OFFICIAL REPORT
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Public Audit Committee

Thursday 23 November 2023

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PUBLIC AUDIT COMMITTEE
30th Meeting 2023, Session 6

CONVENER

*Richard Leonard (Central Scotland) (Lab)

DEPUTY CONVENER

*Sharon Dowey (South Scotland) (Con)

COMMITTEE MEMBERS

*Colin Beattie (Midlothian North and Musselburgh) (SNP)
*Willie Coffey (Kilmarnock and Irvine Valley) (SNP)
*Graham Simpson (Central Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Hannah Axon (Convention of Scottish Local Authorities)
Simon Burt (Scottish Borders Health and Social Care Partnership)
Pamela Cremin (Highland Health and Social Care Partnership)
Fiona Davies (Argyll and Bute Integration Joint Board)
Richmond Davies (Public Health Scotland)
Jillian Galloway (Angus Health and Social Care Partnership)
Jo Gibson (East Ayrshire Health and Social Care Partnership)
Tracey McKigen (NHS Lothian)

CLERK TO THE COMMITTEE

Lynn Russell

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Public Audit Committee

Thursday 23 November 2023

[The Convener opened the meeting at 09:00]

Decision on Taking Business in Private

The Convener (Richard Leonard): Good morning. I welcome everyone to the 30th meeting in 2023 of the Public Audit Committee. I am very pleased to welcome to the public gallery members of the Public Accounts and Public Administration Committee of the Welsh Senedd. Thank you for being here.

The first item on our agenda is a decision on whether to take agenda items 3 and 4 in private. Do we agree to take those items in private?

Members *indicated agreement.*

Section 23 Report: "Adult mental health"

09:00

The Convener: We turn to the principal item on our agenda, which is further consideration of the joint report on adult mental health by the Auditor General for Scotland and the Accounts Commission. I welcome our witnesses to the meeting.

The committee is taking evidence in a round-table format, which is intended to promote discussion between witnesses and participants, so feel free to interact. If anyone in the room wishes to come in on the discussion, indicate as such and one of the clerks will pick that up, and we will do our level best to bring you in. Those who are joining us online are very welcome. If you want to come in further to any times when we direct questions to you, you should use the chat room function and type in "request to speak" or "RTS" or use any other term to communicate the fact that you want to come in on a particular question. We have some time constraints, so do not feel obliged to come in on every single question. I will do my level best to bring in as many of you as possible, but experience tells us that there might be occasions when we cannot bring in everybody on every question.

I also say to those who are joining us remotely that the broadcasting team has set up your audio and camera, so you do not need to do anything with those. You should keep them on at all times, and, when it is your turn to speak, we will make sure that your audio is on so that we can all hear you.

As is customary with a round-table format, I will ask everybody who is taking part to introduce themselves and tell us which organisation they are from. I start by turning to the people who are joining us in the committee room.

Hannah Axon (Convention of Scottish Local Authorities): I am policy manager with remit for mental health at the Convention of Scottish Local Authorities.

Richmond Davies (Public Health Scotland): I work in Public Health Scotland as the head of public health analytics and intelligence.

The Convener: Thank you. I turn to the people who are joining us remotely.

Simon Burt (Scottish Borders Health and Social Care Partnership): I am general manager in the Scottish Borders health and social care partnership, and I manage integrated mental

health services and integrated learning disability services.

Pamela Cremin (Highland Health and Social Care Partnership): I am the chief officer for the Highland health and social care partnership.

Fiona Davies (Argyll and Bute Integration Joint Board): I am the chief officer for the Argyll and Bute health and social care partnership, which has fully delegated mental health services. I am here to represent Health and Social Care Scotland. I am also a registered mental health nurse.

Jillian Galloway (Angus Health and Social Care Partnership): I am the interim chief officer for the Angus health and social care partnership, and I have responsibility for integrated community mental health.

Jo Gibson (East Ayrshire Health and Social Care Partnership): I am from East Ayrshire health and social care partnership. I am head of service for mental health, learning disabilities and drugs and alcohol services.

The Convener: Finally, last but not least, please introduce yourself, Tracey.

Tracey McKigen (NHS Lothian): Morning, everybody. I work in mental health services in NHS Lothian.

The Convener: I will kick us off by asking some questions, before bringing in other members of the committee. I am sure that you will have read the report, which is the genesis of our round-table discussions that have taken place over the past few weeks. It contains a recommendation that people should be provided

"with a choice about whether they access mental health services remotely"—

through telephone or videolink—

"or face-to-face".

I wonder how you, as different agencies responsible for providing the services and for having oversight of them, respond to that recommendation. I will begin by asking Simon Burt to comment.

Simon Burt: All our services in secondary care provide both face-to-face consultations and the opportunity for online interaction with healthcare and social care professionals. In the main, since Covid, we have returned to meeting face to face. In primary care, we have a newish service called renew, which is our primary care mental health service. It is a talking therapies service that is commissioned by our general practitioners, and we provide it. It is predominantly an online service, but, where people struggle to access online services, we provide face-to-face interaction where that is required. The vast majority of it is done online, however. The feedback and the outcomes that we get are very good, both from the commissioners—the GPs—and the people who access the service. We are a rural service in an area with no major cities, so it is a geographical challenge for people to travel and access services. Moreover, as a small board, we tend to get a small amount of funding for various initiatives, so it is about the practicality of being able to provide a service that allows access for the majority. Therefore, there have to be some compromises with face-to-face consultations for the service. Generally, we see between 300 and 350 patients a month, and most of them are seen online.

The Convener: Tracey McKigen, you have a rather more urban landscape in the Lothians. I wonder whether you have a perspective on the recommendation on face-to-face versus remote consultations.

Tracey McKigen: In psychological therapies in child and adolescent mental health services—CAMHS—we are the highest users of Near Me consultations in NHS Lothian. We have not shifted back after Covid, and we give everybody who is able to have one the opportunity to have a Near Me consultation. For psychological therapies, we also have a number of online platforms that people can use for cognitive behavioural therapy and so on, so we are embracing the online option where possible. The feedback is positive, especially from children. They like it because they are used to using devices. We obviously have to take into consideration things such as privacy, making sure that young people are not being coerced when we are not in the room with them and that they have the ability to speak freely. All of that is risk assessed before we start the consultation.

The Convener: I do not know whether you saw the evidence session that we had last week. Kirsten Urquhart from Young Scot took part and, regarding young people, said:

"going on TikTok is not the same as knowing where to find and how to use a mental health support tool."—[*Official Report, Public Audit Committee,* 9 November, c.9.]

In other words, she was saying that, among younger adults, there were issues around whether they could access online appointments or whether they, too, would prefer face-to-face appointments.

Tracey McKigen: About a year ago, we ran a survey, and online consultations were very well received by the young people whom we surveyed. We risk assess and give them a choice, but the majority of young people access the service well, and the feedback is very positive.

The Convener: I am going to reflect on exhibit 3 in the report. It is a chart that shows the variations among health board areas for psychological

therapies appointment types. It is for the year 2022. Does anybody want to comment on why there are such huge variations?

For me, what comes out of this evidence, and I cited an example last week, is the big difference between the number of face-to-face appointments in NHS Ayrshire and Arran, for example, where the figure is as high as 86 per cent, and an area that Graham Simpson and I represent, NHS Lanarkshire, where the figure is just 32 per cent—less than a third of appointments there are face to face and 68 per cent are conducted through remote video and telephone links. Does anybody have a view on why two areas with a slightly different population size but a more or less similar demographic have such a big variation? Richmond Davies, do you have any perspectives on that?

Richmond Davies: No, we do not. Those figures and data come into Public Health Scotland by way of an established method, and that is what happens in NHS Ayrshire and Arran. It appears that it has a lot of face-to-face appointments compared with some other areas. The reasons might vary: it could be choice or different deprivation demographics. There might be so many other reasons, which the local boards will be able to provide. In the reports that we provide, however, we have metadata. A quality section at the end of our reports highlights challenges that some boards have in relation to various aspects of their data. The local boards will know why there are nuances around attendances and populations.

The Convener: Does Public Health Scotland dig into the reasons why there are such stark variances in areas that cover similar population types?

Richmond Davies: Yes. We have staff who interact quite a lot with the boards, and they tend to understand the reasons why those variations exist. However, I do not think that there is anything in particular that you can latch on to. It is a combination of, for example, resources, people's deprivation and the availability of public transport or parking. There are so many reasons, and it is very difficult to latch on to one of those.

The Convener: Jillian Galloway wants to come in on this question.

Jillian Galloway: The levels of remote consultation that take place do not take into account the levels that are offered. It might be that a high number of remote consultations have been offered and that it is purely about uptake rather than the availability of a face-to-face appointment as an option. We could, perhaps, consider looking into the information behind that, as well.

The Convener: Thank you for that. Graham Simpson, did you want to come in on this question?

Graham Simpson (Central Scotland) (Con): I want to go back to Tracey McKigen's answer to the previous question. When you are dealing with young people, in particular, and you are having online consultations, how do you ensure that there is nobody else in the room prodding them to say certain things?

Tracey McKigen: When we set up our online delivery service, as I said earlier, we included a risk assessment process, so, if there is any intelligence that there is a risk to the young person, we do not go ahead. We also request consent from a child if they are aged 12 or over. They need to tell us that it is okay to go ahead and that they are okay with us sharing or not sharing information. We try to put in as many safeguards as possible. If, during a consultation, we felt that there was risk, we would suggest that we end the consultation and reconvene in person.

Graham Simpson: How, though, do you ensure that there is nobody else in the room? We can see you, but the background is blurred, and I have no idea whether there is anyone else with you and, perhaps, passing you notes on what to say. We just do not know, do we? How do you ensure, with a young person, that there is nobody else there?

Tracey McKigen: There might be other people there, but the young person will have given consent for them to be there or not. It is not about saying that they have to be completely on their own; it is about what they are comfortable with. If they say that they want a parent, guardian or friend with them and give consent for that, we will go ahead. We assess the risk as best we can. I accept that we will never completely eliminate the risk, but the young people who were surveyed felt that this is a good way to get their healthcare. It also allows us to see more people than if we were to bring everyone into an in-patient or clinic setting.

09:15

Graham Simpson: You do not eliminate the risk. However, the risk would be virtually eliminated if a consultation was face to face. Do you accept that?

Tracey McKigen: There would probably be less risk. There could still be people in the room, and some young people might still feel under pressure to have a person in the room. I do not think that you can say that you would eliminate the risk completely, although it might be less. However, this system has worked well for us since the start of Covid.

The Convener: Let us go back to the variability question, which Simon Burt wants to come in on.

Simon Burt: It is really interesting to see the variability. Some areas that have real geographical and transport challenges are almost the exact opposite to others. NHS Borders is rural and most of our appointments are online; whereas, in some neighbouring boards, it is the other way around. Resources being committed to that area of activity must be one of the big reasons for that, because it is more resource intensive to offer predominantly face-to-face appointments. We were starting from a standstill, more or less, with regard to our primary care psychological therapy services. That is my assumption, without seeing the investment figures for those areas.

On the risk issue, risk assessments are undertaken, because some young people might be at risk at home. I am sure that that is taken into account in the risk assessment of whether an online or face-to-face appointment is required. That will mitigate some of the obvious risks but, clearly, not all the risks.

The Convener: A couple of you have mentioned funding. That leads me to ask about the impact of last year's emergency budget review, which led to a £38 million cut in mental health funding for 2022-23. There was also a £65 million cut in funding for improving primary care services. We know that primary care GPs are principally—almost always—people's route of entry to adult mental health services. Does anyone want to reflect on how you have coped with that, the impact of the cut and whether it has affected your ability to provide sustainable and effective adult mental health services, including at a primary care level? Simon Burt can start off on that question, and I hope that others will contribute after that.

Simon Burt: We anticipated additional funding for primary care, as was originally indicated. We did quite a lot of stakeholder engagement on the gaps in primary care. We were pretty much unified in our view that, in the Borders, the gap relates to young people, particularly those with anxiety disorders and depression. We know that there is a gap in that regard. The impact of not having the funding has been that our plans to bridge that gap have had to be held in abeyance. We also know that there are gaps relating to people with neurodevelopmental disorders who need an assessment but do not necessarily have complex needs requiring secondary care. There is a big and quickly growing gap in that regard. Another area of need relates to people with emotionally unstable personality disorders, particularly in primary care, outwith secondary care services. With those gaps, the impact on general practices is obvious, notwithstanding the impact on individuals themselves.

The Convener: Pamela Cremin, from a Highland health and social care partnership perspective, will you give us your reflection on the impact of the emergency budget review and any effects that it had on services in your area?

Pamela Cremin: Given that we cover remote and rural areas, most of our services are delivered in the community, with a centralised in-patient adult mental health unit in Inverness. We have been doing quite a lot of work.

I will reflect on the discussion about the Near Me service and digital therapies. Engagement with the public and people who use our services has been important in shaping and changing our service. It has also been important to discuss our financial position with them in relation to opportunities for redesign and co-producing service ideas.

At exhibit 3 in the report, you will see that 58 per cent of NHS Highland appointments for psychological therapies take place online. That has been a really positive experience. We measured people's experience in that regard, but we also engaged with them on the services that we are able to deliver within our financial envelope and how to make them sustainable. That included engaging with them on choice and what we can all do to improve the situation. One of the ways to engage them was to talk about waiting times and how we could modify and redesign our service to get them to be seen more quickly.

We have just finished work on two strategic plans. One of those is our joint strategic plan, which covers a wider area than just mental health. In parallel with that, we have developed a mental health and learning disability strategy, which has been co-produced with people with lived experience and with other sector organisations. It is a really good live document.

We have mental health services in primary care. We have structures in the organisation to engage with our GPs in relation to our primary mental health workers. One of our outputs has been trying to create a tiered model and equitable services across the Highlands. They will not all be equitable when it comes to face-to-face contact or visiting clinicians, but we have robust community mental health teams, which we have been able to staff much better recently. We have looked at using our workforce and developing it in a different way, so that it is not all about having higher-level clinicians, for example. We have been able to diversify. The primary mental health worker service is a good example of that.

The Convener: We have taken evidence on whether the whole system is overmedicalised. We might get on to that issue during our discussions this morning.

I ask Fiona Davies to come in.

Fiona Davies: As you can imagine, Argyll and Bute's rural and island geography is similar to that in the Highlands, as Pam Cremin described. Over the past few years, our mental health service journey has been about moving away from the traditional medical model by investing in urgent care services, being responsive to people who are in mental health crises, offering earlier intervention in primary care and other settings, and developing community hubs where people get support from peers and people who have had mental health issues themselves.

The changes in the budget last year and in the funding coming through from primary care have limited our ability to take forward all our plans on the timescale that we were looking to do so. Implementing primary care changes for mental health has been particularly challenging in our island settings and our most rural communities in Argyll. We have not been able to get coverage for every general practice, which was the ambition in the primary care improvement plan. Our intention was to build on existing services with new funding. The absence of that funding meant that we had to curtail our planning on ensuring that we have appropriate access to early intervention services across every general practice in Argyll and Bute. We are still committed to that, but we will need to work through how we do it with the delay in funding.

The Convener: That is a clear and illuminating answer.

I turn to Jo Gibson.

Jo Gibson: I agree with the points that have been made. In Ayrshire, we have been building a pathway for mental health support from the front door, as you describe it, of general practice right through to a significant acute mental health response. Our work in primary care has gone really well. We have provided mental health practitioners in all practices in Ayrshire, particularly in East Ayrshire, which I am representing today. We had hoped to consolidate our mental health practitioner service. Each general practice has some time from a mental health practitioner, but there is no buffer in the system, so if a mental health practitioner is off sick, needs to attend training or is on maternity leave, there is no cover. That means that that service can suddenly no longer be available at the primary care surgery for a person in the community who has built up a relationship with the mental health practitioner. We had hoped to consolidate and expand the service, but we can now no longer do so.

However, we are working closely with the third sector. We have a vibrant third sector in East Ayrshire. We have community link workers who have been developed through the third sector and are available across our communities. The pathway from community groups, community link workers and mental health practitioners into secondary care services is really important, but it is also really challenging. The capacity that we have built in primary care has taken some pressure off primary care mental health teams—our specialist teams—and community mental health teams, but those teams are still extremely busy. Demand has certainly gone up. Making sure that they can focus on the people who are more significantly unwell remains a challenge.

I think that Simon Burt brought this up. "Demand" is an awful word. We are talking about the needs of people and families who are struggling. A lot more people need help to understand the neurodivergence in themselves and their families. That is new work; it is not what mental health teams were originally built, funded or trained for. We are doing a lot of work to understand the size of that need, and it is significant. We need to think about the best way to address that that does not further overwhelm existing specialist teams.

The Convener: You have described all the increased needs. In an area such as East Ayrshire, the cost of living crisis and the pandemic have presumably heightened need in the community that you serve. Is that a fair assessment?

Jo Gibson: Absolutely. That is the case across all levels of mental ill health. There have been significant increases in the demand for acute admission and referral to a community mental health team and in the use of detention. There is also a group of people in the middle who are distressed and are not coping with life. We would not describe them as having a mental illness, but all parts of our system are aware of the challenge in meeting the needs of those people. Some of that is definitely linked to the cost of living and the challenges with heating, housing and eating—all the things that have been discussed before.

The Convener: Thanks very much for your comments on that.

I will bring in Hannah Axon from COSLA.

09:30

Hannah Axon: I want to add a couple of points on wider funding arrangements around mental health. There are long-standing issues with annual funding and directed pots of money for specific purposes. We know that we have challenges in the mental health workforce and annual funding is amplifying the issue that we have with the retention of staff, while the directed pots of funding can restrict partnership working. We look to see

how we can make best use of the money in the system. Yes, the reduction in funding is problematic, but we also need to look at the models that we use to fund services more generally, to make sure that we can make best use of the money that we have. There are a number of issues around that at the moment.

The Convener: Thanks. We will certainly return to workforce planning and some of the other points that you raise. We are pressed for time, so I will move to questions from the deputy convener, Sharon Dowey.

Sharon Dowey (South Scotland) (Con): I will ask about partnership working to address poor mental health. This question is for Fiona Davies and then Hannah Axon. How are integration joint boards and councils addressing the recommendation to

"urgently improve how mental health, primary care, housing, employability, and welfare support services work together to address and prevent the causes of poor mental health, by developing shared goals and targets, sharing data and jointly funding services"?

Fiona Davies: I cannot speak on behalf of every partnership. Every partnership is required to produce a joint strategic plan that does all the things that you just listed—I will not repeat them back to you—but I cannot speak for the quality or extent of all those plans. That is not how the Health and Social Care Scotland network works. However, I can certainly speak to my experience in Argyll and Bute where we have a fully delegated model. That means that we have all health and social care services for adults and children within our integration joint board. That maximises our opportunity to hear from all our partners and communities, and to bring together all the knowledge and intelligence from our public health data and social care data to understand the experience of people within our geographical areas. It also gives us the opportunity to hear people's qualitative description of their lives and what is happening for them and their families, and to bring all that information together into a planning process.

We have always followed the legislation from the implementation of the Public Bodies (Joint Working) (Scotland) Act 2014, so we are on our third iteration of our joint strategic plan. Over the years, it has matured and deepened in its understanding of and connection with communities. The plan looks across the social determinants of health, into poverty and a wider understanding of the causes of mental distress and mental ill health, and it brings that together. I described how we have tried to move away from traditional models towards much more community-facing, community-engaged and community-led initiatives to build resilience in our communities, and to maximise the chances of people being well, physically and mentally. We also try to do that in the context of where people live.

That is how it operates in my part of the world, and that integrated working is at the heart of all integration joint boards, and the integration authority in the Highlands, which does not have an integration joint board. Obviously, the model varies from area to area, but, to some degree, that planning will be evident within the joint strategic plan of the integration joint boards.

Sharon Dowey: Thank you. Does Hannah Axon want to comment?

Hannah Axon: Obviously, there are local planning arrangements, and Fiona Davies has outlined how the local approach in her area. We will look at how we continue to build on those plans, the role of our community planning partnerships and how we draw that through. There are a number of commitments in the new mental health and wellbeing strategy to look at our current planning structures to see where improvements can be made in mental health, to see how we can improve the understanding of the socioeconomic determinants and to find the levers to support people to work together. It is not a rapid, immediate fix. We need to build on what we have to make what we have better. That action is outlined in the plan.

Sharon Dowey: Are there any barriers to different groups working together? Earlier, you talked about making the best use of money, and you said that direct pots of funding can restrict partnership working. Are you facing any barriers?

Hannah Axon: What jumps to mind in the first instance is making sure that people have the time and space to do that work. When mental health is the core of an organisation's business and people are trying to give support, it can be challenging to build in the time to do that work together. That is a barrier.

The Convener: Richmond Davies wants to come in on those questions.

Richmond Davies: Public Health Scotland has just set up a programme of work on the wider determinants of mental health. We are jointly sponsored by COSLA and the Scottish Government and we plan to bring together a lot of our partners, including people with lived and living experience, to get a better handle on the wider determinants of health, such as housing, unemployment, poverty, living in areas with high levels of crime and places with less green space. Those are the upstream determinants of health, which impact on mental health.

Therefore, while we are sighted on delivering services and on waiting lists—we work with our

partners in HSCPs and NHS boards on waiting times and waiting lists to make sure that people are seen quickly—we are equally sighted on the upstream issues. Those actions take some time get in place, but they are absolutely necessary, because 50 per cent of people who exhibit mental health problems do so before the age of 14 and therefore, it is vital to act early and intervene before things get worse and people present themselves to a service that has resource problems and could be overwhelmed.

The Convener: It is also in line with the Christie commission principles about early intervention being absolutely critical, which we talk about so much at the Public Audit Committee. Thank you for that. Simon Burt and Jo Gibson want to come in on that question, too.

Simon Burt: We have some good local examples of how we have worked better as an integrated network of stakeholders, particularly in secondary care. We have an integrated mental health service and an integrated learning disability service. Unfortunately, we have two budgets, but the head of service—who happens to be me—has overall responsibility for both budgets, so we can plan together. We plan what we are providing from the social care budget and from the healthcare budget. We have some good examples of projects with the third sector, and very recently with the community rehabilitation services, which were redesigned and improved with additional investment from both partners, working with the registered social landlords, the third sector, the council and the health board to provide a new and improved service that is working very well.

The budgets are a problem. Where there is more than one budget, there will be a problem, for obvious reasons. It would be helpful to move to dealing with health and social care budgets as one budget—it is the taxpayers' pound, so let us use it as best we can, with best value. That is what I have always said, but the reality is that the council sets efficiency targets, the health board does the same, and we end up in all those discussions that do not help move things forward for the service user and do not always get best value either.

We have a long way to go in primary care planning in relation to the third sector and people with lived experience. We need to move more towards integrated planning. We have an integrated partnership board for the mental health service, where we have all our partners sitting there and we work together strategically and operationally. We need something similar outwith secondary care, which includes people with lived experience as well. It is helpful to have people with lived experience on our partnership boards. They hold us to account; they ask questions such as, "How have you engaged with us on this proposal?" That happened a couple of times yesterday. We are kept to task, and we improve our engagement in that way. There is a way to go, but in primary care we should be looking to develop the integrated model that we have in secondary care.

Sharon Dowey: We have heard that there are different models around the country. You said that there are two budgets but that you are in charge of both. Is that not the case in other areas?

Simon Burt: I think that, in other areas, services are less integrated. They probably have a mental health service and social work mental health service, and their budgets will be managed by two different managers. That does not happen within our mental health service and learning disability service in the Borders. That is the difference, if that makes sense.

Sharon Dowey: Yes, it does. Thank you.

The Convener: Jo Gibson and Jillian Galloway want to answer that question and then we will move on to the next question.

Jo Gibson: Fiona Davies described the strategic planning landscape and how we work in an integrated way. That is really strong and evidenced. We can see that in our community planning strategic plan and the IJB strategic plan, and then on particular themes. For example, we have a trauma-informed plan and a suicide prevention plan. All those will demonstrate how we work with mental health, housing, employability, the police, et cetera.

I will mention two things. As I think Simon Burt mentioned, there are two levels of how we work to support individuals across the spectrum of factors that affect their wellbeing: the strategic landscape that we described and that is evident; and the very person-specific work, of which we are seeing more evidence. In East Ayrshire, we are piloting an approach that we call "the Tuesday morning". The police, mental health services, addictions services, housing and the third sector get together on a Tuesday morning, and we talk about our 15 most vulnerable people who, across those agencies, we are all worried about and watching very intently. We decide who is best placed to try to engage with each of those 15 people that week, given the scenario that they are in that particular week. Because we do that together, we have greater flexibility in those various departments.

We are seeing some really good results from that, person by person. We are just beginning to write that up to evaluate it effectively. We are looking at sharing information to achieve a shared goal, as you described. On a Tuesday morning, all those agencies are sitting and thinking, "Okay, what are we doing for Jimmy today? Across all of this, what are we doing to get Jimmy more stable?" That will affect the demand that comes

into each of those services. There are two levels to that integrated work, and they are both vital.

Jillian Galloway: I want to follow on from what Simon Burt said about integrated fields. In Angus, we have a geographical challenge in some of our localities, too. We have focused on developing mental health-enhanced community services. We have primary care, community mental health and substance abuse teams supporting that. The cost of living crisis and the pandemic have also resulted in an increase in the number of individuals using substances. In addition, we have wellbeing services, psychology and peer support workers. Everybody can self-refer, or they can be referred by their GP or other partners. We have taken a no-wrong-door approach and we do not reject referrals—we will find the right person. That allows us to better co-ordinate the support required in that joint working between all partners, including our third sector colleagues.

We have not put any ages around it. We have extended our peer support in GP practices to support 11 to 16-year-olds specifically. That has been well received, as has our social prescribers listening service. The evaluation from our enhanced community support hubs is very positive, and it is in the process of being rolled out across Angus. Indeed, Tayside is taking some of that learning as well.

09:45

Sharon Dowey: What is the role of primary care mental health and wellbeing services in supporting people with mental health problems and/or directing people to the most appropriate source of support or service? I ask Jo Gibson to come in first on that.

Jo Gibson: We have covered some of that already. That front door is vital, as is ensuring that the pathway from the front door is smooth. We could make improvements around referrals being bounced about, as we sometimes call it, between different teams. What Jillian Galloway described as a no-wrong-door approach is the key. That is where we need to get to, so that a person can come in, contact their GP practice, hopefully have a conversation with a mental health practitioner or a peer worker and, from there, be directed to the service that will best meet their needs. That should happen once and go smoothly, so that the person gets help sooner and we do not create an unnecessary administrative burden that ties people up.

The report talks about information systems and data collection in mental health. Everyone is aware of how challenging that is. We need investment in information systems so that we can move referrals around in a straightforward way and so that people are clear about where someone is getting support and where they are in the system. That could be improved.

The other thing that we can think about is the need to talk about “referrals” at all in some of this, because that creates another step in the journey for the staff and for the person who is seeking help. When we work deeper in communities and in locality models, we talk about speaking to a colleague or popping along and seeing someone, which is much less clinical and feels more achievable for someone who is feeling that life is very difficult. It would help if we were to declinicalise the language and make things a bit less formal by talking about people seeing someone, joining a group or popping in. It is tricky to achieve both of those—to demedicalise the referral pathway at the same time as improving information and recording—but that is probably where we need to go.

Sharon Dowey: You mentioned community link workers and said that you had a vibrant third sector. Lots of money is being invested in mental health. When groups or organisations in localities get funding from the Scottish Government, is the availability of that extra pathway made clear enough to local authorities or GP practices, so that they are aware that another group has been created that can help?

Jo Gibson: A lot is available for people. There is a challenge in making sure that people are aware of that in keeping service directories up to date and promoting those services. We find that our community link workers and mental health practitioners are key to that. If they are informed and know what is available, they are the link person who moves that information and the people towards those new services.

As Hannah Axon mentioned, the problem with that is that much of the money that goes into the third sector for those wellbeing services is short term in nature, so we just get the service established, people begin to realise that it is good for them or their family, and then there is a challenge about whether it is continuing next year. We need to be more thoughtful about how we do that, because we often put in investment to build a service and its reputation, but then go back to the start again.

Sharon Dowey: I ask Hannah Axon to comment.

Hannah Axon: I will pick up on a number of comments that Jo Gibson made. GPs are crucial in supporting people’s mental health. They are a first port of call for the majority. However, they need knowledge of and confidence in what is out there in order to refer people to it. Funds for third sector organisations and local authority services

are unstable. It is not just mental health provision that link workers need to refer people to; we are talking again about the wider determinants around employability and poverty. Funding in that area is being constantly cut back. Those services are very important. GPs need to be able to refer confidently to services that exist.

Some children's funding goes up to age 26, so there is a bit of a crossover with adults. There have been challenges with GP referrals to those services. The situation is getting better, but ensuring that people have that information and are confident about pressing the button to send a person somewhere other than child and adolescent mental health services is an on-going challenge. That is even more the case given the capacity of GPs; they have more and more information to take on. Services around the GP practice that a GP might be referring to need stability as well.

The Convener: Apologies to those who also wanted to come in on that question—I am sure that you will get an opportunity shortly—but Graham Simpson wants to raise a number of points to keep the conversation going.

Graham Simpson: I will try to keep the conversation going, as always, convener.

In my questions over the past couple of weeks, I have been exploring gaps in the system as it relates to the police. I am sure that this is the same for our colleagues in Wales, but the police tell us that they spend the majority of their time—up to 80 per cent—dealing with people with mental health problems rather than with crime. They are called out to people with mental health problems; that is what they are doing for up to 80 per cent of the time.

There should be no such thing as out of hours when we are talking about mental health, but there is. The services of some of the people who are in this meeting shut down at certain times, and perhaps that is part of the problem. Whole squads of police are sat in hospital accident and emergency departments with people, waiting for them to be seen.

I have heard that, in Lanarkshire, which the convener and I represent, police officers have spent entire shifts sat in hospitals with people. The police have had to introduce what I think is an informal system with NHS Lanarkshire that means that, if they have to do that, they pick up the phone and say, "Look, can you help us out and start moving people through the system?" Does anyone have a better system for working with the police?

The Convener: Tracey McKigen from NHS Lothian wants to come in on that question.

Graham Simpson: That is good, because hospitals in Lothian deal with that on the ground.

Tracey McKigen: In Lothian, we have a mental health assessment service that runs 24/7. It runs from the Royal Edinburgh hospital, and it tries to take people away from emergency departments. We have a professional-to-professional line so that the police can call MHAS before they bring anybody up. If the person is well known to us and we have a safety plan for them, we will have a discussion with the police and the person and make a decision about what needs to happen for the next 12 hours until the day shift starts. If a person is known to community mental health staff or their GP, a safety plan will be put in place that allows the police to leave the person safely. A decision will be made, which might be to bring them to MHAS so that we will look after them, leaving them in their home or taking them to their next-door neighbour, if we know that that is what normally happens. The services will then pick them up the next day.

We have also recently introduced a navigator role that involves people from a third sector organisation who help people to navigate their situation to meet their needs for that period of time. The police can contact us, and we can then contact the navigators so that they can help the person to get emergency housing, emergency social work or whatever they need at the time. In addition, we have recently introduced an unscheduled care service for young people. It has been in place for only the past year. It runs 24/7 and allows the emergency departments at the royal infirmary and St John's hospital to refer straight to the unscheduled care service for children.

Graham Simpson: That is really interesting. You have described a system in which police are, I presume, not having to sit in accident and emergency for hours at a time.

Tracey McKigen: That will happen on occasion, if the person has a physical injury and has to go to the emergency department, but we try to avoid that wherever possible if their mental health is the primary problem.

Graham Simpson: Is anyone aware of anything similar elsewhere in Scotland?

Jillian Galloway: [*Inaudible*.]—triage service in Tayside, which supports individuals who need a mental health assessment if they are being looked after by the police in the first instance. That is run from our Carseview centre in Dundee. It has close links with the emergency department, so people have a good pathway. If someone presents at A and E with no physical injury that requires them to be there, they can be supported and transferred to Carseview safely for that assessment. We also

have arrangements in place for working with the Scottish Ambulance Service. We have a mental health nurse who goes out with a paramedic in a mental health car. The police also have access to that service if they so wish.

The approach is similar to the one that Tracey McKigen talked about, and we are keen to develop it further with our Police Scotland partners.

Graham Simpson: That is fascinating. It is obvious that we have a bit of a patchwork of systems in Scotland. Some places are apparently doing very well, while others are doing less well. The committee would love to hear more details of the schemes that have been described to us. If the witnesses could send us more information, that would be good.

Have any of the people here today had a look at the model that is referred to in the report that operates in Trieste in Italy? Essentially, it is a 24-hours-a-day, seven-days-a-week service to which people can go. There is no waiting list, so people can just turn up. One of the side benefits is that it has saved money, but it has also led to a better service for the people who need it. Have any of you had a look at that model? If so, what do you think of it? I will pick on Hannah Axon.

Hannah Axon: It is very interesting. My first question would be about how it would work if you were to try to scale it up. It might work very well in a city centre where there might be a lot of drop-ins and it was sustainable. However, it might be more difficult to manage in a rural setting, where fewer people might come in. There is probably learning that can be drawn from it, as with many things. However, I do not know that it could be rolled out in other places in the current format. That is my first thought, although there are probably a lot of principles that we can pick up from it and consider.

Simon Burt: We looked at that a few years ago, and it is really interesting. I agree with the previous witness that you would not be able to replicate that across a rural area. We have five localities, and most people—60 per cent of the population—live in the central belt, where there are two big communities. That is a limiting factor, but the principle is around a walk-in service without stigma, if you can avoid it. Stigma is the other issue that people will have. Another witness talked about referrals. A referral in itself creates bureaucracy, because you then have a waiting list and you have to manage it, which does not help anyone.

10:00

A walk-in approach is totally different. The service is there and it is accessible, and you can have a conversation. Health centres are the obvious places where that can happen. Generally, everyone goes to their GP. Perhaps we need to develop some of those into wellbeing centres rather than health centres. Is it more about health and social care and those centres becoming more of a community hub? That is certainly a route to go down, particularly in rural areas; indeed, I do not see why it could not be looked at in all areas.

Graham Simpson: Good—I look forward to you re-looking at it in the Borders.

One problem that we have looked at in previous sessions is that, when you go to a GP, you have to make an appointment and explain your problem to someone who might not be medically qualified. That in itself can be a barrier. Having somewhere where you can just walk in and get help immediately would be a positive development. Good luck to you, Simon, as you look at that system again.

I will move on to data, which was a big area for criticism—I suppose that that is a fair word—in the report. A theme that comes up in a lot of reports from the Auditor General is the lack of data and the lack of quality data. The report states:

> "Data is not available to determine how many people have severe and enduring mental health conditions in Scotland.
>
> Information is not available to accurately assess demand for mental health support in primary care in Scotland, but it is likely that demand is high."

Well, yes. The report goes on to say:

> "In 2018, a survey of more than 1,000 GPs across England and Wales estimated that 41 per cent of appointments relate to mental health."

Do you agree that data collection and, indeed, the quality of data should be improved? If you agree, are any of you tackling that?

The Convener: Richmond Davies might be the best person to start on that.

Richmond Davies: Okay. The data schemes are from various sources. For example, we have robust data on in-patient mental healthcare, which has been collected since 1963 and went digital in 1997. If you are admitted to hospital with a mental health problem, we will know about you and will produce statistics that describe what happened and what happened next. At the moment, there is a problem with psychological therapies and child and adolescent mental health services. We receive aggregate figures from the service. Those are numbers: the numbers who are waiting, being referred, being discharged and that kind of thing. There is only so much that you can do with numbers when you do not have the whole information about each individual who attended.

To address that, we decided to develop what we call a child, adolescent and psychological therapies national dataset, which is in the

experimental phase. That is more individual-level data that we collect from the data suppliers. It is not perfect, and we have a long way to go. We have been working hard with the suppliers to improve the data.

The challenge is that the data does not already exist in the established systems that have been around for many years, through which we receive all our other data from the service. That is an issue. The other issue is about what happens in the community and in primary care—what happens when, say, a school nurse interacts with children with mental health problems, a district nurse interacts with an elderly person with mental health problems or a health visitor goes to see a new mother with mental health problems. Nationally, we do not know about all those interactions. They are known about locally but, if that information is to be collected nationally, we need the sort of established infrastructure that hospital services have for doing that. That is a challenge.

We have been working with partners to see how the data could be improved. We produce things such as definitions to make sure that data is collected consistently and that we are measuring the same thing. We are doing all those things with a view to improving the quality of the data that we receive month on month. That is the journey that we are on. We have not got there yet.

Graham Simpson: That is honest of you, Richmond. It sounds as though you recognise everything that the Auditor General is saying. There is data in one part of the system, and data in another part, but nobody is collecting it. It is probably your job to collect it, is it not?

Richmond Davies: Yes, indeed. Our job is to collect it nationally but, to do that, we need the infrastructure in place locally to make sure that the data that is collected in Ayrshire and Arran, for example, is identical in definitional terms to what is collected in Orkney, and we need the e lectronic mechanism to bring in the information. We are slowly overcoming those challenges, and we will get there.

In primary care, for example, GP information is very rich. Many people who attend their GPs never interact with the hospital—they interact with their GP and go home, and they are managed in that way. Most GP practices have link workers or mental health nurses who manage those individuals at home. We do not have that information, because we have not been able to establish a mechanism to give us a flow of data. However, the good news is that the Scottish Government has worked with NHS National Services Scotland to collect critical information from primary care—there are the means to do so, because it happened during Covid-19. We are developing a primary care intelligence system in Public Health Scotland in anticipation of that new stream of information coming in.

Graham Simpson: Are you getting resistance from anyone?

Richmond Davies: It is not resistance; it is about making sure that the governance framework involves GPs. They need to be involved because, in data protection terms, they are data controllers, and they need to be satisfied that good use is being made of the data that is collected. NHS National Services Scotland will set up the structures for all that, and Public Health Scotland will have the intelligence required to better understand what is happening in primary care.

Graham Simpson: That is interesting. All the rest of you need to work with Richmond and do what he asks, then.

The Convener: I think that Fiona Davies and Simon Burt indicated that they wanted to come in on the data question. Does Fiona Davies want to come in first? I will then bring in Simon Burt. I do not know whether Pamela Cremin has a view on that, as well, before we move on.

Fiona Davies: To continue from where Richmond Davies left off, one local issue with trying to take forward the data issue is that, as Simon Burt mentioned, the council budgets and national health service budgets that come into integration joint boards are not pooled, and our data systems often reflect the difference between an NHS system and a local authority system. Very few places—indeed, I am not aware of any—have really cracked federating or sharing data easily between council-employed staff and NHS-employed staff in integrated arrangements.

We are trying to implement an integrated system, but we have to design it as we go, because there is no off-the-shelf product ready for us to buy. That is a huge amount of work for my staff and the leadership across all the professions, who have to be assured that what goes into that data is appropriate, that when Richmond Davies is ready for us, we can provide what he is looking for to feed his national framework, and that that is appropriately governed.

It really is quite a challenge within our integrated arrangements to have data systems. It is one thing for a health visitor to visit a child, but if I have a children's social worker who visits a child and identifies a mental health issue, I look for that data to cross from a council-employed member of staff into the health part of my data system and, at the moment, that process is very clunky, and it requires manual people skills to get that data to go across.

Graham Simpson: We have set up integration joint boards, but sometimes it does not sound as if they very integrated.

Simon Burt: On that last comment, that is frustrating, but my experience is that it is better than it was. I think that we are going in the right direction. However, we probably all agree that, if we were going to devise a health and social care system from today, we would not devise the one that we have now. It is really hard to go backwards and undo things. That is the problem.

In answer to your original question, data is really important, particularly in relation to outcomes and getting the views of service users and people with lived experience on the input that they have had. The challenge is what has already been described. It is about consistency in collecting the same data and keeping it simple, otherwise we will end up with a huge bureaucracy that takes resources away from helping people. If we do not measure what we do, we will not know whether we have made an impact and therefore whether we need to continue resourcing that service. That is absolutely fundamental.

Ironically, only a tiny element of the number of people whom we support are in hospital. In general psychiatry in the Borders, we have 19 beds, of which 14 or 15 are used generally. The vast majority of people are in the community, and we do little measuring of that. It is completely the wrong way round.

I do not have an answer to that, but we are working at it with Public Health Scotland et cetera. We need to have good data but a not overly bureaucratic system, otherwise smaller organisations in particular will sink with the demands of having to provide that information.

Graham Simpson: Good. I think that you all need to go and see Richmond Davies and get your acts together.

Hannah Axon wanted to come in. I think that you will then want to move on, convener.

The Convener: That is correct. That is great. Does Hannah Axon want to come in?

Hannah Axon: I just want to flag up some of the work that has gone on around the health and social care data strategy. The issue with data sharing is a known one, and there is on-going work to look at that. Work is going on around information governance and approaches to that across health and social care. There is some work related to Microsoft 365 federation of data, which probably goes beyond my technical capacity to explain, but that allows the sharing of information, such as calendar information, across different parts of the system. There is also work that is looking at an integrated health and social care record as well as at the interoperability of data. That is about being able to move data from one system to another.

It is not the case that we do not know that there is a problem or that no one is looking at it. There are a number of streams of work to try to take that issue forward and to look at solutions to a very tricky issue.

The Convener: Right. Thanks very much.

I have to report that Pamela Cremin in the Highlands was having some technical difficulties, but I think that they have now been solved. I will endeavour to bring her in on the next set of questions. I turn to Willie Coffey to put those questions.

Willie Coffey (Kilmarnock and Irvine Valley) (SNP): Good morning, everyone. That takes us neatly into talking about outcomes in general. My question is probably aimed at Dr Davies. The Auditor General for Scotland's report was pretty critical in saying that

"The Scottish Government does not have sufficient oversight of ... mental health services"

and it has no information on the quality of care or outcomes for people. We have discussed a systematic approach to collecting data, but what about outcomes, Dr Davies? The outcomes framework has been published. Do you accept that criticism in the Auditor General's report? What is the Government doing to address that?

10:15

Richmond Davies: The outcomes framework was developed through collaboration, and Public Health Scotland was involved in aspects of developing it. It is a staged process. Having developed and published an outcomes framework, the next stage is what we call an evaluability assessment, which has commenced. Public Health Scotland has a couple of people who are involved in that process, and it is working with others, as well. The evaluability assessment uses evidence to see how we demonstrate what exists in the outcomes framework and how we measure, using proper evidence, whether we are moving in that direction. It is part of the discipline of public health science that we have in PHS.

That is a process. The framework was published only on 3 November, and our people are already working on it. There is a plan for deliverables up until March 2024. We are on the journey to make the framework clearer to those who have been exposed to it so that they can see how it is operationalised and then report on it.

Willie Coffey: In all the years in which people have worked in that area, why have we not reached out and asked people how they feel and

what they think about the quality of the service that they have experienced, for example, and captured that? Is that a fundamental thing that we have just not got around to doing, or will that be at the heart of any new way of measuring real value and outcomes for people in Scotland?

Richmond Davies: The outcomes framework document is linked to the mental health and wellbeing strategy and its delivery action plan. People and organisations representing those with lived and living experience were heavily involved in all those processes. The intelligence from all that exists, and that is the basis that influenced the approach to the outcomes framework. All that work has been done. There was lots of consultation with many people—third sector organisations and individuals. That is why we have outputs that are based on both the soft and hard evidence.

The Convener: I think that Tracey McKigen in the Lothians wants to come in. Hannah Axon, who is in the room, has also indicated that she wants to come in. We will go to Tracey McKigen next.

Tracey McKigen: This point does not cover the national level, which you are talking about, but it deals with what we are doing at a very local level. We are doing on an in-patient basis what you have just suggested. We use the patients council, which is a collective advocacy service. On an annual basis, it provides a report to us that tells us what patients think of the care that they are receiving. We use that to plan improvements in our service.

We are working with the patient-experience team in NHS Lothian to develop a survey for in-patients who are leaving the hospital and their families to complete so that we can use the feedback from it to try to improve the quality of service. It is not scaled up to cover all services at the moment, but it is a start towards doing what you suggested.

The Convener: I think that Hannah Axon wants to come in.

Hannah Axon: I want to emphasise what Richmond Davies said about the lived experience engagement around the mental health and wellbeing strategy and the actions that sit in it.

There was engagement on the strategy itself, but there continues to be engagement in the individual actions with those people for whom the services are relevant. I will give a very live example. There is an on-going piece of work on self-harm. There is a great deal of lived experience engagement there. We are very alive to that. There is a commitment to keep that conversation open where it is needed across the different things that we do.

Willie Coffey: Looking ahead, if the committee or the public wanted to know what the positive outcomes were for people using mental health services in Scotland, would we look to the individual IJBs and health boards or to the Government for the answer? There has been an awful lot of increased spending on that whole area—I will come to that in a wee while. The public can, rightly, ask what is happening with the money that we are spending and whether it is having a positive outcome for people. Where would we get the answer? Should we turn to Dr Davies's team for a national picture, or should we ask all our individual health boards for a response? What do you think?

Richmond Davies: I would say both. Rather than always viewing something nationally, you should do both, because there is a lot of local intelligence and lots of local surveys. Public Health Scotland has local intelligence support teams that support IJBs and GP clusters, and I have been told that they do lots of local surveys. When a GP practice wants to better understand people's experiences or views in its local area, the support teams advise. Our analytical staff will provide advice on how to do things such as structuring questionnaires. That is all happening locally.

Nationally, there are things such as the health survey and the in-patient experience survey, which asks a lot of questions about people's views, how they feel and what they would like to change. It is about looking at all of that rather than just at one area.

Willie Coffey: In the interests of time, convener, this is possibly the last query from me. Earlier, Dr Davies, you mentioned the new psychological therapies specification. The same question applies to that. How will that roll out, and how will you monitor its progress?

Richmond Davies: The new child, adolescent and psychological therapies national dataset will include things such as outcome measures. There are some standardised outcome measures as well. It will include the patient's details—the referral, appointment, diagnosis, treatment and intervention details—and the clinical outcomes for that individual. It will detail what measures were used to determine what the outcomes were for those individuals. It will also include discharge details about what happened next to the individual, where they went and whether they died. That is what we want to collect. It is a very rich dataset that provides an opportunity to have a much fuller understanding of what is happening in those domains of psychological therapy and child and adolescent mental health.

We feel that that is the way to go, because we have the equivalent of that for the in-patient experiences of people who are admitted to

hospital not just for mental health problems but for surgical procedures. We understand a lot about them. This is an opportunity to transfer that experience, which has been in existence for many decades, into a new area and to focus on children and adolescents.

Willie Coffey: Thank you very much for that. In the interests of time, I will leave it there.

The Convener: Thank you for that forbearance, Willie, it is much appreciated.

May I come back on that very last point, Richmond? You talked about CAMHS, which is extremely important to all of us, and it is something that the Parliament has concerned itself a great deal with. This report is about adult mental health, so can you tell us a little bit more about what data collection there is on people's experience of adult mental health, and what those outcomes are?

Richmond Davies: As I said earlier, we have a lot of information about adult mental health in hospitals, and we publish that on our website. There is a gap in the data on adult mental health services in the community, because those services are provided by a whole suite of different organisations, professionals, social care, community-linked workers and third sector bodies. The amount of services that are provided is vast and they are provided in different ways. How they assess what "good" looks like for them differs from place to place. There needs to be some standardisation of what "good" looks like and how it is reported.

The Convener: The evidence that you have given on this area this morning has been very valuable, so thank you for that.

Colin Beattie will now put some questions to you and elicit some more useful information for the committee's consideration.

Colin Beattie (Midlothian North and Musselburgh) (SNP): I would like to look at accountability and performance reporting. Inevitably, I am drawn to IJBs when I look at that. I recall that, some years ago, the Auditor General produced a report on IJBs that were fairly substandard. Now I look at adult mental health services and again see deficiencies in the IJBs. There is a lack of public accountability for IJBs. The Scottish Government holds the NHS boards accountable, but the IJBs are responsible for planning, funding and overseeing the provision of the services. Operationally, they are managed by HSCPs. It seems to be odd to run those services without the national level of accountability that they should have.

The IJBs seem to be hidden someplace in the background, yet they are key to delivering services. Clearly, they are not getting it right. The report says that IJBs have to improve accountability arrangements. That will require everybody to work together to make that happen. How do we make IJBs more accountable and bring in better transparency in regard to their operations?

Hannah Axon, you are here, so I will ask you first.

The Convener: Actually, Colin, in the interests of time, Fiona Davies is online and wants to come in. She is an IJB chief officer. Jillian Galloway is also an IJB chief officer, and I do not know whether Simon Burt has got a view. Fiona has indicated that she wants to come in, so I shall bring her in first.

Fiona Davies: Thank you, convener, and thank you for the question. I am here to represent the chief officer network, so I feel obliged to take the question.

I suggest that, rather than IJBs being deficient, we should perhaps challenge the structure that set them up. IJBs work to the parliamentary act that legislated on the arrangements that you describe, so it might be slightly unfair to say that they are deficient in operating to the legislation as it was written. We do what we can within the framework that is provided for us. Obviously, the proposals for the national care service are well documented and discussed, and I do not want to go down that line today, but part of that reform is recognising some of the limitations in the governance structures that existed under the Public Bodies (Joint Working) (Scotland) Act 2014.

IJBs do a really good job of working with non-executives from the health board for their area, with elected members of local authorities and with a huge range of stakeholders. They work to the highest standards of transparency and accountability in publishing the health and wellbeing outcome data and lots of other information points about what they are doing, in the public domain on the website of each integration joint board.

I certainly would not suggest that there are no limitations in the framework, but the integration joint boards that are currently operating are doing the very best within the structure that is provided for them on the whole. To talk about improving it would probably take us into that national care service discussion, and that is broader than the question we are discussing today.

Colin Beattie: I take on board what you say, but I am looking at the Auditor General's report, and he has highlighted areas where there is a lack of accountability within IJBs. We are not saying that they are not doing a good job; we are just saying that we cannot see it. You may see it locally, but,

on a national basis, we do not see it. What can be done about that?

Fiona Davies: That is the structure as it was designed, so we have to agree that, perhaps, the design needs to be changed. The way that IJBs share that information and how they work with local authorities and boards needs to be done differently. The information is there, so, if it is not being seen, we need to think about how we can make it much more visible to a wider range of people, including those who are interested at a national level.

10:30

The Convener: We lost connection with Jillian Galloway, but it has been restored. I invite Jillian to give any reflections that she has on the point about the governance arrangements with IJBs that Colin made.

Jillian Galloway: I did not hear it. I left the meeting; apologies.

Colin Beattie: You missed the best bit.

Jillian Galloway: I am sorry. It was just due to technical issues.

Colin Beattie: Jillian, I raised the fact that the way in which IJBs are constructed means that they do not have any direct national accountability, and the way in which they operate lacks transparency. That is not to say that they are not operating well locally. I am saying that it is not evident, and the Auditor General's report reflects that. How do we fix that?

Do we have contact with Jillian?

The Convener: We are having technical difficulties again. I will go over to Simon Burt, who can hear us loud and clear. If we can fix Jillian's connection, we will do that. Simon, you have some views on that IJB structure thing.

Simon Burt: I agree with the previous witness that the challenge is in how the structure is made up, but as I said previously, I do think that progress has been made. When the IJB first came into being, it was basically made accountable for everything that was going wrong locally. The health board would say, "It is the IJB", and the council would say, "It is the IJB", or they would say that it was each other. As an integrated manager, I would sit in rooms and hear that sort of thing going on.

We have moved a long way from that now. There is far more structure locally to work collectively across the two main organisations, the health board and the council. We are, collectively, taking more responsibility for the problems and the solutions, irrespective of whether it is predominantly a social care problem or a healthcare problem. It is not ideal, but we are certainly moving there. I think that the IJB does as well as it can within its legal framework. That might be where we need to look.

Colin Beattie: What has to change to make it better and to get proper accountability and performance reviews?

Simon Burt: We are up against it with the whole design, where we have the health board, the council and the IJB. As I said, all that taxpayers and the Government are interested in is that the taxpayer's pound is used as well as it should be to provide the best outcomes. We have already heard that we are not good enough at measuring outcomes to know whether the money that is being invested is invested well enough.

Where there is more than one budget, there will be a problem. It comes down to that fundamental structural problem that we have around budgets and the two organisations. That is a personal view. As an integrated manager, those are the sorts of problems that I have had to deal with all the time over the years. I have to go to the council, the health board and the IJB to explain something. It is almost as if a third party has come in that I have to negotiate with. That has moved on quite a bit locally, but it is a challenge that is inherently there all the time. That is not particularly an answer, but I think that that is the problem area that needs to be looked at.

Colin Beattie: It certainly seems as though the governance structure needs to be looked at. The problem is that service delivery varies in different areas of Scotland. How do we get a more consistent approach? There does not seem to be a consistent approach among IJBs. I am focusing on IJBs for my own particular purpose.

Simon Burt: I—

The Convener: I am sorry, Simon, but I think that Hannah Axon wants to come in on that question. Do you want to come in on that question as well as on your earlier point?

Hannah Axon: I will be very quick. I agree with Fiona Davies's point that the conversation about the national care service and how and where accountability sits is very live. We have agreed shared legal accountability for health and integrated health and social care services, but we will also consider standards accountability and how that works through the structure. That thinking needs to feed into the design of the process. There has been, and continues to be, a lot of engagement and discussion around that.

My question about consistency is, consistency of what? We want consistency of outcomes for people, but consistency in the way in which services are designed and delivered might work or

it might not. That is the point that we made earlier: lifting that model and putting it in different places will not result in success everywhere. The services will look different, and they will need to do things in different ways to deal with the challenges in their respective areas. Consistency of outcomes for people is what we need to look at and work towards.

The Convener: Simon was nodding during that answer from Hannah.

Simon Burt: Absolutely.

The Convener: Great.

Willie Coffey has another area that he wants to explore with you, so I hand over to him.

Willie Coffey: This time, because we are the Public Audit Committee, I want to ask you about money. If you look at exhibit 7 in the Auditor General's report, you can see quite clearly that the funding allocation for adult mental health services has significantly increased over the years. In 2020, it was £130 million; in 2021, it was £296 million; in 2022, it was £258 million; and this year, it was £290 million. Is that money being spent wisely and appropriately, and is it having a positive impact on adult mental health services in the areas that you collectively represent? Can you see the benefit of the money and the spend? The public are bound to want to know that. I would welcome a view from any of our colleagues from the health boards, as quickly as you can.

Tracey McKigen: We have the Lothian strategic development framework, which has a number of pillars and parameters. One of the pillars is mental health, illness and wellbeing, which involves a joint plan on the part of the four integration joint boards and the health board. The money flows from the priorities that are agreed to the Lothian strategic development framework. There is complete oversight across in-patient and community services of how we best spend the money for the priority areas that have been identified. There is always room for improvement, but we see more rigour in how we spend and allocate resources.

The other thing to mention goes back to the data and digital systems. We are looking at how we can consolidate those, because they work on different systems, as other people mentioned. If we could get that nailed, it would help us to make better use of resources, because you waste money when you have to use multiple different systems.

I hope that that gives some reassurance that we have a governance arrangement for how we use resource on an annual basis.

Willie Coffey: What is the money doing? We keep hearing about high vacancy and turnover rates in the service. What is the money—that substantial additional funding across the board—being spent on?

Tracey McKigen: I can give two examples. It was used to reduce quite dramatically the waiting times for psychological therapies and CAMHS. There has been an increase in in-patient requirement post Covid, so we have additional beds open at the moment. We have a ward of 15 beds that is in addition to the normal number, because of the acuity of people. It has been used in different ways to meet the needs that are coming through.

Fiona Davies: As somebody who has worked in mental health services for 30 years, the increased investment is very welcome, timely and overdue. Partly, we have to reflect on certain things. For the whole of my career, I and others have been doing anti-stigma work in order to encourage people to come forward and feel able to say, "I'm struggling with my mental health", "I'm not feeling well", "Things aren't going well for me" or "I'm considering taking my life". Some of the demands that we are seeing are from people who, 20 or 30 years ago, would have tried to manage at home or to hide how they were feeling. It is a wonderful sign of changes in our society and culture that more people are coming forward and telling us that they are having difficulties, but we have to be able to match that with appropriate support.

In my area, the money has given us a 12-hour unscheduled care service that we run from 8 o'clock in the morning until 8 o'clock at night. I remind you that I have 23 inhabited islands to cover, as well as my beautiful peninsulas and the other areas in Argyll where I am sure you have all holidayed, even if you do not know the area very well. Being able to provide a response within an hour to people in a mental health crisis has been a huge boon not only for those individuals but for all the practitioners in our A and Es and in other services who previously would have struggled with those people overnight, with nothing to offer them. In addition, it has brought a huge variety of new practitioners to work in primary care. As I said, we do not have a person in every practice—some of our practices are very small and very rural—but the majority of our larger town practices and our small and medium-sized practices have mental health practitioner access at various points through the week, which they did not have before.

The money is making a difference, and when Richmond Davies finalises his outcome, I will be able to prove that to you with more rigour and in more detail than I can now. These are real posts that are making a real difference to real people.

Willie Coffey: That is good to hear. Does anyone else want to come in?

The Convener: I think that Simon Burt wants to come in briefly on this point.

Simon Burt: I echo everything that Fiona said, but I will give some concrete examples that are local to me. The distress brief interventions—DBIs—were funded centrally through pilot funding, but we have committed to funding them through our action 15 funding. They are evaluated and provide good outcome data. That is a welcome service that we have in the Borders. I mentioned our primary care mental health service, which is delivered through psychological therapies. It is a huge success. It was developed fairly closely with GPs. They love the service. The main outcome for them is that people do not keep coming back—the GPs gave them drugs before, but that does not work, obviously. That is all that they could do. Now we have talking therapies, and, generally, those people are not coming back to the GP practices. GPs are thrilled with that. Obviously, that must also be a good outcome for the individual; it is well measured. That is a huge change for us locally.

We work well with the Borders Addiction Service, which has received a lot of additional investment. It provides good outcomes and meets its three-week treatment target 100 per cent of the time. Again, that is a huge change. We also have what are called local area co-ordination service workers, who are an added extra to our community link workers. They do more or less the same as a link worker, but, crucially, they also do the community capacity-building element. They will work with communities in order to help them to develop opportunities that were not there previously and with which people can engage. Evaluation and research into that has shown that, for every pound that you invest in that regard, you get a £4 return. That community capacity-building element is a crucial area. Some funding has gone into that service and has enhanced it.

There are also advanced nurse practitioners. As we have heard before, there is a huge recruitment challenge not only for consultants in particular but for community psychiatric nurses. Advanced nurse practitioners work in partnership with our consultants, so where we have those pressures, we have that different skills mix. That is proving to be successful, although it is early days. Those are some examples of how the money is being spent and the value that it has created.

Willie Coffey: That is great to hear. It would be great if colleagues around the online table could send the committee some examples of where the spend is making a positive difference in their areas. I am sure that the committee would greatly welcome that.

The Convener: Absolutely. Hannah Axon has a quick last word on this topic before we come to our last question.

10:45

Hannah Axon: I will be quick. Recognising some of the investment in early intervention and prevention, off the top of my head, I can think of two funds that focus on really early intervention in the community. Some work is leisure-focused, some is sports-focused, some brings in counselling and some focuses on minority groups. Given the earlier discussion about the risk of overmedicalisation and overclinicalisation, that is welcome. A caveat is my concern about the ring-fenced funding, the directed funding and the annual funding, but the shift to models that are not medical is welcome.

The Convener: Jo Gibson, I will bring you in first on the last question because I have not heard from you for a while. It is on plans and strategic direction. In 2017, the Government published the "Mental Health Strategy 2017-2027" document. In October 2020, there was "Mental Health—Scotland's Transition and Recovery". There was a mental health and wellbeing strategy a couple of years later, and we have heard this morning about the launch at the beginning of this month of a delivery plan, a workforce action plan and the outcomes framework about which we spoke. Has there been a surfeit of plans and strategies? Do they demonstrate an evolution of thinking, or is it a matter of keeping on reinventing the wheel and not enough changing on the ground?

Jo Gibson: That is a tricky question. There are copious strategies. In a way, it is a positive sign, because it shows that mental health's profile has gone up the national agenda, for which many of us have lobbied for some years. That links to the increased funding that we saw in the previous exhibit. There is a wee risk that not all the strategies are aligned. The convener has mentioned three or four strategies, but there is also a reasonably new suicide prevention strategy and an upcoming self-harm strategy.

On the ground, we are trying to work in our integrated teams and across partners to understand what the ask is of all those strategies and how we can implement them locally. That is a big piece of work. It is useful work, because it helps us refine our priorities and investment plans. Future investment is a bit unknown. We are developing plans but are not sure whether we will have the investment to implement them.

The other point is that we need the underlying architecture to deliver some of this. We do not want to come back here in three or five years and say that we do not have a great account to give of the outcomes that we have achieved. None of us wants that. We need information systems, particularly for data analysis and evaluation, to demonstrate the impact that we have. That is important for all of us.

There is a wealth of strategies, but there is still a challenge in supporting people with serious mental illness and improving the general mental health of our population. Those are different things, although they are obviously connected. In Scotland, however, we have got to a point at which anything to do with mental wellbeing is considered the job of mental health services, and that is not sustainable.

The report also demonstrates the challenges in our workforce, such as vacancy rates and sickness. We have a stressed workforce. We need to safeguard their wellbeing as well. We need to be more specific. We need to be clear about what we are asking our teams to do and what is not in their job. Some of the work on the wellbeing of individuals is for communities and other parts of the system to think about, but we need to be clear about what is separate from specialist mental health care.

The Convener: Jo Gibson, thank you very much for that perspective. It is a really good note on which to conclude our evidence session this morning.

I thank everyone who has taken part. I am sorry that we have had some technical difficulties, which has meant that not everyone has been able to hear everything and we have not been able to hear you as much as we would have liked. Apologies for that.

I thank our witnesses—those who joined us online, and Hannah and Richmond, who joined us in the committee room. It has been a valuable session for us. We have gathered a lot of important evidence, and we will have discussions about how best we can marshal that evidence in order to improve the resourcing of and support for the important work that you do and of which you have oversight. Thank you very much.

10:50

Meeting continued in private until 11:25.

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