we have actually made a difference. It is in providing such evidence that we need to get better.

Dr Simpson: So the child and adolescent mental health development group was disbanded after the SNAP report. There is no framework implementation or other continuing group, then.

Professor McMahon: The group that I would probably identify is the one that the Scottish Government has established through the mental health division. It is chaired by Caroline Selkirk, who is the commissioner for child health in Tayside, and it supports implementation around the framework. Graham Bryce, who has given evidence to the committee before, is a member of that group.

Ross Finnie (West of Scotland) (LD): I have a supplementary question. The framework document refers to all the agencies and health boards in different areas having their own frameworks. I did not read that document with an idea that individual bodies were simply going to say that the Scottish Government would provide the framework. The document clearly sets out all the various elements, and there was a high level of expectation that individual health boards, local groups and health partnerships would provide the framework. If you are telling me that your body has abrogated that responsibility, we are entitled to ask whether there is any element of the framework that it is actively pursuing.

Professor McMahon: Let me be clear about what I was saying to Dr Simpson: I was talking about being held to account—I thought that that was the question. The framework and the actions under it are being taken forward in NHS Lothian and partner agencies, but I am not aware of the framework being a formal agenda item at any meetings with the Scottish Government or local authorities.

We are doing what you asked about. Perhaps our presentation of the information is not as robust as you would like it to be, but I do not think that anyone in NHS Lothian or other agencies is not using the framework—and the principles and action that it sets out—to ensure that we deliver the best care to children.

10:30

Jan Baird: In NHS Highland, accountability is managed through our children's services network, which reports regularly to the board and, during the past year, has produced two update reports for the board. Accountability is also managed through the chief officers group in Highland Council, as part of the NHS Highland partnership, which reports to the joint committee for children and young people.

Carol Fisher: In NHS Ayrshire and Arran, the approach is to report through the officer locality groups in the three community health partnerships and into the NHS board.

Dr Simpson: The framework contains tables with columns that are entitled "service elements", "activity", "outcomes" and "lead partners". If we asked you to provide in written supplementary evidence a further column entitled "date of implementation", could you do so? The information would be useful, because—

The Convener: I think that Michael Matheson has pursued that issue.

Dr Simpson: Throughout the framework there are references to "primary mental health workers", who were previously known as mental health link workers, and to "public health nurses", which includes health visitors and school nurses. Do those staff posts exist? Does the approach work?

As Mary Scanlon said, school nurses might see children who are five years old—I suppose we might also include children at nursery who are three years old—but we have heard evidence that the first three years of life are crucial. Audit Scotland recently produced the report "Drug and alcohol services in Scotland". We know that about 100,000 children live in families in which there are drug and alcohol problems. There are 14,000 looked-after children, and every year about 600 children are born to drug-using parents.

We have begun to consider early identification, but health visitors are mentioned in the framework only in the context of the new role of "public health nurse", which includes school nurses. Where is the programme of early identification and support that can prevent a child from becoming a disturbed three-year-old, having to be looked after, becoming one of the 35,000 children who are referred to the children's hearings system every year or becoming one of the young people who enter HM Young Offenders Institution Polmont, where there is a preponderance of looked-after children? How do we prevent all that from happening? I cannot see provision in the framework for early identification and intervention.

Jan Baird: In Highland, our approach to link workers is slightly different from the approach that is recommended in the framework. That is because the framework envisages a job whereas in Highland, given our geography, we regard the link worker as a role that should be incorporated into a variety of roles in education, social work and health. We are developing that approach.

We had developed the role of primary mental health worker prior to the document's publication, but we have subsequently reviewed our approach to ascertain whether our primary mental health workers are fulfilling the role that is envisaged. In the context of early intervention and identification—although not necessarily in the pre-school years, on which you focused—the role of the primary mental health worker was designed to make the link between services that are delivered by general practitioners, health visitors, school nurses and schools, who were identifying problems but did not know how to deal with them, and specialist services, which were difficult to access. NHS Highland appointed nine primary mental health workers, who at the time related only to the Highland partnership and were located in nine areas, which were based on the old council boundaries.

The primary mental health worker's role is to improve links between front-line and specialist

services to support young people with emotional, behavioural or mental health problems; to improve skills—I mentioned the training element to build the primary health care team's confidence and competence; and to increase accessibility by identifying when specialist services are needed. That service has been welcome, and the Argyll and Bute partnership wants to develop the service because it thinks that it would deal with rurality in that area. We are keen to expand the service throughout NHS Highland.

By developing local services more to deal with tier 3 cases—the more acute, intense and difficult cases—we can maintain young people at home. We know from our surveys that they want that, particularly in rural areas—they do not want to leave their home, school and friends. We want to develop links between different levels of service to keep young people at home.

Dr Simpson: So such workers operate at tier 2 but link to tiers 1 and 3.

Jan Baird: Yes.

Dr Simpson: Okay—I understand. That is grand.

Jackie Baillie (Dumbarton) (Lab): The committee heard evidence last week that the SNAP report and the framework were right, but that the challenge lay in implementation. Do you agree? If so, what are the challenges and obstacles that you will face in achieving full implementation in your area? We will start with Professor McMahon, who is smiling.

The Convener: It is fatal to smile or move in any way—you will be picked on first.

Professor McMahon: Eye contact is the dangerous thing.

I know that Dr Bryce, the SNAP report's author, gave evidence. As we have tried to explain, a raft of initiatives is under way in each area to adhere to the principles and to implement the framework's key elements. The NHS cannot deliver on its own; implementation depends on our working with local authorities and the voluntary sector to maximise each organisation's capacity to deal with the agenda, which is significant.

The aspiration in the report on the child and adolescent mental health workforce is to have a mixture of about 20 such staff per 100,000 population. The figure in NHS Lothian is way below that—it is about eight per 100,000. We know that if we are to achieve the staffing level that we require to deliver the quality of service that is needed, we must work to develop the infrastructure. It is fair to say that that is a huge jump to ask for financially and in recruiting, training and retaining staff in such posts. Dr Simpson asked about link workers. An opportunity exists to consider different models and approaches and whether we could formalise links through staff who are already doing good work, to build capacity better and ensure that we implement the recommendations.

I repeat that what matters is not just implementing the recommendations but knowing that we have made a difference. The point is whether we have made a difference to the quality of life of the children whom we have identified as being at risk, and whether we have supported their families. Parenting and the early years are key parts of that.

All partners are signed up to the framework. The development of single outcome agreements and the health improvement, efficiency, access and treatment target in relation to waiting times for children are also relevant. We have the opportunity to build on that, but we must consider across agencies the significant issue of how we work collectively to implement the recommendations.

Jan Baird: I will expand on that. The issue is not financial resources, but human resources. We are talking about a fairly small specialist service. In rural areas, we are trying to build expertise in our existing workforce. It is a bit of a chicken-and-egg situation. We want to attract people into teams in which they feel that their skills will be maintained and developed, and in which we can retain their services, but they cannot join a team if no team exists.

It is a difficult situation; it is as difficult in Argyll and Bute as it is in the rest of the Highlands. That is why we are putting a lot of effort into considering how we can expand our generic teams and how we can use our financial resources differently, so that we do not have a medical model, or a doctor-heavy model, but instead use the wider skills mix to meet need, which is the only way things can be sustained.

Carol Fisher: We are in the process of recruiting primary care link workers for our schools. We will have three in Ayrshire. We are working with school nurses to enhance their understanding of CAMHS. One of our schools in South Ayrshire is one of the pilot sites for the primary care link workers. We anticipate that we will learn a lot from the pilot about how to proceed. We are in the process of developing a relatively small specialist team to identify needs and to continue to meet them. The emphasis is on partnership working. Not all children have to come into a specialist CAMH service. We have to work with our partners to ensure that we care for and support those children in their communities through the services with which they come into contact, such as education and primary care services.

The Convener: I want to ask what is probably a stupid question. You said that you were recruiting primary care link workers. What qualifications do such workers need? What does the advert for the post say?

Carol Fisher: They should have experience in working in mental health services, and in CAMHS in particular. The posts are generic. They are not necessarily nursing posts; they are clinical posts, which could cover occupational therapy, nursing and social work. We would be looking for someone with keen enthusiasm for the CAMHS agenda and a broad knowledge of mental health issues and of the services that are already available in the community. We want somebody who can work with partners.

The Convener: So, you are looking for somebody with a background of working in mental health.

Carol Fisher: Yes.

The Convener: Thank you. I was not quite sure about that.

Jackie Baillie: That was interesting. I want to return to the three issues that you all identified in different ways. The first is partnership working. For me, it is about ownership of the agenda. To what extent do you have a relationship with local authorities? I am quite clear about the relationship that you described in Argyll and Bute and Highland. Does that relationship extend beyond social work? Are you talking to schools? What is your relationship with the voluntary sector? I am sure that the picture is not the same throughout Scotland.

Jan Baird: Absolutely. When we talk about local authorities, we are talking about social work and education. Education authorities are key partners in developing these services. Staff recognise that they cannot deliver the services on their own and that they have to work with the young person in whatever environment they are in. Working with schools is absolutely essential. The voluntary sector also has a key role to play, so I agree that it is one of our partners.

Professor McMahon: Jackie Baillie is right to raise the issue of ownership. No one is not taking responsibility for implementation of this work. The relationship is about using the opportunities that come through community planning and single outcome agreements. We are looking at how we can measure and evidence the actions that we are taking. Education has a key role. We are linking with not just school nurses but with teachers, too, in order to maximise the support and contribution that they can offer. The voluntary sector throughout Lothian is playing a key role in supporting and enabling a lot of the parenting and play skills work that has to be done.

The Convener: Where does the buck stop? Does it stop with you? At the end of the day, if the plan does not get implemented properly, you are the man whose job is on the line, to put it bluntly.

Ian McKee (Lothians) (SNP): Do not worry—it is a 10-year plan.

Professor McMahon: I might dispute that.

At the end of the day, we are all responsible. As far as strategic planning is concerned, our job is to ensure that we deliver and implement what we said we would. I am not trying to fudge the point about operational responsibility for implementing this stuff; after all, we are partners in organisations that are seeking to ensure that this happens on the ground.

10:45

The Convener: I think that the question was about ownership, which for me is about who is responsible for deciding overall whether something will be implemented or not. I realise that I was being a bit rude when I said that your job was on the line, but are you that person?

Jackie Baillie: It might be helpful to point out that, according to page 6 of the framework document, NHS and local authority chief executives are responsible—in other words, Professor McMahon, your bosses.

Professor McMahon: Thank you for that.

Jackie Baillie: I thought that it might be helpful to put that on the record.

With regard to workforce capacity, I do not doubt what you say about trying to work smarter, given the resources in the generic teams. However, are they really a substitute for the more specialist services that we need? If, for example, you are looking to go from having eight members of staff in every 100,000 to 20 in every 100,000, are these generic teams the whole answer or should Government be doing something to increase workforce supply?

Jan Baird: There is a need to increase workforce supply and to encourage people to go not only into paediatrics—where, as we know, there are issues—but into very specialist services. After all, if you try to build generic services without the support of a core of specialism, they will simply fall apart. There is a tipping point at which we need supervision and support to be available, and we are finding it difficult to get enough people to deliver in that respect.

We are considering the same sort of sectorisation model for child and adolescent mental health services as we have for adult mental health, in which a consultant is aligned to each community health partnership. Such an approach

will allow us to build in the consistency and the relationships that are key in supporting people, but we need a core of consultants to carry out that work at specialist level and to support the generic teams in the CHP.

Jackie Baillie: I would like to hear more detail from one of you on that matter. What is the gap between what you have at the moment and what you need?

Professor McMahon: In each specialism?

Jackie Baillie: No, in general. How big does the core of specialist consultants that you absolutely need have to be?

Professor McMahon: Colleagues might dispute this, but I think that investment is needed in tier 3, particularly in primary care and in specialist support for children who are ill but do not require to be admitted to hospital and can be supported better at home. We are all aware of the detrimental effect that admission has on everyone's health, particularly children—certainly when they are first admitted, when they tend to stay in for a long time. If your family cannot be with you, that will have a negative effect, although staff try to manage that as effectively as they can.

There is also more work to be done at tier 1, which relates to the wider community. As Mary Scanlon pointed out, the question is how we identify the issues earlier and provide support. Evidence suggests that the earlier we can intervene, the more we can minimise behaviours and manage things better, which might well lead to more successful outcomes.

I do not think that the answer is necessarily to have more psychiatrists; instead, we should look across the disciplines and focus more on nursing, social work and certain lower-level play and therapist support. As I have said a couple of times, our focus will be driven by the HEAT target that the Scottish Government is about to introduce with regard to waiting times. I am sure that, if the Government were to introduce an 18-week waiting times target, we would all say that in some cases that is too long and that we should aspire to a lower target. In any case, it will certainly make us focus on ensuring that the workforce is in the right place to deliver the right care at the right time, and on ensuring that people do not have to wait.

Jan Baird: We welcome the national delivery plan funding for specialist services, which has been top-sliced for investment in CAMHS at tier 3 level, and which will give us an opportunity to consider flexible models to keep young people in their own communities.

The Convener: I will take a very short supplementary question from Mary Scanlon, but I note that Ross Finnie, Ian McKee and Helen Eadie want to ask questions. I remind members that we have another panel of witnesses.

Jackie Baillie: My final question is on monitoring. I agree that outcomes need to be monitored. How do you do that? Are you aware of, and do you contribute to, the integrated children's services plans, the joint health improvement plans and the joint local implementation planning mechanisms in relation to the Mental Health (Care and Treatment) (Scotland) Act 2003? Apparently, that is how the monitoring is to be done.

Jan Baird: The answer to that last question is yes. We have a six-monthly monitoring meeting with the Government on the Mental Health (Care and Treatment) (Scotland) Act 2003, which includes CAMHS. An update on our framework implementation is incorporated into that.

The Convener: So that is three yeses.

Professor McMahon: My answer is yes. On the point that Jan Baird makes, I should have mentioned earlier the framework for holding boards to account on delivery of mental health services, because I was instrumental in setting it up before I left the Scottish Government.

Jan Baird: I will say something about how we measure outcomes. Part of measuring outcomes involves asking young people and families. That requires a longer-term view, but it is important that we find a way of doing that. That is why we are expanding the Highland users group to include young people with mental health problems.

The Convener: I want to move on, because a lot of members are waiting to ask questions.

Mary Scanlon: I have a question on the point that Christine Grahame and Jackie Baillie raised about partnership and accountability. I have listened carefully, but I am trying to understand why a six-year-old child of a single mother was at home for five months after being excluded from school. During that time, he was given no education and he was not allowed treatment because he was not in school. I have raised that matter in the committee previously. His mother received help only after she went, out of desperation, to the *Inverness Courier*. It is a little difficult to understand all the talk about partnership working and care in the community when that sort of thing happens. Why was that boy given no help or education for at least five months?

The Convener: That is a very specific case.

Jan Baird: I am happy to look into that specific case.

The Convener: That is on the record now.

Ross Finnie: I am slightly puzzled about who takes responsibility for what in relation to the implementation of the framework. The framework

document makes it absolutely explicit that it is not intended to be prescriptive. The witnesses have helpfully given us good examples—Jan Baird told us about how things are dealt with differently to reflect the different circumstances in the NHS Highland area. I accept that, but there is a lack of clarity.

We are told that you are not aware of the Government specifically monitoring implementation. However, the document is explicit that the framework is intended as "a self-assessment tool"—it says that in black and white in the introduction. As my colleague Jackie Baillie mentioned, it also makes clear that

"responsibility for ensuring delivery of this Framework rests with both NHS and local authority Chief Executives."

So there cannot be any doubt about with whom the ownership and responsibility rests. The witnesses ought to be able to indicate to the committee who has wholly bought into the process.

However, with respect, although a lot of the evidence has been extraordinarily helpful and interesting, I am still slightly unclear about the status and standing that your respective authorities give to the framework. I am still unclear whether your authorities have accepted that they have responsibility for delivery, in co-operation and close collaboration with their partners. My fellow committee members and I would find it helpful to have a clear exposition of where you stand on that.

The Convener: The paragraphs to which Ross Finnie referred are 1.24 and 1.25, which are on page 6 in the introduction.

Jan Baird: I have with me a copy of our implementation plan, which we use for self-assessment. The improvement objectives and key outcomes are included as headers. The plan also provides information on the delivery strategy, progress, timescale, operational responsibility, management responsibility and strategic responsibility, and is the means by which we report to the board of NHS Highland and to our joint committee for children and young people. It makes clear who is responsible for each of the actions that are detailed in the plan and how they are being delivered. Progress is monitored—we have reported to the board twice in the past year.

The Convener: It would be helpful if we could have a look at the implementation plan. Could you provide the other members of the panel with copies?

Jan Baird: It is the plan to which we alluded earlier.

Professor McMahon: We can provide the committee with a diagrammatical explanation of how each part of the system is held to account, through NHS Lothian partnerships, if that would be helpful.

Carol Fisher: As we said earlier, we would be happy to supply the committee with more detailed information.

The Convener: That would be helpful.

Ian McKee: My question relates to the specific problem of adolescents with mental health problems, especially those who live in rural communities. My colleague Helen Eadie and I were fortunate enough to go to Lochgilphead to meet the CAMHS team, whose members struck me as being incredibly hard working and conscientious.

However, the jam seems to be pretty thinly spread; I believe that the team includes four nurses, who cover an area that includes 20 inhabited islands and a large geographical area. Adolescents do not really have contact with health visitors or midwives, and often their school is in a different place. The few who need hospital admission are often admitted to adult psychiatric units, because the contract is with Gartnavel royal hospital, which is in greater Glasgow, and treatment there can take time to organise. The service does not seem desperately appropriate to the challenges that it faces. I appreciate that those challenges are huge, but can you explain in more detail how you look after young people in such situations?

Jan Baird: That is a big challenge in Argyll and Bute, and we have assumed responsibility for the area in the past few years. Rightly, the direction of patient flow is to Glasgow; that suits the patients and was the original arrangement.

Like the Highland partnership, Argyll and Bute partnership is committed to trying to retain young people at home. Argyll and Bute community health partnership is looking to invest in the primary mental health worker role, which it sees as a link between specialist services and the general services that are delivered in island or rural communities. The failure to create that role previously may have been an omission, because staff on the ground had no alternatives. A key part of the role will be to work with staff in primary care teams and school nurses and to train them to work with adolescents, especially those who are involved in transitions. The aim is to enable us to retain those young people at home, on the basis that they will want to stay there.

In Argyll and Bute, we have a good relationship with young people, through the chief officers group for the council, the NHS and the police. We will use that forum to ensure that we meet young people's needs. At the moment we need to build up the primary mental health worker role.

Ian McKee: The CAMHS team in Lochgilphead is loyal and supportive—I do not want you to think that its members were grumbling. However, the direct questions that they asked indicated that, because the team is so small, they have difficulty getting time off for continuous professional development, let alone to provide support and training to other workers in the area. I thought that the fact that there were only four mental health workers in an area of that size suggested a lack of commitment to providing a good service. Will you comment on that? Have you investigated more technological ways of keeping in touch, such as texting and videolink? One would think that the tools that are available to us now would be useful in areas in which face-to-face contact is difficult because of the rural and island nature of the area.

11:00

Jan Baird: Boards such as NHS Highland must champion such technologies, because they are extremely helpful when they work. There has been a lack of investment over a number of years, so staff are stretched. As a board, we have recognised the need to invest. We have a commitment to developing and implementing the framework over 10 years, which will require investment. We were clear at the outset when we went to the board with our implementation plan that we could not implement the framework within existing resources. Over the past two years, NHS Highland has invested in CAMH services. We must accept that investment is necessary. The staff are thinly spread.

Ian McKee: You accept that the service is inadequate to deal with the needs that are presented to it.

Jan Baird: As you said, the jam is thinly spread.

Helen Eadie (Dunfermline East) (Lab): You are going to provide us with supplementary evidence about the joint implementation plans. What joint resourcing has been agreed in each area? It has emerged that resourcing is a major issue. Is there joint resourcing, joint management and joint delivery? I invite each witness to say what happens in their area.

Jan Baird: We do not have joint posts in community care, as such. Following the joint future agenda, we are focusing on outcomes rather than delivery through joint posts, which we have not seen as being the way forward. In children's services, we align our resources within the joint committee, so there is an element of pooled resource, but a lot of the NHS resources are out in the community health partnerships for delivery there.

It is a question of bringing the human resources together and ensuring that we locate teams close together. We do a considerable amount of joint training—as well as NHS training, we do joint training with social work, education and, sometimes, the police. We do a lot of such work, which builds trust and relationships between people and enables them to deliver a joint delivery plan. Joint posts are not necessarily the answer.

Carol Fisher: NHS Ayrshire and Arran is in a similar position. We do not have what would be identified as joint posts, but we have staff who work closely together in locality teams. Through such partnership working, we use resources at the coalface. We are in the process of implementing our CHP review. We have joint posts at that level—the CHP facilitators that we now have are joint health board and local authority partner posts, which are about facilitating joint working at all levels. However, that initiative is in its infancy and is not specific to children's services—it applies to all services across the three CHP areas.

Professor McMahon: In West Lothian, we have a community health and care partnership, so we have a director who is responsible to the chief executive of the local authority and to the NHS board. In Edinburgh, we have a joint director, who is accountable to City of Edinburgh Council and to the NHS board, and there are a number of jointly funded posts in mental health and learning disabilities, for example. In East Lothian and Midlothian, we have a joint general manager of services, but those areas do not function in a connected way as a CHP. However, we have started a dialogue on shared service provision so that we can maximise the resource and the capacity that we have in those areas. There is a slightly different model in each area, but there are elements of joined-upness as regards the approach and staffing.

Helen Eadie: It is interesting that the picture across Scotland is varied, given that the framework calls for joint resourcing—it is quite firm about that.

My other question is on workforce development. The shortage of specialists has been flagged up as an issue. To what extent has that shortage been identified in each of the areas that you represent? Has there been an assessment of unmet need and to what extent is that a problem within your areas?

Carol Fisher: We have just completed a review of our mental health services in NHS Ayrshire and Arran and identified the models within each of them. Through that, we have identified what staff we need to deliver the services. Investment was made in CAMHS last year and we anticipate further investment this year. We have identified a shortage of specialists at tier 3: part of the anticipated investment would go into those tier 3

services. We also continue to invest in the primary care services with the link workers.

That is the extent of need that we have identified at the moment. We continue to develop, review our outcomes, examine what works and determine what skills we require to deliver the outcomes.

Helen Eadie: Would it be possible to get a copy of the review, which would help to inform us because it identifies need that has not been met?

Carol Fisher: Yes.

Professor McMahon: NHS Lothian is doing a stocktake on our mental health strategy, which is now four years old. In that stocktake, we identified the need to be more explicit about the CAMHS agenda—particularly, the workforce issues within it. We are examining other national work on benchmarking and the data standards that have been set. At the same time, we are considering what workforce we currently have and identifying how we could use it better. For example, I do not think that we use the resource in psychological therapies—which represent a key approach to supporting children and their families—as efficiently as we could throughout NHS Lothian's area.

We also need to do a bit of mapping following on from the evidence that the Scottish Government published last year on what interventions are most effective in particular populations and age groups. That picks up Helen Eadie's point about determining where need is, what interventions the evidence supports and how we realign our services to ensure that we do not miss people, but support them as effectively as we can. That work has started.

The Convener: The chief medical officer said to us that, if we want to start helping children, we must start in the womb. I will ask about neonatal services. What is being done across the areas that the panel of witnesses represent to identify cases in which problems will start before children are born because of their social environment? What is done at that stage and how is it sustained? It was mentioned in passing. We also touched on health visitors and mentioned midwives. We all know families in which it is obvious that history will repeat itself unless something is done.

Jan Baird: As you probably know, NHS Highland is a pathfinder site for the getting it right for every child programme. One of the things that we identified early in the development of the principles is that we must address the adult mental health and substance misuse services, because that is where some of the issues can begin. Therefore, we incorporate adult services into the getting it right for every child principles and try to engage them in the early stages. For example, we have a pathway to support a young mother with a mental illness or a substance misuse problem. With our adult services, we try to identify the necessary support early on—in the run-up to and following the child's birth. We hope that the getting it right for every child approach will enable us to ensure that that happens.

The Convener: I understand that you are doing that, but do you find that it works? We need to know. Does sustaining the mother mean that the child is not emotionally constrained and does not have all kinds of problems right from the start?

Jan Baird: The difficulty with answering that question is that it is fairly early in the implementation of that approach, so we do not have the evidence from young people further down the line to show whether the effect has been sustainable. However, it is one way of addressing the early stages with prospective parents.

Carol Fisher: NHS Ayrshire and Arran has a liaison psychiatry service that connects with women before and after they have babies. That provides an opportunity to pick up any issues within the family or that the mother might have that may have an impact on the child. However, I will come back with more information about how that links through.

Professor McMahon: The nature of the question means that we are not able to give a robust answer as to whether what we do has the direct effect that people would like to see. There is an issue with evaluation of outcomes. We probably are evaluating them, but our evaluation is probably not as sophisticated as it should be.

Neonatal services are important—Dr Burns would say that the evidence suggests that we should start there. We know—or have a good sense of—who the current substance misusers are. The issue is how they and their children are supported when they come into contact with midwives after becoming pregnant and through other life stages. How are the children supported, and how are the adults supported in parenting them, through school age into adulthood? Early intervention will reduce behavioural disruption and psychological deterioration. We need to build on the interface that we have through community midwives, health visitors, school nurses, teachers and other professionals to ensure that the children and their families are adequately supported.

I can come back with further information for the committee on neonatal services. They are important.

The Convener: I hear what you say about children wanting to stay in the family, but—this might be controversial—should some children be taken out of the family, even if only for a while, because supporting them through it is not going to help if they have a substance-abusing parent?

That is a huge issue now. Are you considering that approach instead of, or in addition to, emphasising support for the family?

Jan Baird: Some of those issues were raised through the "Hidden Harm" policy document. Within child protection committees and our drug and alcohol forum, we try to make the links to ensure that people are aware of the child at the centre of the issues rather than just the adult.

The Convener: I will stop there. I thank the witnesses very much. It was a long evidence-taking session. We will have an informal break, so I ask the committee members not to disappear. I will suspend for two minutes to allow witnesses to change places and for people to stretch their legs.

11:12

Meeting suspended.

11:18

On resuming—

The Convener: We come to our second panel of witnesses. Jennifer Milligan is the child health commissioner in NHS Dumfries and Galloway, and Julie Metcalfe is the clinical director for child and adolescent mental health services in NHS Greater Glasgow and Clyde. They sat through the previous evidence-taking session, so they know our direction of travel.

Dr Simpson: Ms Metcalfe, you were one of the SNAP group, so it is extremely useful to have you with us—not that I am putting down Ms Milligan in any way.

Section 7.2 on page 45 of the SNAP report lists a number of groups of children and young people who are at greater risk of developing mental health problems.

The Convener: Can I just correct you? For the record, that list is in the framework document, not the SNAP report. You were at the right section, but the *Official Report* should have the correct reference.

Dr Simpson: Thank you, convener.

A number of groups are listed, including those suffering from domestic abuse, which we know that general practitioners can be slow to identify—they can be poor at identifying it; those who are neglected or abused; those whose parents are in prison; those who are involved in custody and access disputes; and those who have suffered trauma and loss.

Under the present system, how are those individuals identified by any of the services involved?

Julie Metcalfe (NHS Greater Glasgow and Clyde): They are identified by those who come into contact with them, such as those in primary care. As you say, there are issues around the identification of people in the groups that you mention in a primary care context. They might be in contact with social work staff, who will identify them. If they are in school, they will be identified by school staff, including health workers in schools, such as school nurses.

We have a protocol whereby any of those professionals can refer someone to child and adolescent mental health services. However, in areas of high deprivation, such as those in Glasgow, there is an issue about how many of those children are referred to services and end up accessing the mental health support that is available, given the span of need that we have.

People are aware that the services are in place. Recently, there was a big push in our community health and care partnership structures in Glasgow around the identification of domestic abuse, so work is being done in that area, but more needs to be done.

Dr Simpson: Other groups on that list include those who have a chronic or enduring illness, including mental illness, and those whose parents have problems of illness, dependency or addiction. As was said earlier, there are 100,000 children in that last category.

Once those children are identified, are they recorded in any multidisciplinary system? Is there a transfer of information? We know that the Government is not going to implement GIRFEC, but that would have made communication between services of potential identifiers mandatory, by law. I suppose that the idea is that, even though that will not be required by law, it will happen because we all want it to happen. However, after 40 years in the service—and especially after spending four years recently as an addictions consultant—I know that it has not happened yet.

I know that Glasgow is ahead of the game. What steps have you taken towards sharing that information? Jennifer Milligan might want to speak about the experience in Dumfries and Galloway as well.

The Convener: Can you tell us what GIRFEC is, please?

Dr Simpson: "Getting it Right For Every Child".

The Convener: So it is an acronym. We know what that document is. It is just that I saw puzzled looks on some people's faces.

Jennifer Milligan (NHS Dumfries and Galloway): Getting our priorities right, we have established a data-recording system and have a

dedicated member of staff who draws down the information from addiction services, the local authority and health workers. That links in with the system that we have created around domestic abuse and child protection. There is a common thread of identification of those children.

Dr Simpson: Is that accessible by general practitioners, health visitors, CAMHS tier 2 and tier 3 workers and so on?

Jennifer Milligan: At the moment, the domestic abuse system is the most advanced one. We are a GIRFEC pilot site and, the day after the police go to an incident, an electronic record of the incident is sent to the GP and the health visitor.

Dr Simpson: That is excellent.

Mary Scanlon: I have two questions, so I will ask them both at once. First, can you explain how children between the ages of 15 months and five years old are checked to determine whether they have any developmental or mental health needs?

My second question is also very short. On page 6 of the framework document, under the heading "Accountability and monitoring", paragraph 1.26 says:

"The Child Health Commissioners are expected to take the lead in ensuring this happens."

I ask Jennifer Milligan, how, as a child health commissioner, she was accountable for and monitored the implementation of the framework document.

Jennifer Milligan: Can we deal first with the identification of mental health problems in the group of children from just over one year old to five years old? I listened to the committee's debate with the previous panel and it seems that members are concerned about the "Health for All Children 4" report and the changes that have flowed from that.

Identifying children who may well require additional help is a complex area. Children in the group to which I referred will require extra help because of issues around neglect, lack of stimulation in the family home and so on. Under Hall 4, they are likely to be in the health visitor's additional or intensive service case loads—that is one route in. However, for children who are beginning to develop communication problems, families will compare their child with other children and recognise that perhaps their child is a bit different. They may then go down the health visitor route, the GP route or the speech and language therapy route.

In our health board area, children of or around the age of two onwards who have more complex communication issues will be referred to a multi-agency communication clinic. Children who are recognised at birth as having complex needs will go into a multi-agency arrangement at a locality level; they will then be drawn into the additional support for learning requirements.

There is therefore quite a mesh of structures for families. While bringing in blanket changes, Hall 4 also says that many children will not need all the available routine contacts but that some children definitely will—the skill is in recognising the difference.

Mary Scanlon: My question was really quite general. I appreciate that health visitors now tend to look after complex cases and that, sadly, we no longer have a universal health visitor service. You said that families will pick up problems, but not every mother or father will do so. For example, I know someone whose child does not speak even though they are three. A friend of mine suggested that the parents should get help to ensure that there was nothing wrong. Not everyone recognises—perhaps they do not want to—as a problem the fact that their child does not speak.

My concern is about what the professionals do to pick up things, perhaps reinforcing the mother's concern, or to pick up things when the parents do not know that something is wrong. My concern is that there is a huge gap of three years and nine months between the ages of 15 months and five years when there is the potential for change, help and support but pretty well nothing is offered.

Jennifer Milligan: It would be fair to say that, nationally, the Hall 4 group—the committee may be familiar with the work that the group's chair, Dr Zoe Dunhill, is leading on for Scotland—is beginning to review allocation across the country. You said that there is no universal service, but there is. However, going into that universal service, decisions are made about whether the child and the family should have a core, additional or intensive service. The view now is that such decisions were perhaps taken a bit too early under the initial implementation of Hall 4 and that families should probably not be classified in a child's first year.

Mary Scanlon: I do not want to on about Highland again. I have said my bit this morning. Can we move on to your role in auditing and monitoring the implementation of the framework document?

11:30

Jennifer Milligan: Yes. I have a strange role in our board because the board is small. I am the child health commissioner, which means that I have responsibilities in responding to all guidance from the Scottish Government, but I am also the general manager of children's heath services, including CAMHS. At an operational level, I

monitor implementation, and at the commissioning level, I make the board aware of requirements and gaps in our services. I also work on a multi-agency basis in the chief officer group as one of the chief officers in our structure. I ensure that emotional and behavioural issues in the area of mental health and wellbeing are focused on in our integrated children's services planning structures.

Mary Scanlon: We hear a lot about structures, strategies, partnerships and so on. Do you use the framework document as a checklist for implementation?

Jennifer Milligan: We have used it to consult across the whole of Dumfries and Galloway, and we have identified the gaps in our services.

Mary Scanlon: So you are on the way to implementing the framework.

Jennifer Milligan: Yes, within our resource constraints.

The Convener: We will come to that with another member's questions.

Helen Eadie: I want to follow up on that thread of inquiry. You say that you have been implementing the framework. How do you do so? How do you cascade all the messages that are out there? That is a question for both witnesses.

Julie Metcalfe: We monitor what is happening with the framework and a number of other developments in child and adolescent mental health and community child health in our senior management meetings and in our programme management group in specialist children's services. We have an integrated community child health and child and adolescent mental health structure.

Helen Eadie: Are things done through conferences? If a document such as the framework document arrives, will there be a big conference in the health board area at which the document is discussed and people are taken step by step through what Government ministers expect to happen on the ground?

Julie Metcalfe: There have been a number of meetings about the framework at the senior level in the board and with clinical staff. A number of our clinical staff were well involved in the development of the SNAP report and the framework. People on the ground and senior managers are very familiar with what is required. The targets and the implications of the framework for service developments are very much part of all our discussions about service development. Things are done informally in every service development meeting and more formally around our programme management structure. We have a development or action plan that contains—

Helen Eadie: So there are milestones and the chief executive gets involved. The report says that the chief executive is ultimately responsible.

Julie Metcalfe: Yes. Things are reported through our CHCP directors group, which the chief executive attends.

Helen Eadie: How frequently does monitoring take place? Is there annual or monthly monitoring, or monitoring every half year?

Julie Metcalfe: I do not go to those meetings, but I think that monitoring takes place quarterly. I can find that out for the committee and get back to you if that would be helpful.

Helen Eadie: That would be helpful.

Jennifer Milligan: I suppose that it is a matter of breaking down the framework. The framework is so complex that I do not think there is one structure that just monitors the whole implementation process. The children's change fund, sure start and initiatives such as the choose life initiative relate to prevention and come under that constellation. Promotion is a matter of getting into the education arena. There are the health-promoting schools, the hungry for success initiative and whole-school approaches to working with children and encouraging schools to have a supportive ethos. With care, we get into the realms of social work, adoption, fostering and so on. The treatment aspects involve additional support for learning, the Mental Health (Care and Treatment) (Scotland) Act 2003 and consideration of how we work with children with complex needs. I do not think that one structure could oversee monitoring altogether. The document recognises the complexity that exists.

The Convener: The committee has focused on identification and barriers to identification. We appreciate that the area is big and complex, which is why we have tried to keep our inquiry pretty narrow. It would be helpful if we kept focusing on that. We understand that we cannot just go into mental health services at large; as you say, the area crosses many disciplines.

Helen Eadie: Jennifer Milligan referred to constraints. What are those constraints?

Jennifer Milligan: I can speak only about constraints in the health service. When we reviewed our services, we found that we do not meet the level of resourcing that has been identified at tier 3. We have limited resources for our learning disability service and fairly restricted access to clinical psychology. We have identified those constraints for the board in a commissioning plan. In effect, we are saying, "These are the areas that are giving us concern."

Helen Eadie: Can you give us a copy of that plan?

Jennifer Milligan: Yes.

Ian McKee: My question is on the list of children who are at greater risk of developing mental health problems that is to be found on page 45 of the framework document. Before I came to the Parliament, I worked in a medical practice in an area that has people in those categories in spades. We had loads of people on our list with such problems—the problems were identifiable. Our GPs, health visitors, midwives and social workers were distributed on a population basis. It was difficult to get a social worker even to take up a case: not only were their case loads full but they worked some miles away from the area concerned. I am aware that that set-up might have been particular to that area.

Do you use small-area data to deploy the resources in your area where they are most needed? If not, do children who live in areas of multiple deprivation get a poorer service because there are more of them and yet the number of professionals in the area is the same as that in areas of lesser need?

The Convener: I take it that the question has been corroborated by Dr Simpson.

Dr Simpson *indicated agreement*.

Jennifer Milligan: The direct answer on staffing allocation is that we have the same historical arrangement that Ian McKee described. However, any additional funding that we get goes to address problems in areas of deprivation. We have five distinct areas of deprivation in Dumfries and Galloway and additional resources—around the children's change fund and developing children's centres—have been put into those areas. In that way, we can collectively target resources more effectively. We have on-going issues around GP attachment and balancing the benefits of GP attachment against the benefits of the geographical zoning of teams.

Julie Metcalfe: We are looking at deprivation and how we use our staff across the board area. At the moment, most of our child and adolescent mental health services are population based. However, we have developed a number of speciality services that are area wide. They include a mental health service for looked-after and accommodated children. That specialist service works with locality services to provide support for that vulnerable group of children, who have greater mental health needs.

We also have a learning disability service and a youth alcohol and drug service. By way of additional service development, we have picked up on some of the risk factors that were highlighted in the framework. Those additional services work with our locality services to provide some of that extra resource.

Ian McKee: The small-area morbidity data go back more than 30 years and show conclusively that people in some areas have greater needs than people in other areas. I am a little bit impatient when I hear people say that they will probably put extra services that become available in a particular area. We are discussing the national health service looking after the needs of children who are tremendously vulnerable. Are you happy with the progress that you are making? Is it fast enough, given the needs that we are talking about?

Jennifer Milligan: We use small-area data. In fact, we have taken a detailed look into deprivation in Dumfries and Galloway. However, that is very difficult in rural areas, where tiny pockets of deprivation are to be found in quite affluent areas. The issue for us is how to provide accessible services across a vast geographical area.

We are making a secondary school and its feeder primary schools in an area of deprivation our integrated children's services plan demonstration site. We are working across all the agencies to see whether we can better focus services in that area and whether all services working together, with a local feel for the work, will create better outcomes for children.

Ian McKee: I totally accept that things are different in rural areas. On the other hand, a small area of deprivation in a large area can be accommodated within the overall set-up, whereas in somewhere such as greater Glasgow, where a whole practice and social work area is in need, it seems inappropriate to distribute the resources on a total population basis, given that other parts of Glasgow are affluent and can cope much better. I am not saying that there are not problems in those areas—there are problems in all areas—but we know that the problems in deprived areas are threefold, fourfold or fivefold.

Julie Metcalfe: That is true. That is why, in the more deprived areas, in east and north Glasgow in particular, we work closely with our local authority colleagues and the additional support services that are available within the localities. We work in different ways in those areas and use our resources differently.

I go back to the point that we are fishing in a relatively small pool of staff. We do not have a lot of staff that we can deploy in particular areas to meet all the need. We meet the need as best we can within the resources that we have, and we take account of deprivation. We plan with our local authority colleagues how we can best meet that need within the resources that we have.

The Convener: When was the rule made about the allocation of the posts on the basis of population? Who was responsible for that?

Dr Simpson: It is historical. Out of the 100 practices in Scotland that have the most deprived populations, 88 are in Glasgow. However, those 88 practices do not have more staff than the average practice in much more affluent areas.

The Convener: The question is whether that formula should be changed. You talk about topping up, integrating and using your resources better, but should the formula be changed?

Julie Metcalfe: We need to work with the huge risk factors in the populations that you are talking about, so, yes—absolutely.

Dr Simpson: I have a supplementary question on integration. From 1978 to 1985, I was involved in a pilot project in three areas in Stirling—Bridge of Allan, which was a relatively affluent area; Cornton and the Raploch, which was a poor area; and one of the eastern villages, which was also a poor area. We attached social workers to those areas—we did not have a social work team that just came; social workers were attached to the areas. The identification of child protection issues increased by 180 per cent in all three areas. Are any social workers attached to any of those 88 practices in Glasgow? The Mitchell report of 1978 or 1979 recommended that social workers be either attached as liaison workers or specifically embedded in the primary care team. Has that happened for any of the teams in those deprived areas?

Julie Metcalfe: I do not believe so, but that is not my area within the board. We can check that for you.

Dr Simpson: I would be very interested to know.

The Convener: Those are very good questions.

Jackie Baillie: My question relates to what we have been talking about. You have touched on the issue of staffing capacity, which is equally about resources. NHS Lothian estimated that it had eight mental health staff members per 100,000 of the population, although the recommended staffing level is 20 per 100,000. Where are you both on that spectrum?

Jennifer Milligan: For a population of roughly 150,000, we have just under 20 whole-time equivalents in our team.

Julie Metcalfe: For the population of under-19s, which is around 245,000, we have around 230 staff, so we are not there.

Jackie Baillie: You are some way off.

Julie Metcalfe: We are.

11:45

Jackie Baillie: How do you close that gap? Is that work owned locally, or are you looking for assistance from Government, too?

Jennifer Milligan: As child health commissioners we lobbied our chief executives when the national development plan funding became available. We said that CAMHS funding should be considered within the overall pot. I know that that debate was complex, but an allocation of £2 million was dedicated to CAMHS this year.

Jackie Baillie: Will that do the trick?

Jennifer Milligan: For Dumfries and Galloway, the figure works out at £63,000.

Jackie Baillie: So it will not do the trick.

The Convener: That was a politic response.

Jackie Baillie: It was useful to get a sense of the scale of the challenge that you face. I am now clear about the scale of the challenge in that area.

My final question relates to something that Mary Scanlon said earlier. My understanding is that the child health commissioners have specific responsibility not for the overall monitoring of the framework but for the involvement of children, young people and their families. How is that done in your area?

Jennifer Milligan: When the framework went out for consultation we had five events throughout Dumfries and Galloway, in each of the localities and one of the deprived areas. I suppose that the children from the secondary schools were selected by their headmaster, but they were certainly involved. Since then, we have involved Inspector8 in the process of looking at health services for acute paediatrics. It is about ensuring that youngsters are prepared for their role and feel empowered to look at services with a critical eye and comment on what we are providing and what improvements they would like to see.

When we asked youngsters about the framework, they were quite explicit about not wanting problems to be identified in the school population to the extent that they felt stigmatised. One practical comment was that we should not imagine that youngsters will pick up leaflets on mental health issues in schools, because they will not do so. We got practical input from the youngsters.

Jackie Baillie: Is the experience in Glasgow similar?

Julie Metcalfe: Yes. We have had a number of meetings with young people to talk through some of the issues that are covered in the framework. For example, we involved young people who were in our adolescent in-patient service, which is a

west of Scotland service, in the design of the new service. We have just opened a new 24-bed adolescent psychiatry in-patient service in Skye house at Stobhill hospital. The young people were heavily involved in the design of that on the clinical side and in relation to the lay-out. Partners in Advocacy is a voluntary organisation that helps us get young people's views about service provision and what we are doing. We also use the CAMHS outcomes research consortium process, which allows us to look at outcomes. Part of that is about taking on young people's views of the services that they receive and what they would like to change. We are doing all that actively.

Jackie Baillie: You mentioned the CAMHS outcomes research consortium. Is that Glasgow specific? I have not heard of it before. Will you give us some information on it?

Julie Metcalfe: It is a British organisation, which involves a number of CAMH services throughout Britain. It was set up to allow us to compare our outcomes throughout Britain. There is difficulty in ensuring that all the data are collected throughout the whole country. We do that well in Glasgow, but there is an issue around the integrity of the data and how many data there are to compare ourselves against. We use the data internally and we are continuing to work with the national group to try to improve the value of the data throughout Britain.

The Convener: We can get a Scottish Parliament information centre briefing on that.

Jennifer Milligan: The other organisation on which you might want a briefing is the Royal College of Psychiatrists, which is now identifying standards, getting self-reviews from CAMHS teams and doing comparative work.

The Convener: I want to draw the evidence session to a close. Thank you for your evidence, which was helpful.

Dr Simpson: Does the committee agree that we should write to every health board and local authority to get their framework implementation plans, some of which may be joint plans? We should ask whether target dates have been set for the implementation of the framework and whether there are risks associated with those targets. I am talking about a modern planning system, which most authorities adopt now.

The Convener: I am happy to circulate that suggestion to members so that we can see the exact wording. Are members content with that?

Members *indicated agreement*.

Helen Eadie: When we write to each health board, can we ask to what extent they have attempted to estimate staffing need and how many whole-time equivalents per 100,000 at the generic, multi-disciplinary level have been agreed?

The Convener: Yes. Speak to the clerks after the meeting and we can agree the exact wording. We will circulate the letter.

Proposed Palliative Care Bill

11:51

The Convener: Item 2 is consideration of Gil Paterson's statement of reasons why the case for his proposed palliative care bill has already been established. I am sure that members have read the papers on this item. We can either agree that we are satisfied with the reasons given by Gil Paterson for not consulting on the draft proposal or agree to take oral evidence from him on 22 April. Do members have any comments?

Jackie Baillie: The committee should be satisfied with the reasons given.

The Convener: Is that agreed?

Members *indicated agreement*.

The Convener: Right. I suspend proceedings until the Cabinet Secretary for Health and Wellbeing arrives.

11:52

Meeting suspended.

12:00

On resuming—

Subordinate Legislation

Health Care and Associated Professions (Miscellaneous Amendments and Practitioner Psychologists) Order 2009 (Draft)

The Convener: For item 3, I welcome the Cabinet Secretary for Health and Wellbeing and her officials Catherine Clark, head of regulatory unit, and Beth Elliot, solicitor. I invite the cabinet secretary to make some opening remarks.

The Deputy First Minister and Cabinet Secretary for Health and Wellbeing (Nicola Sturgeon): I should inform the committee that I have just been advised that the order went through the relevant committee in the House of Commons in 13 minutes, so you have a record to beat. I am not sure whether you will choose to beat it by being quicker or by taking more time. I will leave that up to you.

The Convener: As a pre-emptive strike, I say that I think we will probably fail to be quicker than the House of Commons committee.

Nicola Sturgeon: The order aims to improve patient safety through a range of measures that relate to the regulation of health care professions. Members will know that many of the measures were included in the white paper "Trust, Assurance and Safety: The Regulation of Health Professionals in the 21st Century". The white paper followed some high-profile cases, including that of Harold Shipman, that highlighted public concern and some doubts about the impartiality of the regulators and threatened to undermine the public's trust in our system of professional regulation. The reforms in the order aim to enhance public confidence in the regulators' ability to protect the public and deal with poor professional standards.

The order amends framework legislation for the regulation of dentists and dental care professionals by the General Dental Council, the regulation of pharmacists and pharmacy technicians by the Royal Pharmaceutical Society of Great Britain, and the regulation of professions that are regulated by the Health Professions Council. Those regulators all operate in devolved as well as reserved areas. Similar changes have already been made to legislation for the health care regulators that operate only in reserved areas.

Other provisions introduce regulation for practitioner psychologists throughout the United

Kingdom and extend the regulation of pharmacy technicians to Scotland in the interest of patient safety. UK-wide regulation aids the cross-border flow of staff and enhances public understanding.

Finally, I highlight a couple of miscellaneous amendments in the order. First, it makes changes to the Protection of Vulnerable Groups (Scotland) Act 2007 and its English equivalent, and to a range of fitness-to-practise rules for health profession regulators. Those changes will ensure that there are appropriate exchanges of relevant information and that regulators can remove registration from anyone who is barred from working with children or vulnerable adults.

Secondly, the order makes changes that will enable the registration of suitably experienced people as pharmacists and enhance prescribing rights for registrants in emergencies such as pandemic flu.

All the measures are supported by the regulatory bodies that are covered by the order. I am happy to take any questions that the committee may have.

The Convener: I remind the committee that this is an evidence session, so the civil servants can participate. After the evidence session, we will move on to the debate, at which point they cannot participate.

Dr Simpson: On page 51, just above the heading "Other changes relating to the regulation of pharmacists and pharmacy technicians", the explanatory note states that the order contains

"a new requirement to submit accounts to the Auditor General for Scotland (paragraphs 11 and 12 of Schedule 2)."

I cannot find that requirement in those paragraphs. There is a passing reference on page 16 of the order, in the paragraph entitled "Amendment of article 46", which extends the provision to include the Auditor General for Scotland. I am sorry that the question is slightly technical.

Nicola Sturgeon: The order imposes new reporting obligations on the regulatory bodies: to have strategic plans and to account for those to Parliament. We will come back to the issue once my officials have found the cross-reference that you seek.

Dr Simpson: I raised the issue first because I realised that I might not get an immediate answer. I could not find the reference, so it will be interesting to see whether you can.

I have several other questions. I welcome the order, which is part of a process of restoring public confidence in professions and ensuring that they are appropriately regulated—hopefully, not overregulated. However, I have received representations from two groups—I do not know whether other members have, too—that are not included in the regulations. Could the cabinet secretary indicate whether she has discussed those groups with colleagues at UK level?

The first group is physiologists, who include cardiac physiologists, gastroenterological physiologists and neurophysiologists. There is a whole tribe of physiologists, if I may use that term—I cannot think of another collective noun for physiologists.

The Convener: I do not think that you can settle for "tribe".

Dr Simpson: I was half apologising, because I could not think of a better name for a collection of physiologists. If someone can come up with one, there may be a prize for them. The group has considerable and increasing clinical contact with members of the public. There is agreement in principle that it should come under the provisions in the order that deal with allied health professionals, but there has been no movement on the issue for the past two and a half to three years. Is there likely to be any such movement?

I know less about the second group from which we have received representations—an independent group of dental technicians—but the cabinet secretary has received correspondence on the issue. The group feels that it will be excluded in some way by the order. Has the cabinet secretary had a chance to ascertain whether that is the case and whether the issue is likely to have a significant effect on our already stretched dental services?

Convener, you will be glad to hear that I have only one more question, in view of the time challenge that the cabinet secretary set for us.

The Convener: I have already said that we will take longer than 13 minutes.

Dr Simpson: I welcome the fact that there will be special arrangements for pandemic flu and presume that those will apply to all the regulated professions. In the event of an outbreak of pandemic flu, it will be of crucial importance to bring back into play those who are retired or who were previously deemed to be fit to practise but are no longer practising. How comfortable is the cabinet secretary with the way in which the matter is being pursued? Will the individuals concerned have to continue to pay a registration fee—as is now the case for doctors—to maintain themselves on the register, or will they be able to do so, despite being retired, without paying a fee?

Nicola Sturgeon: Richard Simpson almost beat the record single-handedly there. Before I answer his questions, I award him the prize of the day for his eagle eye. The cross-reference in the

explanatory note is incorrect—it should be to paragraphs 13 and 14 of schedule 2. We will arrange for that to be corrected by reprinting the document. Well done for spotting the error.

I agree with the general premise that, although the order is welcome, we should pursue appropriate and proportionate regulation, not regulation for regulation's sake—it is about protecting the public.

As far as I am aware—I can double-check this and get back to Richard Simpson on it—there has been no specific discussion on regulating physiologists in this context. Richard Simpson referred to neurophysiologists. There has certainly been some debate about some of the sub-specialties of psychology; neuropsychology is one area where representations for registration have been made. However, it has been decided not to go for registration in the case of the sub-specialties. I am not aware of discussions on physiologists.

As Richard Simpson rightly indicated, the order does not include dental technicians, who are otherwise known as denturists. The legal change in relation to dental technicians has already been made, under the previous Administration, in fact. The present Administration has been working to ensure that educational provision is in place to allow dental technicians to obtain the registration that they now need. The Minister for Public Health has been pursuing that matter. Courses are in the process of being approved by the General Dental Council, and I am happy to provide Richard Simpson with more information on that.

Arrangements for the registration of retired professionals in the event of pandemic flu will apply to pharmacists under the order. Arrangements are already in place for doctors and, I believe, for nurses, too. People who register in an emergency will not have to pay a registration fee. That has already been determined under a previous order. I think that that covers Richard Simpson's main questions.

Dr Simpson: That was very helpful.

The Convener: Before we move on, I would like to discuss issues to do with psychologists. I note that the British Psychological Society is very content with the order; I understand why, as we would not want people who turn out to be charlatans to be able to set themselves up saying, "I'm a psychologist." The provisions on that are very agreeable.

I notice from the explanatory note that the Association of Educational Psychologists is going on to the Health Professions Council register for the first time. Like Richard Simpson, I have received representations—very late in the day—from the Scottish division of the Association of Educational Psychologists. Its members are concerned that they are going on to the HPC register despite the fact that they feel that they have more in common with education. I understand that they are currently in discussions with the General Teaching Council for Scotland about being approved and registered with it. Was the minister aware of that, and could she comment on it? I understand that not all educational psychologists have to have teaching qualifications, as was previously the case, but there is a sense among members of the Scottish division of the AEP that they really belong in the education system, not with health professionals.

Nicola Sturgeon: I am aware of that point of view. I am also aware of the opposite point of view, which is held by some educational psychologists, who would say that they want to come under the regulation that is governed by the order. The matter relates to the point that Richard Simpson made about ensuring appropriate and proportionate regulation, not regulation for regulation's sake. There is an argument that all psychologists should be regulated, but the order does not do that. Some psychologists work purely in the academic sphere and have no direct relationship with patients or the public. We have taken the decision that it would not be appropriate or proportionate to regulate them.

Educational psychologists are different. They are involved in professional-client relationships, and they provide services to the public—often children, in the case of educational psychologists. Those services are about improving the health and wellbeing of individuals. For that reason—because of their direct professional public relationship—and given that the driving force behind the order is public safety, it is appropriate to regulate educational psychologists. They are one of the seven divisions that the British Psychological Society currently uses.

The Convener: I am grateful to the minister for putting that on the record. That will be useful in relation to any discussions that the organisations in question are having.

Ian McKee: In her opening remarks, the cabinet secretary mentioned the case of Dr Harold Shipman. Could she tell us how the order will help to prevent a Harold Shipman in the future? A lot of people think that a Harold Shipman might actually end up on the Health Professions Council. How will regulating the profession in the way that is set out stop someone like Harold Shipman in the future?

12:15

Nicola Sturgeon: The Health Professions Council does not regulate GPs, but some of the

concerns that were raised in the wake of the Harold Shipman case and other high-profile cases centred on the independence and impartiality of regulators. Because of the composition of the regulatory bodies and the route that people took to being on them, there was a feeling that the bodies were perhaps too much in favour of the profession rather than regulating for the public—although "biased" would be too strong a word.

In part, the changes are to the governance arrangements for the regulatory bodies. For example, people will no longer be elected by the professions to the bodies; instead, they will be appointed by the Privy Council, although in practice that will be delegated to the Appointments Commission. The bodies that we are talking about will have on them someone who lives or works entirely in Scotland. The aim is in part to ensure that the bodies are put together in a much more independent and impartial way. Further, some of the duties that are placed on councils, such as the duties to engage with stakeholders, to have clear strategies in place and to report and be accountable to Parliament, will help to ensure that the operation of the bodies is firmly about the protection of the public.

Mary Scanlon: I seek clarity on one issue. When chiropodists or podiatrists had to register, some practising chiropodists who did not have the general qualifications and could no longer call themselves chiropodists advertised their services as foot care specialists. If we apply that analogy, is it possible that people who are not registered could advertise their services in a different way? For example, I am thinking about services such as cognitive behavioural therapy, psychological support and counselling. Will someone who is not registered be able to offer psychological support and help simply by not calling themselves a psychologist?

Nicola Sturgeon: As I said in response to Richard Simpson, some of the sub-specialities of psychology are not included in the provisions. Mary Scanlon raises a legitimate point. We must be vigilant and ensure that the situation that she describes does not arise. The situation with psychology is similar to the one that Mary Scanlon mentioned with chiropodists, in that there is a group of psychologists called chartered psychologists who are currently given practising certificates by the BPS, but who do not fall under one of the seven divisions. Therefore, they will not automatically move to registration under the Health Professions Council, but routes are being made available to allow them to register, with a three-year window in which to do that.

Mary Scanlon: Irrespective of the measures, someone will still be able to practise and give psychological support if they advertise as a counsellor or cognitive behavioural therapist.

Nicola Sturgeon: Yes, because only the titles that are in the order are protected—for psychology, there are seven divisions. Somebody who does what the member describes and does not use a protected title would not be regulated. We must be vigilant in case a problem arises with people who are not regulated advertising services when it is perceived that they should be regulated.

The Convener: There could also be misrepresentation.

Nicola Sturgeon: Indeed.

Ross Finnie: I have a brief supplementary question on the issue that Richard Simpson raised about physiologists. You said that that matter had not been raised with you. One might understand that, in that you are not responsible because the bodies are organised on a UK basis. Nevertheless, representations have been made to parliamentarians by physiologists who are practising in Scotland. By the nature of their profession, those people have relationships with patients or clients, so any unprofessional or improper practice could lead to harm. The process of registrations is moving apace, but physiologists see a danger that they will be regarded as second-class citizens. They are in a category in which harm is possible, yet they will not be properly regulated.

Would you be able to raise the issue at UK level, rather than waiting for the issue to be raised with you? I understand that the process has been discussed, but that it has gone completely flat for the past two years.

Nicola Sturgeon: I did not say that the issue had never been raised with me, because it is quite likely to have been raised with me. What I said was that I was not aware of discussions having taken place about the inclusion of physiologists in this order or in related orders. I will be more than happy to consider the points that members are making and to consider whether we should be raising the issue proactively.

The door of regulation will never be closed; different groups will be able to come within the regulatory framework. As changes are made in the way in which services are delivered, we will have to keep an open mind on regulation. I therefore have no objection to giving more consideration to the points that have been raised.

Ross Finnie: As I understand it, groups of people actively wish to be regulated.

Dr Simpson: Some of us were given a presentation in which we learned of individuals who had moved from board to board, who had now moved abroad, and who had repeatedly been

guilty of malpractice, causing considerable damage and danger. Because there is no system of registration, the public are not being protected. Specific examples of that were given to us.

Nicola Sturgeon: I appreciate the points that have been made about direct relationships between the public and practitioners but, as I understand it—and the doctors around the table will probably know better than I do—physiologists are considered to be scientists, so much of the discussion on the subject of regulation takes place in the context of physiologists being scientists. The modernising scientific careers programme is under way. Discussions are taking place with UK departments other than the Department of Health about the possibility of regulation.

The Convener: Thank you, that was all very helpful.

Following those questions, we come now to the formal debate on the order, and I invite the cabinet secretary to move motion S3M-3654.

Motion moved,

That the Health and Sport Committee recommends that the draft Health Care and Associated Professions (Miscellaneous Amendments and Practitioner Psychologists) Order 2009 be approved.—[*Nicola Sturgeon.*]

The Convener: We can have a debate, but I take it that, having asked questions, committee members are happy not to do so.

Members *indicated agreement*.

Motion agreed to.

The Convener: That took 23 minutes and 14 seconds, but only because we are very thorough.

Nicola Sturgeon: Well done.

Regulation of Care (Requirements as to Limited Registration Services) (Scotland) Amendment Regulations 2009 (SSI 2009/90)

The Convener: The regulations give providers of a limited registration service an element of discretion in considering whether someone with a conviction is fit to manage or be employed in such a service.

No comments have been received from members and no motions to annul have been lodged. The Subordinate Legislation Committee drew the regulations to our attention on the grounds of a failure to follow normal drafting practice—we have heard that before—and two cases of defective drafting—we have also heard that before—that are not thought likely to affect the validity of the regulations.

Are we agreed that the committee does not wish to make any recommendations in relation to this instrument?

Members *indicated agreement*.

The Convener: That concludes today's business. Thank you very much.

Meeting closed at 12:24.

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