OFFICIAL REPORT
AITHISG OIFIGEIL

DRAFT

Health, Social Care and Sport Committee

Tuesday 16 September 2025

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 16 September 2025

CONTENTS

	Col.
DECISION ON TAKING BUSINESS IN PRIVATE	1
PRE-BUDGET SCRUTINY 2026-27	2

HEALTH, SOCIAL CARE AND SPORT COMMITTEE
23rd Meeting 2025, Session 6

CONVENER

*Clare Haughey (Rutherglen) (SNP)

DEPUTY CONVENER

*Paul Sweeney (Glasgow) (Lab)

COMMITTEE MEMBERS

Joe FitzPatrick (Dundee City West) (SNP)
Sandesh Gulhane (Glasgow) (Con)
*Emma Harper (South Scotland) (SNP)
*Patrick Harvie (Glasgow) (Green)
*Carol Mochan (South Scotland) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Elena Whitham (Carrick, Cumnock and Doon Valley) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Duncan Black (Glasgow City Health and Social Care Partnership)
Emma Congreve (Scottish Health Equity Research Unit)
Jackie Dunbar (Aberdeen Donside) (SNP) (Committee Substitute)
Hamish Hamilton (West Lothian Integration Joint Board)
Calum MacLeod (Mental Health Foundation)
Professor Colin McKay (Edinburgh Napier University)
Craig Smith (Scottish Action for Mental Health)
Annie Wells (Glasgow) (Con) (Committee Substitute)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 16 September 2025

[The Convener opened the meeting at 09:00]

Decision on Taking Business in Private

The Convener (Clare Haughey): Good morning, and welcome to the 23rd meeting in 2025 of the Health, Social Care and Sport Committee. I have received apologies from Joe FitzPatrick and Sandesh Gulhane. Jackie Dunbar joins us as a substitute member.

Under agenda item 1, does the committee agree to take items 3 and 4 in private?

Members *indicated agreement.*

Pre-budget Scrutiny 2026-27

09:00

The Convener: The next item on the agenda is oral evidence on the committee's pre-budget scrutiny for 2026-27. I welcome the first of our two panels of witnesses. Emma Congreve is co-lead of the Scottish Health Equity Research Unit, University of Strathclyde; Professor Colin McKay is professor of mental health and capacity law, Edinburgh Napier University; Calum MacLeod is senior policy and public affairs officer, Mental Health Foundation; and Craig Smith is public affairs and policy manager, Scottish Action for Mental Health.

We will move straight to questions. I call Emma Harper.

Emma Harper (South Scotland) (SNP): Good morning, everyone. I get to kick off today.

I always feel that, within our health budget, and even within our mental health budget, there are so many priorities to consider, from child and adolescent mental health and community-based mental health support to adult mental health and, now, the increase in eating disorders. To what extent do you consider that the Scottish Government's strategy for mental health sets out the appropriate priorities?

Calum MacLeod (Mental Health Foundation): As there is no rush to come in, I will go first. The Mental Health Foundation very much welcomes the opportunity to give evidence today. We are a charity. We do not provide services; we focus on prevention, as we all do. That is where our interest lies.

Broadly, the overall focus in the strategy's priorities is appropriate. Clearly, the focus on community supports and on children and young people is fundamental. The focus on suicide prevention is, of course, very appropriate as well. The critical issue is how we implement the objectives in practice and what difference doing so makes to people's lives. That sounds blindingly obvious, but, as I am sure we will come on to discuss, there are real challenges in implementation within the context of the health and social care portfolio itself and what is delivered in practice. There are also challenges in the substantial amount of policy focus, resource and activity in relation to impact that needs to be addressed beyond the health and social care portfolio.

There is a challenge in how we connect the priorities of the strategy itself to wider policy portfolios, get a cross-cutting dimension and make sure that implementation happens and makes a

real and genuine impact for communities and individuals when we are, frankly, in the midst of a mental health emergency. I do not think that it is too strong to say that at this point.

Craig Smith (Scottish Action for Mental Health): I will jump in, if that is all right.

The Convener: Of course.

Craig Smith: I absolutely agree with Calum MacLeod. Fundamentally, I do not think that anyone would disagree with the priorities for the strategy, particularly the focus on children and young people's mental health and community mental health. However, as has been said already, it is how the priorities are implemented and linked to budget and spend.

SAMH is a national organisation and primarily delivers services in community settings that are funded through—but also beyond—social care budgets. We see a long-running disconnect between positive national policy, strategic objectives and strategic direction, and implementation on the ground in communities, particularly around the resourcing of community services. We have seen that in the real pressure on integration joint boards, local authorities and health boards. We may have a positive national strategy that calls for more and easier access to community support and the prioritisation of suicide prevention, but without follow through and spend, local decision making is constrained in terms of what can be provided on the ground. For example, many of you will know about the real challenges in Edinburgh this summer with the proposals to basically wipe out the community mental health budget. Thankfully, those proposals did not come to full fruition, but the integration joint board still made significant cuts to community provision.

It goes back to what has been said about how we link positive national strategy and policy to local delivery and how we get accountability right when it comes to Scottish Government national policy pledges. For example, we have not achieved the target of spending 10 per cent of the national health service budget on front-line mental health services, and there is a lack of accountability around that. The Scottish Government, I suppose rightfully, says, "We can't dictate to boards what proportion they spend." However, it set that policy, so is there space for more ministerial direction?

I know that ring fencing is quite a contested concept, but is there a role for it, particularly around areas such as suicide prevention? Rightfully, suicide prevention is a priority, but there is very limited direct budget for it and it is very difficult to track what is being spent locally. For example, in Aberdeenshire, suicide prevention spending has been cut entirely because there is no statutory obligation on the local authority or the integration joint board to deliver the service.

There is probably something that we can do to tie accountability to strategic objectives and policy.

Emma Congreve (Scottish Health Equity Research Unit): I am here today representing the Scottish Health Equity Research Unit, which is a programme that focuses on the socioeconomic determinants of health, so that is largely what I will speak about. I am also a deputy director at the Fraser of Allander Institute, so I can talk a bit about some of the specifics on budgets later.

Our focus is on understanding what we call primary prevention, which is the upstream determinants. As Calum MacLeod alluded to, we have little understanding of spend related to prevention in mental health outwith the health budget. I think that we struggle to understand the breadth and the ups and downs of the budgets in that space, such as those that relate to housing, people who live in poverty and people in the criminal justice system. There are many aspects that are relevant for mental health. At the moment, we are focusing on younger adult men—we have a big report out on this later this week. Men make up the bulk of the deaths from drugs, alcohol and suicide later on in their lives. We are seeking to understand that, and we believe that there is a lack of prioritisation of prevention to help that group of people, once they leave education, their family or the care system, to integrate and thrive in their environments and to prevent issues coming up later. That is one area that we feel is a bit of a blind spot for policymakers.

However, I am here to talk about the primary prevention space, whereas my colleagues on the panel have more expertise in the tertiary prevention space, which is the treatment side of things.

Professor Colin McKay (Edinburgh Napier University): I am here partly because I was on the Scottish Mental Health Law Review, which looked at mental health and incapacity law in Scotland. In looking at the law, we quickly realised that, particularly if we were to focus on a human rights-based approach, we could not do that without thinking about resourcing and how decisions are made in the mental health system.

The review focused very much on taking a human rights-based approach, which includes human rights budgeting, to setting priorities. That was one of the review's recommendations. There are two things to say about that. One is about the process by which you decide on the priorities and how you engage with the affected communities in making those decisions. However, the approach also has implications for the priorities that you set.

If you are thinking about human rights in human rights treaties, including things such as the right to health and the right to independent living, you start by thinking about who is furthest away from achieving those rights.

At the macro level, the mortality and morbidity of people with mental health issues compared with the general population—the 15 to 20-year gap in life expectancy—is an issue that has been talked about for years. Therefore, there is clearly an urgent human rights need to make mental health a general priority within Government expenditure.

At the micro level, in thinking about the people who are furthest away from having their rights met, you would think about, for example, autistic and learning-disabled people who are trapped in hospital and whose rights to independent living have been denied. There is a plethora of reports about that.

When we engaged with people about what is needed, a number of things came up that probably fall within the category of improved community-based mental health support. People talked about peer support, community wellbeing hubs, open, flexible and accessible crisis and crisis prevention services, and alternative places of safety for people in distress. Some of those things are in the strategy, although some of them get less attention. The broader context is the increase in need and the broadening of the definition of mental health concerns—I think that the Royal College of Psychiatrists included that in its evidence.

A lot of the people who come forward for services do not fit into existing services, particularly neurodivergent people, people with a complex range of problems and people with issues of intersectionality—the intersection between race and LGBT people, for example. We need to see those as human rights issues.

I will stop in a minute; I am trying not to make my list too long. A human-rights based approach would also tell us that we need to think about current legal duties, and there is clear evidence that the system is not able to fulfil some basic legal duties. Some of those are about people's civil and political rights, such as having a sufficient number of mental health officers to properly evaluate mental health and incapacity cases. However, there are also already duties on local authorities under the Mental Health (Care and Treatment) (Scotland) Act 2003 not only to provide services to allow people with mental health issues to live normal lives but to promote their wellbeing. It is not evident that those duties are being fulfilled—indeed, it is not evident how you would count whether they are being fulfilled.

There are a number of issues that get thrown up if you look at this through a human rights lens, which would help us to think about what the priorities are.

As others have said, it goes much wider than the NHS budget—it goes into local authorities and other parts of government.

Emma Harper: Calum MacLeod mentioned social care and Craig Smith mentioned integration joint boards. Some IJBs do mental health budgeting differently. I am interested to hear your thoughts on how IJBs are using their budgets. Are there good examples of IJBs that are doing very well in budgeting for mental health? Is that budgeting effective? Is it joined up? Are there no good examples?

Craig Smith: I will come in. This may be unfair, but I cannot give you a good example. That is not to say there will not be good examples, as I am sure that there are, but I am probably not close enough to them. You asked about poor examples. The survey that was undertaken by the Scottish Parliament information centre ahead of the pre-budget scrutiny of IJBs on their prioritisation of mental health spend was quite illuminating when it comes to the lack of prioritisation by many of IJBs. As a social care and community mental health provider as well as a campaigning organisation, our reflection is that, over a significant number of years, but particularly over the past couple of years, fiscal constraint has been so challenging at a local level for IJBs that significant cuts are being made without, from our perspective, a clear understanding of the rationale for those cuts and their long-term impacts.

I mentioned Edinburgh IJB, which proposed to disinvest significantly in community mental health provision through the iThrive collective, which SAMH is a part of. When we were challenging those proposals and working with the IJB on them, we saw that there was not much evidence of any analysis of the long-term impact of removing community mental health support, including the impact on statutory services and the wider mental health system. Indeed, it is not just about the impact on the mental health system; there is also the impact on other aspects of public service delivery and, fundamentally, the outcomes for people.

I think that there is a more overarching point about budget setting at both local and national levels. There seems to be a lack of data around outcomes for mental health care and treatment in clinical settings and non-clinical settings. That is not to say that outcomes are not being measured, but there is a lack of consistent and systematic collection and publication of that data to inform service design and budgeting decisions.

09:15

I am straying slightly off your point. We think that the new population health framework and the health and social care service renewal framework are fairly positive documents. However, we would definitely welcome indications of a move towards a more needs-based assessment of the health and social care, on which a pledge has been made, and towards a more outcomes-based model for service design. We need to see much more detail of what the frameworks will mean in practice and whether they will be fully inclusive of mental health and wellbeing and, beyond health outcomes, of people's individual outcomes across all aspects of their lives.

That was a slightly meandering answer. There are definitely examples of bad practice, but that is partly down to the significant fiscal constraint that IJBs and local authorities are under at the moment.

I point again to Aberdeenshire and the example of suicide prevention. The lack of a statutory duty or obligation to provide support has often been the reason that we have been given—in Edinburgh and Aberdeenshire, for example—for proposals to reduce service provision. IJBs and local authorities have retreated to focusing their funding on statutory obligations, which is understandable. They do not have the space to provide the very important early intervention and preventative mental health and wellbeing services. If a longer-term view was taken, providing those services would have a significant and positive impact on services that are provided under a statutory obligation. If we treat and support people with mental ill-health at an earlier part in their journey, we will decrease demand at the more severe, enduring and clinical end. It is about having a longer-term view and a system that is based on needs and outcomes.

Calum MacLeod: I will be brief. I preface my comments by saying that I am conscious that the committee's witnesses on the next panel represent integration joint boards, and we are all aware of the challenges that they face with resources. It is not an easy environment to operate in. However, as Craig Smith said, it is challenging to find positive examples—I am sure that they exist, but it is challenging to identify them. The fundamental reason for that is that there is a lack of transparency in terms of the data. It is difficult—indeed, it is very challenging—to see lines in decision-making processes, outputs and outcomes that are trackable.

The SPICe survey that forms part of the committee's evidence, in terms of the work that was done over the summer, is very graphic about the inconsistencies. There are variations in understanding what prevention means within the context of mental health provision. There are also very uneven elements when it comes to how this is all is put into practice. For those reasons, there is a lack of transparency and there are real challenges in getting the vertical link between what is being aspired to and what is being achieved in practice. One of the critical issues is the need to have consistency and a framework that covers all areas, including, in particular, from the Mental Health Foundation's perspective, a preventative line that is transparent and can be followed through. That is fundamentally important.

I know that, when the committee looked at pre-budget scrutiny last year, you focused on integration joint boards. One of your recommendations to Government was about the scope to have a budget line on preventative spend. I think that the response was fairly amorphous, but there is scope for the committee to return to that, if I may say so, given that we now have a population health framework, as Craig Smith said, that has a focus on prevention and a public services reform strategy that is absolutely saying that we need to move definitively and decisively towards a preventative focus. If we are going to do that, we need to have the mechanics in place to track how funding and resources are being used in practice.

It is difficult to get the examples, but there is a real opportunity to put the conditions in place to enable that focus to happen more clearly.

Carol Mochan (South Scotland) (Lab): I really appreciate the discussion this morning. The move to preventative spend and how we track that is very important.

However, I have some concern that we perhaps do not focus enough on human rights-based stuff, particularly for people with enduring mental illness. The budget can get taken up with preventative and community-based stuff, yet we know that some of our long-term residents are still in long-stay hospitals. That is the reality. Is there anything in the budget that we should look at that would help us to think about that quieter group? We do not hear a lot about how we are supporting those people.

Professor McKay: You are absolutely right. There are certainly people in hospital who should not be in hospital. There are also people in the community who are living lives of quiet desperation—surviving but not flourishing. It is very difficult at a global budget level for the NHS or local government to think about how to get at that. We need to think about how we incentivise the system lower down. It is important that we think about prevention on those three levels, including people with severe and enduring mental health problems or complex long-term conditions.

The people in hospital are not a vast population. Craig Smith used the dreaded words "ring fencing", and that could be the kind of thing where, if you said, "We've got to fix this problem," you could fix the problem. I am always astonished when I think back to the hospital closure programme of the 1990s, when we did a phenomenal thing in shutting down those large hospitals over a short period, with massive improvements in people's quality of life. As one of the witnesses said last week, that was done partly through double running.

There are some specific problems, such as the people with complex needs who are in a hospital. You could just say, "We're going to fix this," and allocate some resource to fixing it, but, when you look into the reason why it has not been fixed, it is often about the complexity of the system rather than the willingness to do something about it. A person cannot come out of hospital until their housing is sorted out. Even if their housing is sorted out, they cannot come out until their social care package is sorted out. If their social care package is sorted out, that has to be procured from somewhere, and, by that time their needs have probably changed and something else will have happened.

The key thing is how we join up the system in a way that has not been done up to now, particularly for that group of people but also more generally. It is about how we align the incentives across the system and develop truly shared accountability, so that we do not have the situation that we have now, which is, "I'd like to help those people but I can't, because I have to concentrate on my core group, who are these people over here. It's very sad, but that other organisation doesn't want to help those people either, because it has to concentrate on its own core group." Unless we can think about shared accountability for outcomes, it is difficult to see how we will make progress.

Craig Smith: I absolutely agree with what Professor McKay says. One of our criticisms of the strategy—when it first came out and while it has been on-going—has been that the focus on the group of people living with severe and enduring or complex and long-term mental health problems is missing. We believe that there needs to be additional focus there. I agree with everything that Colin McKay said about having joined-up support and care to prevent those blockages to people in psychiatric hospital settings accessing care packages. We see that as a long-running problem at the discharge point, but it is also a problem for people being discharged from social care more broadly into independent living.

There is also a significant issue of stigma that needs to be tackled. Stigma is a key priority of the strategy, but we think that more needs to be done, particularly for that population. Anecdotally, we hear that there is a genuine lack of data around stigma more broadly.

There probably has been a lot of progress around what might be called mild to moderate mental health problems. However, a big piece of research that was done two or three years ago by the See Me programme—the national anti-stigma discrimination programme for mental health—which looked at people's experience of mental illness, showed not only that stigma was absolutely pervasive in personal life but that there was structural stigma in people's interactions with health services, mental health services and other public bodies and settings. That has a significant impact.

There is clear data showing that the life expectancy of people who are living with a long-term mental health problem is 20 to 25 years less than that of people who are not. There are many complex reasons for that, but it is partly due to a lack of access to support for treatable physical health conditions—people not being taken seriously enough or a lack of physical health checks. We know that work has been done to introduce annual physical health checks for people with learning disabilities. The implementation of that measure has been challenging, but something similar could potentially be done for people living with long-term mental health problems. We know that they experience multiple complex inequalities and discrimination, and it is key that we support people in all aspects of their health in order to tackle some of the long-standing inequalities and challenges. That needs to be a policy focus and a budget focus in order to get the balance right in where we are spending.

Paul Sweeney (Glasgow) (Lab): I thank the members of the panel for attending today. I think that we have already heard consensus among the panel that the current data on mental health budgets does not give a clear picture of activity at a national level and that there could perhaps be an improved connection between budget allocations and stated priorities for mental health at national and local levels. Feel free to correct me if I am wrong in that assessment.

Our main source of data is Public Health Scotland's costs book, and the latest figures are for the financial year 2023-24. The 2023 report from Audit Scotland on adult mental health highlights that

"Limited data and inconsistency in how spending is categorised make it difficult to track spending on adult mental health."

The Mental Health Foundation's submission also highlighted the issue of data gaps and inconsistencies, and it is not clear that the Government has responded to those data gaps.

Perhaps Mr MacLeod could highlight what we need to do, or what the Government needs to do, to improve the data picture. It is one thing to criticise the lack of data, but what would good look like? Could you hint at what that should look like? Are there other countries or other methodologies that we should emulate?

Calum MacLeod: It is a fundamental issue. Clearly, we need to have a much better sense of what the outcomes are for people who are the recipients of services. What difference is that making to their mental health? What qualitatively is making a difference to that? That is one element. That happens at the moment but in quite an ad hoc way, and it is not ingrained into the evaluation processes.

I will give you one example of that. It does not come directly under the mental health portfolio or the health portfolio, for that matter, but, nevertheless, I think that it is indicative of the cross-cutting dimension to what we are doing here. The Scottish child payment has just been evaluated as one of the five family payments, and the report found that the individuals themselves say that getting that payment has had a significant impact on their mental health and their happiness. That is fundamental at the perceptual level—it is a qualitative element.

We also need to be clear about what the throughput is and the outcomes of other elements across different aspects of government. For example, what difference is the housing provision for people having? What are the impacts of affordability and the capacity to access housing? What are the impacts of other measures across different portfolios with a trackable element? We have challenges there at the moment, and a more coherent, structured approach with consistent indicators would allow us to track that in practice. If you look at it from a macro level through to the more meso and micro levels, part of it is about the national performance framework and where that sits. That is potentially up for review as well.

09:30

How do the objectives, in terms of the outcomes and the indicators, translate into the actual spend and the activities that are being undertaken in practice? We need a more systematic, robust approach to that, and there is no one magic bullet. The principles need to be put into practice in ways that are consistent, easy to understand and accessible but impactful as well in the types of outcomes that are being measured and the difference that they will achieve. We would be happy to come back on that in more detail outwith the committee meeting.

Paul Sweeney: To summarise, Professor McKay, are you saying that we need more qualitative data and perhaps more contextual data?

Professor McKay: The mental health law review said that there is certainly a problem in not having good data, but we also found that

"different bodies across the system are sitting on large pockets of data that cannot be accessed easily and are not routinely published or analysed".

The issue is not that there is no information; it is that the information is in the wrong place and is not accessible. The review recommended creating a formal network of the many scrutiny bodies in the field, including Public Health Scotland and the Mental Welfare Commission for Scotland, and that they should develop a cross-agency framework for monitoring outcomes in mental health care. That may be a glimmer of a way forward in some of this.

Calum MacLeod: Forgive me, but can I follow up on what Professor McKay just said? You are absolutely right to say that some of the data is sitting there but is just not accessible. The Mental Health Foundation is calling for precisely that, given that, as we have talked about before, there is activity across the different strategies to have a co-ordinated approach to mapping out—having the contours and the context of—the specific data that we need in a systematic way across Government portfolios and vertically, as well, within delivery bodies. That is fundamentally important.

The accessibility issue is fundamental to this. The foundation is calling for a new, strategic, innovative improving Scotland's mental health fund, and we will be calling for that in our manifesto for the next election. At the moment, there is a save to invest fund that the Scottish Government has for prevention, which is mentioned in the public service reform strategy. Maybe I am looking in the wrong places, but it is difficult to find out what that is funding in practice. If you look for that—if you google it—the first thing that you get is responses to freedom of information requests saying what it is being spent on. To me, that is indicative of a cultural malaise that we need to collectively try to get through in order to get the culture change that we need and to get practical inputs in terms of the different measurement indices that we need if resources are to provide the most value for money—and I am talking about social as well as economic value for money—in practice.

Emma Congreve: I will come in on some of the work that we are doing at the Fraser of Allander Institute that is looking specifically at understanding outturn expenditure. It is relevant

across the Scottish Government, local authorities and health boards.

We feel that, to date, there has been a lack of utilisation of audited outturn spend. The audit of outturn spend is a process that all public bodies have to go through, yet what is presented publicly is much more limited. Calum MacLeod mentioned how funds are reported. We often hear announcements of funds, but it is then quite hard to find out what money was spent from those funds. What did the outturn spend look like compared to the budget? We rely hugely on just reporting budgets—saying that the Fraser of Allander Institute has put X amount towards this or X amount towards that—without full accountability, at a detailed level, to understand whether that spend has occurred, although that information is available.

As I said, there are processes that public bodies must go through to satisfy auditors of what is being spent, so there is the potential to focus down on something that we know is there and scrutinise it. That is what we have been doing at the Scottish Government level. I have been doing some work specifically on child poverty, trying to trace that money through from the strategies to outturn expenditure, where there are lots of gaps, which we have pointed out. Doing something similar for some of the mental health strategies could be a good way to scrutinise what has happened as a result of them, using audited outturn spend. It is then a much easier task to align the spend to outcomes. Has the money been spent according to how the outcomes in the national performance framework, or elsewhere in the strategies, say it should be spent?

You need to start somewhere, and this is so complex. For us, it was about finding the route in, so that we could with some certainty start somewhere. Focusing on outturn expenditure feels like a good place to start.

Paul Sweeney: I have heard that there is data that is not being utilised to give a picture but that there is an audit trail that could be potentially helpful in drilling down into outturns. Who takes responsibility here? The issue is the span of control. Often, there is a dissonance between local IJBs, health and social care partnerships or boards and the collation of data at a national level . Where does the optimum balance sit? Does anyone have a view on what that should look like for the control, collation and publication of data?

Emma Congreve: We have looked at the child poverty strategy, for example, many aspects of which are delivered locally. It is a Scottish Government strategy that is based on the Scottish Government's set outcomes, and the accountability for understanding where the money has been spent sits with the Scottish Government. That is not to say that there cannot be local divergence; that is partly why we have localised systems. However, on the question of who needs to know where the money has been spent, we think that the buck needs to stop with the people who set the policy and the outcomes at a national level. If they do not know where the money is being spent, what hope for the rest of us?

Accountability is a real issue, and the public service reform strategy talks about the need for better governance and accountability that goes across Government, vertically and horizontally. It is an issue that we think needs more attention and scrutiny.

Paul Sweeney: Thank you. The rest of the panel members are nodding.

Craig Smith: I absolutely agree that accountability for national strategies and budget ultimately sits with the Scottish Government, although the data generated will obviously come from a variety of sources, including providers. The third sector has a key role in providing that, as do local authorities and IJBs, but there needs to be some sort of systematic attempt at having coherent data sets that goes beyond what we have at the moment.

On publicly available mental health system performance data, we have the mental health indicators and, more broadly, waiting times, referral numbers and delayed discharge figures. However, we are lacking outcomes-based data, which we have all been calling for and which is definitely, as has been said, sitting there in various places, possibly in very different forms. There is a key role for Government in working with partners to have nationally consistent sets of outcome data that are available to inform national planning but also local planning for service delivery and reform.

Going back to your original point, there are definitely examples of that happening with outcomes-based data. In England, for the NHS's national programme of talking therapies for depression and anxiety, patient-level outcome data on recovery rates and people's movement towards employment is routinely collected and published at a national level. There are definitely models in which that is happening in different areas, but, in the system as a whole, we need a fundamental shift to measuring the impact of what is being delivered. We know anecdotally that there is a lot of good work being delivered in clinical settings and in third sector and community settings, but we do not have a consistent approach to data and the sharing of that data to allow good practice to be shared and learned from, but also to allow a more strategic approach to designing our services.

SAMH is about to launch what we are calling the nook, which will be a network of walk-in mental health hubs. We will be taking a really intentional approach to managing and developing our data sets around the impact that the nook will have. It will provide free access to non-clinical psychological support, group support and a wide variety of interventions without waiting lists. We will take a very systematic approach to the data on how the nook impacts people's individual mental health and wellbeing but also to the wider system data on what impact it has locally on access to wider mental health services and pressure on the statutory sector. We need to do that more consistently as a country and as providers, so that we have that national programme.

It goes back to some of the positive stuff that we see in the population health framework and in the health and social service renewal framework about commitments to having a needs-based assessment of the health and social care setting and a desire to move towards an outcomes-based model of system design. However, we are still far away from knowing how that will be implemented, and we do not really have any information yet. It is definitely positive that that seems to be the direction of travel, but we need much more detail about how it will be operationalised in practice.

Brian Whittle (South Scotland) (Con): Unsurprisingly, I will continue the conversation on preventative spend and how we deal with that issue. In Scotland, we have a comparatively high level of economically inactive people, and a high proportion of that is health related. I have quoted extensively the—now dated—Mental Health Foundation's "Food for thought: Mental health and nutrition briefing", which looks at the impact of food on mental health, and SAMH's connection with physical activity. We recognise—I am quite sure that everybody here recognises—that, if we could tackle the issue of economically inactive people by preventing that from happening in the first place, that would mean more money coming into the system. However, that money would not come to the health budget.

On preventative spend, I believe 100 per cent that what we eat and how we move about has a huge impact on our mental health. How does that weave its way into the budget in a way that is effective and that we can measure? That is an easy question to start with.

Calum MacLeod: That is one for a three-day conference, I think.

You are right to raise the challenge of how that is weaved in in practice. As I said, that goes beyond the mental health budget itself. If we look at the national picture, there needs to be a focus on what the preventative dimensions of other portfolios are. However, although the population health framework talks about taking a whole-Government approach and having a "health lens approach" when looking at different activities, we are not near putting that into practice at the moment.

This sounds very dry, but we need to be in a situation where Government departments are able to identify what lines of activity they are undertaking—in relation to good food or physical exercise, for example—that have a preventative dimension to them. They need to be able to quantify and document that. Until we have that, it will be very difficult to move forward beyond the warm words about prevention and actually put that into practice.

We have already alluded to, as Mr Whittle has, the challenges and profound dimensions of economic inactivity. When people are living in extreme poverty, it is incredibly challenging for them to engage in ways that will enable them to make the most of their life chances.

09:45

We also need to think about how poverty ties into this and the types of interventions that will help people to move out of poverty. I think that we all share the ambition to fundamentally reduce child poverty. What are the mechanisms that will enable that to happen? This is not the only thing, because this is a much more complex set of issues, but, when you look at the Scottish child payment and its impact on child poverty, that is a fairly fundamental dimension, and it has an impact on people in poverty who are in work and the opportunities that they have.

We need to be able to cut across the different portfolios and have transparency and accountability for the types of activities that they are undertaking, so that we can start to track that in practice. Until we have that, it will be incredibly challenging to move that agenda forward. I welcome the framing through the strategies, but more needs to be done in relation to the practicalities.

Brian Whittle: I will summarise that. You are saying that the Government's overall policy strategy is the strand that should run through all the other portfolios.

Calum MacLeod: Absolutely. That is fundamental. I will go slightly further than that. There absolutely should be a "health in all policies" approach, but we need a "mental health in all policies" approach. Mental and physical health are intimately correlated—we know that. That is a very strong message that the Mental Health Foundation is pushing.

Emma Congreve: At the Scottish Health Equity Research Unit, we have talked a lot about the warm words in many of the strategies about producing a cross-Government approach to health and about the realities of how the Scottish Government operates in quite distinct silos by portfolio. I agree that shifting that to find a way whereby civil servants, including those in the finance and exchequer teams, can grasp the issue in a meaningful way will be difficult. I am worried that it could go too far one way, with almost every portfolio claiming that it is preventing poor health. The entirety of the early years budget could be talked about as being key for child development and for health among children and in later life. The entirety of the affordable housing budget could come under that, too.

We must be careful, in trying to do the right thing in identifying how prevention works for health, that we do not oversimplify things. Unfortunately, that means a lot of quite nuanced work is needed to understand the evidence that comes from good-quality evaluations that show where particular interventions feed through into longer-term health outcomes.

The Scottish Government's evaluation of the effect of the five family payments on child poverty said that it was a mixed-method evaluation. However, it was mainly a qualitative evaluation in which parents were asked how they felt about what the payments had done for them. That is totally valid evidence, but it is not enough in itself to determine whether the Scottish child payment is impacting on health. To do that, you need to compare it with a group that did not get the Scottish child payment, such as a group in the north of England that shares similar characteristics, in order to look at the differences in their health outcomes. There needs to be a lot more evidence-based thinking about how you do this. I know that the Scottish Government is thinking about preventative spend, and the public service reform strategy talks about it.

We are looking for the spending review and budget this autumn to start to set out from the Government's perspective how it will shift to preventative budgeting in a way that is robust and on which there is consensus. There are round-table discussions happening with Public Health Scotland support. There is activity happening here, but there is no easy solution. It is not just about moving numbers around on a page; it is about really understanding the good-quality evidence that exists that helps us to understand what the long-term outcomes could be.

My view is that, rather than trying to tackle the whole health, housing and early years budget at once, we need to start small. We should look at where marginal changes are being made to budgets year on year, really understand why those decisions are being made and what evidence supports them—it could be a change in priority for affordable housing, for example—and then track that over time to look at outcomes with good-quality evaluation evidence.

It is a big task and it needs to be broken down into small parts. It will become meaningless if you just chuck whole portfolios into a prevention bucket. Trying to find a way to do something meaningful that everyone can understand and get behind will be very important moving forward.

Professor McKay: I have spent a long time on this, and we have been talking about prevention since at least the Christie commission, which was 14 years ago. We have not done it—and not because people do not want to do it. We must recognise that there are very big conceptual and practical obstacles to doing it.

Perhaps starting with mental health and looking out to wider Scotland on wellbeing is looking at the wrong end of the telescope. I tend to agree with Emma Congreve. One of the things that we commented on in the Scottish mental health law review was that—certainly in mental health services, but you can say this about public services more generally—there has not been a lot of innovation or new things tried over the past 10 years. There are international models of mental health services and community-based services, but we do not see them here. We need to build in scope to do some things differently and properly evaluate whether they make a difference, and then think about how we can scale them up across public services more generally.

Calum MacLeod: Can I briefly come back?

Brian Whittle: Of course.

Calum MacLeod: I want to clarify the qualitative-quantitative dimension. I am absolutely as one with my colleagues here on the need to be systematic in the approach that is taken to evaluation. Going back to Colin McKay's latter point on innovation and opportunities and perhaps what has been stymied in the Scottish context, from a mental health cross-portfolio perspective, there are opportunities. The foundation is developing a proposal, which is included in Scotland's Mental Health Partnership manifesto for the next election, which calls for the establishment of an improving Scotland's mental health fund. That is designed to do precisely what we are talking about, which is to have strategic innovative interventions that can be scaled up and applied across different portfolios in different contexts.

At the moment, we have a communities mental health and wellbeing fund, which has been running since 2020. The fund has been very useful,

delivering £81 million of funding for prevention, promotion and other elements. That has been at a very localised community level—at grass-roots level—which is hugely important. It has delivered funding of £10,000 for community groups to do things. That is brilliant. What would be very helpful to complement that activity is precisely what Colin McKay is suggesting: scaling up things, being innovative, mainstreaming them and seeing what difference they are making in practice. There is an opportunity to do that.

Brian Whittle: I have a quick question. Do politicians think too short term to adopt effective preventative approaches?

Calum MacLeod: We will soon find out, because an election is coming quite soon. I absolutely agree that they do, because there are political cycles.

We see that with the Christie commission. The report was published in 2011, and we are all familiar with what the issues are. We know that there is pressure on services. We know that there are different ways to untie that Gordian knot, but no one, for all sorts of reasons, is able, or thinks that they are able, to begin to do that. We must start to look to the longer term and have in place practical measures to address those issues. The projections show that public services are fiscally unsustainable, so, unless we do that, we will not meet the challenge.

Yes, we need to think about political cycles. Other committees in this Parliament have carried out similar inquiries in the past. We need to think about turf and resources and about how different organisations are ready to collaborate and collate their resources for the common good. There is a whole bunch of issues that are structural and cultural and that are by no means easy to address, but we absolutely must start to address them, because they are not going to go away.

Brian Whittle: Given that we are not having a three-day conference, convener, I will leave the point there, but I hope to be able to come back in later.

Patrick Harvie (Glasgow) (Green): This is day 2 of our taking evidence on the same topic. I want to explore the same territory that I did previously, on the prevention aspect.

First, I will set out the current state of affairs. The Mental Health Foundation's evidence says that

"the policy dial has yet to shift decisively towards primary prevention",

but that

"there is clear evidence of preventative spending activities in relation to mental health."

I suggest that we are seeing some positive evidence about what we might call discrete preventative activities—in particular, those provided for individuals who are known to have challenges or issues in their lives, which aim to prevent them from becoming more seriously detrimental to their mental health. However, we are not yet seeing the avoidance of decision making that can create such detriment in a wider sense.

We have all spoken about the pressures on IJBs and other parts of the public sector. In my own area alone, I have recently had to raise issues about cuts to community mental health teams, specialist services for people with acute needs caused by trauma, and counselling for survivors of sexual violence. Glasgow MSPs have recently been briefed that there will be a withdrawal of assessments for attention deficit hyperactivity disorder in adults in our area. I am constantly being contacted by people who are waiting for gender-related healthcare, who are being told that they will have to wait for many years even to begin to access the process.

Therefore, although some positive preventative activity is happening, a great deal of the decision making that is going on actively undermines people's mental health. We are firefighting while setting fires. Is that a fair analogy?

Craig Smith: Yes—that basically summarises our position. It comes back to what I said in one of my first interventions. There is a really positive direction in policy making. For example, there is a lot of great stuff in the mental health and wellbeing strategy and in the "Creating Hope Together" suicide prevention action plan. However, there is a real disconnect between people's experience of mental healthcare and treatment, and support more broadly, and all the intersectional aspects on the ground that you mentioned. That is partly down to budget. Over the past few years, we have seen local budgets being hugely constrained, which impedes the ability of IJBs, health boards and local authorities to deliver services that meet people's needs.

As has been mentioned, we are currently in a mental health crisis. According to census data, in the past 10 years the number of people who have self-disclosed mental health problems has more than doubled, and it has gone up more quickly than the figure for any other group of illnesses or diseases. The number of young people who self-disclose such problems has gone up by more than six times. We are in the midst of a crisis, yet there is a significant disconnect between national policy and local delivery.

The community wellbeing funds that have been mentioned, which include separate funds for adults and for children and young people, are very

welcome. They represent the Scottish Government's flagship approach to tackling inequalities in mental health services at community level.

10:00

Those funds absolutely do deliver good pieces of work, but when the £15 million in each of them is spread across the piece—among third sector interfaces in the case of the adult fund and among local authorities in that of the children and young people's fund—it means that in each case a tiny piece of money is trying to go a long way. The funds are also very project based, so there is a lack of data about their overall impact on the mental health system and the people whom they support. I should caveat that by saying that the funds are supporting really important projects.

SAMH would like to see a much more systematic approach to community mental health. That is one of the reasons why we are opening the nook, which I mentioned earlier. It is a network of walk-in hubs for mental health services, which will be free for people to access. They will also provide significant outreach services, particularly to various communities, through aiming to tackle inequalities caused by identity or deprivation issues. However, we need to self-fund that work, so we are trying to develop the evidence and case for a more systematic approach to community mental health in the future.

There absolutely is good policy direction and there are some very good individual pieces of work, which could broadly be termed prevention activity, ranging from primary prevention all the way through to secondary and tertiary intervention. However, the approach is very piecemeal: not enough is being done to collect evidence or to share good practice, because the systems are not there.

Fundamentally, that comes down to the lack of funding. Across the country, IJBs are closing services. For example, as I said earlier, Aberdeenshire defunded its suicide prevention budget entirely because it was not under a statutory obligation to deliver such services. That is not necessarily the IJB's fault—it does not have the money. The overall approach needs to come back to fundamental questions about how we should design the system so that it is effective, represents value for money and makes positive impacts on the individuals, families, wider communities and society that it supports.

However, there needs to be a fair funding package for local government. The third sector clearly has a key role to play in that. There also needs to be fairer funding for third sector delivery organisations, which, in general, are still subject to annual funding cycles and so have constrained budgets. We need to make much quicker progress towards having multiyear funding at a local level, so that we can develop innovative projects and have confidence that they will be retained and not be subject, each year, to the threat of having their budgets slashed or of simply being closed.

Patrick Harvie: Thank you. Would anyone else like to come in on that point?

Professor McKay: There is no getting away from the fact that, if we are talking about prioritising certain things, that will also mean deprioritising others. We have to acknowledge that reality. However, I am perhaps pre-empting what the next set of witnesses will tell you.

We must consider the process for doing that and how we can bring people along within it. Again, there is potentially a role for a human rights-based approach that would address the minimum core obligations. It should ask what healthcare everybody in society should be entitled to. For example, should there be a certain level of access to healthcare that people simply have a right to, which we should ensure that everybody has?

There might be other aspects where we just have to say that we are not yet in a position to do all that we would like to—perhaps for a certain group whose needs have emerged more recently. The concept of progressive realisation involves asking how we can get there. What will be different in 10 years' time that might allow us to say that, even if we cannot do everything that we would want to do now, we will have a structured, concrete and targeted process to accommodate the needs that we cannot meet just now because our systems are not set up to do so?

There is no getting away from the fact that choices need to be made, but there are also choices about how we should make them.

Calum MacLeod: Colin McKay is absolutely right to say that hard choices have to be made. In some respects, they are also political ones, given that the allocation of scarce resources is pretty fundamental to them. Mr Harvie, you mentioned a litany of issues and challenges that you are having to deal with in your constituency, which we are all very familiar with.

I will give an example of something that is working well. My work does not overlap with your other area of inquiry, which was the pathways for autism spectrum disorder and ADHD. However, the Mental Health Foundation is involved in a project called together to thrive, which is based in Dundee, in the constituency of one of your fellow MSPs, Joe FitzPatrick, who has been along to see it. The project provides support through a task-sharing approach. A partnership across the Mental

Health Foundation, CAMHS, the local authority and local primary schools supports the parents of children with neurodevelopmental support needs to manage aspects of their behaviour that can encroach upon the parents' own mental health. The project is working effectively. It has recently been evaluated, which showed that the opportunities and practice that it provides are making a difference to kids' lives.

Although that is an example of a particular project in a particular locality, there is no reason whatsoever why it could not be scaled up—with the caveat about available resources, of course—to contribute to an area of public policy that is extremely challenging, which the committee is having to deal with.

Patrick Harvie: I have a final question. In response to quite a few of our comments, all our witnesses have spoken about the need for cross-governmental approaches and for not seeing the issue as relating to health budgets in isolation.

Also there has been a heavy emphasis on having a more systematic approach to gathering data and evidence to show that preventative approaches work. If I might play devil's advocate a little, I suggest that perhaps we need to be less focused on that data and evidence. Let us imagine that, somewhere out there, there is a parallel world in which Scotland has already got to grips with the issue and has deeply embedded a preventative approach to health, including mental health, right across Government. I suggest that, in that world, in economic policy, transport policy, food policy and all sorts of other areas, decisions would routinely be made in the knowledge that their health effects would not be felt for many years. Therefore, the least-cost or quickest options would often be set aside; the policy choices that would boost economic growth—or whatever the other immediate Government objectives might be—would not be prioritised; and the Government would accept that evidence for any health impact would be felt over a much longer period than it is realistic to measure.

Brian Whittle is right about the effect of the short-term political cycle, which runs for five years. However, there is a much longer-term cycle—which runs across decades of people's lives—over which the impact of genuinely preventative approaches to health problems will be felt. Do we not need to be just a little bit less rigorous about saying that preventative approaches must be able to show the same robust data as would be provided for, say, a vaccine programme?

Calum MacLeod: I will come back on your devil's advocate point; I am glad that you have raised it. I have some sympathy with that framing of the issue, but we need evidence. Frankly, we have evidence of the challenges that people are facing in their everyday lives. We know that already. What we need is political will translated into policy action that will move the warm words, the rhetoric of frameworks into—I will defend this—measurable or impactful policies that will make a difference to people's lives. It seems trite to say that, but that is fundamentally what it is.

If we are talking about timeframes, yes, there is a political cycle and there are issues with the fiscal sustainability of the public purse. Fundamentally, we need to extend the time horizon and to start acting now. We need an evidence base that we know already exists in data across different organisations and entities. We need to connect them up in a much more cohesive way. Frankly, that will only come from direction from parliamentarians and Government.

We have talked about different approaches to tracking spending, the need to go across different portfolios to look at differences in practice, a human rights approach to budgeting and so on. We need to do all of that and we need to do it in a way that can be evidenced because we need to see that it will make changes to people's lives, in your constituency and everybody else's constituencies, across the different elements that we are looking at. If we do not do that and if we do not have a focus that enables us to put the warm words of policy ambition into practical action, the generational dimension of this is lost and, fundamentally, people's lives will be blighted and will continue to be blighted in ways that they should not be in 21st-century Scotland.

Emma Congreve: I will come in on two points. The first place to start when you are trying to build an evidence base is to understand what your logic model is. A lot more transparency is needed when decisions are being made to cut services, to scrutinise—without needing a peer-reviewed journal that says this will have a negative impact on health—what impact will logically follow that decision.

I am the interim chair of the equality and human rights budget advisory group, and we have been asking for that scrutiny in the equality and fairer Scotland budget statement. We need to look at not just the good examples of an increase in spending and the logic and the evidence that supports what that will produce, but examples of decisions that are made to cut funding. The same transparency needs to follow through in what the people who are making that decision understand to be the short, medium and long-term impacts. That is a step that we can take in the scrutiny space, and I think that the Parliament has a role there.

It feels quite messy and I do like your question, but I also want to talk about the issue of deaths from drugs, alcohol and suicide, of which we know that mental health is a big part. We know that

those deaths will peak in people's 40s and 50s, although obviously it depends on people's unique circumstances. However, we are spending a lot of time, energy and money on the crisis intervention point there and not a lot of thought is going into the primary prevention part of it. I think that , when we have any big crisis—economic inactivity, the drug deaths crisis—there is a role in being able to properly scrutinise the response. Is it a crisis response only or is it thinking about what will happen for the next generation?

We are facing huge human as well as economic and social costs with some of these crises. With attention earlier in people's lives, you can prevent a lot of that from escalating and happening. That involves housing, social security and all those portfolios. It then goes through into the early intervention spaces in the homelessness system and the criminal justice system. Those are all joined together, but we do not really have that debate when we get these big national crises. It is, "Well, we need to do something here, now." We forget about prevention, and then, when some of the big crises emerge, it is suddenly, "What are we going do about this now?" That is, in part, an issue of scrutiny from the media and other places of what a minister is doing about this right now. I think that there needs to be a bit more of, "What are you going to do to prevent this from happening in the first place?"

Patrick Harvie: Thank you.

The Convener: We are rapidly running out of time and we have one final theme to cover. If witnesses could be concise in their answers, that would be very helpful.

Elena Whitham (Carrick, Cumnock and Doon Valley) (SNP): We have already touched massively on the theme of prioritisation approaches, which I was going to look at. I am interested in understanding how integration authorities can use a programme budgeting and margin analysis approach—we really delved into that last week—when they set their budgets at a local level, in the light of the resource pressures that are out there, obviously with the aim of progressive realisation over a period of preventative spend so that everybody gets to a space where they have good mental health and any acute issues are addressed quickly. Is that an approach that you recognise and that you would say needs to be followed in order to be transparent and to have the decisions that are taken understood by everyone, as opposed to just the firefighting and salami slicing that we are seeing at the moment?

10:15

Emma Congreve: I am not an expert on PBMA approaches. The principles of it are understanding the totality of your programme budget and then looking in detail at the marginal decisions that are made—where money is put up here and down there. There is a system of prioritisation and a systematic framework so that there can be an understanding of the decisions that are taken, how they align to an outcome and then how decisions are prioritised on that basis. It makes a lot of sense, but my concern about that is that it is a big leap from where we are now to where we need to be. It is potentially an approach that may work, I do not have enough knowledge and experience of it. However, the principles make a lot of sense: understanding where you are now and then taking an approach where you look at the decisions in front of you each year and have a process for prioritising those. It feels like that is how you should do budgets yearly or three-yearly. It makes sense to me, but it feels like we are quite far away from being able to recommend that or know whether that is the right approach in its specifics for what we are talking about today.

Elena Whitham: Is there a risk that, in employing that approach, you could end up with a head-down look as opposed to a wider look across different silos and how decision making extends beyond the immediate decision for that particular budget?

Emma Congreve: Absolutely. When I was here last year with Cam Donaldson we talked about that a little bit. If you were talking about the mental health budget, say, that approach could not be taken just by the mental health decision makers, because decisions across Government affect the demand for mental health services and the wellbeing of the population as a whole. If you were to use that approach for mental health, you could not base it just within the health portfolio—I think that that is the key thing. You would need buy-in from across different parts of Government. PBMA exists, is used and has a methodology behind it, so it could be explored more widely. Fundamentally, yes, I agree; it cannot be happening just within the health portfolio if mental health is the subject that you are looking at.

Elena Whitham: In 2016, the Scottish Government issued guidance that a prioritisation approach was the decision making process that should be utilised. If we think more widely, the survey of the integration authorities showed a stark picture as to how that is looking on the ground. In the absence of something as direct as a PBMA approach, how do we get our integration authorities to use prioritisation? Do you have any suggestions, considering the prevention agenda

but also the big reform that is needed? How do you do that in the light of those things?

Professor McKay: The point about programmes is that they probably need to be at a larger scale than an individual agency or an individual local authority. Unless you get into issues around pooling budgets and moving resources around the system, I do not think that it will work. You need to think about what the other levers are that will facilitate money being moved from the place where it is now to the place where it would need to be to make a real difference.

Elena Whitham: In that light, is there perhaps a need for a transformational reform-type budget to be made available to drive decision making from other places, levering money and resource from other places into making those tough decisions? If not, you will be trying to make decisions in an ever-reducing budgetary context, and that makes it really difficult.

Calum MacLeod: First, I agree entirely with what Emma Congreve said about the approach. Yes, I think that there is an opportunity to do that. That would have to be done or certainly examined—we are not looking at Etch-A-Sketch budgeting here, but we are looking at quite a change in the approach. There is a public finance budget obviously, but there are principles as well around how to encourage that approach. There is a public service reform process that has been on-going for some time and that will go beyond the next election. There is perhaps something to be explored, and I put it no stronger than that, in terms of what duties lie with particular authorities and how they are acting in practice, for example, in terms of the reporting that is done and the mechanisms that are used in that. There is also, more broadly, an opportunity—I will come back to our improving Scotland's mental health fund concept; this is a more specific point—for harnessing resource from the public purse, but also from other sources, to enable us to do the innovative, at scale, strategic resourcing that can be done to put outputs and outcomes into practice that make a difference for people. There is a whole bunch of stuff that can be taken forward in that sense.

Elena Whitham: Okay. Finally from me, in that vein, where is the role for community planning partners in that space? If community planning partners are the ones that take in all of those different elements of our society, where is their role in setting the transformation agenda and driving forward the expectation as to how budgets are prioritised?

Calum MacLeod: At community and regional levels, they have a very important role to play. What that looks like in decision-making processes and interaction with other governance structures needs a bit more thought than we can have in probably 30 seconds. I think that there is certainly something around how we co-ordinate existing governance structures at the local and national level to bring all the factors into play in a much more cohesive way than we have been able to do up to now. I am afraid, that that means trying to break the circuit between short-term focus and longer-term preventative investment.

The Convener: I thank the panel for their evidence. We will suspend briefly to change witnesses.

10:22

Meeting suspended.

10:30

On resuming—

The Convener: Welcome back. Under agenda item 2, we will continue to take oral evidence as part of the committee's pre-budget scrutiny for 2026-27. I welcome to the committee Duncan Black, who is chief officer for finance and resources at Glasgow city health and social care partnership, and Hamish Hamilton, who is chief finance officer at West Lothian IJB. We will move straight to questions.

Emma Harper: Good morning. I found the previous session very interesting. I know that our population health framework is a joint Scottish Government and Convention of Scottish Local Authorities framework. I am interested in how mental health funding is delivered for integration joint boards, because some IJBs have different mental health approaches. How do we compare and know whether some things are working well and others could be done differently?

Duncan Black (Glasgow City Health and Social Care Partnership): I can speak for the Glasgow city IJB, if that is helpful. Mental health services are a function delegated to the IJB and are a core part of the services that we are responsible for directing back to the health board and the council. The lion's share of the spend is on health budgets and employee costs. It is a central part of our strategic plan—you will see it throughout that. It is reflected very strongly in a lot of our performance information, which you might have seen.

On how it is delivered, there are elements of what we call hosted services. I am not sure whether the committee is fully familiar with those. There are areas of specialist services that are hosted across the health board area. For example, specialist children's mental health services are hosted by East Dunbartonshire integration joint

board, and there are other pockets of those services across the city.

There is a function delegated to the integration joint board, which I am pretty sure is constant across the country—perhaps Hamish Hamilton will come in and describe what is happening in Lothian. However, within that, there are elements of nuance around hosted services, as I say, which are at health board level.

Hamish Hamilton (West Lothian Integration Joint Board): Our mental health arrangements in Lothian are similar. In West Lothian, we are slightly different in that our HSCP, which is coterminous with the integration joint board, manages a lot of the services itself. We manage our own adult mental health in-patient services, right through to mental health officers, supported accommodation and care at home—that is all done by West Lothian health and social care partnership. In the Edinburgh and Midlothian integration joint boards, the situation is similar to what Duncan Black has described. The in-patient services are hosted—they are managed in an operational business unit within NHS Lothian on behalf of those IJBs—whereas the community services and social care services sit within the HSCPs.

It is helpful that Lothian and Glasgow have multiple HSCPs and IJBs, so that we can benchmark, see how we compare with one another and try to learn from one another. In Lothian, we have a mental health and learning disabilities transformation programme with membership of chief officers from across the four IJBs—I am on it as one of the chief finance officers—and membership from NHS Lothian. We have a number of workstreams that are focused on looking at what we could do better.

What is delegated to IJBs for mental health is extremely complex across the country. I think that CAMHS is delegated to Glasgow city IJB, but it is not delegated in Lothian at all. Making comparisons across the country can sometimes be extremely complex; you have probably seen that in the returns that you have had from IJBs.

Emma Harper: Other colleagues will come on to prevention issues, so I will not go down that route. Are there any changes that you would like to see? Everybody would probably say, “Yes, give us some more money.” Are there changes that could be made to improve mental health?

Duncan Black: Yes. The asks that I would have are pretty strategic in nature. To illustrate them, I need to talk a little bit about the challenges that we have, certainly in Glasgow, although these are not just Glasgow problems. You will have heard evidence on this already, but I want to stress the point as strongly as I can. The level of demand has grown significantly over the past number of years. The complexity of the demand has also grown significantly. In Glasgow, we have particular issues around poverty, which brings with it comorbidities, and the way that mental health needs to be addressed through things such as alcohol and drugs and so on.

In Glasgow, we have the huge additional consideration of homelessness, with 7,000 people in homeless accommodation. Not entirely unrelated to that, we have issues relating to the communities that we serve; at the moment, there are about 169 languages spoken in Glasgow. We have an incredibly complex environment and an increasing level of demand, and those two things together are putting extraordinary pressures on the IJB and the services that the HSCP deliver.

Funding is obviously crucial. As we know, funding is restricted and is not able to meet the level of complexity in the demand. My first key ask, as chief finance officer, on what would help in our very challenging environment is certainty. The point was made earlier about multiyear budgeting. I know that that is not entirely within the gift of the Scottish Parliament, but getting earlier notice of our funding settlement and having longer-term certainty around it would be enormously helpful with the strategic response to the crucial issues that I have just outlined.

I also point to non-recurring funding, which, as an issue, is perhaps more around the edges but is still an irritation, if I can put it that way. It feels, at times, that my hands are tied in terms of the agility of services, whereby, as CFO, I might not be able to permit a longer-term commitment to services if they are not underpinned by recurring funding. In that, we are thinking about contracts with commissioning services and the contracts that employees have. Therefore, we have a number of service areas in which the approach is more short term, which is obviously not helpful when it comes to a strategic response.

My final point—there are probably two parts to it—is about new legislative asks. New legislation goes through the Scottish Parliament all the time; that is the case as we speak. My ask is that any new duties are fully funded, because, if they are not, that adds to the complex decisions that we have to take around the allocation of our finite resource.

The second part of that is about ring fencing, which was alluded to earlier as a tool that can be used by Scottish ministers to direct funding. My slight pushback on ring fencing is that it begins to undermine local agility. You will have seen views from local organisations on that. It begins to cut across what we can and cannot do with our finite budgets in that complex environment.

Emma Harper: My final question is about multi-annual funding, which came up in the earlier session. Brian Whittle asked how we manage that away from the politics. Full fiscal autonomy for Scotland would allow us to deliver policies independently. The last time that the figures were published, we saw that £600 million—more than half a billion pounds—was invested to mitigate the bedroom tax that was implemented by another Government. As well as multi-annual funding, would it not be beneficial to have more fiscal autonomy?

Duncan Black: I refer to my previous answer. At a local level, as the CFO of an integration joint board, it would be incredibly helpful to have greater certainty around funding, providing a forward look not just to the next financial year but over multiple years. If we can get greater certainty on funding, it would allow us to plan more effectively and strategically.

Hamish Hamilton: I will add to that. We receive our funding from our council and NHS Lothian partners. We do not have certainty on our budgets until February and we set our budget in March. With the way that it works for the health boards, their financial plans are normally only indicative until April. Therefore, although we agree our budgets in March, which we are required to do, that is with the caveat that the health board budget might change and we might have to go back to the integration joint board with a subsequent change. That just adds a bit of context and clarity to what Duncan has already said.

Paul Sweeney: Thank you for coming. Our previous witnesses told us about some of the difficulties with the picture that the data that is collected gives at a national level vis-à-vis the local level. The committee issued a survey to integration authorities to get a feel for the data gathering that is undertaken. It has proven to be challenging to draw firm conclusions from the data that is gathered, and it is not clear that the data is comparable across different IJBs or health and social care partnerships because of the variation in delegation of mental health services and the different formats in which it is gathered.

I would like to get an understanding of how and where you report on mental health spending and of how you categorise that spending as part of your wider financial controls process.

Hamish Hamilton: In West Lothian, I report to our integration joint board. We meet seven times a year. Regular updates are provided to the board on the forecast outturn for the year—in other words, where we think that we will be against our budget at the end of the year. Mental health is a category within social care and within health. To put the issue into context, West Lothian IJB has a mental health budget of around £38 million, which is about 11 per cent of our IJB budget. The majority of that sits in health, and just shy of £8 million sits in social care.

On the detail that we get into on the integration joint board and the discussion and scrutiny that take place around mental health, there tends to be a focus on the financial pressures on the mental health budget. In the past year, those pressures have predominantly related to social care. Last year, we overspent against the mental health budget in social care by about £800,000, largely due to increases in demand and complexity.

We also have regular budget development sessions in which we look at savings for future years, but, by and large, we have tried to protect the mental health budget. We have not had to make extremely difficult choices about savings. We are still focusing on efficiency. That involves reducing the costs of inputs—for example, by trying to get permanent staff as opposed to using expensive agency staff, thinking about where we can recruit nurses in places where we cannot get doctors and looking to do things differently.

10:45

Within social care, we are looking to do more closer to home, in an effort to reduce out-of-area residential spend. Our fiscal position for the next three years is extremely challenging. As an IJB, we have a budget gap of £23 million, and the majority of the pressure is on the social care budget.

Duncan Black: I can give a flavour of the financial situation that we face in Glasgow. Last year, we had to come up with £42 million-worth of savings as part of our budget setting. Around £2 million of those were allocated to mental health services. As Hamish Hamilton outlined in relation to West Lothian, a smaller portion of our overall savings as a proportion of overall spend has been coming from mental health services as opposed to non-mental health services.

That is a reflection of two factors. The first is the sheer scale and complexity of the demand, which I outlined earlier. Secondly, the nature of that spend is such that a huge chunk of it goes on employee costs, which are fixed. From a core accounting point of view—putting aside the question of whether it is the right thing or the wrong thing to do—that is not an area of cashable savings, if I can put it that way. That sounds a bit blunt, but, frankly, that is the reality of the situation when it comes to the raw numbers.

Your question was about the availability of financial information and the comparability of that information across the country. As Hamish Hamilton outlined in relation to West Lothian, in Glasgow we report regularly on our budget, our

monitoring and our outturn. We do that initially through our integration joint board and subsequently to the health board and the council. Over and above that, numerous layers of information are requested by the Scottish Government and other bodies. We can cut that information as requested.

As with any data collection, comparability is always an issue. A lot of the devil is in the detail, but if an ask for information is made to us as chief finance officers, we should be able to collect that for you. We should be able to find ways around any comparability issues within materiality levels that are useful.

Paul Sweeney: We know from the survey that the committee carried out how difficult it is to get robust figures and how difficult it is to collect consistent data that enables sufficiently detailed comparisons to be made to provide an insight into how mental health budgets are allocated. What needs to be done to ensure consistent reporting of mental health spending at a national level? How can we get that functioning for IJBs and health and social care partnerships?

In previous evidence sessions, the committee has discussed the idea of PBMA models, which could allow us to have real-time assessments of incremental changes in performance and would allow financing to be adjusted in a more consistent way. One of our frustrations is that we have heard anecdotal evidence that programmes are funded one year and then switched off the next year. There seems to be a reactive approach to overspends or saving requirements, which might not measure value, as opposed to cost savings.

If you were designing the system and you had total control over what you could do to optimise its performance, what improvements would you make? Could you give us a flavour of what you find frustrating, from your perspective, in trying to deliver a high-quality public service?

Duncan Black: In the Glasgow HSCP, the integration joint board has asked officers to take a different approach in responding to the budget challenge over the next three years. In the past, we have had a savings target, which has been allocated across services and in relation to which options have emerged from senior management. To be fair, a nuanced approach has been taken to potential impacts, and the adverse impacts of different options have been compared. As an approach, it is not entirely blunt.

However, in looking ahead to the budget-setting process for 2026-27 and the three-year period beyond, we are in the process of implementing—to use our terminology—a service prioritisation approach, which, on the face of it, has certain similarities to the PBMA approach that the committee has heard about in previous sessions.

That will be a really different and new way of looking at our budget-setting process, which will involve looking at every line in the budget functionally and subjectively in order to get an initial understanding of what the money is spent on. That might involve tidy-ups to make sure that things are reported in the right place. We will then apply a service prioritisation lens to each functional area over a three-year period to make sure that we look at every aspect of the HSCP's activity. As part of that assessment, we will apply critical success factors, against which we will score each area.

There are some obvious factors that we will consider initially, such as whether the area of spend is a delegated function that we have been tasked to do, whether it is a statutory function and whether it is a strategic priority. That will involve thinking about each of our strategic priorities. We will probably come on to this, but prevention and early intervention is the first strategic priority in our IJB strategic plan. We will assess each area of spend in relation to various factors.

As part of that process—this is where it will get really tricky—we will look at the evidence base for the impact of each area of spend and the outcomes. Perhaps the committee will explore that in further questions. The main challenge that I foresee relates to the availability of impact and outcome evidence in support of that assessment. That was touched on in a previous question.

That is the intention—that is what we will try to do. That will allow us to assess the impact of each area of spend across the IJB and to identify which has the most impact within the boundaries of statutory and non-statutory services and so on.

I hope that that was helpful.

Paul Sweeney: It was helpful. Do you have any insights into how the reporting process could be optimised? How can we make it consistent at a national level?

Hamish Hamilton: The integration joint boards have been set up in such a way that each IJB area has its own integration scheme, which is local. In West Lothian, the scheme involves NHS Lothian and West Lothian Council. However, the functions that West Lothian Council has chosen to delegate to the IJB are different from those that the City of Edinburgh Council has chosen to delegate to the Edinburgh IJB. I am not sure that there is an easy way to make everything consistent. Child and adolescent mental health services are not delegated in Lothian, but they are in Glasgow.

On reporting, I think that the PBMA approach is fantastic, and it is one that we would strive to take.

However, if I can zone in on mental health in particular, I am not sure where we could stop doing something to invest in something else, because we are under immense pressure across the full spectrum of our services, and we have a finite amount of money. In addition, we are a public-facing board, and it can be very challenging to get decisions made that may be unpopular. Let me take the specific example of neurodevelopmental disorders. In West Lothian, the waiting list doubled between 2023 and 2025, and it has increased by about 900 per cent since 2020. That is not an area that we have taken any savings out of; it is simply that demand has exploded.

Although the principle that you are talking about is a very good one and is one that we would like to adopt, it is difficult to make that happen because, as Duncan Black mentioned, the majority of our budgets are fixed in that they relate to staffing costs. We cannot suddenly not have our staff just because we want to do something different in a part of our service. Mental health is a very good example of an area that is extremely geared towards staffing costs. Some of the acute services have big medicines budgets, and when new drug contracts come into play, it might be possible to take out savings and do something different. However, our mental health budgets relate predominantly to staffing; the non-pay budgets are very small. The budgets cover statutory staff and commissioned staff.

Paul Sweeney: That was an interesting insight into the extent to which demand has increased and how that constrains your freedom in relation to resource allocation. We will need to consider that further.

David Torrance (Kirkcaldy) (SNP): Good morning. What evidence on outcomes do you use to inform spending decisions in relation to mental health budgets?

Duncan Black: I refer to my previous outline of our service prioritisation approach. The intention there is to do exactly that: to identify evidence of the impact of the spend and assess how effective it is, which then allows us to prioritise accordingly within the boundaries that Hamish Hamilton outlined regarding what can be adjusted and what cannot.

I view it as a matter of sliding scales. For mental health, we have a sliding scale, and we then have stoppers on that scale—for example, statutory levels of care that need to be provided that we cannot go below. The lens that we will apply allows us to see what it looks like if we reduce a level of spend in one area, albeit that that is bound to have an impact that nobody particularly wants to see, and consider what it allows us to protect or invest in in certain other areas. That is the panacea if we can get to that level of sophistication in our understanding of the impact of the money that we are spending on front-line services and, therefore, prioritise that using those sliding scales. If that allows us to look at areas of protection or investment, it will put us in a pretty strong place.

Our approach to date has been to look at prevention and early intervention where we can. We have undertaken various activities around that in Glasgow, which I can go into if you wish. The overriding principle is to provide mental health services in the community wherever possible, taking them out of hospital environments and transferring the care to community services. There is a challenge in that because, in order to make that switch, the funding needs to follow it, which is often really hard. If we have adult in-patient mental health bed capacity at 100 per cent or, as it often is, at more than 100 per cent, it is a very difficult task to turn off beds to allow us to switch to community services. We need to find some capacity and headroom to allow us to do that, because the strategic direction definitely needs to take us to that switch into community-based services wherever possible.

Hamish Hamilton: One of our strategic priorities is the home first approach. The Scottish Government has made a lot of investment in home first in relation to unscheduled care, with £100 million across Scotland this year, and one of our priorities is to do something similar in mental health. As Duncan Black mentioned, adult in-patient services are often at more than 100 per cent occupancy. How can we leverage and look to invest in our community mental health teams and our intensive home treatment teams and do something similar in the mental health space?

On the specific question about measuring outcomes, I note that, because of how we are set up, a lot of what we do in the performance management environment involves measuring quantitative outcomes. How are we performing against our psychological therapies waiting list and the local delivery plan standard? What is our bed occupancy? What is our length of stay? We are looking to develop and improve on that by measuring outcomes on a more qualitative basis, which is more difficult. How can we evidence that outcomes are being delivered through early intervention and prevention and the greater focus on self-management, which is in our strategic plan? That is harder, because the data is not as readily available. What we are set up to report on routinely is our waiting list performance and our occupancy.

11:00

David Torrance: On data collection and the measuring of outcomes, is financial restraint preventing you from getting better data and information out there in order to make better services because most of the money is spent on front-line services?

Hamish Hamilton: Absolutely. We are having to prioritise front-line services. We constantly look at our statutory provision and what we have to do. On finance and the priorities around data, I note that, in my time working in West Lothian, we have had seven individuals involved in finance support to the HSCP and the IJB. We now have four, so we have had to cut back on what we are able to do.

On our systems and data, I reference again our £23 million budget gap over the next three years. That means that, as I said, we are looking at what we have to provide and what our statutory services are. We would like to do something in the background that will focus on data and potentially give us a benefit further down the road, but I do not think that I would be able to convince my board to support that, given the fiscal environment that you have highlighted.

Duncan Black: Even with additional resource, that is a really hard thing to do. It has been talked about for a while, as I am sure everyone is aware. There is source information that we can use, and it will be our intention over the next year to try to use that. We have been subject to a very recent inspection of our children's services in Glasgow, which have been given a good rating, and that in-depth and significant piece of inspection work gives us a level of assurance on the impact that our children's services are having. There was an inspection of our adult services a few years ago.

There is information out there that we can draw from, and it is important to ensure that, as much as we can, we tap into what is already out there. However, it is a challenge. I think that it was Mr Harvie who mentioned that everyone accepts that focusing on prevention and early intervention is the right thing to do but that, when we are fighting fires to maintain statutory services, it feels as if we are doing different things with each hand. That is the other challenge here.

It will not be easy, but I think that there is space to do a bit more through identifying the good-quality outcome impact information that we already have. I agree with Hamish Hamilton that, when we look at performance information, it all relates to waiting list times, bed capacity and so on. We need to get a bit more nuanced around that.

Brian Whittle: Good morning, gentlemen. I will continue with questions on preventative spend. I have a particular interest in the impact of physical activity on health, including mental health. However, we also heard from the previous panel about the impacts on mental health of housing, transport and poverty, so we have a multiportfolio issue here. I whole-heartedly agree with your priority on preventative spend, but how do you justify that spend by measuring outcomes? As you know, we are all going to ask that question. How do you follow the money?

Duncan Black: It was interesting to read the responses that you received from the IJBs on what is meant by the term "preventative spend". SPICe picked up on those as well. In Glasgow, we came up with the figure of £10 million, but, to be honest, it depends on where we draw the line. There is an important point about the language and what we are referring to.

That being said, there are a host of things that come into play with the preventative spend that is currently going on, and I can point to numerous examples in Glasgow. We have the youth health service and the children and young people's networking team, which support families throughout Glasgow with a focus on early intervention and prevention.

Digital is clearly a massive area of focus, and it involves early intervention through, for example, the provision of access to information and support for people who may not be in need of acute care, in order to short-circuit problems through accessible information and self-support on the digital side. Some of these services are provided not only in Glasgow, but examples of that include Kooth, which is a free online mental health digital support service for 10 to 16-year-olds. It is a text-based counselling service with self-help material. Similarly, we have Togetherall, which is another free online mental health support resource for communities.

There are other examples where we provide early access to support for people who are at higher risk of developing mental health problems. For example, we fund the Glasgow Association for Mental Health compassionate distress response service, which provides phone-based support for people in emotional distress.

I refer the committee to our performance report, which outlines those things and gives some useful case studies. Case studies are a useful tool to get in and about impacts and outcomes, because they give us a sense of what things actually mean for people on the ground.

The trick will be to consider, as I will be doing as part of the exercise that I will be working on over the next few years, how we capture that in a meaningful way that allows us to take strategic decisions on allocating spend. There has to be an

evidence base around that. There was a question or a challenge about that earlier. How much evidence does there have to be around this? I need to see a certain level of certainty, rather than just an assumption about protecting an area of spend, because of the sheer pressure on the budget.

Hamish Hamilton: Like Duncan Black, I found the different comments from the IJBs about what preventative spend is incredibly interesting. It probably comes down to people's interpretation of the term. Dundee highlighted that we could class all community and social care spend as preventative spend around mental health. For us in West Lothian, that would be about £20 million, or half of our budget, being spent on primary, secondary and tertiary prevention. However, it is very open to interpretation.

Brian Whittle mentioned physical activity and its impact on mental health. We have our Xcite health and wellbeing referral programme in partnership with West Lothian Leisure, whereby people can be referred by a general practitioner, a community link worker or another health professional and they will get lifestyle and nutritional advice and activity programmes from West Lothian Leisure. That involves using physical activity to support other treatments, or maybe as an alternative to treatment, in order to try to improve people's physical and/or mental health.

On following the money in relation to prevention and measuring outcomes, I agree with Duncan Black that case studies can be powerful. How can we say that referring someone to the programme that I have just mentioned has prevented them from needing to be taken on by the community mental health team and added to its case load? I am not sure we can definitively make that link, but that takes me back the point about getting better qualitative information on what has helped people. That area needs to be a focus for us.

I return to the point that we sometimes have to make hard decisions given our statutory spend and what we are absolutely required to do. That can sometimes be at odds with some of the really good preventative measures, because some of those things might not be classed as statutory. When we are faced with the savings targets that we are all faced with across the country, we sometimes have to make difficult decisions. However, measuring outcomes around prevention should be an area of focus, as Duncan Black highlighted.

Brian Whittle: You have got to the crux of the matter there. For example, I think that we would all agree that, if we could get good-quality housing for those caught in that trap, that would inevitably, as part of an overall outcome, improve physical and mental health; and if we improved public transport and the ability to get around, that would also improve physical and mental health. Those are budgets that are spent somewhere else—they are not budgets that you are spending—but their impact is felt within the health budget. Of course, the converse of that is also true. Is it time that we had a wee look at how we can fuzzy the edges, for want of a better expression, around budgets and the potential impact across portfolios? How do we justify that?

Duncan Black: I totally agree. It feels like everything comes back to housing. If you can get good-quality accommodation for people, a host of spend down the track can be avoided or minimised. I totally agree with the premise of your argument, but there is a practical element to this. This will be hard enough for us to do, certainly within the Glasgow IJB budget environment. We need to see how we go on with this and then look at widening it out.

That said, there are areas of good practice that I am sure the committee will be familiar with. For example, in Glasgow, there have been huge efforts in recent years on child poverty, and the impact of that is being seen on wider budgets. I come back to the point about measuring this and demonstrating this through evidence, but it seems certain that, if some of the early intervention work in children's services and on child poverty had not happened, we would have seen cases of children ending up in high-cost care packages. We could probably provide you with some very good examples that show that, if it had not been for that early intervention, our children's services budget would be in a much worse state of play and our budget gap would be far exceeding the one that I am reporting today. Although children's services are a delegated function, a lot of the work was done outwith the boundary of that.

You are right, and we are not being precious about what services we are talking about here, veering into the council, health board and other partners. There is definitely a lot in that. It is a big ask to do it at the macro level—to flick the switch overnight—but there is a lot of mileage in it.

Hamish Hamilton: I absolutely agree on the premise. We have quite a lot of good examples in health and social care. For instance, we have been able to close in-patient beds. For example, where we had people with learning disabilities and intellectual disabilities living in hospital, we were able to close those beds and take that money and commission something in people's local community so that they could be supported to live locally. That is an example of where breaking down what were traditionally the NHS budget and the council budget and bringing them together in integration joint boards—losing the fuzziness, I think you described it as—has been successful.

It would be hugely beneficial to go further than that and look at areas such as housing and how you can be more dynamic there. Housing also comes up a lot in our local area as a key issue and determinant of mental and physical health, as you have highlighted. However, sometimes the systems do not allow us to work in that way. A lot of that probably comes back to local relationships and having people who are happy to be flexible and take more of a risk. Ultimately, sometimes organisational barriers go up, which makes it more tricky. As a principle, however, I would agree whole-heartedly that we should be looking across the public sector as much as we can.

Brian Whittle: Thank you.

11:15

Patrick Harvie: Good morning. Still on prevention, as I did with the last panel I would like to ask two questions, one about the current state of affairs and one about how we would be doing things differently if we were really serious about this.

Before I ask the question about the current state of affairs, it is important to acknowledge the point that has been made that this is not about berating your organisations for the position that you are in. Some of the decisions that you are having to make are the result of a shared responsibility. It is important that we acknowledge that. Some of it is about legislative decisions that the Parliament has made; some of it is about budget decisions that the Government has made; some of it is about the United Kingdom's approach to setting budgets late and having no multiyear funding for Scotland, which has a knock-on effect; and some of it is about wider circumstances, whether it is 15 years of austerity, the pandemic, the cost of living crisis, overpriced, insecure housing or underpaid and insecure work. All those circumstances face us and we have a shared responsibility for it. I want to acknowledge that before I come on to the decisions that some of your organisations are making in that context and are maybe unable to avoid making.

Is it fair to say that we are seeing prevention being put into the Government's strategies, plans and policies but decisions being made routinely to cut really important services that act in the interests of preventing poor health and mental health outcomes? I mentioned in the earlier session community mental health teams, specialist trauma support, counselling for survivors of sexual violence, employability support and ADHD assessments for adults. All those things have been subject to cuts just in my own area alone, and there will be similar stuff happening around the country. I said that we are firefighting while we are setting fires. To torture another metaphor, we are forcing people to try to run up the down escalator to get anything done. Is that a fair and accurate assessment of the current situation?

Duncan Black: Yes, it is certainly fair to say that the scale of the financial challenge that we have faced in recent years and are facing over the foreseeable future is such that it is enormously difficult to find investment in activity that is not delivering immediate services in statutory care and so on. A huge proportion of our budget is set against providing statutory levels of care or care that is very hard to shift to be delivered in a different fashion without time, space and, frankly, the money to do it. I agree with the assessment that it is very hard to do that.

As I said in my previous answer, it is not that there is nothing happening in that space. I have alluded to a few examples in Glasgow of early intervention and prevention happening and continuing to work. I would probably put my hand up and say that we need to get a lot better at capturing that information, talking about it and using it to inform decision making. A lot of it happens, but we are not necessarily capturing and categorising it as such. Hopefully, our new approach will pick up a lot of that. Certainly, the scale of the challenge is such that it is very difficult.

To reassure the committee, as I said in my opening remarks, prevention and early intervention are our first strategic priorities in the strategic plan. They are the first things that we should be thinking about as an IJB when we are setting policies and creating our strategies. They are very much at the forefront of our minds. We do not need to be reminded of their importance, and we will be applying the strategies wherever we can in our future budget decisions, whether in mental health or our wider budget.

Patrick Harvie: In short, when we see the Scottish Government's budget—this is pre-budget scrutiny; we have not seen the budget yet—how should we judge whether it will continue to put your organisations and others in that invidious position or whether it will be adequate to start to allow us to take prevention commitments from policy into reality? What is the test?

Hamish Hamilton: Your question is how we can get assurance that the Scottish Government is putting preventative measures at the forefront. The budget is set at such a macro level that I certainly would not like to comment on how we can get that assurance from the budget. What we tend to get from the budget is what our uplift will be. For us in integration joint boards, as I have already said, it is February before we get the detail of what the budget means for us, because local authorities and health boards have to work through what the budget means for them. Ultimately, there will be

specific policy commitments; I think that I have already mentioned the £100 million for unscheduled care, which is part of the 2025-26 budget. There will be a headline around what the baseline uplift is for health boards, or maybe what has been agreed for pay, although we have a two-year pay deal for health at the minute. How do we take that macro-level document and get assurance around how preventative activities are being prioritised? I would not like to comment on that.

Patrick Harvie: I am not sure that any of us will want to comment on it in that case, even when we see the budget.

Finally, if we were already taking a much deeper approach to prevention for mental health and the other challenges that we are facing in how we do cross-governmental working, how we shift within budgets and how we prevent some of the bad actors in the private sector from making decisions that impact negatively on people's health and wellbeing, is it reasonable to say that we would still be holding some of these preventative health investment decisions to the same evidential standard? Some of these decisions are, by definition, really long term, and they will have a pay-off only over many years, potentially even decades. How do we get to a point where people can make and justify such decisions, which really cannot be evidenced in the way that a short-term decision can be?

Duncan Black: That is a question that I and the rest of my senior management team have been grappling with when thinking about the new service prioritisation approach that we will be applying. What is the timeframe lens, and what is the evidential requirement for us to tick that box? This is probably not the answer that you are looking for, but the answer that I have struck on is that I am not producing a calculator here that will throw out a yes or no answer. It will be much more subjective than that, but it is a can opener. It allows us to begin to ask those questions and look into the impact of the service and have a slightly broader lens than there might traditionally have been. It also allows that same lens to be applied across the piece, which I think is an important part of it, so that we are not just looking at functional areas in isolation. However, it is a fair challenge, and there will be a point at which we will have to say, "I am more attracted to something that will save me money within the next five years than I am to something that will save money in the next 40 years." I say that as somebody who tends to think in macro terms, and I quite like that, but the reality of budget setting and public finance is that that is where we will end up.

Hamish Hamilton: One-year budgets are very challenging. Certainly in my area, we had earmarked what we were calling our transformation fund, which was to enable good pieces of work that would transform services to be taken forward for the benefit of people in West Lothian. That fund ended up having to be used to go to the bottom line to balance the budget because of the day-to-day pressures that we were under—I think that you called it "firefighting".

I absolutely agree that we should be looking at a five-year period for what we can do today—and perhaps take a financial risk on—that will save money in five years. This is not mental health, but weight management drugs are a good example of something that is extremely expensive right now but will have downstream effects. Given the reductions in type 2 diabetes and all the care that individuals might need, they are something that we would absolutely prioritise if money were available, because we would hope that, in five years, we would see big reductions in other services, as well as reducing costs as medicines come off patent and so on. Today, however, the cost of weight management drugs would blow our budget, so the decision, as you have highlighted, is around the firefight in the short term and how we balance the budget. We would appreciate three or five-year budgets that would allow us to do some longer-term planning and to do the sort of scenario modelling that Duncan Black has highlighted.

Paul Sweeney: Capital and revenue budgets have been split since 1998, and there is a proposal to have preventative expenditure as a third component. In Glasgow, the situation around homelessness services is particularly acute—I understand that there is an overspend in the current financial year of £27 million, and that is forecast to increase next year. Preventative expenditure could act almost as a kind of automatic stabiliser, because there is a statutory obligation to meet that need, which can create an uncontrolled spiral in expenditure. We must also consider the opportunity cost with regard to capital investment in housing stock and the expansion of housing acquisition and supply and so on—I accept that that is not necessarily within the control of an IJB-HSCP. We want to achieve our mental health goals, but one of the foundations of good mental health involves meeting the hierarchy of needs—shelter, housing and so on.

It is quite clear that we are treating a symptom of a wider structural problem, and the essence of preventative spend would involve punching through that silo and taking a cross-cutting approach to dealing with the immediate crisis. How is the particular scenario that I mentioned playing out? It seems to me like there is quite a looming crisis in Glasgow, and it is probably the case in other parts of Scotland as well. However, we appear to be in a straitjacket with regard to our capacity to bring public resources to bear to deal with homelessness in a structural and preventative

way by, for example, building new stock rather than simply treating the symptoms by renting hotels.

Duncan Black: Homelessness is a function delegated to the Glasgow IJB by the council. The spend and direction of services around homelessness are within the IJB's remit. As you have outlined, Mr Sweeney, the projected overspend in the current year is significant and is predicted to grow to somewhere in the region of £60 million the following year. That pressure is enormously significant in the context of the IJB's projected budget gap next year of between £30 million and £40 million—it comes on top of that. The reason why it does not appear in my presentation to you today is that Glasgow City Council has undertaken to fund that overspend in the current year, so it is carrying the risk around that. However, regardless of who is carrying that financial risk, the issue is enormously significant for the council.

The pressure that drives those figures is purely around the provision of the housing requirement—that is, providing people with appropriate accommodation, as is required under statute. What is not captured within that is the wider impact on the services that the city provides, and, of course, the IJB will be a big part of that provision. When I was talking about the complexity of need and so on earlier, that was one of the things that I was referring to, because we have people in accommodation that is not ideal or in temporary accommodation, and there is an impact on their mental health, for example, and the services required around that.

I also alluded to the shift in the make-up of our communities, which has a big impact on the services that we deliver in terms of culture and language and so on, which adds complexity to the service response when it comes to HSCP services.

The final component is that there are also lots of associated legal costs hitting those budget lines. The issue that you raise is a huge issue for the city—it is arguably the biggest issue that we currently face financially.

You are right that the solution must involve not only funding to address the immediate pressure, but the provision of more housing, which is needed in order to solve the underlying issue. Obviously, however, funding for housing supply and consideration of the types of houses that are required to house some of the families that we see presenting as homeless in the city are not within the IJB's remit.

11:30

Elena Whitham: Good morning. I want to focus on prioritisation approaches. You have both already touched on that in the evidence that you have sent to us. Hamish Hamilton touched on the PBMA approach and the difficulties with it, and Duncan Black spoke about using a kind of slider to see what would happen in one place if more money were spent in another.

I am particularly interested in understanding IJBs' approaches to situations in which they are faced with an in-year reduction in funding. We saw that in 2024-25, when the incoming UK Government took decisions that immediately impacted Scottish Government budgets in a way that then impacted local budgets. At that point, how did you decide where you were going to prioritise the spending, and what was the fallout from that? We have heard about firefighting this morning and decisions that had to be taken. Given the context of the delegated functions, your statutory duties and the strategic plan that you are working to, how do you prioritise spending in situations involving in-year budget reductions?

Hamish Hamilton: It is extremely challenging. The mental health outcomes framework is a good example of that happening, and there is a bit of a history there. In 2022-23, we were three quarters of the way through the financial year before that funding was cut. NHS Lothian's share of that funding was cut from £10.4 million one year to £9.2 million the next, but we did not know about that until December. In reality, that meant that we ran with a big overspend that year—there was not much that we could do about it. Last year, we were six months into the financial year before we were informed, in October, that the mental health outcomes framework funding was being reduced by 4.5 or 4.6 per cent, which was just shy of £1 million for Lothian.

How did we implement that cut? We took a quite practical approach, frankly, to what we could actually do and where we could reduce the spend to match that reduced envelope. We looked at where we had temporary staff in place and made a reduction of £250,000 in psychology. There was also a decision across Lothian—the matter is not delegated to me in West Lothian—to reduce the CAMHS budget by £400,000.

Those decisions were made in relation to areas where we could influence the spend. A large proportion of the mental health outcomes framework spend was quite historical. Of the £18 million spend in Lothian, £6 million related to action 15 funding, which originated in 2017-18—that goes back to the point that Duncan Black made about funding being non-recurring for a number of years—and just shy of £3 million related to the old mental health bundle, which is at

least 10 years old. We had to look at areas where it was possible to cut costs—that is the reality of the firefighting approach that we often find ourselves having to take.

Elena Whitham: What is the long-term impact of the type of approach that we have discussed, involving year-to-year settlements, the requirement for more resourcing and the overspends that we see in different areas? I have heard from my health and social care partnership that there are major pressures in social care, so that is where the overspends are. Duncan, you have Glasgow City Council willing to underwrite and support the overspend in the homelessness budget at the moment. In the absence of that, how will you protect the mental health spend?

Duncan Black: I will illustrate how Glasgow responded to the situation that Hamish Hamilton outlined, although I only started in June, so I do not have the exact detail of how we responded. My understanding is that there was a significant in-year cut to our funding that was not anticipated. I stress that that makes things very difficult from a financial management perspective. However, across greater Glasgow health board areas, we utilised earmarked reserves to bridge fund for a period to allow for a more considered approach to how to respond to that level of cuts.

The one important thing in our favour is that IJBs are, in effect, constituted as local authorities, so we can hold reserve funds. It is incredibly important that we do that, because it allows flexibility to respond to unexpected in-year fluctuations in funding or demand. When that letter hit, a proactive decision was made to utilise some earmarked reserves, bridge fund it, and then build that pressure into the budget-setting framework in future years. That allowed us to take a slightly more strategic approach.

The impact of that kind of short-notice in-year change in funding is really unwelcome and must be avoided at all costs. The only thing that we have in our armoury to protect us against it is the use of reserves, where we have them—not all IJBs do—to allow flexibility to deal with the issue in a slightly more strategic way.

Elena Whitham: I imagine that those reserves will be dwindling and that you need to carry them at a certain level to be able to operate in a fiscally responsible way. Going forward, is there a need for an injection of some type of moneys for reform to give that kind of headspace to be able to look strategically and lift your head up from the firefighting aspect?

Hamish Hamilton: I fully expect to have no reserves by the end of this financial year, 2025-26. As Duncan Black highlighted, that means that there is no way to cover an unexpected event.

Reform funding or pump-priming investment in, say, weight management drugs or preventative spend in mental health means that we can maybe boost CMHTs or intensive home treatment teams to take the pressure off the hospital sector. In Lothian, we constantly run at over 100 per cent bed occupancy. Reform funding to pump-prime that investment over a five-year timescale would be incredibly welcome.

Going back to reserves, I have a policy of trying to hold general reserves at a minimum level of £2 million, which is not much in the context of a £330 million budget. However, getting back to holding reserves would mean that I would have to agree a budget that took out more savings than were required. Given the scale of the challenge, I cannot see that being agreed to. Reform funding, transformational funding or pump-prime funding—whatever you want to call it—would be incredibly helpful.

Duncan Black: It important to distinguish a level of reserves that, as section 95 officers of the IJBs, we see as prudent. Generally, that is around 2 per cent of the net expenditure budget. In Glasgow, we are in a slightly better position thanks to some good decisions by the IJB and officers before me in that we are currently projected to outturn with general reserves at around 1.5 to 2 per cent, but that is for unexpected events, to allow us to continue in a sustainable way. You are right that, ideally, we would have an element of funding that we could use for spend that would, in effect, buy savings in future years.

Elena Whitham: I always wonder how we look above the silo that we are operating in. When I was COSLA's community wellbeing spokesperson, I had responsibility for looking at rapid rehousing transition plans and getting 32 councils to look beyond homelessness being just at the door of housing departments. Obviously, Glasgow has a different situation with delegated powers, but how can we ensure that areas that are working in silos look at their responsibility for the mental health budget and at what they can do to help to deliver on the local strategy?

Duncan Black: I would push back a little on the assumption that there is siloed working around mental health, for example. In the Glasgow health board area, there is really good joint working across the six IJBs, interlinking closely with the health board. There was a paper, which I am sure that we can share, that went to the health board or the clinical management team on the mental health strategy for the wider health board and the contribution from each IJB, including sharing of best practice.

It is important to note the intricacies of how mental health services are delegated in different areas, which Hamish Hamilton has alluded to. For

example, elements that go across the whole area are hosted by Glasgow or East Dunbartonshire. There is pretty strong joint working on the delivery of the strategy at health board area level. On the situation more widely than that, I could not comment.

Elena Whitham: I guess that it is about community planning partners and everybody locally in an area working towards improving mental health and how that all joins up.

Hamish Hamilton: The situation is similar in Lothian. I have alluded to our mental health and learning disabilities transformation board. Through PBMA—the programme budgeting approach—we undertook a piece of work in which we quantified and set up a programme budget across mental health, learning disabilities and intellectual disabilities in Lothian, which cuts across our four IJBs as well as the health board.

In Lothian, we can look at our spend across the piece on adult mental health, psychology or older people's mental health. When it comes to using that to move things about and make decisions, that is where it gets more challenging, because, as you alluded to, we have five separate partners, and what might be a priority for one area will not be for another. However, we do a lot around sharing best practice and trying to improve things for the Lothian system. Ultimately, however, we have five organisations, each of which has its own budget and a requirement to balance that budget, and sometimes those things might be at odds with one another.

The Convener: I thank the witnesses for their attendance.

At next week's meeting, we will take evidence from the Scottish Football Association and the Scottish Professional Football League on topical themes including the sustainability of Scottish youth football and promoting children and young people's participation in sport and physical activity. That concludes the public part of our meeting today.

11:43

Meeting continued in private until 12:26.

Official Report
Room T2.20
Scottish Parliament
Edinburgh
EH99 1SP

Email: official.report@parliament.scot
Telephone: 0131 348 5447

The deadline for corrections to this edition is:

Friday 14 November 2025

Published in Edinburgh by the Scottish Parliamentary Corporate Body, the Scottish Parliament, Edinburgh, EH99 1SP

All documents are available on
the Scottish Parliament website at:

www.parliament.scot

Information on non-endorsed print suppliers
is available here:

www.parliament.scot/documents

For information on the Scottish Parliament contact
Public Information on:

Telephone: 0131 348 5000
Textphone: 0800 092 7100
Email: sp.info@parliament.scot

The Scottish Parliament
Pàrlamaid na h-Alba