PUBLIC AUDIT COMMITTEE

Wednesday 13 January 2010

Session 3

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PUBLIC AUDIT COMMITTEE
1st Meeting 2010, 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 Cullen (Audit Scotland)
Dick Gill (Audit Scotland)

THE FOLLOWING GAVE EVIDENCE:

Dr Denise Coia (Scottish Government Chief Medical Officer and Public Health Directorate)
Graeme Dickson (Scottish Government Primary and Community Care Directorate)
Ruth Glassborow (Scottish Government Health Delivery Directorate)
Geoff Huggins (Scottish Government Primary and Community Care Directorate)
Dr Kevin Woods (Scottish Government Director General Health and NHS Scotland)

CLERK TO THE COMMITTEE

Tracey White

SENIOR ASSISTANT CLERK

Joanna Hardy

ASSISTANT CLERK

Jason Nairn

LOCATION

Committee Room 4

Scottish Parliament

Public Audit Committee

Wednesday 13 January 2010

[THE CONVENER *opened the meeting at 10:01*]

Decision on Taking Business in Private

The Convener (Hugh Henry): Good morning. I welcome everyone to the first meeting in 2010 of the Public Audit Committee. I remind everyone to ensure that all electronic devices are switched off. I welcome colleagues from Audit Scotland, along with Dr Kevin Woods and his colleagues, who are present for agenda item 2.

Under item 1, does the committee agree to take items 5 to 7 in private?

Members *indicated agreement.*

The Convener: Does the committee agree to consider the draft report that we will produce on "Overview of mental health services" in private at a future meeting?

Members *indicated agreement.*

Section 23 Report

"Overview of mental health services"

10:02

The Convener: Item 2 is consideration of a section 23 report on "Overview of mental health services". The committee has been considering the report for some time, and we have previously taken evidence from a number of health boards. This morning, we have with us Dr Kevin Woods, director general of health and chief executive of the national health service in Scotland, and his colleagues Graeme Dickson, Ruth Glassborow, Geoff Huggins and Dr Denise Coia. I welcome them to the meeting.

I believe that Dr Woods would like to make an opening contribution.

Dr Kevin Woods (Scottish Government Director General Health and NHS Scotland): I will take just a couple of minutes, if I may. At the outset, I should declare to the committee that I am a past chair of the Scottish Association for Mental Health, although I have not been a member of the organisation while in my current position. Dr Coia wishes to record that she is a fellow and a past chair of the Scottish division of the Royal College of Psychiatrists.

Mental health services have not always received the attention that they merit, and in that context the Scottish Government welcomes the Auditor General for Scotland's report and the committee's interest in the subject. In 2005, when I took up my current position, I asked colleagues in the then health department to assess progress on mental health service development. I wanted to obtain a clear understanding of what was working well and where improvement was required in mental health services.

Our work told us that we had in fact made good progress on issues such as stigma and discrimination, and that the legislation that the Parliament had enacted had already been a force for good across the system, in terms of culture and expectations. Most important, it told us that there was a consensus about the sort of mental health services that we want to see in Scotland, and the challenges that we faced in making that a reality. Throughout our work since then, we have been careful to try to maintain and protect that consensus about objectives and goals; I was pleased that the Auditor General's report acknowledged that.

Our work also told us that we needed to improve service delivery and drew particular attention to the need for better measurement of performance and the use of resources. The publication

"Delivery for Mental Health" set out plans to do that through, for instance, the creation of new health improvement, efficiency, access and treatment targets, new standards for the care of people with common mental health problems, a new benchmarking project to help boards assess their performance and the setting up of a mental health collaborative to equip NHS services and others to focus on service improvement.

That work is continuing and we believe that it is showing promising results. I believe that we have raised expectations about performance and outcomes. As ever, there is always more to do, but we believe that the policy consensus that exists and the tools that we have developed are helping us to make progress. On that basis, we are happy to answer the committee's questions.

Murdo Fraser (Mid Scotland and Fife) (Con): Good morning, Dr Woods and colleagues. I will start with a couple of fairly general questions about some of the evidence that we have heard. We know that there is quite a serious issue with mental illness in Scotland. We expect one in four of the population to develop mental health problems at some time in their life and we know that suicide rates are higher in Scotland than they are south of the border.

Oral evidence from NHS and local government representatives and written evidence from the voluntary sector have highlighted the fact that, in services, there tends to be a lot of focus on the severe and enduring end of mental health problems, rather than on preventive work. Do you recognise that situation? If so, what is being done to focus more on preventive work to address mental health problems at an earlier stage? Specifically, what is being done to tackle the high suicide rate in Scotland, particularly among young adult males?

Dr Woods: Thank you for those questions. When the mental health framework was published in 1997—I know that that sounds a long time ago—it deliberately put an emphasis on services for severe and enduring mental health problems, because the perception back then was that such services were a priority for development.

Since then, there has been a growing emphasis on other aspects of mental health problems and on prevention. You will be familiar with the work that we have done on stigma, which is very important in trying to change the climate around mental health problems. I know that you have heard evidence about some of the work that has been done, particularly in relation to suicide, in the context of the choose life strategy. One of the most important recent documents on prevention and a positive approach to mental health, which I think sits at the centre of this, is the document "Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011". I invite Geoff Huggins to say a bit more about the thinking that underpins that work.

Geoff Huggins (Scottish Government Primary and Community Care Directorate): "Towards a Mentally Flourishing Scotland" follows on from the work of the national programme, which began in 2001 and started Scotland's commitment to address suicide and stigma, promote recovery models and focus on social inclusion approaches to tackling mental health problems. It is intended to work across sectors. It identifies the role that exists for early years and education. A tangible example of that is the work that we have done in implementing the child and adolescent mental health services framework and the work on link workers for schools, which picks up on your comment about early intervention.

TAMFS also looks at the role of exercise and good general physical health and diet. Historically, there has been an artificial divide between physical and mental health and no full understanding of the extent to which such factors as exercise and alcohol have a significant impact on the morbidity of the population generally. We are trying to pick up on mental health interventions while ensuring that the broader system of health promotion and health improvement is providing the desired mental health benefits.

Mr Fraser mentioned the one-in-four figure in relation to mental illness. Different people will give us different figures for different periods. Much of that proportion comes down to what have been described, historically, as common mental health problems—not psychosis, bipolar disorders or dementia. It can refer to the conditions that are probably most connected to lifestyle issues, rather than to physical health issues or more severe and enduring conditions. That is why so much of the effort in TAMFS is focused on that territory.

With regard to suicide policy, the choose life work, which began in 2002, represents a courageous attempt to reverse a set of figures that has historically not been good in Scotland. Our suicide rate is higher than that for other countries in the United Kingdom, although it is lower than the rate in many other countries in Europe. Once we place ourselves in that broader context, the picture is not quite so bad, although it is still not satisfactory.

Between 2002 and 2006, the choose life focus was very much on community approaches and on developing knowledge and understanding of suicide and the risk factors. The work identified at-risk populations such as young men, and then embedded and supported local training through processes such as the assist programme, which gives better awareness and knowledge of suicide, as well as mental health first aid, which focuses on the workplace.

When we reviewed the policy in 2006, we identified that we were perhaps doing less in NHS services and front-line services than we might be. Many people have had contact with health or social care services in the month or three months before they complete suicide, so we modified the target to include a training target for front-line staff; we focused more on general practitioners and accident and emergency services; and we picked up on issues around community mental health nurses and GP receptionists—people who might see that somebody is disturbed, upset or potentially in a crisis.

We do not expect that such a policy will prevent every suicide but, broadly speaking, we think that it will improve our batting average. We seek to ensure that, at each stage of the process, we take each of the actions that we can to reduce the likelihood that somebody will commit suicide.

Murdo Fraser: That is a helpful response. It has been some years now since the introduction of choose life. Have you seen any improvement in the figures as a result of that initiative, or is it too early to say?

Dr Woods: There has been an improvement. One must be careful, as there are annual fluctuations in numbers. We try to monitor them using a three-year average. Since we started on this journey back in 2002, there has been a reduction of about 10 per cent in the average number of suicides per 100,000 population. The target, as the committee knows, is a 20 per cent reduction by 2013. We started at 17.4 per 100,000, which means that we seek to get the figure down to 13.9 by 2013. The latest data, over a three-year period from 2006 to 2008, give a figure of about 15.6 per 100,000. That sits behind my suggestion that the numbers are going down.

As well as annual fluctuations, there are important differences in the rates between health board areas. There are some significant relationships between rates of suicide and social deprivation. You have heard some evidence about that from Anne Hawkins of NHS Greater Glasgow and Clyde.

10:15

The Convener: Let us stick with that point about deprivation and the associated problems. Largely, the suicides that we will be dealing with will be of people who were born either in the 1980s or before. The 1980s was a period of significant social upheaval, with rises in unemployment and deprivation in many parts of the country. However, some of those who were born in the 1990s are probably among the first generations to be born into households with not only significant alcohol problems, but drug problems. Is any work being done to examine the medium to long-term implications for mental health of children who are being born into those circumstances and what the implications might be, in the longer term, for suicides?

Dr Woods: Geoff Huggins will want to pick up the threads of that, and Dr Coia may want to add something.

Geoff Huggins: Part of the work that we agreed to undertake following the publication in 2008—less than two years ago—of the conclusions of the national confidential inquiry identified a significant relation between suicide and alcohol at this stage. Even now, alcohol is one of the key factors in relation to suicide throughout the United Kingdom. In response to that, we have been keen to develop a better local understanding of the factors relating to specific suicides. We have worked with NHS Health Scotland to establish an effective suicide register that will enable us to track back case by case and develop an understanding of the particular factors relating to individual cases.

The evidence base and the work that we undertook in 2006 and 2007 on effective responses to suicide showed that there was, generally, no strong evidence for many of the interventions that were being applied. It was interesting to find that the intervention that probably had an evidence base to show its direct impact on suicidal behaviour was the use of antidepressant medication. We have developed an approach that will enable us to acquire the knowledge to respond to the factors that you identified in relation to suicides.

It is phenomenally challenging to produce an analysis of child health to make predictions of future suicidal behaviour simply because, with all the issues, we face a set of contributing and confounding factors in relation to development opportunities. You have identified deprivation, alcohol and drugs, but it is equally true that many people in deprived areas do well in life.

The Convener: Let us leave aside suicide for the moment. You spoke about the need for early intervention. From the 1990s onward, the problem of children being born into and growing up in households in which not only alcohol but, increasingly, drugs are a problem has become a major issue for health services and education. Many teachers and those who are employed in early years services tell us that the behaviour of many youngsters, even before the age of five, is extremely challenging. Are we doing any work on how that is starting to impact on the mental health of the child? What are we doing to address a problem that is a major worry in many parts of Scotland?

Dr Denise Coia (Scottish Government Chief Medical Officer and Public Health Directorate): There is a huge evidence base around that. A lot of research is being pursued into parents with alcohol or drug problems or comorbid mental illnesses and children coming from families with those problems. The evidence is focused on infants, and the greatest impact seems to be made in the zero to five-year-old group.

There is a lot of evidence that putting in place significant parenting interventions in that age group prevents problems further upstream. I refer, in particular, to evidence on hyperarousal in children who do not form attachment bonds and become overactive at that point. Some really good schemes have started up in Scotland. Mellow babies parenting programmes are run not just through health boards but through local authorities; Barnardo's has considerable expertise in the area. It comes back to the issue of early intervention and focusing programmes downstream.

The Convener: Are you spending more money on early intervention—for example, among the nought-to-threes? I refer not just to health, but to the broad spectrum of services, including education and parenting.

Dr Coia: First, we must look at reshaping services. Given the way in which resources are allocated at present, we must be clear about what interventions give the best outcomes. There is increasing evidence that resources should be shifted into areas where there is a good evidence base. We are still at the stage of scoping out the evidence on different levels of activity.

The Convener: You are right to say that there needs to be an evidence base, but Geoff Huggins spoke about the significant amount of evidence that exists regarding problems in areas of deprivation. Dr Woods also alluded to that. There is already evidence of significant mental health issues in areas of deprivation; we do not need more evidence there. You are right to say that we need evidence of what works. You may not be able to do this today, but can you provide us with details of the initiatives that have been tried over the past five to six years among the nought-to-fives to improve parenting and to invest in early years education? Can you look at what you are doing now and tell us whether you are increasing investment in the nought-to-fives across the range in health and education to address the issues?

Dr Woods: We will be happy to do that. As a preface to the submission that we make to you, it is important to say a little about the important policy that we have been developing in the area. There is our work in the health care sector on CAMHS. You are right to make the point—we strongly agree with you—that it is a collective endeavour for the Scottish Government, local authorities and other partners to work with such particularly vulnerable groups. That is why we have placed emphasis on an early years framework, are supporting the child focus and early intervention that is associated with getting it right for every child and are trying to provide more intensive support. I do not know whether the committee has heard of the pilot project that we have established in Lothian to develop a family nurse partnership to provide intensive support for particularly vulnerable children. We would be happy to pull all that together for the committee in a note setting out both the policy and the resources that are invested in the area.

The Convener: I am interested in hearing more about the family nurse initiative, which sounds encouraging. Could you also provide us with information about what you are doing on school-based nurses?

Dr Woods: Indeed. We will ensure that we cover community nursing, health visiting and so on. The issue of child and adolescent mental health was discussed by the Parliament last week, so there is already quite a lot on the official record.

Nicol Stephen (Aberdeen South) (LD): On that point, I agree that support for children in the zero-to-five age group is important, but so too is co-ordinated activity. The changing children's services fund has been scrapped—ring-fenced funds have gone—and I notice from the Audit Scotland report that, although there is a figure for total spending on mental health services, the figure is likely to be underestimated because there is no good tracking of spend through local authorities. What is your view on that? Do you have concerns about the scrapping of the ring-fenced funds, in light of the pressure on local authorities—certain authorities more than others—to make efficiency savings and reduce expenditure? Are you tracking the impact of the removal of ring-fenced funds? Are you ensuring that the sort of early support for young people that we are talking about takes place not only in showcase pilot projects but across every local authority, and that local authorities can work with health boards to provide joint initiatives?

When the financial cosh falls, it is easy for a local authority to step away from some of the good things that it was forced to do because of the existence of initiatives such as the changing children's services fund, and to go back to its old ways, which involve a focus on its own core priorities in education and health. It is easy for a local authority to do that rather than to take part in new initiatives and the sort of change that Dr Coia talked about.

Dr Coia talked about evidence but, when she said that action was at a relatively early scoping

stage, some alarm bells started to ring for me in terms of the progress that you might hope to make in that area.

Dr Woods: You are referring to the new relationship between local government and the Scottish Government and how that operates—

Nicol Stephen: Exactly. I am interested in how the Scottish Government monitors the situation. What do you do, other than talking about things in a strategic way? How do you ensure that things are being delivered on the ground?

Dr Woods: I will ask Graeme Dickson to elaborate on some of that, as he is closely involved with liaison with some local authorities with regard to single outcome agreements. It is important to preface that level of detail with some comments about our expectations, however, and to make the observation that the sorts of concerns that we are talking about are common to all local partners.

Our expectations are that, locally, people will work together to establish a common understanding of mental health needs in relation to all segments of the population; that they will work together to reach a common understanding about priorities for investment; that they will work in an open and transparent way in considering the use of resources, whether they have been allocated to local government or to NHS boards; and that they will work collectively to identify those priorities based on need and to allocate resources accordingly.

Mr Dickson can say more about the arrangements for SOAs and how the Scottish Government works with community planning partnerships.

Graeme Dickson (Scottish Government Primary and Community Care Directorate): There are two ways in which we keep track of this area. First, the mental health team has twice-yearly delivery meetings with all health boards, in which it follows up that aspect of partnership working directly with the NHS. The second way involves the single outcome agreements. We are in the first round of the SOAs that have been drawn up by community planning partnerships. In that round, we asked them to concentrate on four particular areas—the relevant ones are reducing health inequalities and early years. Our teams have looked broadly at what the SOAs contain in those areas. There will be an annual report from each of the CPPs on progress on its single outcome agreement. The first one—from the first round of council reports—will be an overview and will be published shortly.

The policy teams have worked with the CPPs to provide feedback about how they are doing in those broad policy areas. However, it is not possible to cumulate activity because, as Dr Woods said, each partnership has taken a different view of the priorities in its area and considered how it will do things, which means that the approach that is taken in one part of the country will be different from that which is taken in another.

10:30

George Foulkes (Lothians) (Lab): Why is that?

Graeme Dickson: Because there are different priorities in different parts of the country. In the first round, I was engaged with three of the Ayrshire councils, and South Ayrshire Council had a different set of priorities around health from North Ayrshire because the two areas have different population profiles.

Nicol Stephen: Action is at an early stage, and there is no baseline that could be used to show the joint spend in each health board and local authority area. Is that right?

Graeme Dickson: It is difficult to provide a precise baseline because much of the activity—

Nicol Stephen: Audit Scotland told us that the figures are quite well analysed for the health boards' spend but not for councils' spend. Do you agree with that?

Graeme Dickson: I was going to go on to say that it is difficult to define an activity as being to do with either the health board or the council. Some areas have taken an approach that links activities to factors that drive health inequality, such as fuel poverty, income inequality and unemployment, which means that it is difficult to put an activity into either a health or a council pigeon hole. The merit of that approach is that it is possible, for the first time, to get a range of people working together to address local challenges in a joined-up way. As the process evolves, the action plans that have been developed by each of the partnerships should begin to bring together the resources that they are devoting to each of the activities. However, the activities may well be different in each of the community planning partnership areas.

Nicol Stephen: In that case, will you monitor total spend?

Graeme Dickson: That is difficult to do, for the reason that I gave you. Expenditure on a cross-cutting activity—such as trying to address issues around people not claiming sufficient benefits—would come from a number of areas.

Nicol Stephen: How will you judge success, progress and achievement?

Dr Woods: Mr Huggins wants to comment on that.

Geoff Huggins: You asked about the changing children's services fund, which is interesting, because it involved a broad range of children's services. Graeme Dickson mentioned the biannual visits to the NHS services and their local government partners. In most cases, we see the local manager or commissioner of children's services as part of that visit.

In 2006, we extended those visits to have a strong focus on the child and adolescent mental health framework for promotion, prevention, treatment and care. When we began that work, we found that an additional group of people came to the meetings who had not been coming to meetings before—those who had the local focus on children's services, including mental health services. One of the interesting things that we found next was that the changing children's services fund had been a key contributor to the growth in child and adolescent mental health services from 2003 to 2006.

Nicol Stephen: But it has gone now.

Geoff Huggins: I am sorry—I just want to make it clear that even before the concordat we had identified the risk that, as these particular resources were being provided by the Scottish Executive to local government for expenditure on children, any future Government might decide to reallocate the funding for different purposes.

Nicol Stephen: Scrap it, in other words.

Geoff Huggins: My point is that it was identified and tied funding. As a result, we tried to ensure that local partners had plans in place and a good understanding of how all this was enabling them to meet their commitments under the framework for promotion, prevention and care, which, I should point out, is cross-sectoral and covers education, social work and mental health services. On our visits, we have been monitoring on-going delivery against the framework and have seen in practice that local government is continuing to support the investments that it had made after the ring fence. We are less bothered about the pounds and more concerned about ensuring that the service continues to be available.

Nicol Stephen: So if the committee or Audit Scotland were concerned about the pounds, your answer to those concerns would be that you are not monitoring them. Is that right?

Geoff Huggins: We are concerned that the staff, resources and facilities that have been put on the ground continue to be available. It could be that local government has decided to fund the service through a different budget, but I do not know that it has necessarily—

The Convener: So you are able to quantify the specific services that are in place, any previously available services that are continuing and any new services that have been added.

Geoff Huggins: We can quantify the work that is going on. However, we also found that the services that were being developed to deliver the framework differed from area to area—and for good reason, because they sat in the context of the different approaches taken by education and social work. The challenges that the specialist mental health or CAMH system had to face were different in practice because of differences in need and the broader structure of services.

The Convener: So, from what I am hearing, you are able to identify what is being provided but not how much is being spent. Is that right?

Dr Woods: Perhaps at this point I should make two comments, the first of which is a technical point about the attribution of spend and the second of which is about other developmental work that is important in this context.

I think that I can illustrate the point about attribution quite easily with reference to the NHS. The figures for spending in the report do not include, for example, the cost of GP time. As we know, a very large proportion of GP consultations in primary care are devoted to mental health care, but how do you divide up the cost of a GP into different categories?

From a broader policy point of view, we are trying to provide boards and local authorities with tools to assess their performance with regard to services and spend. A little while ago, I mentioned the integrated resource framework, which we are working on with four boards and 12 local authorities and which is intended to provide a clear view of how services are being delivered and resources devoted. We have also launched an important benchmarking initiative that is intended to bring together all sorts of information about services, spend and so on to allow boards and local authorities to examine critically the use of the totality of the pot that I referred to earlier. That approach, linked with the work on the collaborative, is undoubtedly leading to the reallocation of resources to support not only local priorities, but the Scottish Government's priorities, and is driving up standards of performance. We will be very happy to tell you more about the benchmarking and collaborative work, because they are among the really important mechanisms that, at a national level, we are trying to support throughout Scotland.

The Convener: We will stick with funding for the moment. Cathie Craigie has a number of questions about resource transfer.

Cathie Craigie (Cumbernauld and Kilsyth) (Lab): Good morning. Thank you for your written response to the convener and your introductory

remarks. Continuing on the theme of spend, the committee would like to know how much is spent across the board on mental health services. From the Auditor General's report, it seems that we have plenty of information on what is spent by the national health service. In 2007-08, it spent some £928 million. We note that, in that year, there were 886,000 contacts with GPs and 35,000 contacts with practice nurses about depression and anxiety, and the Auditor General helpfully provides us with a unit cost per visit.

The difficulty lies in the fact that we are unable to get that information in relation to local government. I share my colleague Nicol Stephen's concerns about that. We have received written evidence that highlights voluntary organisations' concerns that councils are cutting funding for mental health services, but we do not know whether that is the case because we are unable to have any sort of joined-up approach.

You mentioned the partnership approach between the NHS and local authorities. How can we measure whether the partners are playing the game properly in providing services for some of the most vulnerable people out there in our communities? When do you anticipate that information about what is spent by local authorities will be available? NHS boards spend 9.7 to 11 per cent of their budgets on mental health services. What is the equivalent percentage in local government, which is an important part of the partnership?

Dr Woods: I do not know the proportion, I am afraid. I do know—I think that the figure is in Audit Scotland's report—that the amount that was spent by local government, excluding resource transfer, was £142 million in 2008-09. I think that that is the year in the report. On resource transfer, £91 million was transferred from the NHS to local government.

We believe that it is locally where we really need transparency about the resources that are being used. That should be linked back in the way that I mentioned, through the work that we are doing on the IRF, to a clear statement and understanding of priorities.

Cathie Craigie: Can you tell us again, if you have already done so, what you are doing to encourage local authorities to gather information that is comparable across all 32 local authority areas?

Dr Woods: I invite Dr Coia to say a little about the benchmarking project, because I think it may be relevant in that context.

Dr Coia: You mentioned the Audit Scotland report. The benchmarking work from the NHS side has been done to try to dig deeper and further to look at not only what we are spending but whether it is the right amount and, as the convener mentioned earlier, whether we are spending money in the right part of the system or whether it should be spent earlier or in more specialist areas. To achieve that, and to dig far deeper into the money that we have, we needed to have a project in the first instance to agree common definitions of services throughout Scotland.

When people in community teams talk about crisis services in the community, they need to agree, regardless of which part of Scotland they are in, how they are going to count the numbers into that and put staff and money against it. We have joined that up with our social care benchmarking project because mental health, as you rightly say, must involve all agencies. Our social work colleagues have been extremely helpful in trying to begin that process with us, and they have started the process of agreeing common definitions throughout the country. They have had difficulty in extracting data, because a social care package can be applied across the board, whether for mental health problems or care of the elderly, and the funding is lumped together. To extract that from their data system requires a coherent agreement on definitions. They therefore began a pilot, with the agreement of the local authority, to scope out their data systems and what they collect. We have now agreed with the Association of Directors of Social Work and its mental health sub-group to start in March the process of teasing out the functions of services—which they think will be easier to do—so that we can join them up with NHS services. Certainly, at ground level, clinicians and social workers are beginning to agree common definitions, so we hope that we will be able next year to extract costs from the systems in a meaningful way, so that the benchmarking can compare like with like, which is currently difficult to do.

10:45

Cathie Craigie: So we can look forward to that.

Dr Coia: Yes.

Cathie Craigie: Dr Woods gave details of the working group on resource transfer, which we hope will report its findings early this year. As I understand it, resource transfer was linked to the long-stay bed closure programmes, but I have difficulty in understanding the differences between local authority areas as set out in Audit Scotland's report. I understand that some local authorities had large hospitals within their boundaries, but I pick out in particular the difference between NHS Lanarkshire and NHS Greater Glasgow and Clyde. Both boards serve communities that have similar needs, so I cannot understand why there is such a huge difference in the amount of money transferred from the NHS to councils. In NHS

Lanarkshire it is £8.30 per head of population, whereas in NHS Greater Glasgow and Clyde it is £35.33 per head. Can you help me to understand that situation better?

Dr Woods: You have teased out some of the factors that explain the variation. You are right to point to the origins of the resource transfer arrangements being in the early 1990s, when we were very much concerned with the transition from institutional care to community-based care. There are some central points to be made in that context.

In approaching the problem, we were concerned with not just moving the money associated with a bed, but redistributing responsibility among care providers, whether they were in the NHS, local authorities or the voluntary sector. We wanted local people to agree on the pattern of care, which needed to include expanded NHS community services. For instance, we have seen a significant expansion of community mental health teams right across Scotland. In many respects, Glasgow led the way on that work in the 1990s.

There was, therefore, a transfer of resources from institutional care in the NHS to community-based care in the NHS. Of course, there was also a transfer of responsibility to local authorities for activities that had gone on in the institutions, but that was based on local agreements, which are still in force in many places. Since that policy was created, mental health services, health services and social care services generally have developed significantly. That is why we have now judged it appropriate to do two things. One is to establish the working group, to which Cathie Craigie referred, to consider the operational effectiveness of current arrangements and make proposals for ensuring that they are considered fair, transparent and workable by all parties. In taking evidence, the committee has heard different perspectives on the extent to which that is the case. We are trying to address that through the working group, which we expect to report finally by June 2010—before then, the group will give updates to the ministerial strategy group, which the Minister for Public Health and Sport chairs.

For the longer term, I return to the integrated resource framework. Its purpose is to reach a situation in which boards and their partners understand much better needs, priorities and the current use of resources. The benchmarking work helps that. Those requirements are fundamental to assessing whether the resource level and service performance are appropriate and therefore whether the amount of resource transfer is correct.

Much work is under way. In our annual reviews with NHS boards, we ask boards key questions about how they approach all that work, to ensure that the taxpayer's pound is used to maximum effect.

Cathie Craigie: I say with respect, Dr Woods, that you did not really answer my question why the difference between the transfers from NHS Lanarkshire and from NHS Greater Glasgow and Clyde is so huge. As the head of the NHS in Scotland, have you asked boards to report further to you on that?

I represent a constituency in Lanarkshire that also had large hospitals that were closed, after which people were relocated to be housed in their local communities. That is the right way to proceed, but my concern is that the money has not transferred. Am I wrong? Is Glasgow just doing that better? From whom can I find out the reason for the big disparity, if not from you?

Dr Woods: The answer is that the differences in the level of resource transfer reflect local agreements between partners. We have not taken a normative approach to resource transfer—we have not said what the amount should be. We have said that, locally, people should collectively assess the needs of their population and how they want services to develop. If responsibilities for functions shift between bodies, an agreement should be made about resource transfer. The resource transfer reflects local agreements. I would be happy to provide you with a further note on Lanarkshire, if that would help, but the short answer is that the situation reflects local agreements on the level of resource transfer.

Cathie Craigie: If the figures reflect local agreements, am I right in concluding that people in Glasgow are receiving a gold-standard service whereas people in Lanarkshire are receiving an economy service in the community?

Dr Woods: I do not think that you can draw that conclusion—the picture is rather more complex, because it comes back to the pattern of service provision between hospitals, community mental health services and local authority services. As I said, the guidance that was issued in the early 1990s recognised that people had different starting points because of the distribution of large institutions. I defer to Dr Coia's more detailed knowledge of Glasgow's situation at that time, but I think that Glasgow's care services had a significant institutional base.

Conclusions about the quality of the service cannot be based on the quantum of resource transfer. The numbers in the report reflect local agreements. Are those agreements right? That is the question that we are asking people to address. We are trying to equip them with the tools and the data to examine that question. That is how we are pursuing the issue.

Cathie Craigie: I have a detailed point on that. When Lennox Castle hospital, which was in the Greater Glasgow NHS Board area, closed and

people were relocated, the policy, correctly, was to try to house people back where their roots were with their families. If somebody was housed in Kilsyth, for example, which was outwith the Greater Glasgow NHS Board area, would that individual have been accounted for financially by the health board in Glasgow or by NHS Lanarkshire?

Dr Coia: I do not know the answer to that.

Dr Woods: I do not know about Lennox Castle hospital, which was a learning disability hospital, but you will remember that we had a large national hospital for learning disability at Larbert, which is where the new hospital is being built.

Cathie Craigie: People were relocated then, too, and that was in the Forth valley area.

Dr Woods: I am searching in the back of my memory, but I think that the issue of redistribution of resources was handled on a multiple health board and local authority basis at that time, which reflected the fact that people were resettled to a variety of places in Scotland and not just within the Forth valley area. I would need to look into that a bit more if that would be helpful, but that is my recollection of what happened in relation to the Royal Scottish national hospital. I would be surprised if the same had not happened in relation to Lennox Castle.

Dr Coia: Lennox Castle was a learning disability hospital, and the care that was provided to adults with learning disability would be almost 80 per cent social care and 20 per cent NHS care. That is slightly different from the current issues in Lanarkshire. It is important to think about not just the health care or social care, but the whole system. The whole system has to move from institutionalised NHS care to providing a lot of NHS care in the community. At present Lanarkshire is remodelling its system to do that.

Therefore, the issue is not so much about resources; it is about shifting the balance of resources. Through the benchmarking, we track how much each board is shifting the balance into the community in terms of NHS spend. So a resource transfer would not solve the initial problems of having to put a complete package into the community in Lanarkshire. At present, the board is considering a fairly major redesign of its NHS community services to be able to work with local authority services. We need the two together. That process is going on, but we need to see the total system and not just the health services or social work services.

Cathie Craigie: North Lanarkshire Council provides care in the community well, but historically there has always been an argument between the council and the health board regarding the finances for that. The changes either will or will not provide proof that the council has been right that the NHS board has not been transferring enough resources. From the information that I have so far, I cannot come to any conclusion on that, so more information would be welcome.

Geoff Huggins: Since the early 1980s, there has been a significant reduction in the number of beds overall in Scotland, and the figure continues to fall year on year. It is important to draw distinctions between different things that are happening within that. A good example is Lennox Castle hospital, which as a learning disability facility largely had people going out into social care settings such as supported housing and community care.

We can contrast that with, for example, the work that Dumfries and Galloway NHS Board is doing to restructure its in-patient services. As it does that and reduces the number of beds, it is looking at a population of people with adult mental health illnesses such as schizophrenia to a greater degree and bipolar disorder to a lesser degree. The services that the board is putting in place to ensure that people can stay in the community are related predominantly to crisis response, and are therefore the responsibility of community psychiatric nurses and community-based psychiatrists.

11:00

During the period of time that we are discussing, two elements have operated simultaneously. One is—exactly as Cathie Craigie described it—the enormous institutions, which offer very little in respect of care and dignity, returning people to the community. At the same time, however, a more modern mental illness system, which is closing down beds, has developed.

During the period, the average length of stay in adult mental health wards has fallen from 200 days to 40 days, although the number of admissions has remained broadly the same. That suggests that significantly more of the mental illness system now sits within the community. In that context, you probably would not expect significant resource transfer to take place, as in general people live in their own accommodation and receive support from CPNs and mental health officers. The two service types have quite different financial footprints. You need to look at the nature of the different change processes to see what the consequences might have been.

George Foulkes: Good morning, Dr Woods. I am afraid that the answers from you and your colleagues have not improved my mental health this morning, as you have not answered the questions. Mr Huggins has just spoken eloquently

about the situation, but none of it explained why there is a major difference between, for example, NHS Fife, which we can see from the report has a resource transfer of £2.70 per head of population, and NHS Greater Glasgow and Clyde, which has a transfer of £35. Why is there a difference?

Dr Woods: As I said—

George Foulkes: You said that that reflects local agreements. Why should the local agreements in Fife and Glasgow differ so much?

Dr Woods: As I said, it is because services in those places were at different points. The pattern of services that people wanted to develop reflected their local circumstances. I am afraid that that is the answer.

George Foulkes: But that does not explain the situation, does it? Why do you think that it does?

Geoff Huggins: For example—

George Foulkes: Tell me how the historical pattern in Fife is different from that in Glasgow.

Geoff Huggins: To be fair, many of the services could be offered by either the NHS or local government. In Fife, for example, Stratheden hospital provides learning disability services, so those services are effectively provided by the NHS. Different decisions about who provides such services locally impacts on how money is or is not transferred.

The Convener: But as you explained, there has been a policy decision to shift services into the community, so, irrespective of local preferences, all areas should adhere to that policy. The problems predate the change in Administration; it is clear that these issues go back many years. In Lanarkshire, from what I can gather, the council is frustrated at the level of resource transfer, but Dr Woods says that there is local agreement. If there is local agreement, does that suggest that the council is happy with the historical level of resource transfer?

Dr Woods: I am not in a position to comment on the local authority's perspective, because I am not familiar with it. All I am saying is that the policy framework is clear, but with the shift in responsibility people should—I am sorry to repeat myself, but this is the position—identify local needs, priorities for investment and how resources are to be reallocated among themselves. People have addressed that issue, but from rather different starting points. To go back to the question about Fife, my recollection is that Fife did not have a large mental health institution in its midst—although it clearly had some important mental health services—in contrast to the scale of the institutional provision in Glasgow. That may be part of the explanation.

George Foulkes: You see, when we ask you:

"How do you monitor that funds being transferred are being directed to the appropriate services?"

you say:

"It is ... primarily the responsibility of individual partnerships".

You do not answer the question. You are not monitoring that, are you?

Dr Woods: We are monitoring the performance of the health care system in relation to the objectives that we have set, and we are asking some searching questions of boards about the way in which resources are being used. That is why the benchmarking is so important. However, it is the responsibility—

George Foulkes: That does not answer the question. You go on about benchmarking—Denise Coia has gone on about it three or four times—but that does not answer the question. How do you monitor whether the funds that are transferred are directed to the appropriate services? Are you saying that that is a job not for you as director general of the NHS in Scotland but for someone else in the Scottish Government?

Dr Woods: In my letter, I said that responsibility for monitoring the use of transferred resources rests with the accountable officers of the individual NHS boards. That was always understood.

George Foulkes: So the Scottish Government does not monitor it centrally.

Dr Woods: We monitor the performance of mental health services. We are not tracking individual resource transfer agreements.

George Foulkes: What is the difference? Are you monitoring whether the funds that are transferred are used for the appropriate services? Is that being done centrally? If not, why not?

Dr Coia: Could we look at the question in a slightly different way? The aim is to improve the mental health of the population of Scotland and maintain that improvement over time. In terms of looking at indicators, the more important question might be whether we are achieving that and what the outcome indicators are.

George Foulkes: Okay, let us deal with the outcomes. When Nicol Stephen asked about them earlier, the answer was, "We ask them. Each partnership does it differently. It is difficult to determine." That indicates that you do not know, does it not?

Dr Coia: The indicators are not different. Those that we are using and propose to keep using in the benchmarking project are about employment, absence leave and healthy outcomes. The indicators are for the overall population, so while

services in the Highlands and Islands will be delivered differently from those in Glasgow, it is important that everyone's outcomes are equal, in terms of what happens to their mental health and its improvement.

We have looked at the outcome indicators that are used by other countries in the developed world, which are all experiencing the same problems in measuring outcome indicators across mental health. We are applying outcome indicators across Scotland, in the same way that a wide range of other countries are applying them.

George Foulkes: It is all right that you can monitor outcome indicators, but how can you relate that to the variations in expenditure that are occurring if you do not monitor the provision of the services that provide the outcomes?

Dr Coia: There is direct and indirect expenditure. In the NHS, monitoring is relatively easy, because a vast amount of expenditure is direct expenditure: we buy services, and we can set the outcomes against the services and see what we get for that direct spend. The difficulty with mental health services is that we cannot monitor chapter and verse indirect spend, such as spend in communities on exercise in sport centres, or on doing well by people with depression in community libraries. We therefore monitor it by saying that we know what our direct spend is, and social work uses the social work benchmarking project to help us out with what it directly spends, but as for every other country in the world—and most of the benchmarking is international now—we have to ask, what is the outcome for direct and indirect spend? You are right that because indirect spend is spread through libraries, schools—

George Foulkes: That is not what I mean. I am talking about the money that is transferred to local authorities and who monitors that it is used effectively. Does anyone in the Scottish Government monitor whether the money that is transferred is used for the intended purpose?

Dr Woods: Only through the accountability arrangements that we have with NHS boards.

George Foulkes: I am talking about transfers to local authorities. Who checks up on local authorities?

Dr Woods: Under the arrangements that have been introduced in association with the concordat and single outcome agreements, we do not micromanage—to use a well-known term—that detail.

George Foulkes: So you have no idea whether the money that is transferred is used for the purpose.

Dr Woods: From our work with boards and our dialogue with local partners of the sort to which Mr Dickson referred, we know that people are pursuing the policy objectives that have been set. We know a great deal about the relative performance of partnerships in relation to some of the important targets that we have set for readmissions, the use of antidepressants, the development of child and adolescent health services, and suicide, which we have discussed. We are monitoring in relation to policy objectives, rather than the detail of individual resource transfer agreements.

Nicol Stephen: I will come at the same point from a slightly different angle. In paragraph 123 on page 32 of the Audit Scotland report, the amount that Scotland's councils spend on adults with mental health needs is given as £141.9 million; that is the figure to which you referred earlier. As an aside, it appears that there is no figure for local authority spending on children's mental health needs. The report goes on to say:

"The full cost of council services for people with mental health problems is unknown."

Later in the same paragraph, the report looks at the £141.9 million that is being spent. It states:

"Transfer of resources from the NHS is included in the overall £141.9 million but"—

these are the important words—

"a breakdown of how much is transferred to each council is not recorded at a national level."

Do you agree with that?

Dr Woods: I have no reason to disagree with it. I do not have sufficient detail with me to know whether we have the information somewhere in the midst of all of our data, but I have no reason to dispute what has been said.

Nicol Stephen: I assume that Audit Scotland asked you for the information and that you answered that there was no such record. That means not only that the sum is not monitored, but that it is not recorded—or was not recorded back in May 2009. You mentioned the work that is being done to report on and monitor these issues in June 2010. Was that work triggered by the fact that the report clearly identified a gap?

Dr Woods: Are you referring to the working party on resource transfer?

Nicol Stephen: Yes.

Dr Woods: It was prompted partly by the dialogue that we know exists between local authorities and boards. We know that not everyone is happy with the arrangements and that boards and local authorities have approached the handling of inflation, for example, in relation to agreements in rather different ways. As a result of our dialogue with boards and the Convention of Scottish Local Authorities, we have agreed that it

would be desirable to take a fresh look at the arrangements in the short term, to see whether we can improve the operation and get it on to a common good-practice basis.

Nicol Stephen: You have referred a great deal to different local agreements that are appropriate to the circumstances of different areas. Is it fair to say that, currently, you do not know whether an appropriate local agreement has been reached or whether there has been a total and abject failure to transfer resources? You simply do not know that, because you have not monitored it and you have not discussed it at the local level.

11:15

Dr Woods: We have a pretty good idea of the extent to which services are functioning well. The nature of resource discussions is always difficult, particularly at the boundary.

Nicol Stephen: With respect, you accept that you did not even have a record of how much was transferred in May 2009. How can you comment on the appropriateness of the local agreements if you did not even keep track of how much was transferred? Is that not a fair point?

Dr Woods: Mr Huggins wants to comment on particular aspects of that. Is it in respect of dementia or readmissions?

Geoff Huggins: It is in respect of both.

Nicol Stephen: Hang on. Sorry, but, before you move on to dementia and readmissions, can you comment on that point?

Dr Woods: About monitoring?

Nicol Stephen: About the fact that you could not carry out monitoring or have a view on whether local agreements were appropriate because, at a national level, you did not keep a record of how much was transferred. Paragraph 123 of the report confirms that that was the position as recently as May 2009.

Dr Woods: It is not our role to second-guess whether local agreements are the correct agreements. The arrangements, which have been in existence—

Nicol Stephen: These are public funds.

Dr Woods: Yes, I know that they are public funds, and that is—

George Foulkes: And you are the accountable officer.

The Convener: Let Dr Woods finish.

George Foulkes: Let him answer the point. That would be helpful.

The Convener: Let him finish.

Dr Woods: The guidance makes it clear that responsibility for monitoring the use of the funds, the effectiveness of funds and the development of services rests with local accountable officers.

Inevitably, in relation to agreements on resources, there are annual discussions about the adequacy of the arrangements. As you have observed, we did not assemble the information. Only in recent years have we become aware of concerns about the machinery, which we are now trying to address.

The Convener: If it is not your job to resolve the local arrangements for resource transfer, why have you set up the working party to look into them?

Dr Woods: It is our job to consider the functioning of the arrangements, but not the monitoring of the deals that are struck between individual NHS boards and their local authority partners. We accept that we have a responsibility for the policy framework within which the arrangements sit, which is why we have decided to do what we have done, but for a long time a great deal of our work has been about moving beyond focusing on resource transfer arrangements; our focus has been on the totality of the available resource for mental health and other services and on asking questions about the extent to which services are being delivered in the way that we would like. I am sorry if that brings us back to the question of benchmarking, but that is why the work that we started in 2006 is so important.

The Convener: You say that it is your responsibility to consider functioning. How can you examine functioning if you do not know how much money is spent and what it is spent on?

Dr Woods: As I have said, we welcome Audit Scotland's report. It raises a number of important questions, which complement some of the work that we have already kicked off. We will see what emerges from the working party's analysis.

Cathie Craigie: Do you believe that community mental health services in Glasgow, which are provided as a result of resource transfer, are better or more developed than in other parts of Scotland?

Dr Woods: I hesitate to say that services in Glasgow are more advanced than in other parts of Scotland. It is well understood that Glasgow was very much in the vanguard of developing community mental health services in the 1990s and the early part of this century. The significant developments that were made there in relation to community mental health teams and primary mental health care have been widely acknowledged. Dr Coia works in that part of the country and might want to add something.

Dr Coia: I should add that my previous job was in planning in NHS Greater Glasgow and Clyde during that period.

On resource transfer and community services in Glasgow, there has been a redesign of in-patient services and a transfer of their staff into the community. There were two phases, which brings me back to what I said earlier. The first phase was a shift of resources and the closure of in-patient beds to release funding for community teams. Staff on those teams—psychiatrists, psychologists and nurses—were shifted out into the community. It was a cultural change rather than just a practical change.

The second phase was integrated commissioning involving social work and health. A clear strategic plan to modernise mental health services in Glasgow ran from 2000 right up to 2006. Social work and health joined together to work out, in a needs assessment, what was required in the community. That was a complete shift in the way that institutions delivered services. There was not so much a resource transfer as a shift in where staff worked.

Cathie Craigie: Okay. My last point in this bit is on the Auditor General's report. Paragraph 126 on page 33 highlights the mental health specific grant and states:

"Up to 2006/07, the Scottish Executive provided 70 per cent of MHSG funding (about £20 million) and councils were required to provide the remaining 30 per cent from their general allocation."

From 2007-08, the Scottish Government provided a similar amount, but it was up the councils to decide how they spent it. In paragraph 127, the Auditor General concludes that it was "too early to assess" the impact of that change, as the councils' funding had not changed much in that year, but that the feedback from councils was that they would make changes in the second year of the single outcome agreements. Dr Woods, you said that you welcome the report. What has the department done to follow up on those two paragraphs?

Dr Woods: Mr Huggins will respond.

Geoff Huggins: There are two or three issues to address. I will begin by putting the matter in the context of what local government spends on mental health. The figure in the report is around £141 million, which relates predominantly to illness services; it probably does not take account of dementia. The estimated figure for spending on dementia services in Scotland is around £1 billion, of which the majority is spent within local government services. The figure also probably does not take account of learning disability services.

Cathie Craigie: Can you confirm that the mental health specific grant was provided to help councils to develop local community-based services for people with mental health needs?

Geoff Huggins: The services are provided predominantly by the voluntary sector and include advocacy, which is a statutory right in respect of mental health services. They might also include local employment projects, drop-in centres and things such as the clubhouse movement—effectively, places where people with mental health problems can meet others to get employment advice and social support. I am not sure whether you are familiar with the model, but there are plans to develop more clubhouses in Scotland. We are seeing continued development of voluntary sector services.

The mental health specific grant is not predominantly about what one might consider core statutory services such as contracts for the provision of social work services to individuals or people with long-term or chronic health needs; it tends to be more about the wraparound services. That reflects the scale of expenditure in this area, if we take the £141 million plus the additional dementia money. There is no reference to the broad work in respect of children's health, community support and schools work, all of which is mental health activity but is also development and education activity—that takes us into issues of attribution.

We will retain close links with the voluntary sector. We regularly meet many of the organisations from which you have received evidence: Penumbra, SAMH and the National Schizophrenia Fellowship. In the current context, they are clearly concerned about funding, which will be challenging across the board in the next three or four years. We need to see how that impacts on those organisations. We use our regular meetings to keep our finger on the pulse of what is going on, and we will continue to do so.

The Convener: If there are any follow-up questions on that, we will put them to you in writing, because I am aware that we have to cover a number of other issues. I also have questions about whether NHS Lanarkshire could afford more resource transfer and whether there are pressures on existing health services in Lanarkshire. I will follow that up in writing, rather than take up more time just now.

Bill Kidd (Glasgow) (SNP): I will follow on from the previous line of questioning but pursue a slightly different angle. The committee is concerned with how the finances and resources that are provided by the Government are being used, but it is also involved in considering the outcomes that we get from those finances and resources. Given that people with mental health

problems often receive services from more than one agency, it is about joined-up delivery outcomes. NHS boards and councils are using different information systems for mental health services, which can limit the delivery of joined-up services. The NHS, councils and the voluntary sector all provide services. Can you give us evidence that the partnerships across those three areas are improving the mental health services that are delivered to individuals with mental health problems?

Dr Coia: That is a very important point. It does not matter how much we put into the inputs and processes if we do not achieve outcomes. In the benchmarking work we were keen to look at not just health outcomes, because there is not much use in improving somebody's mental health outcome clinically if they do not have a house or relationships and are not functioning within the community. The balanced scorecard that we have developed, which has taken us over the past 18 months, has been a joint effort with the NHS, local authority colleagues, the voluntary sector and the service user movement to devise outcome measures that we can put into a number of domains. We can look at clinical outcomes, social care outcomes and the broader spectrum of whether people are in employment. We have developed those outcomes. The work has been trying to ensure that we can measure those outcomes and put them into a structure that we can measure. In the report that we will produce in March, we now have the measurements attached to the outcomes and agreements. The data sources come from not just the NHS but local authorities—they come from the Information Services Division and local authorities.

Community care outcomes that are much broader than that have been developed jointly between health and social work. They are at a much higher level. We are doing work at the moment to fit our practical outcomes that can be measured on the ground into that community care outcome structure. That work will take some time.

11:30

Geoff Huggins: When focusing on and establishing our targets, we sought in each case to identify targets that will require action right across the system. The in-patient readmission target is a good example of that, because we had three ideas in mind when we put it together. We reflected on the reports that Sandra Grant produced in advance of the implementation of the Mental Health (Care and Treatment) (Scotland) act 2003, which identified issues with crisis services; what we heard from clinicians and service users about in-patient units; and the development and quality of community services, which are provided by both local government and the NHS.

In framing the in-patient readmission target, we therefore tried to find something that would engage action right across the system. Interestingly, the voluntary sector, particularly SAMH, responded on that. It developed in-patient forums, looking at the quality of activity within in-patient units, the degree of staff contact time and purposive activity, and the developmental work. We regarded that as supporting the target. As we took the work forward to local delivery, we sought to ensure that the target had the effect of mobilising action right across the system.

Interestingly, as with each target, the work taught us things that we did not know when we started. A key element is discharge planning, which is a key delivery issue that engages both local government and the NHS. It is about the availability of, and regular access to, a CPN and issues such as housing and benefits, and connection to substance misuse services, which are largely delivered within local government, in order to ensure that people are not simply discharged and then readmitted. We have tried to ensure that that approach is taken across the system, which requires partnership working to achieve the outcomes.

Bill Kidd: We have been talking about the NHS and local health boards, but are we receiving measurable results from primary care and GPs? Obviously, there are differences between short-term mental health conditions and long-term ones. Can such differences be shown statistically? I know that it sounds prosaic, but is it possible to produce that type of statistic?

Geoff Huggins: There are a couple of key features in that regard. Over recent years, the number of factors that are covered by the UK quality and outcomes framework, which is the GP contract, has increased. I will bring Ruth Glassborow in shortly to talk about how we have used that for the work on depression.

We have gone from having a very small number of points within the overall points matrix largely connected to the treatment of chronic conditions, to having 20 points offered for dementia identification. We have then used those points in our target on dementia. Additional points are also offered for case finding in respect of depression and in responding to people with coronary heart disease or diabetes who have an underlying comorbid problem in respect of depression. We know that that factor is determinative for their long-term health outcomes, because if we do not treat depression in people with CHD, they will probably have significantly worse outcomes. That data source has become quite rich, enabling us to track effectiveness, performance and change over time. I ask Ruth Glassborow to say something about how we have used the QOF data in data mining.

Ruth Glassborow (Scottish Government Health Delivery Directorate): In the work that we have done to support boards to deliver the antidepressant health improvement, efficiency, access and treatment target, we have focused on two primary issues: supporting improvements in evidence-based prescribing, and supporting improvements in access to non-drug treatments.

I will focus on issues to do with evidence-based prescribing, on which we have worked with primary care and GPs. Our work concentrated first on getting a better understanding of what currently happens. Historically, our understanding of prescribing issues has been quite poor. Over the past four to five years since the target has come into play, our understanding of the extent to which prescribing is evidence based and of the reasons for the rise in prescribing has improved significantly. We have focused on the drivers in the quality and outcomes framework in that regard.

For instance, we have looked at GP compliance with formulary, which basically sets out the drugs that should be used as first preference for new presentations of depression. There are two reasons for initially sticking to formulary drugs: cost effectiveness and quality. As the drugs of first preference in the formulary have longer half-lives, they have fewer side effects for people who come off them.

In the quarter ending March 2009, the two drugs recommended as first-line drugs had increased from 39 to 48 per cent of all the antidepressants prescribed. One would not expect 100 per cent compliance. After all, there are always reasons to prescribe other drugs and, indeed, if someone has responded well to a certain antidepressant for a long time, one would not change them to another drug.

The quality and outcomes framework encourages GPs to use a standardised assessment to assess the severity of symptoms. Such an approach assists rational prescribing, ensuring that drugs are prescribed only when the assessment indicates that the symptoms are severe enough. In 2006-07, that approach was being taken with 90 per cent of people who were diagnosed with depression. That was already good but, in 2008-09, the figure increased to 95 per cent.

The Scotland-wide figures can hide significant improvements in individual practices. For example, in two practices in Greater Glasgow and Clyde, there was a 16.7 per cent increase in the number of people for whom the standardised assessment tool was being used to inform prescribing decisions.

Bill Kidd: Does that show that improvements are being made across the board as a result of the NHS, councils and the voluntary sector working together? Might any difficulties arise if certain voluntary sector bodies or organisations cease to operate without their places being filled?

Geoff Huggins: The answer to your first question is yes. Effective joint working is resulting in significant improvement.

Bill Kidd: Which is measurable.

Geoff Huggins: Well, with regard to the readmission target, for example, performance has improved by 20 per cent over three years; indeed, in five or six boards, it has improved by more than 25 per cent. Performance across partnerships has certainly altered significantly.

As we know, individual voluntary sector organisations have different arrangements with different councils, and they have always changed from year to year as business has been taken or lost. I guess that that will continue to happen.

The Convener: Just before I bring in Willie Coffey on the issue of prescribing, I want to follow up Bill Kidd's point, which I believe is critical. Many decisions might be made locally, but the fact is that cumulatively such decisions can profoundly affect the national picture. How important are voluntary organisations to the delivery of mental health services in Scotland? If those organisations had to cut services, how significant would the impact be?

Dr Woods: In my answer to your first question, members should bear in mind my previous association with SAMH. We think that voluntary organisations play a very important part in provision for a number of reasons. One of the most important is that they are often user led, which provides an important perspective. Also, sometimes they can move more rapidly and develop new, innovative services. An effective and vibrant voluntary sector is an important part of the provider landscape. We are aware that a number of voluntary organisations are involved in difficult discussions about projects and services. It varies a lot across the piece, but we are keeping an eye on how that is developing. We always want voluntary organisations to contribute to mental health services, primarily because of the user-led perspective that they bring to service provision.

Willie Coffey (Kilmarnock and Loudoun) (SNP): My question relates to the level of antidepressant prescribing and the management information that allows us to develop public policy in that regard. On page 25 of the Audit Scotland report, there is a table that shows us that the level of antidepressant prescribing in terms of the defined daily dose has increased almost fivefold since 1993.

I have read your responses to the committee, one of which suggests that the increase may be attributable to small numbers of people being on increased dosages or perhaps being on antidepressants for a longer time. However, one of your other responses suggests that you could see higher levels of prescribing for what I regard as non-clinical reasons—for example, where there is

"a greater proportion of female GPs in the practices."

Conversely, some of the reasons given for lower levels of antidepressant prescribing are also non-clinical—for example,

"single-handed practices, higher than average practice list size ... and higher mean GP age."

When MSPs read something like that, alarm bells start to ring because it suggests that antidepressants are being prescribed in greater numbers or dosages for non-clinical reasons. Will you address that point?

Dr Woods: This is a complex area. The central point in it is that we are interested in the appropriateness of prescribing and best practice in prescribing. Ruth Glassborow referred to some of that a moment ago.

The comment in my letter about some people being on larger doses of antidepressants or on them for longer periods of time does not explain the trend that is observed in exhibit 10 and I was not saying that it did. I was saying that, in recent times, there has been a decrease in the rate of increase. That sounds a bit complex, but we have been trying with the target on antidepressant prescribing to reduce the rate of increase and, for a number of quarters, we achieved that. However, in the past couple of quarters, we have seen a slight upturn and we think that that is a consequence of prescribers adopting what is now regarded as best prescribing practice. That was the point that I was trying to make in the letter.

The trend that is observed in exhibit 10 is important because it was that observation that led us to the view that we needed an antidepressant target for the twin reasons of appropriateness of prescribing and the widespread acceptance that there are other possible treatments for anxiety and depression and that it would be desirable to expand a range of psychological therapies. In that context, I am talking not only about psychologists but about a range of therapies that are sometimes referred to as talking therapies and that can be delivered by more than just psychologists.

In relation to that trend, we have tried to examine the appropriateness of prescribing and work with boards to expand the availability of psychological therapies as alternatives, where appropriate, for the management of individual patients. That is what we were trying to convey in the letter that I sent to you.

11:45

Willie Coffey: How can we develop a policy to reduce the prescribing of antidepressants if we do not know how many people in Scotland are being prescribed antidepressants? It is a consistent theme in the report that we do not know the numbers involved, although one of the health boards is trying to collect that information. How can you make choices about the development of a policy to shift the emphasis to the provision of more non-drug-related support services to treat depression if you do not know the numbers that you are dealing with?

Dr Woods: You are right to point to a bit of a chicken-and-egg problem. It was clearly desirable to create such a focus so that we could get to grips with what was going on and improve the quality of the service that is delivered pharmaceutically, as well as look at how we could expand a range of important alternative therapies. We did not necessarily have all the data that we would have liked to have. The data that we have are still not a measure of the incidence and prevalence of anxiety and depression; they are a measure of the consumption of a particular range of drugs. We have been trying to use that information as a way of provoking analysis and wider change, which we believe will improve the quality of service. We believe that there is evidence of that. I am happy to invite Denise Coia and Geoff Huggins to elaborate on some of that.

Geoff Huggins: The first thing to say is that we are having a conversation that we could not have had three or four years ago. It is a conversation that is based on knowledge, research and data, which have given us answers to some questions. You have focused on the difference in prescribing patterns based on who is prescribing. That can be set alongside some work by people from the University of Aberdeen that identified that, in around 98 per cent of cases, people on a prescription were receiving medication appropriately. We need to put those two bits of information together as well.

In Tayside, where psychological therapies are being offered, largely within 18 weeks and, in some cases, with no waiting time at all, that is not having a significant impact on prescribing patterns at this stage. There are questions about the short-term and long-term impacts of different policies. Both in Scotland and in England, through the improving access to psychological therapies programme, there has been a growth in the use of therapies, but we have questions. Increasingly, we see such illnesses as ones that remit and return rather than as one-off illnesses. That raises questions about the longer-term prognosis in respect of the need for antidepressants, therapies and other approaches, such as exercise and other

social interventions. We are engaged in a learning process that has given us access to significant service improvement right across the system, which can be identified in the work of GPs and in the recognition that there is of depression.

The target was accompanied almost immediately by the offering of additional points to GPs for case finding—GPs were offered an additional 20 points towards the quality and outcomes framework for identifying cases of depression, so we might have expected to have seen a rise in the number of cases that were identified when we launched the target. That is also significant. There is a range of factors. We worked the available information systems hard to develop a better understanding so that we could move to the next stage of our policy, which is to focus increasingly on the therapies agenda.

Anne McLaughlin (Glasgow) (SNP): I have a supplementary. We have heard that, in GP surgeries in which the average age of the GP is older, doctors are less likely to prescribe antidepressants. When we took evidence on the issue, someone—I cannot remember who—highlighted the fact that younger GPs are far more likely to prescribe antidepressants. I was extremely surprised to hear that because I would have expected it to be more difficult to change the minds of older GPs, who might be more set in their ways, but the witness spoke about the emergence of a risk-averse generation of doctors. If that is the case, is there a case for asking why that is and looking at the training of people who are studying for a medical degree with a view to redressing that balance?

Dr Coia: I am not sure about that. The evidence base is unclear, so both of us are surmising the reasons, but I would probably interpret the situation in the opposite way and say that the younger generation of doctors have had proper training in identifying depression, whereas the older generation probably stigmatised depression and regarded it as something that people got on with and had to manage. The younger generation of doctors are much better at picking up depression as well as trauma and anxiety.

The issue is to ensure that, when doctors pick up depression, the process is not just about assessment. Several articles, including a recent one in the *British Medical Journal,* have stated that the increase in prescribing seems to be related to a chronic group of patients who are on antidepressants for a period. It is important that we examine the review processes in primary care.

I add that I think the reason why female GPs identify depression more is probably that everybody who is depressed goes to a female GP. There are other factors.

Cathie Craigie: The issue is interesting. Is research on-going? Is prescribing antidepressants such a bad thing if it controls a person's illness and the long-term outcomes? Will the outcomes be measured through on-going work? I understand the concerns about the level of prescribing, but if antidepressants work for the individual, that is surely a success.

Geoff Huggins: To be clear, although the target was about reducing the annual increase, throughout the process we have been fully committed to the idea that we must provide the appropriate treatment response. In many cases, that will be an antidepressant and a therapy. Although our position might have been portrayed as being anti-drug, we have been careful to ensure that it has not been anti-drug. Similarly, we would not be asked to reduce the application of cancer or CHD drugs.

We need to be clear that we are focused on the best effective treatment. The target was a proxy to get us into that discussion, and it has taken us a long way. We will continue to track antidepressant prescribing alongside our work to develop therapies, which is the new commitment. The tracking has given us a lot of rich data on what happens at local level in individual practices and that enables us to do a lot.

Nicol Stephen: I am interested in comparisons with other parts of the UK and Europe and with other countries. Do we track in the same way as the rest of Europe and other developed nations? How do the trends here in the past 20 or 30 years compare with those in other nations?

Ruth Glassborow: The trend in other nations is that antidepressant prescribing has been increasing. The situation here is in line with what has happened elsewhere.

Nicol Stephen: Are the increases of a similar extent?

Ruth Glassborow: That is my understanding, although we would have to double-check the data.

Geoff Huggins: It is important to reflect on the point that how the NHS in Scotland or the UK picks up depression is somewhat different from what happens in health services in other countries, even other industrial countries. When I meet colleagues from the States, I regularly find that depression is not on their agenda. Their focus is on long-term chronic illnesses such as schizophrenia, dementia and bipolar disorder. Depression sits underneath those chronic functional illnesses or at a different level of consideration from them. Similarly, in eastern Europe, there is a completely different situation. A small group of countries have a focus on depression in their health services and in expectations. As Ruth Glassborow said, we are broadly in the same zone as they are.

Nicol Stephen: That is one reason why I asked how we monitor in Scotland. Do other countries take the same approach as we do to monitoring, whereby we do not know the number of patients involved but we know about daily dosage levels?

Geoff Huggins: Different systems have different information, but few systems have information of the quality that we are now getting from the QOF system. Some countries are able to track prescriptions against patients and some are not. It varies from country to country.

Dr Coia: One advantage that we have in Scotland is that we can track defined daily doses. A number of countries cannot even do that. For that reason, we probably know more about depression than many other countries in the world do.

Nicol Stephen: If there is any useful and meaningful information on where we come in any table, that would be most interesting and helpful.

The Convener: I intend to draw this part of the meeting to a close.

George Foulkes: May I ask one quick question?

The Convener: Yes.

George Foulkes: Dr Woods, are you responsible for appointments to the Mental Health Tribunal for Scotland?

Dr Woods: Ministers are responsible for that.

George Foulkes: Do you make recommendations to ministers?

Dr Woods: The sponsorship of the Mental Health Tribunal sits within the health directorates—

George Foulkes: In your department.

Dr Woods:—and filling of posts is conducted through an open and competitive process.

George Foulkes: It is your responsibility.

Dr Woods: Yes.

The Convener: Anne McLaughlin wanted to ask a question.

Anne McLaughlin: I have a series of questions, but I will cut it down and ask one question about our work with members of black and minority ethnic communities. Anne Hawkins from the Greater Glasgow and Clyde NHS Board drew to the committee's attention a body of work that was sponsored by the NHS in Scotland about getting the regions in Scotland to work together on issues that affect access to services by and delivery of services to people from black and minority ethnic backgrounds. What progress is being made on that?

We need to be aware that Greater Glasgow and Clyde NHS Board's area has a higher proportion of people from BME backgrounds than elsewhere in Scotland. However, wherever someone lives, if they have cultural or language difficulties in accessing services, that needs to be addressed. I wanted to ask about progress on that. I then have one more question on a different issue, if that is okay.

Geoff Huggins: Broadly, for the past five or six years, NHS Health Scotland has hosted a programme that focuses on BME mental health issues and offers guidance. When we did some work with colleagues from Canada and North America about three or four years ago, we recognised that we needed to address a set of issues in order to respond better. The Glasgow experience was significant in that regard, both in relation to the choices that people make about when they come forward, or do not come forward, to access services—we might describe those as the pull issues—and in relation to the way in which our services respond to people when they do come forward, which we might describe as the push issues. There is a question of reach and the degree to which we effectively engage with BME communities. A lot of the focus at that time was on the processes that might change the outcomes that we were getting.

The second set of issues concerns the degree to which particular approaches and particular interventions that we offer are sufficiently culturally sensitive. A good example of that is the therapies agenda, where we have a focus on approaches such as cognitive behavioural therapy. We are not clear about the degree to which that operates in the same way across cultural boundaries. In addition to the general programme that NHS Health Scotland has taken forward, we have developed two local approaches, one of which is in Lothian. That work is supporting particular primary care areas or GP practices to identify ways in which they can reach out and engage with particular communities so that we can use that as a learning process and, in time, become better at it.

That work sits in the context of the work that is being done in Alaska with the Cook island inlet community and some work in Toronto. We are trying to compare and contrast approaches to engaging with minority communities in those slightly different cultural settings. As you will know, Toronto prides itself on being the most diverse city in the world, with 42 different languages, although I suspect that Glasgow must now be quite close behind in that respect. The cities sit in similar situations, so we are trying to learn together. We recognise the challenge and we have work in progress to try to respond to it differently.

In the future, we will probably have something that involves alliances with other countries. We will have a community from Pakistan or Bangladesh and similar communities will exist in Holland or France, which will face exactly the same challenges of cultural sensitivity in relation to services, language, materials and approaches. We are trying to become a bit cuter about how we respond to that, and we are using our relations with the European Union expert group on mental health to take that forward.

12:00

Anne McLaughlin: Glasgow trumps Toronto—126 languages are spoken in Glasgow.

I have three quick questions about the fact that our population is ageing. What planning is being done for the capacity that is needed to deliver services to older people with dementia?

Separately, what planning is being done on delivering services to older people with mental health problems other than dementia? Often, we overlook the fact that, like everybody else, older people suffer from a range of mental health problems.

Not only the population that the NHS treats, but the NHS workforce, is ageing. What is being done to prepare for that twin ageing problem?

Geoff Huggins: You are probably aware that we have a commitment to deliver a dementia strategy by April 2010. For that, we are considering a series of issues that relate to the diagnosis of and treatment responses to dementia.

Graeme Dickson might add something about wider work by the Scottish Government and local government on the overall structure of care for older people.

As you said, the demographic aspect of dementia is significant. We expect the figure involved to increase rapidly in the next 10, 20 and 30 years. That raises significant questions about the model of service delivery that will enable us to support that.

I will talk about older adults and perhaps Graeme Dickson will talk about the structural issue. We face new problems in relation to older adults. Historically—we have the evidence base for the position, although the situation is improving—people with chronic mental illness problems have died on average 10 years younger than others and have been significantly more likely to take their own lives. Only in recent years has a significant number of older psychiatric patients—people with mental illness—been in the system. The number of people with schizophrenia who are now entering their 60s and 70s is growing.

In the past four or five years, we have rebalanced the overall pattern of psychiatrists, so that the proportion with a subspecialism in older adult psychiatry has increased. If you would like, we can offer you those numbers. That reflects a situation that was not historically a problem, because people with severe mental illness did not live as long as other people did.

I am sorry—you had a third point.

Anne McLaughlin: I asked about dual planning for an ageing workforce and an ageing population.

Geoff Huggins: The ageing of the workforce is interesting. The nursing figures for mental health have increased by about 10 per cent in the past two years—that represents new entrants with mental health as a specialty. That is against the background of a fairly constant number of nurses overall. That is the pattern.

In the past five or six years, the number of doctors in mental health has increased from about 460 to about 560, which also suggests that we have a relatively younger workforce. Most of the growth in psychology is among younger people, so the picture of the overall structure of the mental health workforce might be different from that for other workforces in the NHS. I am not sure of the broader picture, but that is where we are.

Anne McLaughlin: That is interesting.

Graeme Dickson: Members will recall from their consideration of free personal care that Lord Sutherland recommended that we look much further into the future in considering how we provide services for older people. We have kicked off a piece of work on that and a subject debate was held recently in the Parliament on longer-term services, on which we have kept various health spokespeople up to date.

We have taken forward eight work streams jointly with local government and the NHS. A unique aspect is that some streams are being led by health board chairs and council conveners, who are considering how we provide services; the demand for those services; the link with the acute sector, since emergency admissions of older people are a big part of the cost to the NHS; the workforce; care homes; and home care. That is medium-term work that will take time to roll out, but we are on the case and are examining that in quite a bit of detail.

The Convener: If Anne McLaughlin wants to follow up any questions, we can do that in writing. Similarly, if other members want to clarify aspects, we will do that in writing.

I thank Dr Woods and his colleagues for a very full session. We will raise further issues with you and we look forward to your response. Thank you for your evidence.

We will take a five-minute break.

12:05

Meeting suspended.

12:11

On resuming—

Section 22 Reports

"The 2008/09 audit of Transport Scotland"

"The 2008/09 audit of the Mental Health Tribunal for Scotland Administration"

The Convener: Item 3 is consideration of two section 22 reports. I invite the Auditor General to brief the committee.

Mr Robert Black (Auditor General for Scotland): These reports are designed to inform the committee and Parliament of remuneration arrangements in two public bodies. Both relate to the departures of senior members of staff during 2008-09. The bodies in question are Transport Scotland and the Mental Health Tribunal for Scotland.

I will talk first about the arrangements relating to the chief executive and the former director of finance and corporate services at Transport Scotland. The committee has some knowledge about the departure of those people, which was obtained during evidence sessions on the report "The First ScotRail passenger rail franchise". As the committee is aware, both the chief executive and the director of finance and corporate services left during the 2008-09 financial year.

The chief executive had planned to retire in November 2009, but discussions between him and the Scottish Government concluded that it would be mutually convenient if he were able to retire earlier. He left Transport Scotland in February 2009. His contractual notice period was three months, but the Scottish Government agreed to pay him six months' salary in lieu of notice and untaken annual leave, as it considered that the earlier departure would provide organisational advantages in respect of Transport Scotland's delivery programme. The financial details of that are disclosed in the Transport Scotland accounts.

The director's remuneration arrangements are not disclosed in the Transport Scotland accounts. As the committee will recall, the Scottish Government has indicated that, under the Data Protection Act 1998, Transport Scotland is not in a position to disclose that information without the director's consent. The director's contract of employment contains no clause that specifically requires him to disclose the information, and he declined to allow the information to be disclosed. That is permitted by the Government financial reporting manual 2008-09, which is produced by HM Treasury and applies to all the United Kingdom's devolved Administrations.

The director left Transport Scotland by mutual agreement in November 2008. At that time, the Scottish Government put in place a compromise agreement. The auditor reviewed the remuneration arrangements and confirmed that they were in accordance with the rules and regulations and that the Scottish Government had concluded that they represented value for money. The auditor has highlighted the importance of openness and transparency in the use of public money in the area. As I note in my report, I will ask the auditors to continue to encourage disclosure of remuneration, wherever that is appropriate. I will return to the issue of disclosure in a moment.

12:15

I turn now to the remuneration of the former president of the Mental Health Tribunal for Scotland. Until April 2009 the Mental Health Tribunal for Scotland administration—which I will simply call "the administration" from now on—was an executive agency of the Scottish Government. The administration provided support and services to the tribunal. The work of the administration is now undertaken by a unit within the Scottish Government.

The core work of the tribunal concerns legal decisions about the compulsory care and treatment of people with mental disorders; the administration helped to manage and progress the administrative casework associated with tribunal hearings. The administration also accounted for the tribunal's costs, including the remuneration of its members and president.

The president of the tribunal formally resigned in October 2008, although she was absent from her duties for the whole period between November 2007 and October 2008. During that period the president continued to receive her remuneration. The administration paid fees to the president of between £146,000 and £153,000 and incurred further costs of about £78,000 in relation to her pension. The administration secured the approval of the Scottish Government to continue to pay the president during that period. The accounts of the administration do not provide any further information about that situation and, for legal reasons, I am not in a position to comment further.

A general issue arises from the two reports, regarding the reasonable interest of Parliament in how public money is spent. There will be occasions when compromise agreements are appropriate and personal information about individuals who hold public office is, quite properly, not disclosed. As a general principle, however, I think that Parliament and the committee have the right to know the sums of public money that have been spent on the remuneration of senior public officials, including any sums spent on financial packages when those public office-holders are absent from or leave their posts.

The sums involved might come to a relatively small amount of the total spending of the public bodies in question, but the presumption must be that such items may be of interest to the Parliament and the public. In my opinion, the full amounts and nature of such expenses should always be disclosed in the audited accounts.

Only this week, HM Treasury started a consultation on proposed changes to how public bodies should report senior staff salaries in their accounts in future. In general terms, the proposals include a new requirement for public bodies to publish summary information about the number and cost of all exit packages for senior staff that have been agreed in any year. The information is to be provided in a note to the accounts, and it will therefore be subject to audit. The consultation period closes early next month. We do not know what the outcome will be, but my initial judgment is that the proposals are a step in the right direction.

To return to the cases that are covered in my reports, I am restricted in what I can say regarding issues that are covered by data protection legislation, but my colleagues and I will do our best to answer any questions that the committee has.

The Convener: I welcome your comments about the consultation that is being carried out by the Treasury. The committee may wish to make a contribution to it—we can come back to that later.

I intend to separate out the two reports. First, we will consider the issues around Transport Scotland. I welcome the agreement of the chief executive to the information being released. That is in sharp contrast to the problems that we experienced with the director of finance and corporate services. There remains an issue, however, around how public resources are being used. It is my understanding that Dr Reed could have retired at any time he chose, given his age. Is that correct?

Mr Black: That is correct, yes.

The Convener: So, if he had chosen to leave, he could have done so and drawn his full pension, and there would have been no need to remunerate him. The suggestion is that the civil service felt that there were organisational benefits in his leaving early, so it may have suggested that. People can draw their own conclusions about the fact that he did so in the middle of a parliamentary inquiry into events at Transport Scotland. If there were such organisational benefits, did you look at whether any changes were made to the structure of the organisation and whether any savings were made by allowing the chief executive to go early?

Mr Black: The report that I have made to Parliament is a section 22 report, which is a commentary on the audited accounts that are laid in Parliament. It is therefore not a full audit examination of all the circumstances surrounding that particular issue. My understanding is that, as I mentioned, the Scottish Government saw organisational advantages in the chief executive going earlier to allow a handover of responsibilities and that those advantages were such that the additional three months' pay in lieu of notice would be recovered within a 12-month period because of the consequential knock-on effects for the organisation's management costs.

The Convener: We can explore that issue further.

Murdo Fraser: So that I can get some clarity, can the Auditor General tell us when a new chief executive took up their post and whether their salary was the same as or lower than that of the previous chief executive?

Mr Black: I cannot personally give you the exact date when the new chief executive started—perhaps my colleagues can. It is our understanding that the new chief executive was appointed on a lower salary than his predecessor. Because it was an internal appointment, there were also savings from not going to external recruitment to backfill the post.

Angela Cullen (Audit Scotland): The new chief executive joined in February 2009.

Murdo Fraser: That coincides with the previous chief executive's date of retirement. In effect, the taxpayer was paying for two chief executives for an extended period of time. I think that we have heard that before.

The Convener: It is familiar.

Nicol Stephen: I have a general point. Is there a requirement on an organisation in the public sector to list reasons when deciding that a departure is in the best interests of the service—or whatever phrase is used—so that those reasons can be tracked and audited?

Mr Black: There would be an expectation that, if it were necessary to do so, the auditors could find documentation that provided a justification for such a development.

Nicol Stephen: Just to follow up on the convener's point, I think that some of this is unusual, unique and perhaps trailblazing and that we should contribute to the wider review of these issues that is taking place. Some of the matters that we have still to discuss, as well as the issue relating to the chief executive, should be included in the review. I have some points about the position of the director of finance and corporate services, but perhaps we will come on to that next.

The Convener: Are there any other points of clarification on Transport Scotland? Remember that we are not discussing at this stage what we will do; we will discuss that later in the agenda. This discussion is merely to get any more details from the Auditor General.

George Foulkes: Robert Black said that the appointment of the chief executive's successor was an internal appointment.

Mr Black: That is correct.

George Foulkes: So it was not advertised publicly in any way.

Mr Black: It was not subject to external advertisement.

George Foulkes: Is that normal?

Mr Black: It depends on the circumstances. A judgment is made within the senior civil service about whether a post should be advertised externally or internally.

George Foulkes: My recollection is that, when Dr Reed was appointed, a great deal was made of the fact that he had a lot of experience of transport and had been director general of the Strathclyde Passenger Transport Executive. Is it right to say that his replacement is a career civil servant with no transport experience at all?

Mr Black: I am not really in a position to give you chapter and verse on the background and qualifications of the new appointee. That question would be better directed to the Scottish Government.

Cathie Craigie: In the Auditor General's section 22 report on Transport Scotland, particularly in those paragraphs that deal with the departure of the director of finance and corporate services, he reminds us that a key principle of the use of public money is that its use must be transparent and open to public scrutiny. We will all sign up to and agree with that 100 per cent, and so should all our civil servants, who are paid for out of the public purse. If that is a key principle to which our civil servants should adhere, at whatever level they work, why do we have guidance that allows agreements to be reached that prevent the public from getting access to the information?

Mr Black: The Scottish Government will be in a better position than I am to answer questions about the policy matter of the formulation of guidance in the past.

It is worth my making one point. Senior levels of the Scottish Government have been caught by the fact that a compromise agreement is in place and that data protection legislation relates to the individual in question. Everyone is under a statutory constraint, which means that there is an inability to release the information. However, as I

think I mentioned earlier, the UK Treasury is making moves to ensure that such an arrangement will no longer be appropriate in future.

The Convener: There are two issues there. One is about what is declared and whether that is covered by data protection legislation or anything else. The other issue for us is the fairly cavalier use of public resources. Murdo Fraser has already alluded to the fact that, during our inquiry into NHS Western Isles, we found that we were paying for three chief executives at one time. In the Transport Scotland case, we were paying for two chief executives at once and, indeed, someone who could have gone with a very generous pension was given a fairly large sum of money to go a few months early when heat was applied to the organisation by a parliamentary committee. We are about to look at another report that suggests that we were paying for two presidents of the Mental Health Tribunal at the same time.

Nicol Stephen: For a whole year.

The Convener: Yes. It is a staggering situation, in which public resources seem to have been used in a very cavalier manner by civil servants. We need to look at accountability, which we will address. Are there other points for Robert Black to clarify?

Anne McLaughlin: I have looked at the correspondence between the Scottish Government and the Information Commissioner's office on the compromise agreement. I take on board what Mr Black said, which was that we should

"encourage disclosure of all remuneration, wherever possible."

To be honest, this sort of thing has gone on for years and I have always been against it.

The Information Commissioner's office has written back to say that, in the circumstances,

"disclosure to the public of the details of a compromise agreement, without the consent of the data subject, is likely to be a breach of the DPA."

Does that mean that any review that the Treasury is doing will require the Data Protection Act 1998 to be changed?

Mr Black: That would be best addressed by the clerk and officers of the Parliament.

The Convener: We will check that out.

12:30

Mr Black: My general perception is that it is important not to confuse the overarching framework of the data protection legislation with the contractual arrangements that are put in place with any individual. It seems to me that a good position would be one in which a compromise agreement was available as an option in certain circumstances, as it can be quite a useful mechanism on occasion, but contracts should not permit the withholding of details of the cost to public funds of a severance agreement. That seems to me a simple administrative act that could be achieved beforehand and would avoid such circumstances arising. It strikes me as common sense that the UK Treasury's proposals would in no way cut across provisions in data protection legislation.

Anne McLaughlin: That is probably a good idea. It would be interesting to find out how much has been spent over the past five, 10 or 20 years on people leaving their jobs unexpectedly, but I suppose that we could not do that.

Willie Coffey: If only one individual left in a given calendar year, would not the information be fully revealed anyway? How can that be squared?

Mr Black: If there was a data protection prohibition on such amounts being disclosed, the details would not be separately identified in a note to the accounts.

Nicol Stephen: Perhaps Robert Black and Audit Scotland could help the committee to shape our views in making comments on the issue to the UK Treasury. I think that Audit Scotland's support and input on that would be extremely valuable.

It seems to me that we are talking about the inappropriate use of public funds. Clearly, where there are allegations of criminality, the data protection legislation is swept away and the police are given full access to all the information that is required, but where we are dealing with the inappropriate use of public funds—even scandalously inappropriate use of funds—there seems to be no appropriate scrutiny as long as things have been done within the rules. Perhaps a change to the data protection legislation is required, but my instinct is that we could probably implement change in other areas that would greatly improve the situation and strengthen the position not only of the Public Audit Committee but of Audit Scotland. At times in our inquiry, committee members were very anxious to reinforce the position of the Auditor General and of Audit Scotland when that position was being quite seriously challenged by the civil service.

The Convener: We will move on to the issue of the Mental Health Tribunal for Scotland. During the 11-month absence of the tribunal president, someone else acted as the president and was presumably paid a similar amount of money. The previous president received anywhere between £146,000 and £153,000. Can Mr Black confirm that, for that 11-month period, the pension

contribution from the public purse was £78,000? Am I reading that right?

Mr Black: That is correct, yes.

The Convener: That is unbelievable.

George Foulkes: Is that a full-time position?

Mr Black: Yes.

George Foulkes: What is the salary? If the president gets between £146,000 and £153,000 in 11 months, what is the annual salary?

Mr Black: We believe—we advise the committee to check this with the Scottish Government—that the remuneration is equivalent to that for a sheriff principal. As I said, the banding at that time was somewhere between £146,000 and £153,000 per year.

George Foulkes: Quite apart from the scandal of having two tribunal presidents overlapping for nearly a year, the salary level is quite astonishing. That the president of the Mental Health Tribunal for Scotland is paid more than the Prime Minister—which is the comparison that we use these days—seems astonishing, given that the president of the tribunal is responsible for far less.

The Convener: Also, the pension contribution seems to have been at something like 50 per cent of the annual salary.

George Foulkes: The lawyers are on to a good thing.

Anne McLaughlin: Why was the tribunal president absent? If she was off sick, it is standard that she continued to be paid while someone else was paid to do her job, but that would not have applied if she was just not coming to work. Is there any information on why she was absent for that length of time?

Mr Black: Unfortunately, I cannot help with that due to data protection legislation.

The Convener: If need be, we can pursue that elsewhere.

Nicol Stephen: Can the level of pension contribution be explained?

Mr Black: I do not know whether we have details on that. Perhaps Dick Gill can help us.

Dick Gill (Audit Scotland): The pension contribution was subject to advice from a Government actuary. I am not an expert on judicial pensions but, as Bob Black mentioned, the tribunal president's salary is equivalent to that of a sheriff principal. I cannot confirm this, but I expect that the pension arrangements are also probably equivalent to those of a sheriff principal. We know that the tribunal administration received advice from the Government Actuary's Department or an equivalent body. Part of the reason for the cost in the final year in 2008-09 might have been an actuarial adjustment, such as a catching-up payment for underprovision in earlier years. However, we would need to look at that more carefully before we could give a proper answer.

Nicol Stephen: My instinct is that the payment would be part of some negotiated agreement on departure. There might have been a compromise agreement in this case as well, as that seems an exceptional payment to receive in one year. The payment must be to do with either underpayment to cover previous years, as Dick Gill suggested, or what might have been achieved in the pension fund if the individual had remained in post for a longer period.

The Convener: We can examine that in more detail.

Dick Gill: Let me just clarify that the £78,000 cost was not a payment to the former president but a provision for the future cost of making pension payments to her.

The Convener: However, making that provision cost the public purse nearly half the president's salary. We can return to that point.

Cathie Craigie: During Mr Black's oral briefing on the paper, unless I picked him up wrongly, he mentioned a figure for expenses for the individual. Is that right?

Dick Gill: I think that Bob Black might have referred to fees, which is the terminology that is used for the remuneration of the tribunal president. As I understand it—I am not quite sure about the legal complexities—the position of tribunal president is not a salaried position, so "fees" is the terminology that is used in the accounts for the total payments that she received as the president.

Cathie Craigie: So the figures are as we have them before us in the paper.

Mr Black: Yes.

George Foulkes: Who is the accountable officer?

Mr Black: There was an accountable officer in the form of the head of the administration, but the policy decision on the treatment of the issue was taken within the Scottish Government.

George Foulkes: I think that Dr Woods said earlier that the matter came within his directorates.

Mr Black: Yes, I think that Dr Woods indicated that it was within his directorates.

The Convener: Okay, thank you for that. We shall return to that item later in the agenda.

Given the time, I suggest that we hold back agenda item 4 until our next meeting. Therefore, I draw to a close the public part of the meeting.

12:38

Meeting continued in private until 12:44.

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