HEALTH COMMITTEE

Tuesday 25 January 2005

Session 2

£5.00

Produced and published in Scotland on behalf of the Scottish Parliamentary Corporate Body by Astron.

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HEALTH COMMITTEE

3rd Meeting 2005, Session 2

CONVENER

Roseanna Cunningham (Perth) (SNP)

DEPUTY CONVENER

*Janis Hughes (Glasgow Rutherglen) (Lab)

COMMITTEE MEMBERS

*Mr David Davidson (North East Scotland) (Con)
*Helen Eadie (Dunfermline East) (Lab)
Kate Maclean (Dundee West) (Lab)
*Mr Duncan McNeil (Greenock and Inverclyde) (Lab)
Shona Robison (Dundee East) (SNP)
*Mike Rumbles (West Aberdeenshire and Kincardine) (LD)
*Dr Jean Turner (Strathkelvin and Bearsden) (Ind)

COMMITTEE SUBSTITUTES

Robert Brown (Glasgow) (LD)
Paul Martin (Glasgow Springburn) (Lab)
Mr Stewart Maxwell (West of Scotland) (SNP)
Mrs Nanette Milne (North East Scotland) (Con)

*attended

THE FOLLOWING GAVE EVIDENCE:

Dr Jenny Bennison (Royal College of General Practitioners)
Rhona Brankin (Deputy Minister for Health and Community Care)
Alistair Brown (Scottish Executive Health Department)
Dr Ian Pullen (Scottish Executive Health Department)

CLERK TO THE COMMITTEE

Simon Watkins

SENIOR ASSISTANT CLERK

Tracey White

ASSISTANT CLERK

Roz Wheeler

LOCATION

Committee Room 2

Scottish Parliament

Health Committee

Tuesday 25 January 2005

[THE DEPUTY CONVENER *opened the meeting at 14:01*]

Item in Private

The Deputy Convener (Janis Hughes): I welcome you all to the third meeting in 2005 of the Health Committee. First of all, I intimate that I have received apologies from Shona Robison and Kate Maclean.

The first item on the agenda is to consider whether to take item 4 in private. Item 4 concerns our approach to consideration of the Smoking, Health and Social Care (Scotland) Bill. The reason for the proposal to take that item in private is that we may wish to discuss potential witnesses and options for our approach to evidence-taking sessions. When we have discussed potential witnesses previously, we have chosen to do so in private. If no member objects, I ask the committee to agree to take item 4 in private. Is that agreed?

Members *indicated agreement.*

Subordinate Legislation

Food Labelling (Added Phytosterols or Phytostanols) (Scotland) Regulations 2005 (SSI 2005/1)

National Health Service (Travelling Expenses and Remission of Charges) (Scotland) Amendment Regulations 2005 (SSI 2005/3)

14:02

The Deputy Convener: Item 2 is subordinate legislation, and the committee is asked to consider two instruments that are subject to the negative procedure. We are told that the Subordinate Legislation Committee has no comment to make on either of the instruments, no comments have been received from members and no motions to annul have been lodged in relation to the instruments. Are we agreed that the committee does not wish to make any recommendation in relation to the statutory instruments?

Members *indicated agreement.*

Eating Disorders Inquiry

14:03

The Deputy Convener: Item 3 is the second part of our inquiry into eating disorders. Last week, we visited Stonehaven and heard evidence from a number of people there. This is the final scheduled oral evidence-taking session in the inquiry.

I welcome Dr Jenny Bennison, the deputy chair of policy at the Royal College of General Practitioners. Members may wish to note that a written submission from the college has been circulated to members with the papers for the meeting. If you wish to make a short opening statement, Dr Bennison, please do so.

Dr Jenny Bennison (Royal College of General Practitioners): My perspective on eating disorders is as a working GP as well as someone who works for the Royal College of General Practitioners in Scotland. I have 11 years' experience as a GP working in Leith, so much of my on-the-ground experience is local to the south-east of Scotland, but I have discussed the matter with colleagues throughout Scotland.

I do not know whether you want to pose specific questions or whether I should run through my thoughts on the subject.

The Deputy Convener: No, that is fine. At this stage, we will ask specific questions.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): Last week in Stonehaven, we heard from a petitioner, Mrs Gráinne Smith, about the solution to the problems. She said:

> "Training for GPs would be my number 1 priority. GPs have very little training in eating disorders, despite the incidence of such disorders in our society. They need much more training, with a stress on initially recognising the possibility of an eating disorder, diagnosis and recognising the steps that are involved to pass on sufferers to the next stage. There should be training for all GPs in their general medical training".—[*Official Report*, *Health Committee*, Tuesday 18 January 2005; c 1532.]

I ask Dr Bennison to respond to that.

Dr Bennison: We must consider what goes on from the undergraduate stages of medical training through to the postgraduate stages. In the submissions that I have been given to look at, there is a lot of emphasis on how much time is spent during the undergraduate years on eating disorders, but I am not sure that it is helpful to look at that because, to be realistic, after qualification most doctors do not retain much of what they are taught in the first few years. It is more important to consider what budding general practitioners learn in their postgraduate years, whether they do specific psychiatry placements or not. When we are training GP registrars, who at the moment spend 12 months with us in general practice, we have to assume that none of them has done any psychiatry, because only a relatively small number of them are able to get placements in psychiatry.

During their 12 months with us, the GP registrars build up a core of knowledge, skills and professional attitudes based on problem-solving skills and using time as a tool. Much of the learning is case based, so it depends on what cases come along, but it is supplemented by huge amounts of background reading and by courses. Our GP registrars in south-east Scotland spend two days doing psychiatry, which will include at least a component on eating disorders. That learning has to be built on and reinforced by one-to-one contact with us as GP trainers. That contact is about, for example, examining the appropriateness of their referrals, which we do routinely through the year.

Mike Rumbles: I do not know whether you were being light-hearted in your initial reaction. Is the official view of the Royal College of General Practitioners that the situation is okay because—I have written down what I thought you said—doctors do not retain much of what they learn in their first few years of training?

Dr Bennison: Obviously that was a light-hearted comment. In the early years of a medical curriculum, medical students clearly need to learn overall skills, such as communication with patients and how to build up a link with a patient. That kind of stuff, which they are doing and repeating, is what they will remember and what is really important. If a first-year medical student is given a lecture about a disease when they have never met a patient with that illness, they are much less likely to be able to access that knowledge easily once they are qualified.

Mike Rumbles: The GP is the first line of contact—the first person whom a sufferer contacts—and, in the evidence with which we were presented last week, it was clear from the individuals' personal experiences and the knowledge that they had from other sufferers of eating disorders that although many good GPs identified and diagnosed the problem and referred patients, many others did not. That is why I again go to the quotation from Mrs Smith:

> "Training for GPs would be my number 1 priority."—[*Official Report*, *Health Committee*, Tuesday 18 January 2005; c 1532.]

It is a really serious matter, and I am not sure that the Royal College of General Practitioners has got it right.

Dr Bennison: For a start, the Royal College of General Practitioners is not responsible for the content of the undergraduate medical curriculum. We have an input into the postgraduate curriculum, which is under review at the moment. The GP curriculum committee, which is based in the Royal College of General Practitioners at United Kingdom level, will feed into the Postgraduate Medical Education and Training Board this year.

Mike Rumbles: I am glad that you said that, because I was under a misapprehension. Are you saying that you have no input at all into initial GP training?

Dr Bennison: We are not asked for our opinion, as far as I am aware.

Mike Rumbles: Does the Royal College of General Practitioners have no input into GP training?

Dr Bennison: You are talking about what goes on at undergraduate level in relation to training for all doctors, not just for future GPs.

Mike Rumbles: Do you not feed in at all to the training process?

Dr Bennison: I am not aware that we officially feed into curriculum setting. GPs in university departments of general practice will be involved, rather than the college.

Mike Rumbles: You have educated me. I think that we have identified a gap.

The Deputy Convener: My question is not specifically related to the eating disorders inquiry. Does the fact that you do not feed into undergraduate training contribute to a disincentive to trainees to consider becoming GPs later in their careers?

Dr Bennison: Many highly effective and enthusiastic GPs work in university departments of general practice throughout the country and are well aware of matters that should be in the curriculum. In undergraduate and postgraduate medical education there is a move towards much more integration of different areas. Many of the core skills are extremely important. I mentioned communication, which cuts across almost any specialty that a doctor might end up in.

Mr David Davidson (North East Scotland) (Con): Under the final heading in your submission, you say:

> "While we do not feel there are any particular issues in the diagnosis of eating disorders, one of the main difficulties lies in supporting and encouraging patients to raise this problem with GPs and other health care professionals."

Many people who develop eating disorders are quite young and it is often someone in the family such as a parent or perhaps someone from school who recommends that they go to their GP. I have personal knowledge of the problem and I have spoken to many families, so I can say that sufferers and carers have the overall impression that GPs have little if any knowledge and have to be persuaded to refer people. Is that the college's position or is the college looking ahead to try to change that view?

Dr Bennison: There can never be too much education and training. It would certainly do no harm to raise the profile of eating disorders and I accept that there might be some GPs who are less good at making referrals.

There are many barriers to diagnosis and lack of knowledge among GPs is not the most important one. There are many other difficulties that get in the way of making a diagnosis and an appropriate onward referral. You are well aware that the illness is extremely upsetting and difficult not only for the patient but for the people around them. It is not always easy for sufferers to talk about the illness and when GPs try to address the problem by asking suitable questions such as, "Is eating a problem for you?" or, "Do you think that you are excessively worried about your weight?" they often come up against a defensive wall and have to try again and again. I know from experience that GPs can have a good idea that there is a problem the first time that we meet someone—often someone on the street would know what the problem was just from looking at the person—but we cannot make progress until the person accepts that they have a problem and agrees to onward referral and help.

Most GPs have come across people—particularly sufferers of bulimia—who give a history that clearly indicates that there is a problem. The GP makes a referral, but there is a long wait before the person is offered an appointment and by the time the appointment comes round, the person has moved on and the opportunity has gone. The GP might well have engaged the person sufficiently to persuade them to agree to the referral, but six months later when the appointment comes round things have changed and the person might no longer have the guts to attend. That is one of the most important and difficult aspects of the problem.

There are other issues, particularly for younger patients, about how good the one-to-one relationship is between the GP and the patient. A high degree of engagement with patients with eating disorders is needed before we can move on.

Barriers sometimes exist. If a young person still lives at home, that raises the difficulty of whether to have their parents in with them. Another difficulty is whether a good relationship with some teenagers can be achieved with their parents sitting there. If the parents are not present, issues of confidentiality and so on must be worried about, such as how much the young person wants the

GP to talk to her parents about what she says in a consultation. Sometimes, a young person is worried about that and feels that they cannot tell the GP things because the GP will automatically tell their parents, their school or whomever.

A consultant colleague from the Cullen centre in Edinburgh told me that another big issue was families' perception of blame. He found that a big barrier for patients at the Cullen centre is parents' fear of being blamed by health professionals, which is a terrible state of affairs. For individual patients, that may be a factor. That situation can be improved. We need to make the whole process more open.

14:15

Mr Davidson: I will return to the GP situation. From what you have just said, are you suggesting that in an ideal world, you could have easy referral to a community-based psychiatric team through a practice, rather than waiting six months, or even longer in some cases? Would an instant connection through the therapists or whatever the local team happens to be help GPs? Would they use that, or do they not wish to be too closely involved and want to refer a case to a hospital?

Dr Bennison: It is not the case that GPs do not want to be too closely involved. Even when we make a referral to a specialist unit, we are still very much involved and we maintain contact with patients as they are seen by the multidisciplinary team at the hospital. If the multidisciplinary team were based in the community, close to where we work, and if it were easier for us to meet those people, who share in the care of our patients, that would be fantastic. One difficulty sometimes is that the more people a multidisciplinary team involves, the more difficult it becomes to keep lines of communication open.

Mr Davidson: I do not know what happens in Lothian, but in other parts of Scotland, psychiatrists and therapists who work in the community are attached to practices, which provides a direct link and consistent contact with the individual patient.

Dr Bennison: I think that that varies in different areas. Where I work, we have community mental health teams that are based in local health care co-operatives, which involve local groupings of practices with a geographical link. However, those teams have general psychiatric consultants, rather than people who have a particular interest in eating disorders.

Mr Davidson: Is there one thing that the college could do to improve the early intervention that is required?

Dr Bennison: I would like GP involvement in the new community health partnerships through work in a multidisciplinary team to make early assessment easier and allow people to strike while the iron is hot, before ill eating habits become entrenched. That is the most important matter. Offering more updating courses to established GPs would also be good.

Helen Eadie (Dunfermline East) (Lab): As elected representatives, we frequently see the needs assessment from local health care co-operatives. As well as a needs assessment, is a strengths assessment undertaken among health professionals? At one of its meetings, my area's LHCC talked about the fact that frequently a GP in an LHCC has a particular interest and a strength that he or she can contribute to that locality. We all know that many general practitioners take a more intense interest in a particular aspect. In your experience, is that to be found throughout Scotland? Is it possible that we do not need always to refer upwards and instead could refer across to people who are in our community, if we could identify people who have a particular interest in such work? We could build on that.

I have the impression that there is immense pressure on the psychiatric services. It is said that there is one psychiatrist for every 60,000 constituents. When we are dealing with a challenge on that scale, we must consider other possible solutions. Could one such solution be for parliamentarians and Government to seek to identify all the people with an interest in this issue and to bring them together? Once we had a register of such people, we could build on it.

Dr Bennison: The college is working with the Scottish Executive on the idea of developing GPs with a special interest. That work is in its very early stages. In England, there are already about 16 areas in which the skills that may be needed for someone to become a GP with a special interest are specified. We are examining how much of that work can be transferred to Scotland.

Psychiatry is an area that would lend itself to such an approach. General psychiatric services, let alone specialist services for relatively unusual disorders, are under considerable strain. It is important to make clear that what you are suggesting already happens to some extent. At an informal level, in a general practice in which half a dozen doctors are working together, we often work out which GPs have particular interests. That information is publicised in the practice leaflet, so that patients can self-select or be referred by GPs to their colleagues in the practice. There also a certain amount of LHCC cross-referral—in minor surgery services, for example. I am not aware of any GP-led psychiatry clinics in LHCCs, but that issue may be covered in the new CHPs.

Helen Eadie: I was not necessarily thinking of GPs running psychiatry services. However, a GP in an LHCC area might be known to be particularly good at diagnosing particular conditions and having some knowledge of how to treat them. One solution might be to set up support groups. There are all sorts of methods that could be tried and tested in this context. Ought we to pursue the approach that I have suggested?

Dr Bennison: In the National Institute for Clinical Excellence guidelines on the management of eating disorders in England, the stress is on making the initial diagnosis and referring patients on to multidisciplinary services. GPs are not best placed to offer all the help and care that people need. I am not sure that GPs are the best people to build up support groups, although we would encourage those. There is a limit to what GPs can do. It is important that we know how to diagnose and to refer people on. We should provide continuing support to and knowledge of a person as they travel through their treatment.

The Deputy Convener: In your submission, you refer to private eating disorder clinics that have been established in Scotland. You say:

> "The transfer of resources into private sector is unlikely to offer value for money."

Last week, we heard from a representative of the Priory hospital, which has a different view. Private facilities have been successful in treating patients, often in partnership with the NHS. In the absence of services in the NHS, do private clinics have a role to play?

Dr Bennison: I am sure that they have. There are no NHS in-patient facilities for people with eating disorders, so NHS funding is found where in-patient care is required. Until or unless there are NHS facilities, the private facilities will have a role to play. However, it is a pity that the service cannot be provided in the NHS.

Mr Davidson: Does the college have a view on how regional services for this set of conditions should be spread around Scotland?

Dr Bennison: We do not see it as the college's role to comment specifically on that issue. The fact that there is a huge chunk of population in one part of the country is a problem in many areas for GPs in Scotland. With any rare diseases, there will be difficulties of access in less well-populated areas. We cannot justify having large numbers of specialists in areas where there is only a small number of patients. The Scottish General Practitioners Committee of the British Medical Association is probably better placed to comment on the issue.

The Deputy Convener: Thank you for your attendance. We will conclude our evidence taking today and decide how we wish to proceed on this subject.

Dr Bennison: Please get in touch if there is more information that we can dig out for you.

The Deputy Convener: We will do that.

We are slightly ahead of time. I suspend the meeting until 2.35, when we will hear from our next witness.

14:25

Meeting suspended.

14:31

On resuming—

The Deputy Convener: I can reopen the meeting early because we are all in place. I welcome the Deputy Minister for Health and Community Care, Rhona Brankin, and her officials. Alistair Brown is head of the performance management division of the Scottish Executive Health Department and Dr Ian Pullen is the department's principal medical officer. We are continuing our inquiry into eating disorders and will be happy to hear the deputy minister's opening statement.

The Deputy Minister for Health and Community Care (Rhona Brankin): If I talk for too long, I am sure that somebody will stop me.

I welcome the opportunity to attend the committee's meeting today to assist in your inquiry into services for people who suffer from eating disorders. As you know, I have already written to the committee on the issue to set out my initial views, but I will briefly reiterate what I said.

I know that a number of people who have direct experience of the impact that eating disorders have on sufferers and their families have given evidence to the committee. Having read some of that evidence, I know that it was moving and brings home better than any statistics could do the extent of the misery and distress involved.

In 2001, the Executive published an addition to the "Framework for Mental Health Services in Scotland" to provide guidance on service provision for eating disorders. That guidance was produced with the assistance of a working group that included some of the people from whom the committee has taken evidence. It set up ways in which services can be structured to produce appropriate responses to the differing levels of need that present themselves in the community and in local hospital and regional services. Although the NHS boards are under no obligation to follow the guidance in detail, they are expected to take it into account when they plan and develop new services.

From the evidence that you have taken and from the information that we have provided, it is clear that the guidance continues to describe an ideal that is not being achieved across Scotland. Some areas have made more progress than others in developing services that are targeted at eating disorders. For example, no NHS board has developed its own in-patient specialist care service. However, boards assure us that they can and do purchase places from the independent sector wherever necessary. I know that that is an issue that the committee has examined.

I also referred to the need for boards to collaborate on regional planning of specialist services. The Executive believes that joint planning and delivery of services at regional level is potentially important and has recently issued guidance to health boards on that, which followed the new statutory duty of collaboration among boards in the National Health Service Reform (Scotland) Act 2004. More guidance has been issued to boards about how they can further improve regional planning and co-operation. I know that the committee has received evidence from the north of Scotland planning group that sets out how the boards in the north are getting together to assess need and to plan and provide services for eating disorders. I expect that those joint efforts will produce results more quickly than individual plans and projects would, which will benefit patients.

As well as provision of specialist care, patients need to have effective care pathways that identify problems early and provide an appropriate range of primary care and community interventions. I know that the committee has been examining that. Community health partnerships and joint future partnerships both have important roles to play in establishing the integrated services that we would like.

It is important to state that we are currently consulting widely on the introduction of a framework for children's and young people's mental health. That framework will emphasise an integrated multi-agency approach to service delivery, and we intend to monitor service development and delivery through integrated children's services plans, which we shall ask NHS boards and their partners to submit to us and update annually. Responsibility for delivering those local and regional services will continue to rest with NHS boards, which have the local knowledge that is necessary to create and deliver services. The boards are also able to make the necessary links with the wider public and the voluntary sector.

There are two or three other things that I would like to state briefly. It is important to say that the implementation work that has already been done to support the Mental Health (Care and Treatment) (Scotland) Act 2003 has demonstrated that the local partnerships that have been established between NHS boards and local authorities have been able to make progress in assessing and establishing local mental health services that meet the needs of patients in the areas that are mentioned in the act. I do not intend that implementation should stop at commencement; the structures that have been established should remain in place to support on-going delivery of the modern needs-led mental health service that we are committed to creating in Scotland.

It is also important to look at the national programme on well-being, which focuses on stigma and awareness of mental health issues. That might include work that is focused on eating disorders, with the aim of increasing early identification of problems. I welcome the committee's interest in the needs of patients who have eating disorders; it is important that we keep the entire spectrum of mental health services in view. Despite the priority that we attach to mental health by including it alongside cancer and heart disease as one of the three clinical priorities in Scotland, it can slip down the public's list of priorities and, indeed, those of the NHS. We must be vigilant about that. We need to be able to maintain and improve focus on patient groups whose needs might be overlooked, which includes people who suffer from eating disorders.

I look forward very much to the committee's report and to working in this area and maintaining regular contact with the committee on progress.

The Deputy Convener: Thank you. I welcome your comments.

Mr Davidson: We are talking about a condition that the previous witness from the Royal College of General Practitioners described as a "rare" disease, but in fact one in 10 of the population may suffer from it. Back in 2001, the Executive itself published a framework for mental health services that included a section on eating disorders. A few moments ago, you mentioned monitoring. Could you tell us what action has been taken to monitor implementation of the framework since 2001?

Rhona Brankin: Very little has been done to monitor the framework since 2001. That is a situation that, as a recently appointed minister, I am keen to redress. I would like to offer the committee several suggestions about how I can take that monitoring further. I intend to seek information from the regional planning groups. I understand that the north of Scotland regional planning group is the most advanced in the matter of eating disorders, and I intend to ask the regional planning groups for detailed information on the progress that it has made in considering eating disorders. I shall ask for that information by April or May, and I shall feed it back to the committee.

Furthermore, I am aware that there are NICE guidelines for England and Wales. Although the Scottish Executive has provided guidance as an appendix to existing guidance on the framework for mental health, I realise that we do not have the equivalent of the NICE guidelines. Members will understand that there is a difference between the English and Welsh NICE guidelines and the guidelines from the Scottish intercollegiate guidelines network. It might help if I asked NHS Quality Improvement Scotland to examine the NICE guidelines and translate them into something that might be appropriate for Scotland. I could then feed that information back to the committee.

The advantage of introducing SIGN guidelines is that NHSQIS has a clear role in monitoring their implementation. I think that you have asked the key question, Mr Davidson. Until now, we have not ensured that there is any accountability in development of services, but I am keen to move in that direction.

Mr Davidson: I certainly welcome that. You said that you would meet the north of Scotland regional planning group. Dr Harry Millar gave evidence to the committee as a representative of the group and of his profession. When he was asked why the proposal suggested by Grampian NHS Board and Highland NHS Board to set up a dedicated residential unit at the Royal Cornhill hospital failed, he said that he did not know. I therefore suggest that, as well as meeting the planning group, you write to the two health boards and find out exactly what happened. The general feeling is that many people in the NHS want services to be developed within the health service itself.

There is an opportunity for partnership in treating eating disorders and Mr Kerr's proposals to allow private services to use NHS facilities might provide a way. However, it is important that we find out what is holding health boards back and that we get that information out in the open. Unless you can provide an answer to that question, I ask that you investigate the matter.

Rhona Brankin: I do not have any information about the specific case that you mentioned. However, I will be more than happy to ascertain the reasons for the failure of that proposal when I talk to the health boards.

I am sure that members are well aware that Professor David Kerr is working on a Scotland-wide and regional overview. Our challenge is not only to provide a nationwide overview but to find out how to provide services regionally. It is hugely important that regional planning groups work together, because it will simply not be possible for every single health board to provide specialist acute services for people who have eating disorders.

I am aware of the 10 per cent figure that was mentioned, although I think that the NICE guidelines say 5 per cent. I do not want to quibble about or minimise the matter. I understand that it is serious and I know that many young people, for example, die from anorexia nervosa. However, we must ensure that regional planning groups identify needs and strengths in their regions and that they provide appropriate managed care networks so that eating disorders can be diagnosed early and so that they can ensure that there is a pathway from diagnosis through care and support in the community to acute specialist hospital provision. That must be planned for at regional level.

14:45

Mr Davidson: Is there a role for a national set-up, rather than a regional planning system, that would allow interchange around Scotland, involving sharing of staff and so on? What is the ministerial responsibility in that?

Rhona Brankin: Health ministers must be confident that the range of patients' needs is being met throughout Scotland. Clearly, the current debate is about the extent to which we have specialist services and the extent to which we have services in the community.

On provision of mental health services in Scotland, it would be true to say that that has been hospital-led and that we still have a considerable way to go to develop community-based mental health services. I am very conscious of that and, as I said, following implementation of the Mental Health (Care and Treatment) (Scotland) Act 2003, I am keen to continue to monitor very closely the extent to which community mental health services are developed. I have a strong interest in that. Mental health is one of the three key clinical priorities for Scotland and I want to be assured that community-based mental health services are in place in order to deliver patient support and care. I, as a minister, have a clear responsibility for mental health in ensuring that there are adequate services throughout Scotland and that patients' needs are being met, even before diagnosis. There is a responsibility for us all to consider mental health and well-being. If we go farther back, we would want to look at broader policy areas that touch on education, but I do not want to go into that at this stage.

Mike Rumbles: I noted that you said earlier that the framework document was

> "an ideal that is not being achieved across Scotland."

I was glad to hear in your response to David Davidson that you are taking a personal interest in the issue. Our petitioner said in evidence to the committee last week:

> "On the solution, leadership is crucial, and the first step is co-ordination from the very top."—[*Official Report*, *Health Committee*, 18 January 2005; c 1532.]

I think that she was referring to ministerial level and certainly to co-ordination from the centre.

Following what David Davidson asked, I will quote directly from the evidence that Dr Millar gave us last week, to contrast it with your remark about the framework document's being

> "an ideal that is not being achieved".

Dr Millar said:

> "About three or four years ago the health department produced the framework document … However, most health boards have done nothing or very little. They may have had discussions and drawn up plans, but on the ground nothing has happened. Two health boards have set up and run significant services for adults."—[*Official Report*, *Health Committee*, 18 January 2005; c 1542.]

He went on to say that

> "It appears that the framework document has been issued and just left to gather dust. I do not have a sense that anyone at the centre is following it up and asking what is being done about implementing the framework for eating disorders."—[*Official Report*, *Health Committee*, 18 January 2005; c 1544.]

I am pleased to hear what you have said so far in response to members' questions, but I am not sure that you have grasped the gravity or the depth of the evidence that, for example, Dr Millar gave to us. He suggested that the framework document had been "left to gather dust".

My question runs on from a question that I put to the medical director of Grampian NHS Board who gave evidence to the committee. The reality of effective services is based on the amount of resources that are allocated to them. He gave an example from his documentation: He said that

> "funding for Tayside and Grampian only was £830,000 two years ago"—[*Official Report*, *Health Committee*, 18 January 2005; c 1556.]

and that funding had now decreased to £600,000. When I asked him why, he could not tell us. It seems that there are two issues. One is about leadership and ensuring that when a document is issued by the centre, it is followed up and health boards implement its measures. The second issue is about resources. Can you tell us anything about resources?

Rhona Brankin: You will understand that it is impossible to give detailed guidance from the centre on how health boards should implement strategies locally. The key point about local health boards is that they have to be able to assess particular need in their areas. That takes us back to the balance between central and local control.

The minister has a role to play in performance management and accountability. I have said that it would be useful to involve NHS Quality Improvement Scotland in lines of accountability. We need to improve services in this area regionally and locally. By inviting NHS Quality Improvement Scotland to become involved and to look at the NICE guidelines for England and Wales, we could ask it to translate the guidelines into the Scottish context, which would bring with it a line of accountability when the SIGN guidelines are issued. The extent to which the guidelines are followed would then be monitored by NHSQIS. That is an important and new line of accountability in development of services for people who have eating disorders.

Local mental health plans are being developed in local health boards and health partnerships, which will be very important in the future. The role of community health partnerships will become hugely important because of the need for joint services between the NHS and local government. Carrying on from implementation of the Mental Health (Care and Treatment) (Scotland) Act 2003, there will be a continuing requirement for mental health plans to be drawn up. That will give me an opportunity to ask about issues such as eating disorders, which have come up in the past, in the local mental health plans. There are different lines of accountability. What was your second question?

Mike Rumbles: It was about resources.

Rhona Brankin: Record amounts of broader resources are going out to health boards in Scotland. I have seen evidence of a request that amounts of money should be specifically earmarked for treating eating disorders. You will be aware that there are big discussions about whether one should attach certain amounts to certain conditions. We have taken the view in most cases that we do not want to do that from the centre. It is key that we set out guidance and guidelines and the key issue is then the extent to which the guidance and guidelines are monitored and that there is a line of accountability.

Mike Rumbles: I will pursue the matter, because we want a solution. I acknowledge that you are relatively new in post, but clear evidence has been presented to the committee in the past that eating disorders services have been very much a forgotten area. Witnesses who gave evidence in Stonehaven at last week's meeting confirmed that. I have already quoted Dr Millar. The medical director of Grampian NHS Board said:

> "Boards are geographically different … and the implications of a directive"—

from the Scottish Executive Health Department—

> that says, 'Thou shalt set up these services' vary among boards. That applies particularly to in-patient facilities for eating disorders. I am not saying that there should be national delivery of such services, but we need a national approach to which each board contributes".—[*Official Report*, *Health Committee*, 18 January 2005; c 1556.]

Can I take it from what you have said to the committee that you will consider the issue and ensure that health boards throughout Scotland—not just the two boards that have been mentioned—implement the guidelines that were set out, in a national approach?

Rhona Brankin: Regional planning is the key, as I said. There is now a requirement for health boards to collaborate across their boundaries. Planning must involve more than just me in the centre and health boards out there. Given where the acute services for eating disorders are currently located, people in the Highlands and elsewhere have to travel many miles, so regional solutions must be considered. However, clear guidance and guidelines should come from the centre and it is important that there should be accountability in relation to guidance and guidelines. There has been a lack of follow-up to the guidance that was issued in the past.

Although I have not yet spoken to the north of Scotland regional planning group, I understand that the group is ahead of the game in regional planning for eating disorders services.

Mike Rumbles: Who will do the follow-up? That seems to be the nub of the problem. There has been a failure—if I may call it that—to implement the guidance and guidelines. You recognise—at least you did not contradict the evidence that we received—that the guidelines are not being implemented throughout Scotland and you are taking an interest in the matter. You say that the lines of accountability will go through the new regional structures. Ultimately, however, what will ensure that things change on the ground? Who will do the follow-up to ensure that regional organisations take action to implement the strategy?

Rhona Brankin: As I said, NHS Quality Improvement Scotland will have an important role in ensuring that services are developed in line with the guidelines that I will ask NHSQIS to provide.

I am the minister with responsibility for mental health in Scotland and mental health is one of the three clinical priorities that the Executive identified. Through performance and accountability reviews, ministers hold health boards to account in relation to those priorities. In the context of the broader operation of performance and accountability monitoring, I could ask that eating disorders services, for example, be monitored.

NHSQIS has a key role to play in this respect. The local health boards are also accountable in terms of working together to produce their regional responses. Individual health boards, through the vehicle of community health partnerships, also have a responsibility for the provision of a full range of mental health services in their area. Ministers are accountable on the issue, as is NHSQIS. That accountability is not something that was in place in the past.

15:00

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): From the evidence that we took last week, it is clear that the subject is important—nobody would deny that that is the case. What really struck me was that, regardless of the amount of money that is going into this area, no close monitoring is being done. As the minister said, that could be looked into.

I think that Ayrshire and Arran NHS Board told us in its evidence that it was trying to set up local teams. I recollect that the board said that it was required not to use the Priory. All in-patient services are in the private sector and cost a certain amount of money. If no service is available in the NHS, private sector services will have to be paid for. How can the boards develop services in their areas if they are financially strapped?

Could the Executive—for a period of time and in some way—allow extra money to go towards establishing local eating disorder services? Extra money could be given for treatment of eating disorders that affect a large proportion of the population—indeed, it is likely that they affect a greater number of people than we know about. The money that is available relates to the number of people who work in the teams. If a health board is restricted in what it can do, it will have difficulty in employing people, whether they are part-time or whole-time equivalents.

As Dr Millar said, managed clinical networks are excellent and wonderful things. However, such networks need personnel. The issue comes down to the money that is required for the people to provide the service. I am aware that the Executive gives money to the health boards and that the boards are supposed to provide the service. However, if no one is monitoring the provision within the health board, we could end up with a situation in which a crowd of people feel powerless. People could feel that they are struggling on their own or depending on voluntary services.

Will the minister consider a short-term financial investment to allow teams to build up services in their areas, especially for adolescents? The evidence that we have received proves that it is totally inappropriate for adolescents to be treated in normal psychiatric or other wards.

Again, I think that Ayrshire and Arran NHS Board said that, if beds were available, people could be placed in community hospitals. A lot of information emerged from our evidence-taking sessions, but the key issue is finance. Unless money is earmarked for a specific area, it is difficult to find out where it is going and who is getting it. I am afraid that, if the private sector has to provide the service, that will cost a lot of money, which would not be available to pay for local NHS services.

Rhona Brankin: First, there is extra money. As the member knows, additional money is already going out in general terms to health boards. The situation becomes difficult if we start to earmark certain pots of money for the treatment of different conditions. As I said, the Executive has held back from doing that to any great extent.

To me, the issue rests on the responsibility—at health board level and also, importantly, at regional planning level—to develop the plans that will ensure that services are in place for people with eating disorders. As a minister, part of my role is to oversee NHSQIS, through which we ensure that such plans are put in place.

The member mentioned the need for services for young people. Health boards are responsible for ensuring that appropriate provision is made for young people in their areas who have mental health problems. They are required to provide dedicated beds for young people who have mental health problems. Within the planning process, thought should be given to the beds that may be required for young people who have eating disorders. However, that decision must be taken in the context of regional planning, because it is simply not possible to have many beds in each health board area.

I keep returning to lines of accountability, which have not been strong enough in the past. Where there are lines of accountability, questions can be asked about what has been put in place and the extent to which health boards and regional planning groups are following the guidelines. Through those lines of accountability, I, as a minister, and NHSQIS can drive the process of change.

The additional funding for health boards is intended to support the implementation of change in health boards in relation to a range of conditions. Significant amounts of money are going towards developing provision for mental health and work on promoting mental well-being. I am reluctant to say that it would be useful to badge money specifically for eating disorders, but I am persuaded that we need lines of accountability on the issue. We need to develop guidelines on that, which is an undertaking that I will seek to fulfil and on which I will report back to the committee.

Dr Turner: I welcome that, because doctors do not have many people to whom they can refer such patients and the patients or their relatives do not know where to go. If a lot of money is available, perhaps we need to ask who is accountable for spending it and why the people who need the services are not getting them. There is a time factor. How do we get over the transition from where we are now to where we want to be? How quickly can we find out how the money is being spent? Community health partnerships are excellent, but they are new and are still working out how to run themselves. Meanwhile, patients are waiting. You suggest going through NHSQIS, but perhaps you could do more nudging?

The Deputy Convener: Do you have a magic wand, minister?

Rhona Brankin: I can seek information from the regional planning groups, which are the key partners in the matter. I undertake to get information back to the committee from the planning groups on what progress they have made on the guidance.

I can also usefully talk to my colleague Peter Peacock, the Minister for Education and Young People. The committee is aware that the Education (Additional Support for Learning) (Scotland) Act 2004 requires local authorities and schools to identify pupils who have additional support needs. For example, for youngsters who have input and support from the health service and who require specific planning and inter-agency work, there is a new duty on health boards to provide support. Having been in education myself, I think that there are still issues about training and awareness raising. With specific reference to eating disorders, I am happy to discuss with Peter Peacock how we can feed in and develop that training and awareness raising among education professionals.

As I said, I shall also undertake to look at further anti-stigma work on mental health and to consider the possibility of including eating disorders in future anti-stigma work.

Helen Eadie: I regret that I was unable to be in Stonehaven last week, but I have been aware of Gráinne Smith's submission since it was considered by the Public Petitions Committee. The topic is of great concern to every one of us and I understand from my colleagues who were able to be in Stonehaven that the evidence was very moving. One of the doctors stated that, before health boards would be prepared to invest in new services, the Executive would need to provide a steer on the nature of an appropriate managed clinical network for multidisciplinary care that would include out-patient and in-patient services. Dr Green highlighted the importance of having a local team of eating disorder specialists.

That leads to a topic that emerged earlier today in the evidence from Dr Bennison—the issue of training. GPs do not seem to have any input on eating disorders in the earliest stages of their medical training. That is an issue, but the fundamental point is that few existing specialists seem to be available to train anyone in Scotland. If that is one of the big issues, how can the Executive tackle it? There is a need for trained staff, but if there is no one to train those staff, that is an issue. How might you reflect further on that? You do not have to answer that question today, but it raises an important point, which needs to be taken on board.

Rhona Brankin: From reading the evidence, I am aware that training is being raised time and again as an issue. I shall ask Dr Pullen to say something about that. It might be possible to ask NHS Education for Scotland to give me some feedback about issues on training, which I could then feed back to the committee.

Dr Ian Pullen (Scottish Executive Health Department): The curriculum development for different parts of medical training is complex and changing. The undergraduate curriculum has to be agreed by the General Medical Council on a UK-wide basis, because that is the qualification for being registered as a doctor. Postgraduate training is changing as from now, so that under a policy called modernising medical careers, which is also UK-wide, all doctors in their first two years will have a much wider experience than they have had until now and will go through a number of different short placements. That will ensure that recurrent concerns, such as the inability of some doctors to relate to patients or to interview them adequately, will be addressed and that those skills will be acquired before people decide which branch of medicine or surgery they will enter. That should mean that doctors will be provided with a broader base in their training; I hope that that will include the psychological aspects of both physical ill health and, similarly, physical health.

The royal colleges play a big part in setting the curriculum for doctors at higher levels of training. They do that with the agreement of the General Medical Council, which has final responsibility for deciding whether someone has reached the level at which they can be an independent specialist. It should be possible to influence the colleges on the postgraduate training that they lay down for general practitioners, physicians and psychiatrists. It may also be possible to ask the GMC to consider views on undergraduate training. Although we cannot influence that process directly, there are ways of feeding into it.

15:15

Helen Eadie: If the minister has not had sight of Gráinne Smith's supplementary submission, it might be worth while our giving her a copy. Among the various issues that the paper highlights, the key issue that raises questions in my mind is the lack of information on the topic across Scotland. A fundamental reason for the establishment of the Scottish Parliament was that, for many years, many decisions about Scotland had been made on the basis of too little information and without the centralised data, statistics and other tools that were needed to do the job. To what extent is that a continuing problem in this area? If the minister acknowledges that lack of centralised knowledge on the subject is one of the difficulties with which we must grapple, does she accept the need for a co-ordinator on eating disorder development and for research to be undertaken on that subject? If we are to make the best decisions, will we not need a lot more information than we have at present?

I commend Gráinne Smith's supplementary submission, which outlines entirely reasonable and possibly quite achievable ways of helping to deal with the problem. It might be helpful if the north of Scotland regional planning group was asked to take on a lead role.

The Deputy Convener: I confirm that the Executive received a copy of Ms Smith's supplementary submission as part of the papers for today's meeting.

Further to Dr Pullen's answer a moment ago, I have a supplementary question on training. In previous evidence, we heard that the incidence of schizophrenia is similar to the incidence of anorexia nervosa but that psychiatrists spend less time on anorexia in their training. Dr Millar explained to us last week that anorexia is not as common as bulimia, which tends to be dealt with by non-medical people such as nurse specialists. Dr Millar highlighted the fact that the difficulty in encouraging medical specialists such as psychiatrists to specialise in eating disorders is that there are few centres in which they can receive appropriate training. That lack of facilities means that trainees do not receive the specialist experience that they need, so there is a chicken-and-egg situation. Will the minister or Dr Pullen comment on that?

Rhona Brankin: I agree that it is a chicken-and-egg situation. I have listened to the evidence that has been given on the need for further training and, as I said, I would be happy to get further information for the committee and to feed back on the extent to which we could ask NHS Education for Scotland to investigate the need for further training. I undertake to do that.

We need to develop a range of expertise throughout Scotland. I have said that we would consider a regional model for developing a continuum of provision, from ensuring that people can enjoy mental health and well-being right through to diagnosis. There is a belief that because of lack of training, there is significant under-diagnosis. I agree strongly that training is an important issue. I would be keen to examine the extent to which community health partnerships, when they identify the services that should be provided, consider the possibility of using continuing professional development for GPs so that some GPs can develop a particular interest in eating disorders.

Acute services are at one end of the continuum, but our objective must always be to prevent things from reaching the stage at which a person has to go into the acute sector. As part of the development of the new GP contract, there should be a responsibility on community health partnerships to consider the provision in their area. If they identify a need for GPs to develop a specialism in eating disorders, they should seek to facilitate that process. I agree that, at the moment, the issue is where that specialism lies.

It might be helpful to consider Helen Eadie's suggestion about the north of Scotland regional planning group taking a lead on eating disorders, as it seems to be slightly further ahead in its thinking. Clinicians in various parts of Scotland have specialist knowledge that it is important to share. I will ask Dr Pullen to talk about that. As the committee knows, there is also considerable experience and expertise in the private sector, of which we can take advantage, which is important.

Dr Pullen: I have a few quick points. First, quite a level of expertise is available in Scotland. The Cullen centre in Edinburgh and Harry Millar's department in Aberdeen train many people from different disciplines. It is important that we have a multidisciplinary response. As members are well aware, many such illnesses develop in adolescence and a fair proportion of the beds in the two in-patient units for adolescents with mental health problems in Edinburgh and Glasgow are occupied by young people with severe eating disorders. Again, there are multidisciplinary bodies of expertise there.

Those two centres for adolescents and the two centres for adults have trained many people and contributed a great deal to the awareness of eating disorders in Scotland. In most health board areas, a consultant psychiatrist who has an interest in eating disorders will be the local lead, just as Harry Millar, who is a general psychiatrist with a special interest in eating disorders, spends a proportion of his time running the eating disorders service in Aberdeen.

It is important that the response includes not only secondary and tertiary care, but primary care or care in the community. That is where the development of managed clinical networks and integrated care pathways comes in, so that young people and adults receive the right level of care at the right time. Those who have looked at the NICE guidelines will realise that a lot of that care is guided self-help at the right time to prevent progression. It is a matter of building up the different tiers of the approach and tying them together.

NHS Quality Improvement Scotland takes an interest in integrated care pathways and, in mental health, seeks to provide a standard for integrated care pathways. NHSQIS has also taken an interest in perinatal mental health. It will be interesting to see whether, with the minister inviting it to look at the SIGN guidelines, NHSQIS will also consider integrated care pathways for eating disorders.

Rhona Brankin: I do not know whether the committee has had an opportunity to discuss further the points on training that Gráinne Smith makes in her supplementary submission. She makes some valid points, which I am more than happy to consider. I will go on what the committee comes up with in its report.

The Deputy Convener: If you have any further thoughts that might inform our deliberations, you could communicate them to the clerks.

Rhona Brankin: I am happy to examine the points on training and to respond to them.

Mr Davidson: I welcome the minister's comments on getting involved with the north of Scotland regional planning group and using its expertise, but I suggest that the minister, perhaps with her officials, should also have discussions with and possibly visit the two residential facilities in the private sector to experience how people end up if they are not dealt with at the beginning. If the minister is going to consider the possibility of the health service providing models of care and facilities on a regional basis, I recommend that she talk to those who run those facilities, because they have great in-depth knowledge. I am not aware that they have offered to do any training, but I believe that some GPs in Glasgow have been to the Priory and received informal training—I am not sure whether that training is accredited. There is expertise in those facilities and, until the health service develops the tertiary level of care, it is important that the minister be involved with the sector, because its service is the interim standard.

We were led to believe from the evidence that we heard last week that the health service could make cost savings by using those facilities in return for a sharing of risk. Would the minister care to take that up with the facilities?

Rhona Brankin: I am happy to visit some of those facilities, as it is important that I have an up-to-date view of the range of provision that exists throughout Scotland. When regional planning groups consider provision, they need to think carefully about what is most appropriate for them and to decide on the extent to which they will continue to use the private sector or develop their own provision. They need to base that decision on what is best for their circumstances, what is best for patients and what represents best value.

The Deputy Convener: That concludes our evidence for today. I thank the Deputy Minister for Health and Community Care, Dr Pullen and Mr Brown for coming along and for their evidence.

How does the committee wish to proceed following the conclusion of our oral evidence-taking sessions? Would the committee be content that a short report be prepared on the basis of the evidence that we received this week and last week?

Mr Davidson: Would we then have a discussion based on that report?

The Deputy Convener: Yes. With the agreement of the clerks, a short paper identifying the key themes that have emerged from our evidence taking can be prepared for consideration at next week's meeting. Is that acceptable?

Members *indicated agreement*.

15:30

Meeting continued in private until 16:08.

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