PUBLIC AUDIT COMMITTEE

Wednesday 7 October 2009

Session 3

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PUBLIC AUDIT COMMITTEE
15th Meeting 2009, Session 3

CONVENER

*Hugh Henry (Paisley South) (Lab)

DEPUTY CONVENER

*Murdo Fraser (Mid Scotland and Fife) (Con)

COMMITTEE MEMBERS

*Willie Coffey (Kilmarnock and Loudoun) (SNP)
*Cathie Craigie (Cumbernauld and Kilsyth) (Lab)
*George Foulkes (Lothians) (Lab)
*Bill Kidd (Glasgow) SNP
*Anne McLaughlin (Glasgow) (SNP)
*Nicol Stephen (Aberdeen South) (LD)

COMMITTEE SUBSTITUTES

Derek Brownlee (South of Scotland) (Con)
Linda Fabiani (Central Scotland) (SNP)
James Kelly (Glasgow Rutherglen) (Lab)
John Farquhar Munro (Ross, Skye and Inverness West) (LD)

*attended

THE FOLLOWING ALSO ATTENDED:

Mr Robert Black (Auditor General for Scotland)
Angela Canning (Audit Scotland)
Caroline Gardner (Audit Scotland)

THE FOLLOWING GAVE EVIDENCE:

Raymond Bell (Glasgow City Council)
Mairi Brackenridge (South Lanarkshire Council)
Harriet Dempster (Highland Council)
Anne Hawkins (NHS Greater Glasgow and Clyde)
Peter MacLeod (Renfrewshire Council)
Bobby Miller (North Lanarkshire Council)
Dr Ken Proctor (NHS Highland)
Colin Sloey (NHS Lanarkshire)

CLERK TO THE COMMITTEE

Tracey White

SENIOR ASSISTANT CLERK

Joanna Hardy

ASSISTANT CLERK

Jason Nairn

LOCATION

Committee Room 2

Scottish Parliament

Public Audit Committee

Wednesday 7 October 2009

[THE CONVENER *opened the meeting at 10:04*]

Decision on Taking Business in Private

The Convener (Hugh Henry): I convene the 15th meeting of the Public Audit Committee in 2009. I welcome our witnesses, members of Audit Scotland and anyone else who is in attendance. I ask that all electronic devices be switched off so that they do not interfere with the sound recording. There are name plates in front of all the witnesses, and I hope that they can see the names of all the committee members.

I thank the witnesses for coming along; we look forward to your evidence. I am delighted to see some familiar faces, albeit that I am in a slightly different capacity. I chose my words carefully, rather than saying "old faces", given the length of time that I have known some of you.

The issue that we will consider later this morning is significant not only for public expenditure, but for delivery of public services in Scotland. A number of people feel that it is not given sufficient attention and is often regarded as an afterthought, whether we like it or not.

When I was listening to the radio this morning, I noted that NHS Greater Glasgow and Clyde had commented on the issues, which have to some extent become pertinent because of the tragic events this week in Renfrewshire: the suicides of two young girls. Our condolences and thoughts are with their families. There may be a causal link to resources and services, but that remains to be seen, and I do not want to go into any of the detail today. It is right that we let proper procedures take their course. We can reflect thereafter on what happened. Today, we will consider the bigger and broader issues.

Before we go into the detail of today's discussion, I ask committee members to agree to take item 3 in public and item 4 in private.

Members *indicated agreement*.

Section 23 Report

"Overview of mental health services"

10:07

The Convener: Because of the number of witnesses on the panel, I will not ask for opening contributions. Knowing some of you, I think that we would be here all week, never mind all day.

I will ask a couple of introductory questions, but do not feel that you have to comment. What are the biggest problems in dealing with mental health services? What are the biggest barriers to improvements that you face in trying to deal with vulnerable people?

Colin Sloey (NHS Lanarkshire): Different barriers are pertinent to different localities. NHS Lanarkshire's submission highlights that we have a legacy issue around investment. Although we have close partnerships and a well thought through service strategy, which is now being backed with additional investment by the existing NHS board, our biggest hurdle—as the Audit Scotland report, "Overview of mental health services", bears out—is the rate of investment in mental health services relative to other areas in Scotland.

We have a clear vision about what our service models need to look like, and we have strong engagement with our communities around what their needs are and how those can best be met by the local partnerships, but we are constrained by our available capacity.

The Convener: I will return to resources later: I know that Cathie Craigie wants to ask specifically about investment in Lanarkshire. We will stick to the generalities just now.

Anne Hawkins (NHS Greater Glasgow and Clyde): There are three areas that present challenges—I am not sure whether you would call them barriers—for us. The first is dealing with the implications of multiple deprivation, the impact it has on individuals' mental health and wellbeing, and how we cope with that. The second concerns the implications of alcohol, which are linked to deprivation and to co-morbidity problems. That problem involves dealing not only with individuals who have alcohol issues and the impact that that has on their mental health, but with the impact that alcohol has on communities and family life, and the consequences of that on individuals' mental health and wellbeing.

The third issue that we are still tackling, and which I think is a barrier, is stigma. What the papers that are before us today say about antidepressant prescribing probably links quite

well to that. Because mental illness is stigmatised, there is still a view on the part of many people that taking antidepressants is a bad thing.

Those are some of the general barriers that we face—as opposed to Colin Sloey's specific example, which involved money—and they have a huge impact on everything that we are trying to do.

The Convener: I will come back to deprivation and alcohol later, and will deal first with the negative view of antidepressant prescribing. Exhibit 10 on page 25 of the Audit Scotland report shows that there was a huge increase in antidepressant prescribing between 1993-94 and 2007-08, which Willie Coffey mentioned before the meeting began. According to the report, the defined daily dose per thousand people more than quadrupled in that period. Is that simply because more people are suffering from mental health problems? Has there been a change in policy or medical opinion that would justify that increase? What has driven that staggering increase?

Anne Hawkins: It is a multifaceted issue. Jill Morrison, from the University of Glasgow, produced a good piece of research about the factors that influence antidepressant prescribing and the variations that exist across Scotland. I cannot summarise it just now—it would probably take me the entire meeting to do so—but this committee and Audit Scotland might want to read her results. She closely examined 983 practices and considered all the factors that contribute to antidepressant prescribing and the increase in prescribing. She found that the types of antidepressant that are being used have changed over time and that some now require higher dosages to be prescribed and to be taken for longer.

The research also found that, taking account of deprivation, there had been a fourfold increase across Scotland in the defined daily dose. All sorts of factors play into that, such as the age of the general practitioner—younger doctors seem to prescribe more antidepressants. Before the meeting, Ken Proctor and I discussed whether that might be an issue in terms of certain people being more risk averse. Another issue is that female GPs seem to prescribe more. There seems to be no link between the level of psychological therapies that are available to the practice and the level of antidepressants that are prescribed.

I could list a series of other factors, but it is probably worth having a look at the summary article, which is quite short.

Willie Coffey (Kilmarnock and Loudoun) (SNP): Is there any indication in that report that the level of prescribing has increased more in deprived communities, or has the increase been broadly similar across Scotland? Is the increase higher in certain pockets? We might delve into this issue in detail at a later stage, but I would appreciate a little information at the moment.

Anne Hawkins: Where there is social deprivation and educational deprivation—where people's educational attainment is particularly low—the levels of antidepressant prescribing are higher.

Willie Coffey: That is quite worrying.

10:15

The Convener: Do you feel that sufficient resource has been allocated to tackling deprivation in the greater Glasgow area?

Anne Hawkins: That is a huge challenge. The problem of deprivation covers many areas, such as housing, urban regeneration, employment and so on. In terms of resource, much of our effort around trying to change the shape of the more deprived parts of the entire patch is channelled through the relatively robust community planning process that NHS Greater Glasgow and Clyde has.

We cover a big area, and the situation is different in different patches. The Glasgow works partnership concentrates on employment issues, which feeds into the issue that we are talking about. Local authorities place a similar emphasis on employment. As we say in our submission, we have employment advisers in some local authority areas who specifically target people with mental health problems in order to get them back into work.

I do not know whether we could ever have enough resource, but our approach involves partnership working and trying to get people's efforts joined up in order to achieve goals.

The Convener: I accept that you are saying that you could never have enough resource. However, I am asking whether the resources that are being allocated are being used effectively and efficiently.

Anne Hawkins: That is a good question. I would say that we are much better now than we have ever been. The planning processes are much more robust, and community planning helps in that respect. Of course, the situation could always be better.

The Convener: Does anyone else want to address the issue?

Peter MacLeod (Renfrewshire Council): I would like to make a couple of comments on the opening question, which was about barriers.

I would emphasise what Anne Hawkins said about deprivation and alcohol. The toll of alcohol in our communities is well known to you all, but it

is worth noting that the councils with the four highest male death rates from alcohol in the United Kingdom are in the NHS Greater Glasgow and Clyde area—Renfrewshire Council, Glasgow City Council, West Dunbartonshire Council and Inverclyde Council. That is a shocking and stark fact, which led us to hold a joint summit in Glasgow on Monday this week—Anne Hawkins and I attended that meeting, along with representatives of the four councils and others. That represents an important step forward in the recognition of the issue and of the need for us to take action together.

I want to underline the link between alcohol and mental health issues in our communities. If you look at the rising number of people with alcohol-related brain damage, you can see that there is a gap in our services across the country in that regard, which we must address comprehensively.

I would add something else to the list of barriers or things that could be done better. As was suggested in the submissions that you have received for today's meeting, there must be an emphasis on wellbeing—we should not simply see people as having mental health issues or problems, because that results in their being stigmatised. To borrow a phrase from another area of work that I have a particular interest in, it is everybody's job to promote the notion of wellbeing, which is absolutely central to the groundbreaking Mental Health (Care and Treatment) (Scotland) Act 2003. That relates to employability, activity, fitness and the need to recognise that people should be able to contribute to their communities as fully as they can.

On resources, one of the challenges involves the fact that the increasing number of alcohol-related conditions and deaths brings about an increasing demand on mental health services. The situation is more robust than it used to be in respect of how we use those resources together, but there are huge challenges in how we currently use them. One challenge is to shift to community-based care—as we have increasingly done. We have made massive steps in that regard in the past five to 10 years. We must also shift resources to become much more preventive—hence my emphasis on wellbeing, rather than on reactive or crisis response—although recently we have developed many such services.

Mairi Brackenridge (South Lanarkshire Council): Peter MacLeod mentioned the preventive agenda and wellbeing. I know that we will come back to resources, but limited resources mean that the emphases of our services are on severe and enduring mental illness. We have important and positive strategies in place. The legislation has provided the basis for a positive view of mental health in Scotland, but we need the opportunity to develop community capacity and to invest in change.

The community now needs to own some of the problems. That point cannot be separated from some of the issues on which Anne Hawkins touched. In some deprived communities, people are alienated from engagement with the process. Engagement with people so that they take ownership of problems will allow the preventive agenda to be developed outwith core services, and it will allow us to use our services much more effectively for those who require additional support. We use our resources effectively and efficiently, but if there were a different way of distributing them we might be able to put more emphasis on the preventive agenda. In part, that is not about specialist workers doing things to the community but about supporting the community to develop responses that are relevant to it. Frankly, the response that is required in rural Clydeside is very different from that which is required in a scheme in Glasgow.

Harriet Dempster (Highland Council): I will offer a different perspective on the challenges that we face. In the Highlands, the challenges are about getting services out to people in remote and rural areas. According to the Highland user group, one of the biggest challenges is transport. Both the availability and the cost of transport affect people's ability to get to services, to socialise and to take part in events.

Housing is another issue. If people do not manage to access housing, they may find themselves in a circular route—in temporary housing—which prevents them from stabilising themselves in the community. I echo my colleagues' earlier point that preventive services need to be supported. Our resources have been targeted at the extreme end, so we are not doing enough to sustain people once they get well, or to prevent things happening later.

The Convener: After Raymond Bell has spoken, we will move on to accessibility, on which Harriet Dempster touched.

Raymond Bell (Glasgow City Council): The challenge that you pose—how we tackle deprivation in communities—is a live one in Glasgow. The audit work that we have done suggests that, if someone is unwell and ends up in one of our more traditional mainstream services, the service that they get is usually of a high quality and their outcomes are pretty good.

As well as having strategic responsibility for the city, I manage both council and NHS services in the east end of Glasgow for mental health and, currently, for learning disability, so I have experience in one of the most deprived communities in Scotland. Significant resources are

available. You asked whether they are enough: any official would say no, but my experience is that we need to exert much more leadership in community planning, with community planning partners, around the social determinants of mental health. In particular, we must upstream some activities as a form of early intervention in our communities, to prevent the acute problems that we encounter when people come to us.

As the convener said, some of us have been around for a long time. Lessons can be learned from the past, in particular around some of the community development roles that social work services have promoted. We need to revisit how that social capital, which Mairi Brackenridge mentioned, is constructed.

There is clearly significant investment in regeneration of the east end. I work with Glasgow East Regeneration Agency and we are increasingly asking about the millions of pounds that go into regeneration and getting people into employment training. Are those measures tackling the social inclusion issues or are the difficulties that have led to policy development around social inclusion still reflected in how some of our other partners work? We have a bridging service in which £2 million is invested. The question is: how many people is it getting into employment? The question for education services is: what are you doing in the curriculum, as a form of early intervention, in relation to building emotional resilience? We could take that challenge across services. We are trying to get to grips with a leadership issue in respect of our services in Glasgow. If what others are doing in a mental health context is maximised, we have perhaps answered the question, but is there enough resource?

Murdo Fraser (Mid Scotland and Fife) (Con): Good morning. I will ask about accessibility, which is an issue that came out of Audit Scotland's report. Some work was done in examining what were in some cases very long waits for access to services, particularly for children and adolescents. Many of you have addressed the issue in your written submissions.

What targets have been set for access to services, including waiting times? Do you collect that information? Do you know how many people are waiting and for how long? What action are you taking to address the problem and to reduce, in particular, the long waits that some people in some categories are facing?

The Convener: Would Ken Proctor or Bobby Miller, who have not contributed, like to comment?

Dr Ken Proctor (NHS Highland): One of the main areas in which we have been criticised in the past is psychology services, so we have a major redesign under way around that. It is an interesting issue to think about for a minute. To answer the convener's first question, our biggest challenges have been around stigma. There is stigma as mental health services have generally been a bit of a Cinderella service for a very long time. The new policy direction on the health improvement, efficiency, access and treatment targets are making a significant difference and are bringing regularly to the health board table the issue of mental health, one aspect of which is how we access services.

There are currently no national access targets for psychology or for child and adolescent mental health services, which is something that the committee might want to consider. NHS Highland has done a number of things to try to help within the psychology service. We have found that it is a very traditional service and that the issue will not be resolved by having more psychologists. We are having to change the thinking of our professional colleagues in respect of how they go about their business. There should be a tiered service that is about the access that is required by the individual, rather than its simply being about the GP or the psychiatrist referring the individual to a psychologist. Some of the challenges that we face are more to do with the professionals than with the patients. I reiterate that a traditional view is taken by many of our clinical colleagues on the issue, which is what we are currently working on. If there were to be an 18-week target in psychology, our service would suddenly look very different in the next two or three years.

Bobby Miller (North Lanarkshire Council): Colin Sloey highlighted funding issues around services and CAMHS would certainly come into that category in Lanarkshire. I am sure that Colin Sloey would be happy to tell you about some of the plans that have been prepared in the national health service, subject to funding availability.

As has been said, issues around mental health and wellbeing will feature in the agenda for children. We have been doing some excellent work around emotional resilience as part of the curriculum development in all secondary schools in North Lanarkshire.

We have been developing, and are just about to launch, work around a new approach to training for all education, health and social work staff that will help young people who self-harm. In social work, we have invested time in earlier intervention in families' lives. We suspect that the answer is not that we always require more clinical interventions, but good clinical interventions must be available for a small number of children. We need to address the issue as part of a wellbeing agenda, and that is where a lot of our effort is directed.

10:30

Mairi Brackenridge: Targets can be important in driving and achieving change in practice, but sometimes the focus is on the target. If we are talking about supporting resilience and developing a wide range of support so that the right people get the right service at the right time, we must be careful how we target that so that people get access to a wide range of support at an earlier stage.

The Convener: Is there sufficient discussion between social work and health boards on setting targets?

Mairi Brackenridge: The problem is that when targets are imposed centrally, that form of discussion is not allowed. One of our criticisms is that the targets are very medically or health oriented in their description; that focuses the health services on meeting particular targets, but the local authority appears to play a lesser role. If we were allowed to reinterpret those targets more widely, we could bring in the agenda that my colleagues have talked about.

The Convener: So, at national level there is insufficient communication in the setting of meaningful targets between those who are responsible for social work and those who are responsible for health.

Mairi Brackenridge: Yes, but housing, education and other services need to be included, too. The resilience agenda is a joint agenda. Social work and health have an important role to play with those who are at the severe and enduring end of the spectrum, but other services will play a more critical role at the preventive end.

Harriet Dempster: In Highland, we have been doing redesign work around the getting it right for every child programme and CAMHS in trying to promote accessibility by a single door and ensuring appropriate triage so that we get the right help to children at the right time. One of the issues with CAMHS is that multiple referrals have come in from everywhere, but they might have not been the right referrals for the right children at the right time. Our approach will get better outcomes, while using existing resources.

I echo the comments about targets being driven centrally and perhaps not pressing the right buttons for outcomes in the wider sense. Driving health targets centrally also works against good discussions taking place locally about what is important in local areas. My perspective on that is that there is a degree of tension because of the concordat. One part of the Scottish Government has a hands-off approach to local government and recognises a different kind of partnership, but that is not the case for health. That does not quite fit.

Anne Hawkins: It is important to recognise that there are different types of target. The HEAT targets are driven centrally, but, from a health perspective, there has always been an opportunity to play into those targets. We also have local access targets for our community mental health teams, for example, which are agreed with our social work colleagues and are jointly managed.

Our submission sets out our targets for community mental health teams, emergency referrals, same day or 24-hour response and so on, on which we gather information. We gather information on case loads and so on, and produce it on a comparative basis so that people can see where they sit. Such local targets—on the speed with which people should be seen, waiting times and so on—are important because they help to force change and they help people to consider their practice.

You will have heard about the mental health collaborative, which is primarily a mechanism to support the health improvement, efficiency, access and treatment targets. We are using the collaborative's tools and techniques in other areas, too. Our submission describes the seven helpful habits for effective CAMHS, which are basically tools and techniques that enable teams to consider how they are working, what the demand is, who is coming through their door, how they could deal with people differently, how they could make better use of their resource, and so on. The targets help to give people something to focus on. Lots of tools and techniques are available to us. Our challenge throughout Scotland is to ensure that we are learning from one another, that we are using all the right tools and techniques and that we are making a difference. The collaborative is one of the mechanisms to support that.

Colin Sloey: Our submission refers to our capacity planning system in NHS Lanarkshire. The idea is to track referral rates, and to consider how we triage and how we admit those persons to the case load. The system enables us to consider the relationship between supply and demand. As Anne Hawkins said, such a tool enables clinicians and teams to use the data to consider the efficiency of their services, how long patients are on the case load, what the evidence base tells us about the appropriateness of that, and how we manage did-not-attend rates so that they are not wasteful and so that we can provide other people with such appointments. The bottom line is that we have been able to use that data to identify gaps in the service.

One of the exhibits in the Audit Scotland report highlights that, for CAMHS, we had 4.2 whole-time equivalent staff per 100,000 population. However, that data is from 2007, and we now have around 8.8 WTE staff per 100,000. Our waiting times for

CAMHS are not mentioned specifically because of the absence of national benchmarking information, but although they were 72 days—we reported 52 days in our submission—I can report that the latest round of data shows that that has dropped to 46. That is the power that comes from providing clinicians with data on the way in which their service is modelled, and providing managers with data on the way in which they need to consider investment in services.

Dr Proctor: I did not want to give the impression that targets were a bad thing. Targets in themselves are okay, but it is possible to hit the target and miss the point. We have used the targets as important by-products of the redesign and modernisation of the service. The example from NHS Highland would be the readmission target. It is easy to say, "We're going to reduce readmissions to Newcraigs by X", but to achieve that we have to go right back upstream and start with the GPs, then the community mental health teams, then access to other services. In the past five years, we have had a seven-day-a-week hospital—we did not have that before. We have a community psychiatric nurse service at weekends and in the evenings. An overnight specialist nurse is available at Newcraigs. Those are all things that we have put in place and which have enhanced the service for patients. In addition, we have hit the target. However, that was a driver rather than an end in itself, and we are continuing to develop.

George Foulkes (Lothians) (Lab): I add my thanks to those of the convener. Your submissions were excellent and I found them interesting.

The NHS Highland submission picks up on your point, Dr Proctor, when it says:

"In summary, NHS Highland has met the readmission target ahead of schedule. We are confident of meeting the suicide prevention training target on time. The anti-depressant target and the dementia target are less under the direct control of NHS Highland as an organisation, as they both depend on influencing independent practitioners."

The NHS Greater Glasgow and Clyde submission says that

"there are significant variations amongst CH(C)Ps and more so amongst GP practices."

Are there problems in getting GPs to accept responsibility for contributing to meeting the targets? They are the only people who can see everyone in the community, so they must have an important and principal responsibility for finding out whether people need particular services. Obviously, GPs are the people who prescribe the antidepressants.

Dr Proctor: May I respond to that? Just to let the committee know: I am not a psychiatrist but a GP.

George Foulkes: Ah, even better!

Dr Proctor: How long have you got? The new general medical services contract that started in 2004 has fundamentally changed how general practice works and how GPs are beginning to think. If we reflect back to Anne Hawkins's comments on the report from the University of Glasgow, it is clear that our newer breed of GPs is very different from the traditional one—dare I say it, from the Dr Finlay model—whereby the GP had a 24-hour, seven-days-a-week commitment, understood risk and took risks. We are moving rapidly away from that. I think that that was part of the discussion about why more antidepressants are prescribed. We now have a different cohort of GPs, who are trained in hospital in a different way, which is to work in teams and shifts. They continue to do that in general practice, and they do not tend to work in isolation.

We could have many complicated discussions outwith this meeting about general practice, but it will remain, particularly in remote and rural Scotland, the cornerstone for solving many problems. However, it will not do that in isolation.

George Foulkes: How will you ever achieve the target, if the GPs do not co-operate?

Dr Proctor: Under the new GMS contract, there are ways of encouraging GPs to co-operate. We have a locally enhanced service. If I say that we dangle a little money in front of them, I am not being flippant. General practice is a business and is run as such. If the price is right—again, I do not mean that flippantly—GPs are exceedingly good at changing what they do, following guidelines and proving that they do that.

In North Highland, we have a bespoke software system called the enhanced services contract reporting options—EScro—which measures everything that the GPs do for our patients with depression. The GPs are paid only if they have taken a certain number of pre-agreed actions, which include using the mental health assessment "The Patient Health Questionnaire"—PHQ 9, for short—whereby they must ask specific questions of a patient regularly to monitor the individual's progress. They have to use the Highland formulary when they prescribe so that they do not just prescribe any old drug, and they must do it within certain drug levels and for a certain length of time.

There are ways in which GPs' independence can be brought into the fold. The GPs embrace all that. We monitor it closely and we have a very high compliance rate. Frankly, the GPs do not get paid if they do not comply.

Colin Sloey: NHS Quality Improvement Scotland has introduced one generic and five condition-specific integrated care pathways, one of which is around depression. GPs are pivotal in that process in the identification and diagnosis of

depression and the use of validated measurement tools, not only at the point of first assessment but in bringing patients back to reassess. We encourage GPs to ensure that any prescription is part of an overall package of care that may or may not include psychological therapies, rather than to look singularly to prescribe antidepressants. However, we recognise that everything does not need to be medicalised. We need to look, too, to community planning partners to optimise the use of available community supports through education, recreation, job opportunities and volunteering, all of which have an evidence base around them that shows that that can improve people's self-esteem and mood. GPs have co-operated particularly well in those processes—certainly from a Lanarkshire perspective—which augurs well for the future.

The Convener: We move on to minority ethnic issues.

Anne McLaughlin (Glasgow) (SNP): I want to ask about access to mental health services for people from minority ethnic communities. As you would expect, my question is not specific to Glasgow—as everyone in the room is aware, if someone needs access to mental health services it does not matter where they live. The challenge is perhaps even greater in areas in which there are fewer people from minority ethnic backgrounds.

Are there any data—I am not aware of any—on the percentage of people from minority ethnic backgrounds who use mental health services? How does uptake among such users compare with uptake among the rest of Scotland's population?

If I may, I will group together a couple of questions. First, what are we doing—indeed, what can we do—to address the difficulty, highlighted I think in the NHS Greater Glasgow and Clyde submission, in recruiting mental health staff from minority ethnic backgrounds? Secondly, what has been done to ensure a minority ethnic component to suicide risk assessment training for staff? Statistics from down south show that the risk of suicide is higher among certain sections of minority ethnic groups, and I imagine that if someone comes from a culturally different background they will present differently.

I have a couple of further questions, but I will bring them up later.

10:45

Raymond Bell: I do not have either with me or in my head the data on the number of black and ethnic minority communities who access statutory social work services. However, I am happy to share with the committee uptake figures for the bulk of adult mental health service provision in Glasgow that is outsourced and purchased from the voluntary and private sectors. They are not good; last year, there were 4,530 service users of our purchased services, of whom 92.7 per cent were white Scottish, 1.9 per cent were of Pakistani origin, 1 per cent were other Asian and 4.4 per cent were of other origin. As a result, the percentage is low compared with the size of our community.

I do not expect the figures for access to mainstream services to be much, if at all, higher than those figures. However, in the south side of the city in particular, the council and NHS colleagues have made a number of targeted interventions including, for example, joint homeless services for asylum seekers, which will obviously cover a broad spectrum of people and for which uptake is relatively high. Some of those asylum seeker services, including those for which I am responsible in the east of the city, have been effective and people have been receiving appropriate responses, although I should point out that if someone has, for example, failed to be granted asylum, the NHS's response will differ from that of the council, which might well have assessed the person as having a statutory need for community care services. Challenges can certainly arise in that respect.

In Pollokshields and Pollokshaws on the south side of the city, services particularly for older people but including mental health have been targeted at Asian communities, and my colleague on the south side has done a lot of work with the faith communities to get through some of the barriers that have sprung up between the statutory services and the communities we want to serve. Members might have picked up some of the media interest about Glasgow's Roma community, for whom specific responses not just with regard to mental health services but on a range of issues across partner agencies have been constructed.

That kind of targeted approach will change because the council and the NHS are determined to meet their responsibilities under equality legislation. I am not just being glib and saying that we have to do something about that; we have already formulated a work plan for some of our services. As those of us brought up in anti-racist traditions will acknowledge, we need to move away from targeted responses to specific problems towards making all our services accessible to everyone. As a result, we are performing equality impact assessments on each of our service designs. For example, one major issue in the east end is ensuring that all the communities that I serve can access crisis services; in that respect, if I find that the current model does not meet that test, I will have to think how it might be redesigned. We are prioritising that issue because, as we can all imagine, there is

nothing worse for people than not being able to access a service when they are in crisis. I know that all my colleagues need to do some work on that, but we hope that we will see progress.

Those are some examples.

Anne Hawkins: Let me try to pick up on the various points that Anne McLaughlin made.

On the first issue, the need to train staff in suicide awareness is a point that is well made. Asian women who have come to Glasgow for arranged marriages seem to be particularly vulnerable. We have started a piece of work with Glasgow Anti-Racist Alliance's researcher to consider how we can better target support to such individuals through, for example, primary care. We are also looking at how we can enhance suicide training in primary care and, potentially, in accident and emergency services. That will be an interesting piece of work, but it has just started.

Getting the right balance of BME representation in our workforce is a real challenge. Such communities have a pretty good representation in medicine and to some extent in psychology, but that is not the case in nursing. We perhaps need to work harder with schools—we are always trying to work with them on NHS recruitment anyway—to encourage people to stick with mental health nursing and learning disability nursing, although those are not always the most attractive fields.

However, I was quite heartened to learn from one of the advocacy leads in Glasgow that in the past month—I met him only recently—40 per cent of those who engaged with advocacy services were from BME communities. That seems very positive. I have linked him up with Glasgow Anti-Racist Alliance, for which he will also do some work. For me, it was heartening to hear that figure because I was not confident that advocacy services would work to that extent with BME communities.

In Glasgow, we also have compass, which is a service that is targeted at asylum seekers. The service primarily supports people who have been through significant trauma, but it also provides advice and support to all community mental health services. For example, compass can advise whether information is available in a particular language. The service provides advice and support on a much broader basis as well as support that is targeted at those who are seeking asylum.

As we mention in our submission, we face a particular issue with individuals who have failed to gain asylum seeker status, who therefore have no rights and receive no benefits. Those are a particularly vulnerable group. Some of them end up in hospital because they become severely unwell. Discharging such people is a huge issue for us, because they have nowhere to go and they have no money. They have nothing. Compared with other challenges that we face, that group presents a relatively small challenge, but it is a challenge.

Anne McLaughlin: I thank you both for those comprehensive responses. As a Glasgow MSP, I am obviously most interested in Glasgow, which has the highest proportion of people from minority ethnic communities. However, I am also concerned about what happens throughout Scotland. Is that challenge being addressed and met? I am interested to know whether work is being done on the issue outwith Glasgow.

Colin Sloey: For minority ethnic groups, access is a difficulty that prevails across all health services, not just mental health services. We have introduced community health educators to work with local groups that are supported by faith leaders in order to identify those people—particularly women—who do not take up general primary care provision, such as well-woman services for cervical and breast cancer screening or measles, mumps and rubella vaccination for children.

We try to build up confidence that their needs will be catered for within the primary care environment. People often have cultural concerns around gender. For example, they ask, "Who will see me when I come along?" It is a question of building up an understanding of what they need and what we can provide to ensure that we can have a connection and can use different ways of supporting and facilitating them into services other than just sending them an appointment card. It remains a problem, even though less than 2 per cent of the population in Lanarkshire are from ethnic groups. It is a live issue.

Anne Hawkins: I draw the committee's attention to the fact that there is a programme of work sponsored by NHS Health Scotland that is about getting each of the regions in Scotland to network on BME issues. A woman called Dale Meller leads a small team that works across Scotland to bring together people in mental health to look at learning. The team has worked with some of NHS Lothian's targeted groups, with HUG in Highland and with the Chinese community in Forth valley. That mechanism is being used as a catalyst for learning and change on the BME agenda.

Dr Proctor: The situation is quite different in remote and rural Scotland. There are small BME communities, but they tend to be very small and, from what we can gather, they tend to be mostly eastern European. It is an issue on which I cannot give you any statistics. In comparison with the information from Glasgow, our submission is quite feeble, although we have a translation service, which general practitioners and the community

mental health team can access. In crisis situations, it can be extremely difficult. Although the number of people involved is small, when there is a problem, it can be quite substantial, because we do not have the sort of infrastructure that Anne Hawkins has mentioned. Proportionately, we are talking about small numbers, but when an issue arises, it can be quite complicated. The cultural context in the north-west of Scotland is utterly different from that in Leipzig.

Cathie Craigie (Cumbernauld and Kilsyth) (Lab): I have a follow-up question on the theme of access for people in minority groups. The Auditor General highlighted the difficulties that people from the deaf and deafblind community face when they try to access mental health services. How have the boards taken on that challenge?

The Convener: I am aware that before I invited Cathie Craigie to ask her question, Bobby Miller had indicated that he wanted to respond on the previous issue.

Bobby Miller: I think that I can pick up on Cathie Craigie's question at the same time. There is an overlap because equality impact assessments touch on both issues. A proper equality impact assessment tackles the range of issues that might lead to a person's being excluded and having difficulty accessing services. As is happening in Glasgow, we are pursuing a review of all our services for which equality impact assessments are carried out. In addition, we have been working jointly with South Lanarkshire Council to develop some of the links that Colin Sloey talked about in relation to ethnic minority groups. In North Lanarkshire, a very small percentage of the population—1.3 per cent, I think—are from ethnic minority groups. In some ways, that means that we should be trying harder. If people are not pushing themselves forward, there is even more need for us to try to reach what is only a small sector of the population. I think that we are doing that.

We purchase support for people who are deafblind. Being deafblind is a particular difficulty and we provide support for people who require any service. Again, it is a question of making links through voluntary organisations. One of the challenges is in making known the services that are available. We rely on purchased services to do that.

Peter MacLeod: It is absolutely the case that the report highlights challenges that the deaf and deafblind communities face. In Renfrewshire, we have had in place for many years a specific social work service for people who are deaf and deafblind. We also invest in services that are provided by the voluntary agencies, which Bobby Miller referred to, but having a dedicated service has a powerful effect. It means, for example, that our social work service has one of the highest proportions in Scotland of staff who are trained in the use of sign language.

11:00

That means that if a person comes into one of our area service offices who requires to communicate about an issue to do with access to mental health services, there is a strong chance that somebody will be able to provide that service to them and to communicate with them in a manner that is appropriate to their need. This is not necessarily a recommendation, but the committee could consider the level of training that is in place on effective communication with people who are seeking services and who have a variety of communication difficulties. We have found that our dedicated service has had cultural importance for us, because we have more trained staff who more clearly understand people's needs. That includes business support staff, as well as professionally qualified social workers and so on. That approach is hugely important, as is the linkage with specialist services in the voluntary sector in particular. Staff who understand and are properly trained to communicate are absolutely key to how people can access services, when their communication needs are of the nature that Cathie Craigie mentioned .

Bill Kidd (Glasgow) (SNP): I will go off at a slight tangent, although my question is still linked; it is not on communication difficulties and small numbers but on the specialist mental health care that is required for children and adolescents. In the not-too-distant past, it was not always easy to treat cases of self-harming, anorexia and the particular problems that children and adolescents have, because there was not always a specialist available to deal with those issues. What are the numbers involved? How many more people are being trained specifically to deal with children and adolescents? Has that been targeted specifically?

Bobby Miller: I want to answer the previous question first. I referred only to deafblind people in response to Cathie Craigie's question. In relation to people who are deaf, North Lanarkshire has first-stop shops in each of the six main townships. We are rolling out communication opportunities for people to come in and have direct access to assistance through the use of British Sign Language, which has been recognised as a considerable development. There are relatively small numbers of BSL users in the council area, but the development has been welcomed by that community. It is one of the routes into services that people can use.

Within North Lanarkshire, we are hoping to develop further the personalisation agenda, which is really about tailoring support around individuals'

needs, rather than having block services that people have to fit into.

We know that the in-control model, which has been further developed in England, has been welcomed by ethnic minority groups because it allows people to have much more control over how to use an individualised budget to secure the support that they need.

The Convener: Are there any other comments on that? I want to move on to other issues.

Colin Sloey: I want to respond to the previous question. The Health and Sport Committee, chaired by Shona Robison, has taken representation from the deafblind community about the availability of health services within Scotland. She commissioned a group that I was asked to chair to do a feasibility study on developing a specialist residential centre somewhere in Scotland, which would mean that people would not have to travel to the John Denmark unit in Manchester. That group also identified the need for the relationship between specialist residential care and the community infrastructure in order better to support people who are deaf and deafblind and who have mental health problems. It is looking to each board to build up its capacity and capability with staff who have BSL level 3 training, which will enable them to communicate and engage appropriately with such people.

Shona Robison has established an expert group to consider how to develop an implementation plan to improve the overall services for that client group here in Scotland generally, and within individual health boards. That work is continuing.

The Convener: Is the committee to which you refer a ministerial committee, rather than a committee of the Parliament?

Colin Sloey: It is the Health and Sport Committee, which had received petitions about—

The Convener: You mean a committee of the Parliament, in that case. It is not chaired by Shona Robison—she is the Minister for Public Health and Sport.

Cathie Craigie: The Health and Sport Committee conducted an inquiry on the matter. The issue was raised via the cross-party group on deafness. I am aware of that work, and I know that many deafblind people have had to make their way down to England for services in the past. Changes have now been made there. I was hoping to hear that health boards have been working jointly with local authorities to provide services for all sorts of vulnerable groups.

We are dealing with small numbers of people in this instance, but they have serious problems. Boards could perhaps work across boundaries to provide services for them. It is to be hoped that when the recommendations of the expert group are published, boards will be able to take them up.

Mairi Brackenridge: There is some cross-board working, particularly in relation to the issue that Anne Hawkins raised about the vulnerability of asylum seekers and women in forced marriages—rather than arranged marriages—who are very vulnerable. We rely to an extent on there being a certain level of expertise in the city of Glasgow. Anne Hawkins spoke about the challenges in Glasgow, but when just one or two people in an area fall into the categories that we are discussing, the challenge is even greater. We therefore rely on the expertise and knowledge that have been developed in the cities to support us in taking the agenda forward. We rely not just on the statutory organisations, but on such organisations as Hemat Gryffe Women's Aid, which has a lot of expertise and has helped us to understand how to proceed. We use expertise where we know it exists, both formally and informally, in order to develop our services.

I will answer the point about self-harm. The need to make progress in children and adolescent services has already been touched on, I think. Although we are making progress, there is some way to go. Through the choose life programme, we are working in schools on targeting young people whom we know to be vulnerable. In partnership with health services covering both North Lanarkshire and South Lanarkshire, a team is working with accommodated young people and developing the support that is offered to them.

We have identified that staff who work with accommodated young people in North Lanarkshire and South Lanarkshire, including foster parents, should be prioritised, so they have been offered the opportunity to participate in and assist with safeTALK training, which is specific training for suicide prevention. That prioritisation helps staff to identify young people who could be at risk and to find out from where they can pull in the appropriate services. It signposts them to appropriate support, and it helps in overcoming the stigma that sometimes exists, through its message that it is okay to talk about people feeling suicidal, because that acknowledges that there is a problem. It allows articulation of the fact that people can access services that will support them. The training gives staff confidence as they take those things on board.

The Convener: I invite Ken Proctor to come in at this point; then I will call George Foulkes, who wishes to highlight the issue of resources.

Dr Proctor: I will just answer the question on cross-board working. We inherited the Argyll and Bute bit of Argyll and Clyde NHS Board, and there is now a lot of cross-board working between Argyll

and Bute and Greater Glasgow and Clyde NHS Board. In the north of Scotland there is now a network for eating disorders, in which we are working together with NHS Grampian. We are always looking for cross-border working wherever we can, because of the small numbers involved and because we cannot always provide all the services ourselves.

The Convener: Let us move on—we have a couple of other big issues to consider. I invite George Foulkes to discuss resourcing.

George Foulkes: I want to talk about single outcome agreements. Renfrewshire Council has made a gallant attempt at outlining how single outcome agreements are relevant to local authorities in the context of mental health. However, I find NHS Greater Glasgow and Clyde's submission interesting. It says—I refer to page 21 of paper PA/S3/09/15/2—that single outcome agreements

"are not underpinned by a robust enough infrastructure of joint national priorities, or money following delivery, and in practice have led to a less transparent 'below the line' loss of funding to mental health, from previously ring fenced funding sources."

Will you elaborate on that?

Raymond Bell: The only cut to a ring-fenced budget in Glasgow following the single outcome agreement was in the former supporting people budget that was allocated to the city council.

Peter MacLeod: I recognise that a valiant attempt has been made by Renfrewshire Council. I have tried to describe a theme that has emerged at several points during the meeting. It is hugely important to focus on working together to improve mental health and wellbeing in our communities, and I recognise that at issue is perhaps the robustness of what are described as "key outcomes".

Having been around community planning tables over a number of years, I think that we now have, with single outcome agreements, a real opportunity to have descriptions of what we must tackle in our communities embedded in our planning structures and in our intent to improve communities. Therefore, single outcome agreements and some of the indicators that I included in my submission probably represent ways by which for the first time in a long time we can come together and say, "Listen, antidepressant prescribing is not just a health service issue and self-harm is not just a social work and health service issue. They're much wider issues." However, further refinement is required. With single outcome agreements, we need and aspire to describe and measure outcomes rather than outputs from services.

George Foulkes: I hoped that Anne Hawkins would answer my question, as I quoted from NHS Greater Glasgow and Clyde's submission. I have the national concordat with me. Nothing in the indicators specifically refers to mental health. Indeed, if we look at the ring-fenced—I was going to say "earmarked" and nearly said "ear-fenced", but members know what I mean—funds, we will see that the mental health fund was rolled up into the settlement. From what NHS Greater Glasgow and Clyde says on page 21 of paper PA/S3/09/15/2, that is creating problems in greater Glasgow and Clyde.

Anne Hawkins: What we tried to say in our submission—perhaps our words are a bit robust—is that there is a fear. Members should bear in mind that we work with a number of local authorities. Because specific grant moneys are no longer ring fenced, it is much more difficult to track where money is going. That is the bottom line. However, I think that there is one specific mental health indicator in the single outcome agreement.

George Foulkes: In the national one?

Anne Hawkins: Yes. Is there not an indicator to do with mental wellbeing and utilising the Edinburgh scale?

George Foulkes: Are you referring to the Warwick-Edinburgh mental wellbeing scale?

Anne Hawkins: Yes. I think that that is the only specific indicator.

George Foulkes: I am going to be rubbished by you and your colleagues, but I sometimes get the strong impression that local authorities are a bit reluctant to criticise the current Scottish Executive. Do you think that? If you think that things are not adequate, are you intimidated in any way?

The Convener: Anne Hawkins is with the health board, so—

George Foulkes: I mean health boards as well. I have detected that reluctance in voluntary organisations and universities, and I am now detecting it in health boards and local authorities. Are you frightened of criticising the current Scottish Executive?

11:15

Anne Hawkins: With regard to opportunities for health issues to influence single outcome agreements, I took part in a meeting of the Scottish partnership forum, which is a group of individuals that includes managers and people from the staff side. We were given the opportunity, at relatively short notice, to comment on what the indicators should be and to try to contribute to the first versions of the SOAs and the concordat, but the process was carried out very rapidly, and the

opportunities to contribute were limited. Like everything else, however, such involvement has to start somewhere, and grow from there.

In the current climate, there are many opportunities—such as this committee meeting—for people to influence matters. The debate about what SOAs should contain, how they can be more robust, how they can feature mental health, and how they can relate to resource—which was the point that we made in our submission—is very powerful, and we hope that something will come from it.

George Foulkes: Thank you.

The Convener: We will move on to the impact of an ageing population, on which Cathie Craigie and Anne McLaughlin wish to ask questions.

Cathie Craigie: All the submissions highlight concerns about the impact of the ageing population, but I would like to hear a bit more about dementia services. We are hearing that we will all live longer and that we will have to work for longer, which will be a big problem for the delivery of all services in the coming years, particularly in relation to how we face the issues that the Audit Scotland report raises.

Colin Sloey: I will set that in a national context. My chief executive, Tim Davison, is leading a group with representatives of the Convention of Scottish Local Authorities to consider what issues the demographic information presents to the public sector in relation to older people and their consumption of public services. To lead that work, a high-level group will consider the implications for service delivery.

In North Lanarkshire and South Lanarkshire, we are considering the implications for our communities as we move towards 2031, which is one of the benchmarks in relation to General Register Office data on population size and age construct. We will begin to reflect on what the demands will look like, and on how we will need to change the service models to accommodate the needs of the client groups. On the one hand, if we continue to deliver services in the way that we do, how many more residential care or hospital beds will we need that we perhaps cannot afford? On the other hand, how do we seek to redesign services?

At one end of the spectrum, we can consider prevention, so that we can keep people—and they can keep themselves—healthier for longer as they get older. At the other end, we need to ensure that services are much more efficient and effective, and we need to consider where service integration prevails. We do not want a local authority version and a health board version of the same service: we want one efficient service. The problem is large and it will not be resolved locally without a lot of detailed consideration at national level.

Cathie Craigie: The problem is potentially very resource intensive—everyone on the panel has spoken about resources. We have heard from the panel that GPs and people who work in the primary care sectors will be key in earlier identification of people with dementia. How do we link in with that?

Colin Sloey: The new GMS contract contains an equality and outcomes framework, as Ken Proctor highlighted. We have a target for the number of people with dementia that we can identify early on—we can then register them as such with their GP practice so that they receive the best possible health and social care support packages.

We believe, however, that the work starts well before the point at which someone is diagnosed with dementia. We need to begin now, by considering some of the causal factors and the preventive and health promotion factors, and by looking to communities to change people's mindsets around their own behaviours; in relation to alcohol consumption, for example.

We have mentioned alcohol-related brain damage in our discourse this morning and people—not necessarily in deprived communities—who consume excessive alcohol. We therefore need to get the whole of Scotland, from the various elected representatives down to the communities, to recognise that services will not change the issues and that we will all have to look at not only how we use traditional packages of available services, but at lifestyle issues and behaviours. The demographic information clearly demonstrates that we will simply not be able to sustain current service delivery models.

Bobby Miller: I agree with Colin Sloey about upstream work, but we also need to think about how to use existing resource for those who will definitely need support but cannot self-support or engage in social or family networks to help them sustain their independence and wellbeing. We have adopted a model in North Lanarkshire that ensures that we move away from a building-based service as much as we can. If we lock up our resources in buildings, we have no flexibility to support individual needs. We no longer have any residential accommodation in North Lanarkshire for people under 65 with mental ill health; they are now all supported in their own homes. We also support at home a high percentage—well above the national average—of older people with complex needs, many of whom have dementia. I suppose that the development of, for example, smart technology and using money more creatively is how we will have to go in the future if we are to deal with demographic changes.

Harriet Dempster: I want to pick up on the use of telecare and other technological assistance, which is obviously part of the equation for supporting people for longer at home. However, it is not just about that, because we will have to have much more public dialogue with professionals about risk. As we discussed earlier, in some places there is quite a lot of risk-averse behaviour—we are still struggling with this in Highland because of our rurality—that jettisons people into buildings when their welfare could be sustained and promoted at home. People are worried about the risks of supporting people in their own homes and that issue must be part of the dialogue. It is linked to colleagues' helpful comments on developing communities' capacity and engagement. We need a community system approach, because we have such a big tanker coming towards us.

Peter MacLeod: I echo that point about community capacity building. Unless we grasp the nettle of how we, together, enable communities to care better for those who are ageing in them, and address the vulnerabilities that Cathie Craigie mentioned in relation to dementia, we risk failing to meet need properly, and that will put people at risk. In my area, we estimate that the over-65 population will grow at a rate of 2.5 per cent from now as far into the future as we can see, which will be an enormous demand on services.

Renfrewshire Council has an innovative project called reaching older adults in Renfrewshire, which is a social enterprise that uses volunteering. There will be similar models in other parts of Scotland, but I offer our project as a model of how to use the community's capacity to care for vulnerable older people. Interestingly, many people who have retired from a variety of services are using their skills as volunteers for people who are perhaps more vulnerable and needy. The community development concept is not new, as was said earlier, but we should grasp it and look at exploiting it much more directly.

People around the room may correct me if I am wrong about this, but I read somewhere that a parliamentary initiative to examine demographic need will commence soon. However, the older age component of the discussion on mental health must be urgently addressed. In the Parliament and across the agencies, one of which I represent, we need a national dialogue on what we can do to make services fit for purpose. If all that we do is build more agency response, we will miss the point of what our communities can do to care for the people in them. We need to recapture that kind of community capacity building and to put in place specific service models, such as multidisciplinary older adults teams, in which social care and NHS staff work together to deal specifically with people with dementia. That is hugely important.

Raymond Bell: Other witnesses have spoken about people with dementia and the need for public bodies to become involved in people's lives at an earlier stage. There are challenges around how people are kept safe and how issues of risk are addressed. We are running a pilot project for the Government on personalisation and self-directed support in learning disability services in the east end of Glasgow. There is a tension between giving individuals control of how their care is organised, under the choice agenda, and ensuring that there are duties of care to keep people safe when capacity is questionable. We are riding two horses at once, so it is critical that we make the right decisions. I make that point as I understand that legislation on personalisation may be being considered. We need both to provide choice for the individual and to ensure that there is proper intervention from the state to protect people when they are at risk; there is a balance to be struck. I hope that I have explained myself properly.

Dr Proctor: First, the HEAT target on dementia starts the process—practices are now seeking actively to assess people early. The next challenge is what we do about that, especially in remote and rural areas. We have set up a specialist clinic, which is one of the few specialist clinics in Highland that is not dispersed—it is in Inverness. That is the early work that we are doing.

Secondly, rather than do all the work ourselves, we have started a knowledge transfer partnership with Stirling University, the purpose of which is to amass all the research information worldwide and to translate it into a description of what the service in Highland should look like. I commend to the committee some good work from Australia, which provides all sorts of ideas and directions that we may want to consider. That is a way of fast-forwarding to the future that Peter MacLeod mentioned.

Thirdly, the centre for rural health has a project called O4O—older people for older people. It has gone into communities to encourage people to work together to look after one another. It is a little irreverent of me to say this, but by 2031 all of us will be in that category, if we are still on this earth. It behoves us all to think seriously about the issue, but it is not solely a health issue.

Anne McLaughlin: When we talk about older people and mental health, we almost always talk about dementia. However, is it not generally accepted that older people have the same mental health issues as the rest of the population?

Last night I attended a meeting in the Parliament of psychologists working in the NHS. One of them, who specialised in working with older people, gave an example of an area served by a primary care

mental health team in which 20 per cent of the local population were older people but only about 3.2 per cent of referrals were for older people. There were a number of reasons for that, but if there is general acceptance that older people have mental health problems other than dementia, including depression, what are we doing to encourage those who are suffering from such conditions to take up referrals or to ask GPs for support? If we accept that there is a problem and do something about it, that will add even more pressure and increase the need for capacity building. Has the issue been factored into planning for how we will cope with an ageing population?

I have two brief points for Peter MacLeod. First, I point out that we have a debate coming up in Parliament on older people and the ageing population—I think that it will be on 26 October. Secondly, I back up Peter's point about community groups that work to prevent mental health problems in older people. A group in Glasgow that I think is called Good Morning Scotland—I have probably got the name wrong—involves volunteers who telephone older people in their home every morning and evening to make sure that they are okay and to have a five-minute chat with them. Studies have shown that that approach has helped to prevent mental health problems from developing in older people.

11:30

The Convener: I think that Anne McLaughlin has just identified for George Foulkes a more productive role for our radio colleagues.

Mairi Brackenridge: South Lanarkshire Council has particular problems with new towns, which have populations that are rapidly ageing. That presents particular challenges for services. Community capacity building is important, but when people in the community are all ageing together, that presents different challenges, which we must consider.

Some of the points that were made about community capacity are important. Many old people continue to make a productive contribution to the community, and there are good examples of intergenerational work. An organisation in our area called Better Government for Older People campaigns actively to ensure that service design takes account of older people, so that they are included in the population. That is about services in the broadest sense, not just services that support people because of their caring or medical needs. I suspect that a large element of the depression in older people is a result of the consequences of their growing older and not being able to participate as much as they did previously. The issue is about finding opportunities for participation.

For people in public services, with limited resources, the challenge is about how we direct sufficient resources to build capacity in the community while meeting the demand that comes from several sources, including the significant demand from the growing elderly population. People have to make difficult choices about whether to put resource into meeting that demand or into developing services for children. Also, what about the adults in the middle? They are sometimes the ones who are squeezed at both ends, because they do not fall into either of the priority categories. However, unless we deal with the 30 and 40-year-olds who have alcohol problems, for example, they will place a significant demand on services in future.

Those are some of the challenges that we face.

The Deputy Convener (Murdo Fraser): The convener has had to nip out for a moment.

Cathie Craigie: I thank Mairi Brackenridge for her input—we should all be aware of the issues that she raises.

The Auditor General's report points out that the National Audit Office in England has found that early intervention is key. We all agree with that, but early intervention will perhaps not be delivered by professionals sitting round the table. It might come from community groups, but they need support, including financial support, from the professional organisations. A large number of organisations in my constituency receive support from the council and health board to deliver services that help to keep people well and to prevent their health problems from worsening.

One gap that the Auditor General found in services for older people was in staff vacancies, although I appreciate that the report was published in May. We are told that, in September last year, two NHS boards had long-term vacancies for consultants. On the first reading, it appears that some NHS boards are not putting enough resources into or paying enough attention to services for older people. Those are not the Auditor General's words—his comments are found on page 14 of the report, in paragraph 54, which highlights the level of gaps in staffing.

The Deputy Convener: Does anybody want to respond to that?

Dr Proctor: I think that I should. There is a significant shortage of consultant psychiatrists with an interest in old age. That is not an excuse. We have been trying for a significant length of time and in all sorts of innovative ways to attract more of them to Highland. We are getting there, but far too slowly.

A service might be led by the consultant psychiatrist, but an awful lot of other people are

involved in the team. We have many of the team players in place, and much of the work is being done, but if we do not have leadership from clinicians, it is more difficult to co-ordinate the whole thing.

I suggest that the problem is a national one and I can talk to members outwith the meeting about that. It is not through lack of the health board trying to attract people into such posts, he says, slightly sadly. We have been trying for many years.

Colin Sloey: Sometimes the efforts that Ken Proctor describes pay dividends. Our area is highlighted in the "Overview of mental health services" for the percentage of vacancies in the medical ranks for mental health services. That percentage has dropped significantly from the 22 per cent that was reported to the current 13 per cent, but that number of vacancies is still a gap in service provision. We try to make up for it by locum appointments and the contributions of other clinicians within the team. Nevertheless, we construct those teams with consultants in the lead for a good reason. We are doing everything that we can to make either substantive appointments or to make locum appointments to ensure that the full capacity of service is delivered.

The Convener: I want to move on to the important issue of expenditure. I suspect that there will be quite a lengthy dialogue on this. Willie Coffey wanted to raise the issue of resource transfer.

Willie Coffey: I do not imagine that a proposed increase in the health service budget next year will generate any kind of fear factor, as suggested by my colleague George Foulkes a moment ago. It might be the opposite down south where there is a genuinely large reduction in the health service budget, but I will not ask colleagues around the table to comment on that. I will, however, ask you to comment on some of the data that appear on page 31 of the Audit Scotland report. It shows a disparate amount of spend per head on community mental health services between the NHS boards. Are we getting value for money from the money that the NHS boards allocate to local councils to deliver community mental health services? How do we know that we are? There is quite a range of spend in the various areas.

Anne Hawkins: I will start. The picture of resource transfer and the story behind it is complex. NHS Greater Glasgow and Clyde has two parts to our position, which come from the Greater Glasgow Health Board position, as was, and then that of Clyde. So there are two separate histories.

The process of resource transfer started in the Greater Glasgow Health Board in 1993, as we started to close some of the large institutions and reduce the size of others. There has been a long process of building up community services, which have become integrated over the years. We are now at the stage of producing performance data that look at community services and bed usage. We are also now benchmarking our staffing information and putting it alongside that so that we can look at the differences across all our community health and care partnerships, each of which contains community mental health services, to see where we are getting a better service. We are in the fortunate position of being able to do internal comparisons and to try to bring about change from there.

If we asked service users what they thought, I think that they would say that they are getting a better service. Are we getting value for money? We probably pay more for some community placements, particularly the complex, supported-accommodation ones, than we would pay if we kept the individual in a 30-bed, long-stay ward in an institution, but I do not think that anyone in the room would want that for themselves. Individuals in community placements have a better quality of life, and we are getting a better overall balance of care. That was to start the ball rolling, and I now pass it on to someone else.

Peter MacLeod: I am happy to add to that. The issue is worthy of debate, and it was picked up in some submissions. As Anne Hawkins said—we had some discussion about this earlier this morning—the community care issue has a long and complex history. The National Health Service and Community Care Act 1990 created care in the community and the concept was implemented three years later.

One issue is what resource was available before the legislation came into force, what beds were closed and where the money from that went. I am not being provocative; I am simply saying that it is a historical fact that the balance of care had begun to shift before the legislation came into force. Given the demographic pressures to which we have referred, we could say that we started with a deficit in what was available from 1993 onwards. I hope that I have described that clearly.

Another issue around value for money in resource transfer—again, I think that this is factually correct—is that the 1995 circular that created resource transfer envisaged that it would be transferred in the longer term to local authorities. There is currently a debate around that principle. There are historical and sometimes more recent agreements whereby the cost for closing a bed is agreed and, say, £20,000 or £50,000 is transferred to the local authority. However, the real issue is that that is a standstill sum that does not recognise inflationary increases and demographic

shifts. Anne Hawkins clearly illustrated that resource transfer in its current form does not recognise that the costs of care are not static, because of inflation and the fact that people's needs change over time. People may come from a bed with a relative need, but that need increases over time and there is no recognition of the increasing cost of that. We must be clear that resource transfer is a complicated situation that creates debate. The resourcing demands in our communities are extreme, as has been said.

A couple of things are happening nationally. There is debate about the integrated resource framework, which is being considered at a senior level in Scotland. I think that Colin Sloey referred to that earlier. The framework is a mechanism to consider how we can more clearly deploy resources and agree the levels that operate between NHS boards and local authorities. There is also the COSLA debate about how resource transfer might operate in future, including discussion about whether resource should be transferred to local authorities, given the original intentions.

My key point is that, because of shifting levels of need and the demographic shift, demand levels around older people's services are such that we are chasing a bus that is picking up speed as it leaves the station. That is the real issue for us.

11:45

Colin Sloey: We need to look at whether resource transfer is still a relevant currency in the integrated arena in which health and social care are delivered. Peter MacLeod referred to the national debate that is being led by Tim Davison from the NHS and Ron Culley from COSLA. They will report to Parliament in spring next year.

I ask whether resource transfer is an appropriate currency because we have come a long way in service provision since the original policy document was published in 1990. That spawned reviews of the major in-patient environments—in Lanarkshire, Hartwood hospital and Hartwoodhill hospital had 2,100 beds combined—so that, before the 1995 circular that created resource transfer was published, many of the closures in Lanarkshire had already taken place.

The 1995 circular, to which Peter referred, gave guidance that resource transfer was either around the person moving out of long-stay care or around the closure of the bed, where money was to be transferred at an agreed rate from the health services fund into local authorities. Because many of the Lanarkshire closures had already happened, there was a small per capita investment in NHS Lanarkshire. The Auditor General's report picks that out. From a very small cake, the money was not resource-transferred into the community infrastructure but retained by the NHS board for provision across the fuller spectrum of care, most notably in acute services. Our per capita share of resource transfer is necessarily low, as our investment base is low.

The most important issue, which the joint future group tried to lead us to, is the recognition that the currency of resource transfer is no longer appropriate. We must look at integrated service provision and joint resourcing, rather than spending our time debating who has the money to provide the service. I hope that the discussion that takes place in spring 2010 will generate a new look at how we go about providing better services, with less debate between the local authorities and the health service about the resourcing of those services.

The Convener: I think that Cathie Craigie wants to ask about the issues in Lanarkshire specifically.

Cathie Craigie: We would expect the health boards to make those points, but it seems unbelievable. There is an average resource transfer figure of just over £15 per head of population across all the health boards. Lanarkshire comes in at £8.30. Glasgow, another large authority with large institutions that had to close down, as happened in Lanarkshire, is in a partnership, and there has been a transfer of responsibility over to the local authority, with the involvement of the people in the community who provide the care. There is a huge difference in the figures, and I cannot understand how that difference can be. Can you help me?

The Convener: I will put that in context. The resource transfer per head of population in Lanarkshire is £8.30; in Glasgow—Greater Glasgow and Clyde NHS Board having a similar area—it is £35.33, which is more than four times as much.

Exhibit 12 in the Audit Scotland report shows NHS spend on mental health services per head of population. The figure for Greater Glasgow and Clyde is well over £200; the figure for Lanarkshire is about £120 to £130. Not only are you spending less on mental health care in Lanarkshire per head of population; your resource transfer is way below that of similar neighbouring areas.

Colin Sloey: I will contextualise that. As you know from successive allocation formulas—whether Arbuthnott or the NHS Scotland national resource allocation committee—NHS Lanarkshire is itself £21.5 million below its fair share for health service provision.

Cathie Craigie: But that is not the relevant point here—the point is that resources are supposed to transfer with the patient. When a patient comes out of an institutional facility, the resources are

supposed to transfer with that patient, who is now being cared for and housed within a community setting. Regardless of their overall budget, health boards should have no reason to say, "We do not have enough money, so we cannot pay for such-and-such's care within the community."

Colin Sloey: That is not what is being said. We need to recognise that the level of allocation that is available to a health board is important, because the board must then distribute that allocation across all the different service areas in a way that best meets the needs of the population.

Historically in Lanarkshire, mental health services have received much less of the overall share than is the case in other health board areas. In its defence, Lanarkshire NHS Board would point out that it receives £21.5 million below its fair share allocation. As I have said, given that small cake, Lanarkshire NHS Board invests less in mental health services compared with other boards. Resource transfers indeed take place—both for the individual patient and for an agreed sum for any bed closures—in favour of the local authorities. However, the biggest chunk of bed closures in Lanarkshire happened long before the publication of the 1995 guidance document that describes how boards should transfer that funding to local authorities. There is a relationship between the size of the cake and the amount of the funding that the board can transfer. There is a correlation between having the lowest level of per capita investment in mental health services among mainland boards and the level of resource transfer. The board cannot give away what it does not have.

The Convener: Were resource transfer and investment in mental health services affected by NHS Lanarkshire's problems with expenditure on service redesign?

Colin Sloey: Again, our service strategy clearly sets out what we require for a population of our size, based on deprivation and the demographic profile of the area.

The Convener: Sorry, I am not just talking about mental health service redesign. I know that NHS Lanarkshire wanted to move resources into other areas, but that did not happen. Were resource transfer and investment in mental health services affected by the problems that were encountered with the reconfiguration of services?

Colin Sloey: Again, I think that that is an historical or legacy issue. Since 2000—

The Convener: I am talking about what happened within the past couple of years, when the board wanted to close facilities and reinvest elsewhere. Have those problems had an impact?

Colin Sloey: I think that we have worked on that particularly well, as Mairi Brackenridge and Bobby Miller will perhaps confirm. We do not make decisions on such closures on a unilateral basis. Both local authorities and the health board discussed the service models, including which services would be delivered in the community and how those would be funded largely by the reduction in dependence on in-patient facilities.

The Convener: We are perhaps talking at cross purposes. I am talking about when the board looked at investment in hospital services and wanted to free up resources to invest in other services. However, that did not happen. Did that have an impact on resource transfer and on investment in mental health services?

Colin Sloey: I do not understand the question that is being posed. In recent years, I do not think that our investment in community infrastructure has been impeded by our policy on beds.

The Convener: So the board's proposals on hospital investment, which did not go ahead, had no impact on other investment. That seems quite clear.

Mairi Brackenridge: From a local authority point of view—this is certainly true for South Lanarkshire Council—we considered that NHS Lanarkshire's strategy document "A Picture of Health" offered a positive way forward. However, some of those proposals have had to be reassessed because of the current situation. The point that Colin Sloey is making is that the fact that we started off with a low resource base meant that, even with "A Picture of Health", we were juggling a relatively limited pot of money to try to meet increasing demand.

As Peter MacLeod said, 17 years on from the move to community care, resource transfer does not happen in the same way because people do not necessarily move from a hospital bed straight into the community. Instead, they might have a circuitous route out of hospital because that is appropriate to their particular needs. However, that means that no resource transfer takes place when the patient arrives in the community.

I hope that any debates in the future on new forms of refinancing will help us to find some way of working together, but the issue might well lead to disagreement—conflict is probably too strong a word—between the health service and local authorities about the money available to develop proper community-based infrastructure. No single factor has affected Lanarkshire; instead, the picture has been made difficult by a number of factors. Lanarkshire has good examples of the kind of community-based services that Bobby Miller and Colin Sloey have highlighted, but that has happened despite the fact that we still need

£17 million to restore the base level to what it should have been had the investment in 1990 been made equally. I suspect that that dream is unrealisable in the current financial climate.

Raymond Bell: I think that resource transfer has meant value for money as far as the relationship between NHS Greater Glasgow and Clyde and Glasgow City Council is concerned. After all, it allowed us to deliver all the targets set in the planning assumptions on which our financial framework from 2001 was based. In relation to adult mental health services, for example, those who can remember that far back will know that the closure of Woodilee hospital and Lennox Castle hospital was a good thing. As a result, the outcomes for service users have been huge.

What we need now is more mature public policy decision making. Funding should be aligned with the places where society has transferred those responsibilities and, with the closure of long-term and continuing care beds in the health setting, the balance of care, which I have already referred to, has undoubtedly tipped towards local authorities. Trying to sort out such public policy causes tensions and, as I say, funding needs to be aligned with those who are responsible for meeting care needs. For example, there will be an increase in the number of dementia sufferers, who will all need social care provision. That, along with other issues, will need to be resolved. In that respect, I am talking not necessarily about resource transfer but about the changes that Mairi Brackenridge referred to in the provision of care in the forensic setting. Although the number of state hospital beds has been massively reduced, there has been no resource transfer to health boards or local authorities.

The Convener: What is preventing the requisite funding to which you have referred being made?

Raymond Bell: Are you talking about at a national level?

The Convener: You have expressed frustration at the fact that the setting of a national policy does not always translate into money going to service providers. What is preventing that from happening?

Raymond Bell: The decision about the state hospital was taken by the NHS nationally, and NHS Greater Glasgow and Clyde made representations not only on its own behalf but on behalf of Glasgow City Council that the resource could not simply stay within the estate. The decision that no resources would be transferred was made at Government level.

The Convener: But the problem does not solely lie with the state hospital. The issue that you are describing is wider. Does the problem also lie in the relationship between local authorities and health boards? What is preventing the resource transfer that you think is needed from being made?

Raymond Bell: If the local authority is given the responsibility for this national policy, it should be given the resources as part of the single outcome agreement funding arrangements.

The Convener: So you think that local authorities rather than the health boards should get more in the national allocation of resources.

Raymond Bell: Yes.

The Convener: What is the health board perspective?

Harriet Dempster: There are big issues around resource transfer, partly because it sustains the double system of financing that ends up with everyone in a tennis match. As a result, we need a single financing system.

In Highland, we have been fortunate enough to participate in the integrated resource framework, which is one of the initiatives that the joint improvement team is running. We hope that, through that framework, we will be able to approach the issue from a people perspective and, wherever the money comes from, ask how much it will take to make a person well and improve their quality of life. There is a link to our taking a much clearer joint commissioning role in terms of the types of services that we want—whether redesigned or whatever.

This is not a fight about whose money it is; it is about how we get the best services together. There are still huge tensions around that; part of the issue is structural and part of it is about people, but we definitely need to see it as one system rather than two.

12:00

The Convener: You make a fascinating point about the single-system approach—that chimes with a lot of what we sometimes hear. I do not know whether any of the witnesses are in a position to answer this question but, if it is agreed that a single-system approach is a worthy objective, does it fail to happen because we still have managerial responsibility in different organisations? Do the ultimate responsibilities require to be streamlined? If not, why is it not happening?

Colin Sloey: The group to which I referred earlier, which is led by Tim Davison and Ron Culley, is grappling with the key questions. The expectation is that, when it reports to Shona Robison in spring 2010, the points that you raise should be answered in its report. How do we serve the best interests of communities and provide the

services that they need? Are there any organisational barriers to our achieving those aims? Will service integration and unified management present better and more cost-effective options so that we can, in one fell swoop, clear out any debate about resource transfer?

George Foulkes: On a slightly different point, in paragraph 128 on page 33 of the Audit Scotland report, the Auditor General highlights the dangers and potential dangers to the funding of voluntary organisations. Yesterday I met people who are concerned that the City of Edinburgh Council has reduced funding to organisations that are concerned with mental health and related issues. My question is for all four local authorities that are represented here. Can you tell us whether you have maintained the funds to voluntary organisations in your area, in respect of both grants and contracts for services provided?

The Convener: We will start with Glasgow.

Raymond Bell: Within adult mental health services, part of the settlement involved a reduction of £200,000 in adult mental health and supporting people services. Those savings were applied to three providers. One of the providers was able to get another source of funding, which minimised the impact on the service.

George Foulkes: But that means that two of the providers have not been able to find alternative sources of funding.

Raymond Bell: Yes. The amount involved was just under £100,000. In the current financial year, I am working to a target of saving approximately £380,000 from adult mental health services within Glasgow City Council. There will be a reduction in the number of council staff and in money to the voluntary sector. We are in discussions about how to make those reductions in the most efficient and effective way.

George Foulkes: I do not fully get it. I thought that the services were meant to be improving, but you are reducing the overall funding for mental health services by almost £400,000 in Glasgow in this financial year. How can you—

Raymond Bell: That is against the backdrop of significant and increasing investment, some of it on the back of Mental Health (Care and Treatment) (Scotland) Act 2003 implementation money, which has been mainstreamed. Glasgow City Council needs to deal with the financial challenges that it faces. We need to look at these services, just as we need to look at all other services. I am in dialogue, for example, with a voluntary sector provider about how it can generate efficiencies in service provision, and I have had further discussions with some providers about the whole shared service agenda, which certainly applies to council services in Glasgow—Peter MacLeod is probably involved in that across authorities. Does every voluntary sector provider need a human resource section, a payroll section or whatever? We are trying to get those efficiencies and minimise the impact on service users. I expect that there will be efficiencies to be found from the budgets over the next few years. I will meet Glasgow City Council's director of finance this afternoon, and I expect that he will say that that is the challenge that we face and will have to meet.

George Foulkes: But all the things that we have been talking about and all the questions that we have been asking for the past two hours become almost irrelevant because you will not be able to keep up with all the targets that we have been discussing if you keep on cutting services for vulnerable people who have mental illness. Roads could remain unmaintained, other things could remain unbuilt—

The Convener: Let us not just focus on Glasgow alone. Let us hear from the others.

Peter MacLeod: We have tried to keep our voluntary sector funding levels as intact as possible. However, to echo what Raymond Bell has said for Glasgow City Council, we all accept that we are in almost uncharted territory in terms of the pressures on resources across the public sector. The budgetary pressure that is being placed on social care services means that I have to ask the voluntary sector organisations that provide much of the supported accommodation for people with mental health problems and other issues to seek efficiencies in the contracts that we have with them. Such contracts might be worth £2 million, and I might be asking for £200,000 or £50,000 in efficiencies. However, that does not mean that the service is being denuded; rather, it means that I have asked the organisations to consider how they can reconfigure their services or deliver them more efficiently. For example, where we have groups of services, can they be delivered better locally? Rather than spreading 10 workers far and wide, can they be grouped and managed better? Are there different service models that we can use?

I will share with the committee one difficulty that we have found. Sometimes care services are put in place at a high level. We always have to review how those services operate and whether they can operate differently. For example, can someone go to a day service rather have two support workers in their home at all times, which, in a sense, is not good for the person as it is not good social inclusion? There are different ways of looking at a problem.

There is another perspective to what George Foulkes said. As we sit here, it is a fact that there are immense pressures on social care and other

services for children in Scotland. Senior officers such as me have to make decisions about road paving, if I can borrow George Foulkes's example. Those of us around the table today know what such issues can lead to, so we have to do a balancing act to enable us to meet priorities in all the service areas for which we are responsible.

I am saying that we in Renfrewshire will attempt to meet those priorities and keep services intact through funding the key priorities, but that is against the backdrop of other areas that involve huge risks to service users.

The Convener: Just to clarify, will the budget for mental health services and funding for voluntary organisations be maintained?

Peter MacLeod: I will seek efficiencies from my contractual relationships with my voluntary sector providers, including those that provide mental health services. I do not have absolute agreement about the level of such efficiencies. As far as I am able to, I will try to keep to similar investment levels.

Harriet Dempster: We in Highland Council value our voluntary sector, and we have been working with voluntary sector partners on a concordat or agreement about how we will work together to deliver services. We face a very challenging financial context. I have been asked to find savings of about £5 million from next year's social work budget, which amounts to just in excess of £100 million.

In relation to the question that was asked about value for money and whether the services are delivering outcomes, there is a tension, because we will need to look at outcome indicators in the service level agreements. We are doing that. If voluntary sector organisations are not hitting those outcome indicators, we will go back to reprovision or change. We might bring services in house, for example. It is not a question of protecting voluntary sector services at all costs. If you asked me whether that was the case, I would say that it was not. Like local authorities, voluntary sector organisations are now having to meet single outcome agreement performance targets. That is the context in which the process must take place.

I am not alone on the local government side in facing extremely challenging circumstances. At this point, I cannot say whether cuts will be made in roads or social work. Given the challenging context that we face, I know that some of social work will be affected, but I cannot yet say which part of it.

George Foulkes: But—

The Convener: Hold on. I will let South Lanarkshire Council and North Lanarkshire Council finish commenting and then bring in Nicol Stephen.

Mairi Brackenridge: I echo what has been said. We are in an extremely challenging period. We will need to protect the statutory services, to the provision of which our voluntary sector partners contribute. Like Harriet Dempster, we see voluntary sector organisations as being important partners, not least because they give an active voice to service users and carers in the process, which creates a real sense of partnership.

However, given the level of funding cut that we are likely to face, our local authority is looking at statutory, core and non-core services. The work on building community infrastructure and supporting communities to do preventive work is one of the areas that could be most affected, because it is neither a statutory nor a core service—in effect, it is a non-core service, which means that if the budget overall is limited, it is likely to be one of the areas where there is a cut.

Voluntary sector partners that provide statutory or core services might be more protected, with the caveat that Harriet Dempster mentioned—they will have to be efficient and produce the outcomes. Voluntary sector organisations that develop preventive strategies might be more vulnerable.

Bobby Miller: We face significant challenges, as has been said. We in North Lanarkshire are particularly concerned about maintaining a community infrastructure. If efficiency savings have to be found, we do not want them all to have to be found from the community resources that prevent people becoming ill or more ill and having to move up to a higher level of service need. We are keen to maintain expenditure on initiatives such as the choose life programme and the clubnet service that we purchase from SAMH, which supports about 380 people by helping them to access mainstream activities in the community, whether in the form of employment, social or recreational opportunities.

Like everyone else, we have to find efficiencies from within our own services. In addition, we had a meeting with our direct service providers about the situation. We said to them that we wanted to work with them in partnership to find ways of doing things differently but that that would require them to find efficiency savings, too. We have given a commitment to work with them on our out-of-hours services, which they might be able to use in conjunction with their own services and thereby make savings on overnight support and care. We want to consider how we can help them to develop their use of smart technology. Assisted-living technology has already been mentioned.

Generally, the providers have been receptive to the notion that, in the current situation, it is

reasonable that, if we must find efficiencies, they must find efficiencies. We have said to them that although we will not take any money out of the budget that we make available for some of our support services, we expect them to be able to support more people for the same money by achieving efficiencies.

12:15

Nicol Stephen (Aberdeen South) (LD): Can we ask the health boards the question as well? Paragraph 119 of the Audit Scotland report is concerning. It is clear that the local authorities are facing challenging times, but will the health boards give us an up-to-date position on where they find themselves? The report says that only

"Three NHS boards increased the percentage of their spend between 2006/07 and 2007/08 on mental health services".

None of those boards is represented at this meeting. I suppose that those that are represented here come into the category of health boards in which

"there has been a levelling off or reduction in the percentage of money spent on mental health services."

Is that trend continuing through 2008-09 into 2009-10? Do the health boards think that mental health services are still very much the Cinderella services of the NHS, or is there a realistic and genuine prospect of growth in the percentage of money that is spent on them? If so, is there solid evidence for that?

Colin Sloey: I have now tuned into the question that you asked me, convener, and appreciate that it was not singularly about mental health services but was about the broader picture. Of course it follows that if people are required to deliver services on three sites as opposed to two, the cost base will invariably be larger, so it will be more difficult to use the available resources to develop services in other areas. I apologise for my misinterpretation.

The Convener: So there has been an impact.

Colin Sloey: Retaining three hospital sites means that there are not the same economies of scale and that the workforce is not as flexible, as there must be core teams on all the sites.

The Convener: There is a valid decision to be made about retaining three sites, but it is clear that that was not your preferred option. If you were looking to free up resources for other services and people elsewhere forced a decision about having three sites, were you properly compensated for retaining the three sites?

Colin Sloey: We are now mandated to deliver the services across those three sites with the resources that are available to the board. Therefore, such decisions are not up for debate at the moment.

The Convener: No extra resources came in.

Colin Sloey: No. Our share of resources remains the same.

The Convener: Okay. Let us return to Nicol Stephen's question.

Colin Sloey: Lanarkshire NHS Board has prioritised mental health services. The board recognised our low base, which is illustrated in the Audit Scotland report, and, since 2007-08, which is the period that is reflected in the Audit Scotland report, has invested approximately £3 million in direct service provision in the community. Much of that resource has come from closing down some in-patient accommodation; the resources are not necessarily new.

The board also recognised that the facilities within which we deliver our mental health services required modernisation and has invested significantly in capital developments. Of course, revenue funding is required to support those developments. I think that if Audit Scotland carried out a review using the same data sets, it would find that mental health services in NHS Lanarkshire have received a slightly larger slice of the cake and that they remain, with community care, the top priority for the board. How things will pan out in future years for NHS Lanarkshire and our local authority colleagues will, of course, depend on the levels of income that are received. We all face considerable pressures as a result of the cost base of delivering services not being matched by the uplift in income.

Dr Proctor: I suspect that my answer will be fairly similar to the answer that Colin Sloey has given. The board of NHS Highland has prioritised mental health. That takes us back to the earlier discussions about the use of the targets and how helpful they have been. We all face very tight fiscal settlements. The joint community care plan's aim of trying to get the money to follow the patient properly takes us back to Harriet Dempster's point about the integrated resource framework. We hope that that will get the money to follow patients for their individual requirements. Where that money comes from—health or social services—should not really matter. At the moment, it still does matter, because, ultimately, the board is accountable for its budgets and the social services are accountable for their budgets. Therefore, I suspect that we are entering fairly stormy waters.

Anne Hawkins: In greater Glasgow, we have made a huge investment in mental health services in recent years. The board has a strategy of investment in forensic services, in the new Gartnavel royal hospital and its revenue

consequences, and in enhanced community services, including a crisis service. Those are mentioned in our submission.

In the Clyde area, we have had to redesign the services with our four local authority partners to make a saving of £2 million to contribute to making up the overall deficit that we inherited from Argyll and Clyde NHS Board. We are still in the final stages of that process, which is a challenge. The economic change has affected some of the assumptions that we made about how to release the £2 million. For example, until relatively recently, the health service was disposing of parts of sites but, because of the economic downturn, property developers are not waiting around to purchase NHS sites. Even finding the money to demolish buildings to reduce rates and overhead costs is a challenge just now.

For 2009-10, the savings target is £1.2 million, and, for next year, I am working with a figure of savings of up to £3 million. We have been working to consider how to redesign our beds and protect our community services. That has been the plan so far. It is difficult to see how that will be able to continue, but there are ways in which people can work smarter. We have a comprehensive community service, so there are opportunities to consider the way in which people work and to do some of the things that I talked about earlier. That should give us some savings. However, we do not yet have our final target for next year.

Nicol Stephen: I thank the witnesses for those responses from the NHS boards and the local authorities. You have raised concerning issues and major challenges. I would like to continue to monitor the statistic on the percentage of spending on mental health services because, if what has been said about the priority that is given to them is correct, they should at least maintain their percentage share whatever the size of the cake that is allocated. Everyone has been reassuring and has emphasised the high priority that is given to mental health services but, if the percentage share of the cake is not at least maintained, it is difficult to believe that that priority is genuinely given at the highest level in Government, local authorities and health boards. The fact that the percentage figure in 11 of health boards was static or went down is a concern. We must continue to examine that carefully.

George Foulkes: I have a question for Peter MacLeod and Harriet Dempster, as they are directors of social work and therefore deal with elected members. I accept everything that you have said about the need for efficiency savings, better methods of working and smart working. That approach is right even in times when money is plentiful. However, do you as professionals feel some responsibility to explain to elected members the effects on vulnerable people of the cuts that are being forced on you, and do you argue the case for such people? Do you ask elected members to consider other priorities or to realise the effect of agreeing to a council tax freeze year after year?

The Convener: It is not for the witnesses to comment on the council tax freeze, but they can comment on the general point.

Peter MacLeod: Yes, convener—I will comment on the first part of the question, but maybe not the second part. I think that I can safely speak for Harriet Dempster, too, when I say that an awareness of elected membership is part of the portfolio that we accept as directors of social care services. Recently, sitting in a room similar to the one that we are in now with the convener and people from across the political spectrum in Renfrewshire, we had a discussion about the competing priorities. The convener might recall that we talked about social care issues as diverse as addiction; demography and older people's care; and kinship care.

That is why I made the point earlier about competing demands. In fact, I will go in front of the elected membership of my council in a month's time to talk about the child care and protection issues that arise from the significant case reviews that there have been and the publication of the thematic inspection, such as the management of high-risk offenders in our communities. We also had a Social Work Inspection Agency report in Renfrewshire that was very positive but which highlighted significant resource demands on the competing priorities. It is incumbent on me and my council colleagues to ensure that any discussion of resources has a context like this one on mental health services. Clearly, the links around mental health services relate to my earlier point about children's services. If we cannot care properly for our parents and ensure that their mental health and wellbeing is safeguarded, they will arguably not be able to parent their children well, so the vicious circle of need will continue. I am therefore clearly highlighting the demands and priorities.

Harriet Dempster: I echo Peter's comments. I regard a large part of my role as advising my elected members on social work priorities and the possible adverse impact on the community of any changes. At a national level, I play a part in advising and championing issues through COSLA and the Association of Directors of Social Work.

As directors, we are part of a corporate team in a council. It is important to remember that, so that one does not seem to be chipping off any colleague directors. In Highland, we work conscientiously on the shared services agenda to assess whether we can make corporate savings in the council and work smarter in the infrastructure

and the back office to protect front-line services. It is important to do that and work around asset management and so on to ensure that we protect the hugely important front-line services.

George Foulkes: I thank you both for your helpful answers to what may have appeared to be slightly aggressive questioning.

The Convener: I have a final question for local authorities. When a care assessment is done for someone with mental health problems, or indeed for anyone, is a written community care plan issued to the individual and their family?

Bobby Miller: We have invested considerably in assessment and planning training for all our fieldwork staff. Recently, we had several hundred people undertake six days of training that revisited the principles around the 21st century review of social work. That involved an outcome-based framework for assessment and planning.

We have also developed our paperwork. We have just launched personal outcome plans, which set out expected outcomes for people to achieve in their lives, how they will be achieved, how we will know when that happens and who will be responsible. People should be given a copy of that on completion of their assessment and their plan. People's comments and views are recorded, including any disagreements that they have with the plan. The outcome plan is a major step forward. People have been given copies of their community care assessments. I accept that sometimes that was not done as well as it could have been. However, the new personal outcome plans are a real benefit in that respect.

Mairi Brackenridge: The answer is quite simple, and it echoes Bobby's point: every person who has a community care assessment should get a copy of the plan and should contribute to it.

Harriet Dempster: The answer to the convener's question is yes, but we are not where I want us to be with single shared assessment. Because the electronic capacity to share information was not available when the assessment was introduced, the process became bureaucratic. To an extent, we are still grappling with that bureaucracy in Highland. However, like North Lanarkshire, we are working hard to take an outcome-based approach and to make assessments understandable for service users and carers in dimensions that are important to them—for example, safety and wellbeing and other common matters—so that they can check whether what we do provides a benefit.

The Convener: Are users given a community care plan?

Harriet Dempster: We are focusing on the community care plan, of which users will get a paper copy. Our difficulty at present is that we do not have the right technology, so the plans look like a huge amount of bureaucracy, which is not helpful or service-user-friendly. We are currently working on that.

12:30

Peter MacLeod: My honest answer is that I cannot guarantee that at this time. As Harriet Dempster said, there is a way to go in that context. We have been active in revising our assessment procedures, which the community health partnership director and I are about to relaunch. The procedures will be more interactive in working with the people who receive our services. At the heart of the relaunch is the need to ensure that people have copies of assessments, which I expect to happen in every case. However, I cannot say that that is 100 per cent successful at this time.

The Convener: It is a legal requirement.

Peter MacLeod: I appreciate that, and I acknowledge that issues relating to that have been brought to my attention. That is why we have put our energy into re-examining the matter and ensuring that our success rate is 100 per cent, now and in the future.

The Convener: So although it is a legal requirement, the law might not be being implemented, for whatever reason.

Peter MacLeod: I would need to look at that in detail and come back with a detailed answer, which I am happy to do following this meeting.

Raymond Bell: The expectations are clearly articulated, but they are not always applied, although I am not sure of the scale of that. As other colleagues have said, the piloting of new technology in our other care sections signposts to some extent how we will crack the issue in this area. Our addiction services are piloting the use of mobile technology to produce the assessment and the care plan when the user is present. They are then printed off and given to the user right away.

We have just issued a new core data set, for which a baseline assessment requires to be signed by the practitioner and the service user, which will—up to a certain point—crack the issue for us. We know that care planning is formally shared in our planning around mental health tribunal work and welfare guardianship, for example, in which we seek interventions. In essence, provision is patchy, but it is getting—and going to get—better.

The Convener: I thank you all for a full evidence session. It has been very helpful, although it was quite sobering when we discussed budgets and future pressures, which reinforced the challenges

that lie ahead for mental health, social work and other services. Some of us worry from past experience that when budgets are squeezed, social work is often an easy target, and we understand the consequences of that. There are challenging times ahead, but I thank you for your attendance.

Public Audit Committee Report

"The First ScotRail passenger rail franchise"

12:33

The Convener: We move to item 3. Members have received from the clerks an overview and timeline of what has happened with regard to the First ScotRail franchise. I do not know whether it satisfies the questions that members raised at the previous meeting.

One issue is worthy of note. Members will have seen the e-mail exchange between Guy Houston and other officials, which indicated that he had disposed of the shares at the end of October. It has now transpired that the legal transfer did not take place until 28 November. Indeed, it also appears that Mr Houston did not put in place that transfer until mid-November, so there was an inaccuracy in the information that he gave to other officials. We can speculate about whether it was just a coincidence that the attempt to transfer the shares coincided with Audit Scotland's reported interest in the matter.

I invite members' comments on the information that we have received. Nicol Stephen was the one who asked the questions.

Nicol Stephen: As the convener said, there is some inconsistency in the responses that have been given. I am still left wondering whether we have been told the truth and whether we have a full, accurate picture of what occurred. I am still optimistic that we will get further information from the Scottish Information Commissioner.

For completeness, I ask that we follow up some of the obvious questions with FirstGroup or the company registrar who is responsible for these matters. I refer members to the second page of paper PA/S3/09/15/5(P). The third paragraph under the heading "Week beginning 17 November 2008" states:

> "There is a delay between sending an instruction and a name being removed from the share register which makes it impossible to ascertain precisely when Guy Houston acted to dispose of his shares."

I would like to ask how long that delay was and what was the legal or factual transfer date. We cannot sensibly do anything more at this stage until we find out what further information the Information Commissioner may release to us in due course.

The Convener: We can certainly try to find out a bit more about the process and dates.

George Foulkes: Would it be useful for us to send the report to both Dr Reed and Sir John

Elvidge and to ask each of them whether they wish to correct their evidence in light of it?

The Convener: Guy Houston was the person who gave incorrect information. Before doing what you suggest, I would need to be sure that there was an inconsistency in the evidence of either Malcolm Reed or John Elvidge.

George Foulkes: Would it take some time to check that?

The Convener: I can check and report back to you on the matter. However, I am not sure that there are any inconsistencies in their evidence. The issue is the inaccuracy of the information that Guy Houston gave to others, when taken at face value.

George Foulkes: I may be wrong in my recollection—sometimes I am—but I recall Dr Reed saying that he was not present at meetings that discussed the extension of the franchise at a time when he had shares in the company.

The Convener: Off the top of my head, I cannot remember whether he said that. We can check.

Murdo Fraser: I am a little uneasy about pursuing the matter further. The committee spent a lot of time preparing a thorough report, which was a fair summary of all of the concerns that we uncovered. We have received a good response to the report from the Scottish Government. I am concerned that further pursuit of the matter at this level of detail would appear vindictive. If, as we may have discovered, some of the information that Mr Houston provided to Transport Scotland was not strictly accurate, it is for Transport Scotland, not the committee, to pursue the matter with him.

The Convener: I think that we have done what we set out to do. We await a response from the Scottish Information Commissioner; once we have received it, we can reflect on the matter. I will look into the questions that have been raised about accuracy of evidence. Until the position has been ascertained, I suggest that we do no more than note the information that we have received.

Anne McLaughlin: I agree.

Cathie Craigie: We all know that, from 14 November 2008, when Malcolm Reed received a communication from Audit Scotland, action was taken to cover Guy Houston's back. We have not been told the whole truth about that by Guy Houston and, I suspect, Malcolm Reed. However, there is nothing to be gained now from our trying to get at that.

Nicol Stephen: Will we follow up the matter with FirstGroup, as I suggested?

The Convener: We will try to clarify the factual position.

Nicol Stephen: That is all that I want to do. I am conscious of the point that Murdo Fraser makes and have deliberately not suggested going back to Guy Houston or any of the other officers involved. I would like simply to obtain factual information about the process, which would be helpful.

The Convener: We will try to do that. Other than that, we will simply note the information that we have received.

12:40

Meeting continued in private until 12:49.

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