OFFICIAL REPORT
AITHISG OIFIGEIL

# Public Audit Committee

**Thursday 28 September 2023**

Session 6

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# Thursday 28 September 2023

## CONTENTS



## PUBLIC AUDIT COMMITTEE
**24th Meeting 2023, Session 6**

**CONVENER**

*Richard Leonard (Central Scotland) (Lab)

**DEPUTY CONVENER**

*Sharon Dowey (South Scotland) (Con)

**COMMITTEE MEMBERS**

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

*attended

**THE FOLLOWING ALSO PARTICIPATED:**

Stephen Boyle (Auditor General for Scotland)
Leigh Johnston (Audit Scotland)
Christine Lester (Accounts Commission)
Eva Thomas-Tudo (Audit Scotland)

**CLERK TO THE COMMITTEE**

Lynn Russell

**LOCATION**

The James Clerk Maxwell Room (CR4)

# Scottish Parliament

## Public Audit Committee

*Thursday 28 September 2023*

*[The Convener opened the meeting at 09:00]*

## Decision on Taking Business in Private

**The Convener (Richard Leonard):** Good morning and welcome to the 24th meeting in 2023 of the Public Audit Committee. The first item on our agenda is for members to consider whether to take items 3, 4, 5, 6 and 7 in private. Is that agreed?

**Members** *indicated agreement.*

## Section 23 Report: "Adult mental health"

09:00

**The Convener:** The main item on our agenda is to take evidence on the Auditor General for Scotland's report on adult mental health, which was co-written with the Accounts Commission. I am pleased to welcome our witnesses: Auditor General Stephen Boyle; Leigh Johnston, senior manager, Audit Scotland; Eva Thomas-Tudo, audit manager, Audit Scotland; and Christine Lester, Accounts Commission.

We have a large number of questions to ask but, before we get on to those, I ask the Auditor General to make a short opening statement.

**Stephen Boyle (Auditor General for Scotland):** Good morning. I am pleased to bring to the committee our joint performance audit report on adult mental health services in Scotland.

Our report highlights that many people find accessing mental health services to be a slow and complicated process. The system is both complex and fragmented, with multiple organisations involved in planning, funding and providing adult mental health. In addition, the availability of services varies across Scotland. Further, some groups, such as people from ethnic minorities and those from rural areas, face additional barriers to accessing support.

Progress in addressing mental health inequalities has been slow, but mental health services cannot address those issues alone. Our report is clear that those services need to work more closely with other sectors such as housing, welfare and employability support, to address and prevent the social detriments of poor mental health, which affects around one in four people in Scotland each year.

Over the past three years, people have also grappled with the adverse effects of the Covid-19 pandemic and the more recent cost of living crisis. Those effects have put an additional strain on the mental health of people in Scotland.

More than £1 billion is spent on adult mental health each year, but our report highlights the challenges in assessing the impact of that spending, due to limited financial, workforce and operational data. The Scottish Government focuses on waiting times for psychological therapies to assess performance of adult mental health services. However, it does not report on the quality of services or the outcomes for people who receive mental health support. The Scottish Government recognises those limitations and

plans to publish new standards that aim to address some of those gaps.

Although our report sets out many issues that need to be addressed, it also highlights positive developments. The distress brief intervention—DBI—programme has improved the care that is available for people who experience distress. NHS 24 established a 111 mental health hub during the pandemic, then expanded that to operate 24 hours a day.

The Scottish Government has set ambitious mental health commitments for the end of this parliamentary session, including increasing mental health funding by 25 per cent, allocating 10 per cent of front-line spending to mental health, and increasing mental health and wellbeing support in primary care settings. However, those commitments are not on track to be achieved. The Scottish Government and the Convention of Scottish Local Authorities recently published a new joint mental health and wellbeing strategy. It recognises that a whole-system approach is needed to effectively support mental health and wellbeing. However, much more detail is now needed on how and when the outcomes that are identified will be achieved. The Scottish Government plans to set out that detail in a delivery plan and a workforce action plan, which are expected this autumn. We will continue to monitor the Government's progress on that and on the wider recommendations in the report.

Leigh Johnston, Eva Thomas-Tudo, Christine Lester and I will do our utmost to answer the committee's questions.

**The Convener:** Thank you for that introduction. To go back to the starting point of the audit, the question that you set yourself was:

"How effectively are adult mental health services across Scotland being delivered?"

How would you summarise your answer to that critical question?

**Stephen Boyle:** It is fairly clear from our findings in the report that it is difficult to form an overall assessment. You will see from the report that there is a lack of effective data information to inform the assessment of outcomes. It is much more limited than we would expect, and the fact that there is not clear information on finance, performance and outcomes limits the assessment that can be made.

We dug deeper—colleagues can of course develop my response—during the course of the audit to bring in the views of users of mental health services. Drawing on their assessment, and the assessments of a wide range of practitioners, led us to consider that we have a fragmented system in Scotland for the delivery of mental health services. As I mentioned in my introductory remarks, they are slow and unequal in places. As we set out in a number of exhibits in the report, there is evidence that, depending on where people live in Scotland or which part of society they are part of, they do not get the same range or pace of mental health services.

**The Convener:** I will come on to ask about the focus groups in a second. Before I do so, I note that paragraph 15 in the report sets out the scale of the challenge that we face. It talks about what appear to be almost epidemic proportions, in that 22 per cent of the adult population

"may have a psychiatric disorder".

You talk about the huge expansion in pressure and demand on services. For example,

"The number of police incidents relating to mental health increased by 62 per cent ...The Scottish Association for Mental Health ... reported a 50 per cent increase in demand for its information service"

and

"The number of calls to NHS 24's 111 Mental Health Hub increased by 436 per cent".

Those are startling figures, which are presumably placing huge pressure on the system. We might not have measured the outcomes, but we know something about the scale of the demand that there is.

Do you want to tell us a bit more about the qualitative information that you got from the focus groups that you met and what that told you about their experience?

**Stephen Boyle:** I will bring in Eva Thomas-Tudo to say a bit more, and Leigh Johnston, if she wishes to. They will set out for the committee the rationale for bringing in focus groups and service users, and then talk about what they told us, triangulating that with the qualitative evidence that exists. As I mentioned, convener, I have to manage expectations somewhat in that the qualitative evidence tends to be around psychological therapies; that is the principal method by which the Scottish Government and its partners measure the effectiveness of mental health services.

**Eva Thomas-Tudo (Audit Scotland):** We found that the focus groups brought to life the challenges that we had been finding as part of our other audit work. It was useful to get examples from real life about how the challenges that we had identified were affecting people who were trying to get support for their mental health.

We spoke to a relatively small number of people—about 25 people across a few focus groups—and, although we were not able to make overarching judgments based on the evidence that we received from them, it was really useful in

illustrating the points that we had already found evidence for. It brought the evidence to life. The committee will see that we have included quotes throughout the report to illustrate our points a bit more fully.

**The Convener:** Perhaps Leigh Johnston would like to come in.

**Leigh Johnston (Audit Scotland):** The only thing to add is that the focus groups reinforced how slow and complicated it is to access services. People often expressed their frustration with trying to get the right kind of help and support that they needed at the right time.

**The Convener:** Thank you. That is a theme that we will return to during the course of the morning. I turn to Colin Beattie, who has some questions to put to you.

**Colin Beattie (Midlothian North and Musselburgh) (SNP):** There are a couple of areas that I would like to cover, Auditor General. One is a long-standing favourite: data collection. You are now the third Auditor General in whose time issues with data collection have been highlighted right across the public sector. It is disappointing that we still have this problem, particularly with regard to mental health, and it is a central theme in your report.

We do not really know how much is being spent on adult mental health services, or what their quality or outcomes are, and we do not even know what the demand is. In what must be a long list of deficiencies, what areas should be prioritised to improve the data and information that is available? Resources in any part of the public sector at the moment are quite tight, so they need to be targeted where they will benefit the most.

**Stephen Boyle:** I agree that the quality of data and information has been a recurring theme in my predecessors' and Audit Scotland's reporting for many years. It is disappointing that we are preparing another audit report that reports that neither we nor decision makers have enough information to gauge the impact of considerable sums of public spending.

We broadly know what is being spent on adult mental health services: it is in the realms of £1.4 billion to £1.5 billion each year. However, in the assessment of its impact, there is a very narrow focus on psychological therapies. That is an important element, but it is only one element of adult mental health service provision. We do not know how effective that has been. Did it improve the outcomes for people accessing those services?

I agree that we are in a challenging fiscal environment. I will say a bit more on that, and then I am keen to bring in Christine Lester, who might want to say a bit more about where the Scottish Government and its partners go next on that, because it will require a whole-system effort.

There are signs of progress in prioritisation. The Scottish Government and the Convention of Scottish Local Authorities have set out their new strategy for the delivery of services, and their intent is that that is underpinned by a clear delivery plan. That is fundamental to assessing the impact of mental health spending and what outcomes have been achieved.

The additional context to that is that, as the committee knows, the fiscal environment in which Scotland is operating is very challenging and will require difficult choices. That is alongside some of the changes that are taking place in the relationship between the Scottish Government and local government, with the assertion of the Verity house agreement earlier this summer, which intends to remove some of the fiscal constraints in terms of reporting on individual budget lines between local authorities and the Scottish Government.

As part of that overall consideration, there has to be absolute clarity about what a costed delivery plan can achieve. I am keen to broaden this discussion out to Christine Lester, as I am sure that she will want to comment on that, too.

**Christine Lester (Accounts Commission):** It boils down to the fact that we know that there is a huge sum of money at the top, but we cannot recognise how it is divvied up at the bottom and gets to the service end. That is the issue.

It is very complicated at the service end. With regard to the work that the Accounts Commission does, we know that local authorities, integration joint boards, the third sector and health and social care partnerships are all delivering mental health services, but we do not know the moneys that are spent individually and the impact over time of those services, which are often commissioned services in the third sector.

It is complicated. It takes a long time for someone to get mentally ill to the point that they need to use those services, and then it takes a long time to get better again, so having services that can deliver over a longer timescale than 12 or 18 months is hugely important. I hope that that helps in some way.

09:15

**Colin Beattie:** You touched on an interesting point about the £1.4 billion or so. What proportion of that goes to the third sector?

**Stephen Boyle:** Eva Thomas-Tudo is just looking for the figure on the allocation of resources. It will be really varied. At a high level,

£1.2 billion is allocated to national health service boards. Another £200 million goes to local authorities and a similar amount to the Scottish Government's mental health directorate. Over the course of the pandemic, we have seen a significant increase in the directorate's spend, part of which was for the Covid-related funds.

As Christine Lester said, a number of funds operate to provide mental health services and the different types of interventions that are required. Across the piece, we do not yet have the data on or the evaluation of spending to say whether that made an impact, whether it was in the third sector, NHS boards or local authorities.

The system is complex, and there is not enough evaluation of whether spending has made a difference. I invite Eva to say whether we have more detail on the specifics for the third sector.

**Eva Thomas-Tudo:** That is quite a difficult question to answer. As Stephen Boyle set out on the distribution of funding, some is spent centrally by the Scottish Government, some is allocated to NHS boards and councils spend a proportion of theirs on mental health. NHS boards commission the delivery of services through the third sector. We do not have the detail on how much is spent on commissioned services right now.

We are aware of specifics for some pots of money that go to the third sector. For instance, part of the amount that has been spent centrally by the Scottish Government's mental health directorate has gone on recovery and renewal funding. Part of that was for the communities mental health and wellbeing fund, which we cover in paragraph 71 of our report. As we touch on there, some of that money will have gone to the third sector and will have been distributed by third sector interfaces.

It is very difficult, though, to give an overall figure for the amount of mental health spending that goes to the third sector.

**Colin Beattie:** My concern is that it is difficult to get auditing information from the third sector to validate its outcomes. I know that the Auditor General is limited in what he can do there. The key point is that, if we do not know what the outcomes are across the board, we do not know whether money is being spent in the right places.

**Stephen Boyle:** We agree. There are considerable sums of public spending for which we know where they have been allocated but not whether they have made the intended difference.

I will develop the point about the third sector. As we refer to in our report, the third sector plays an enormously important role in the provision of adult mental health services, including prevention measures and support, across a range of factors and geographies. It is not unique to such services that their funding cycle is almost always annual. They tell us that it is challenging for them to recruit and retain people who can provide those skilled services when such uncertainty exists.

If we are to make a step change in the provision of adult mental health services, accountability for them, and their funding and outcomes, which I hope we will do, careful thought must be given to providing third sector practitioners with certainty on how they can apply their work over a longer period.

**Colin Beattie:** The old difficulty with that is that the Scottish Government is funded annually, too, so there is some uncertainty about what the figures will be.

**Stephen Boyle:** That is fair, to a point. The Scottish Government and local authorities will generally know from year to year what their baseline is, and they have certainty that they will get a sum of money that is generally around the amount that they had last year. However, it takes much longer for such certainty to be given to the third sector, so work needs to be done in that arena, too.

**Colin Beattie:** I take your point on that.

Let me move on to another area. What impact has the Scottish Government's emergency budget review had on the delivery of mental health and wellbeing services in primary care?

**Stephen Boyle:** I will bring in Eva Thomas-Tudo to set that out in a bit more detail. I think that you were referring to paragraph 32 of the report and the circumstances of the Scottish Government's review of its spending plans during 2022, when it identified that it faced challenges to deliver a balanced fiscal position, which, as you referred to, it is required to do each year. I think that there was also some Audit Scotland reporting on that at around the same time.

Part of the Government's analysis involved looking at different budget lines and stopping spending where it was identified that either the budget was not needed or it was going to be underspent. I will ask Eva to say a bit more about some of the numbers and about what judgments we have been able to make, caveated by what we have talked about already in relation to the limited availability of data to make some assessments.

**Eva Thomas-Tudo:** Last year, the EBR cut funding for mental health services by about £38 million and primary care funding by £65 million. The impact of that was that local areas that were trying to develop primary care mental health and wellbeing services by 2026 were unable to recruit for some of the positions that they hoped to last year. One of the main reasons why we have made

the judgment that the commitment to establish primary care mental health and wellbeing services by 2026 is currently not on track is that that progress was delayed.

**Colin Beattie:** Your report recommended that

"The Scottish Government should publish a costed delivery plan that sets out the funding and workforce that will be needed to achieve its aim of establishing sustainable and effective MHWPCS across Scotland by 2026."

What confidence do you have that that recommendation is progressing? Is the Government actively working on it?

**Stephen Boyle:** Work is under way to do so and there are planned publications this autumn. That plan has to be a very comprehensive, clear, transparent document that sets out how funding, performance and workforce will be delivered across a range of service providers. The blunt assessment that I will make is that the Government has to get it right.

There have been mental health strategies before—we touched on that in the report—together with interim progress reports, that have not always given enough clarity or accountability on how public spending on mental health services has performed.

We hope that the judgments and the recommendations that the Accounts Commission has made in the report will be acted on, because that is essential not only for accountability purposes but, building on a number of conversations that the committee has had over many years, because the most effective public spending will be upstream, preventative spending that will be less costly and more effective. If we continue to service a system that is secondary, acute and reacting to crisis, it will be more expensive, and we will find ourselves in the circumstances that we laid out in the report, in which there are workforce challenges in different parts of mental health provision in different pockets of Scotland.

We hope that the work is progressing, and I give the committee an assurance that we will continue to track and monitor the progress that is made with a costed delivery plan.

**Colin Beattie:** On another aspect, in paragraph 37 of the report, you highlighted the inequalities in provision that you also spoke about in your opening statement There are certainly many inequalities in mental health services. If there is a clear link between mental health inequality and inequality in society, can you give us more information about what your audit work found in that area, because it encompasses a broad number of factors?

**Stephen Boyle:** You are absolutely right. I am sure that Eva Thomas-Tudo and Christine Lester will both want to say a word or two about this but, at a headline level, we found some quite stark inequalities in the provision of adult mental health services. Those are not just disparities relating to the provision of service in rural areas. We also found—I am sure that this will come as no surprise to the committee—that, if you are from a deprived area of Scotland, your access and outcomes are not equivalent to those for people in the more affluent parts of the country. In our report, we also note that, for people from ethnic minority backgrounds, there are language barriers to accessing services. Some of that has been impacted by the provision of services remotely rather than face to face.

The situation has led us to our assessment of a large, complex and at times fragmented system. I mentioned in my opening statement that adult mental health service providers cannot resolve the issue themselves—it is a multifaceted and complex area of public service that requires a clear plan, prioritisation, governance and accountability. All those things are required from local authorities, the health service, the Scottish Government, the third sector and housing providers so that we have a much more person-centred and preventative model of mental health services in Scotland.

I will make one last point before I hand over to colleagues. We need a system in which we get the information right. Such a complex system will inevitably continue to need tweaks and evaluation. However, if we do not have the information to make that assessment in the first place, I fear that we will continue to just keep spending year after year without a rounded assessment of what difference that is making.

I will perhaps turn to—

**Colin Beattie:** Before you hand over, perhaps I could broaden that out a little. Paragraph 39 of the report says that the Scottish Government

"recognises the importance of addressing inequalities in mental health",

but you also state that

"the impact of its commitments is not always clear".

Perhaps in your response you could include how the Scottish Government will address those concerns.

**Stephen Boyle:** That is correct. I have noted that the Government has recognised the issue and is making some progress. We want that progress to be built on with a clear and costed delivery plan that sets out how the Government intends to deliver on its commitments.

I will pass to colleagues in a second, but I first want to mention that one of the key drivers through which the Government intends to enact change in mental health service provision to a more upstream preventative approach is by investment in primary care services. The intention is that, by 2026, mental health workers will be based in all general practitioner practices in Scotland. Through the work that we have done and in the report, we have identified that that is at risk unless there is a clear pathway, through spending and workforce performance information, to get to that point. I am sure that the committee will want to talk further about workforce challenges, but that is an absolutely essential component.

You are correct that the Government recognises the issue and has plans. My caution is that successive Governments have had plans, but those have not been followed through with a detailed and costed plan for how to get from a strategy to implementation that can be evaluated.

I will pass to Christine Lester.

**Christine Lester:** A national plan would be fantastic and it is very much needed, as we have said. However, Scotland is a very diverse place so, where I live in rural Moray, the mental health problems that we have are very different from the mental health problems that you might find in Glasgow, Dundee or places such as that. The delivery of services has to be at local level. I go back to the issue that we discussed earlier about how services are commissioned in the third sector. Those services are very much tailored to the individual requirements of the particular locality, and therein lies the problem. The route through which the money has to go to get there is complicated.

Eva Thomas-Tudo mentioned that the money that goes to the NHS is used to commission services. Those services are mainly commissioned at local level through the strategic commissioning plans of integration joint boards and are implemented from there on, so they are very diverse and different. To go back to inequality, inequalities are also different. Rural poverty and cost of living issues—fuel poverty and so on—are very different to the sort of poverty that you see in inner cities.

09:30

Very often, it all comes together—the intersectionality of poverty, belonging to an ethnic minority and having a physical disability along with your mental disability. Those people are very much in crisis, but they are probably known to one or all of the organisations that are tasked by the Government to look after them, by which I mean housing services, GP services and so on. You can see how complicated it becomes at that level. I feel that community planning partnerships have a role in that.

**Eva Thomas-Tudo:** I will mention a couple of things. In 2020, the Scottish Government published "Mental Health—Scotland's Transition and Recovery", in response to the impact of the pandemic on mental health. That plan was quite clear about its recognition of inequalities as a significant issue, and it set out actions to tackle some of the inequalities that relate to employment, women's and girls' mental health and socioeconomic inequalities. However, we say in our report that the plan did not outline timescales for all the actions and a review of progress of the plan has not been carried out.

The new mental health and wellbeing strategy that was published earlier this year also had a significant focus on addressing inequalities but, as the Auditor General mentioned earlier, there is very little detail in that strategy about exactly how it will tackle those. That is why the Scottish Government intends to publish a delivery plan for the mental health and wellbeing strategy this autumn. We hope that that will include some of the detail about exactly how it will tackle some of those inequalities.

**The Convener:** Before I bring in Graham Simpson, I will take you back to the emergency budget review, in order to fully understand what you are saying. Auditor General, you said that the exercise was about identifying underspends and rationing the public finances according to that. However, when Eva Thomas-Tudo spoke about that, she said—as I interpret it—that that exercise has knocked off track the targeted support for GPs by 2026, for example. Was that going to be underspent, and that is the reason why the £38 million cut was made, or has the £38 million cut resulted in your assessment that that will not be on track?

**Stephen Boyle:** It is potentially both those things. I recall that the Finance and Public Administration Committee took evidence from the former Deputy First Minister on some of the emergency budget decisions. I would need to refer back to the *Official Report* to check the precise explanations, but what we have seen from our assessment is that the emergency budget review was, at an overarching level, designed to look at areas of spend that the Government assessed as not progressing, either as a result of not having the anticipated demand or because it needed to deprioritise that spend for other areas to deliver financial balance. I might need to come back to the committee in writing with the precise details.

**The Convener:** Okay, but is it therefore possible that that spend was deprioritised?

**Stephen Boyle:** I think that it is possible, but I will need to check.

**The Convener:** Thank you.

**Graham Simpson (Central Scotland) (Con):** Auditor General, you have spelled out quite a number of stark statistics. The first of those, which you set out in the key facts section of your report, is that about one in four people experiences mental health problems in any given year. Given that we have already discussed the difficulty of getting data, how do we know that?

**Stephen Boyle:** You are right, Mr Simpson. A statistic that is quoted on the scale of mental health challenges is that one in four people is affected. The report also notes that the Mental Health Foundation estimated in 2019 that the cost of mental ill health to the Scottish economy was approaching £9 billion a year. However, as you allude to, the fact that we do not have sufficient robust, reliable data means that those are estimates. Alongside the numbers that are reported lies the possibility that there is unmet need in society for some services. That perhaps illustrates the scale of the challenges, which have of course been exacerbated by Covid-19.

**Graham Simpson:** We cannot really say with any certainty that, in any given year, one in four people will suffer mental health problems. That would mean that, in this room, perhaps three or four people will suffer mental health problems this year. I just do not know how we could possibly know that.

**Stephen Boyle:** Eva Thomas-Tudo can set out for the committee some of the sources that we drew on to arrive at that.

**Eva Thomas-Tudo:** The figure comes from the Scottish household survey, which is carried out each year. The estimate that about one in four people will experience a mental health problem in any given year is based on the survey responses.

**Graham Simpson:** What sort of question would you ask to arrive at that?

**Eva Thomas-Tudo:** I would have to check the specific wording, but that survey is also where the estimate of how many people might have a psychiatric disorder has come from. I can find out the specific wording for you and we can get back to you on that, but it is essentially based on survey responses.

**Stephen Boyle:** To lend some weight to that, Mr Simpson, I note that we draw on a range of sources for our report. Again, we recognise that the quality of data is not what we would like it to be—not just for our purposes, but for the purposes of those who make the decisions on public spending and service provision. One data gap that exists, which the committee has explored previously, is that there is not clear enough data on primary care services—for example, on GP consultations.

We have also drawn on further information from England that notes that around 40 per cent of GP consultations are in respect of mental health concerns. The two statistics do not show the same things, but they illustrate the likely scale of mental ill health in Scotland.

**Graham Simpson:** I was going to ask about GPs. Do we have an equivalent figure for Scotland or do we just not know the position here?

**Stephen Boyle:** Again, we do not have a precise figure to reliably show GP engagement in relation to mental ill health.

**Graham Simpson:** Why do we not have that? Why is that not recorded?

**Stephen Boyle:** Leigh Johnston might want to say a bit more about this, given our review and commentary. As Mr Beattie mentioned, despite the successive reports that we have produced on the NHS in Scotland and despite our having a comprehensive statistical recording arrangement through NHS National Services Scotland and the Information Services Division, we lack information on primary care.

**Leigh Johnston:** I agree with the Auditor General. We have commented on a number of occasions on the lack of data on primary care. Public Heath Scotland is working on that and trying to improve the situation, but the data that is available right now is experimental. Public Health Scotland is trying to develop it so that it becomes more robust and reliable, but whether that will include how many appointments are to do with mental health remains to be seen. We have commented on several occasions on the lack of insight into and data on what is going on in general practice.

**Graham Simpson:** After all, this is pretty fundamental. What comes out very strongly in the report is the lack of data; a confused system that is slow and complicated; and the fact that people do not know where to go. Of course, mental health covers a wide range of things, but for many people, the first port of call could be the general practitioner. However, are GPs really set up to deal with this? It does not sound from your report as though they are.

**Stephen Boyle:** I bring to the committee's attention exhibit 1, in which we set out the patient journey for those experiencing mental ill health. It goes from prevention and self-help to, as you have pointed out, primary care settings and then, if that does not resolve the condition or help it to be managed, to secondary care and specialist tertiary care.

I absolutely recognise that, in its strategy, the Scottish Government has set out that increasing mental health service provision in primary care settings is fundamental to tackling the problem, and its ambition to do so by 2026 is central to that. However, what we note in the report is that that is at risk without a clear and costed delivery plan for getting to that point, given the variables and, indeed, the starting point. In that respect, the report notes not just the lack of high-quality information but some of the workforce challenges that need to be met to ensure comprehensive provision across the country in three years' time.

**Graham Simpson:** You have mentioned a few times the ambition for every GP practice to have a mental health specialist by 2026. Where are we now with that? Do we know?

**Stephen Boyle:** I will bring in Eva Thomas-Tudo to respond to that.

**Eva Thomas-Tudo:** This goes back to the previous response, but one thing to note is that, although there is not good-quality primary care data out there, it is estimated that 41 per cent of GP appointments relate to mental health. It is, therefore, a potentially significant issue. Again, that figure is based on survey data and one-off pieces of work. Moreover, the Royal College of General Practitioners has told us that GPs need more support to tackle mental health issues.

As for where things are now, there have been a couple of surveys to find out the proportion of GP practices in Scotland that have access to mental health workers. In the last survey, 17 per cent of GP practices across Scotland reported having no access to mental health workers, while, the year before, 45 per cent of practices reported having full access. However, because the most recent data counts any access, which can range from minimal to full access, it is very difficult to say how many practices have sufficient mental health workers.

**Graham Simpson:** What years are you referring to?

**Eva Thomas-Tudo:** It was in 2022 that 45 per cent of practices reported full access. We do not have that level of detail for 2023; all we know is that 17 per cent have no access.

**Graham Simpson:** So, last year, 45 per cent of practices had some access—

**Eva Thomas-Tudo:** They had full access.

**Graham Simpson:** Full access.

**Eva Thomas-Tudo:** Yes.

**Graham Simpson:** But we want to get to the position where every practice has full access by 2026. There is clearly an awful long way to go.

I want to ask about one more area. In paragraph 16, which goes across two pages in the report, you refer to the number of police incidents relating to mental health. I am sure that most, if not all, MSPs will be speaking to their local police, and I have to say that, every time I speak to them, what always comes up is that the majority of their work is taken up with mental health cases. Indeed, I have heard quite stark figures ranging from 60 to 80 per cent.

In dealing with people with mental health issues, the police are being taken away from other duties. That is not the fault of the police or of the people with mental health issues, but it is a problem. Did you speak to the police about that? It is a serious issue out there.

09:45

**Stephen Boyle:** Again, Eva Thomas-Tudo can say a bit more about the engagement that we had during the course of the audit, but I will develop a point for a moment. We report that there has been a 62 per cent increase in police response to mental health incidents over the past seven years. Clearly, that is a hugely significant increase in their focus and attention. However, it is also relevant to the financial position of the police and the prioritisation that that organisation will have to make as it, too, looks to deliver a changing service and meet its budget priorities. As has been set out, we drew on a range of sources and evidence. Eva can say more about our wider engagement.

**Eva Thomas-Tudo:** We spoke to the police as part of our audit work early on in the audit. We have not covered in detail the role of the police because His Majesty's Inspectorate of Constabulary in Scotland is publishing a report on policing mental health shortly. We spoke to HMICS about its work and we have left it to it to publish that piece of work.

**Graham Simpson:** Okay—I will leave it there, convener.

**Willie Coffey (Kilmarnock and Irvine Valley) (SNP):** Good morning, Auditor General and colleagues. I have a range of questions to put to you, but I would first like to stick with the GP issue that Graham Simpson asked about. The report refers to a comment from the Royal College of General Practitioners that

"GPs need more support to address the mental health needs of patients."

It is as stark as that. Some comments in the focus groups showed that people seem to prefer the support that they get from their GP rather than from psychiatric services. Somewhere else in the report, it talks about access to mental health officers and the fact that, although the funding is

there, it is not being taken up. A whole range of issues is swirling around.

Stephen, can you say a wee bit more about your understanding of that particular issue and what the GPs are actually asking for?

**Stephen Boyle:** Good morning, Mr Coffey. I am happy to start, and I am sure that Eva Thomas-Tudo will want to say a bit more, particularly about the views of focus group participants and of the royal college.

As we set out in a previous response, just short of 50 per cent of GP practices currently have mental health provision. There is a long way to go, over the course of the next three years, to get to full provision across primary care settings. As things stand, GPs are still providing that service but without the additional skills and capacity in their practices to do so. Inevitably, that brings real pressure on primary care practitioners to deliver the service, and that probably speaks to the views of the royal college about the challenges that its members face.

I am sure that Eva will want to develop the point that there are different views from service users about the best experience that they can get. Some refer to mental health officers, others note the quality of service that they receive from their GP and some note that they receive just as competent a service from the multidisciplinary team. However, in today's report, we really want to illustrate that there is a long way to go for the Government to deliver on its ambition to have that preventative primary care-based mental health service that is expected to deliver the results. We draw on case studies from elsewhere in the world about where that work has been targeted successfully.

I will stop for a moment and bring in Eva to say something further.

**Eva Thomas-Tudo:** As the Auditor General said, the views from the focus groups were mixed. The point that came through strongly—the quote that Mr Coffey referred to illustrated this—is that GPs play a significant role in people's day-to-day health. If someone needs a psychiatrist, they will see the psychiatrist every so often, but that is not enough to keep them well in between the appointments. They get more frequent care from their GP and community support groups, for example. The direction of travel for which we have seen demand is to make available a range of support for people, so that they are not relying on specialists for all their support.

**Willie Coffey:** That is really helpful. The area is very difficult to pin down. Are we saying that GPs need to be more skilled to be able to deal with those needs, or do they need access to those skills to be brought into their practices a bit more closely?

**Stephen Boyle:** I do not know whether we are saying that with quite that precision. A view might be better expressed by GPs and their representatives.

We have assessed that the expansion of mental health services in primary care will involve GPs and the multidisciplinary team of service providers, whether they are psychologists, mental health nurses or mental health officers, so that there is a tailored approach to individual requirements.

**Willie Coffey:** Is there a diagnostic pathway for adults with attention deficit hyperactivity disorder? I ask that because I have a number of constituency cases, and there appears to be no such pathway. Can colleagues help us with that query? Is any work going on to try to address that?

**Stephen Boyle:** Maybe Eva Thomas-Tudo can talk about that. That provision was certainly not a specific focus of the report. In the report, we referred to the extent of prescribing drug usage to treat certain conditions but, on our ability to draw conclusions on specific mental health illnesses, we deliberately sought to make the report an overall assessment of provision. However, Eva Thomas-Tudo may be able to help further with that.

**Eva Thomas-Tudo:** I was essentially going to make that point. We did not look at specific conditions as part of our audit work. However, it has come up that people with ADHD are struggling to get the assessments and other things that they need.

**Willie Coffey:** That is particularly the case for adults. There is a process for younger people, but there appears to be no pathway to diagnosis for the adult population. Is there anything that Christine Lester is familiar with that might help?

**Christine Lester:** No. As Eva Thomas-Tudo said, at the start of scoping with audit, we made the deliberate decision that we would not make it diagnosis specific and that we were going to cover the whole range. However, as well as thinking about those who suffer from ADHD, it is worth thinking about dementia and Alzheimer's. They take up a huge amount of service provision, and quite often the same services provide to other elements of mental health care in a community setting.

Willie Coffey's point about specific conditions is well made. However, adult dementia takes up a huge amount of service provision. By and large, the same services are used across the piece: primary care, support groups, peer groups and the third sector.

**Willie Coffey:** Your report says that access to a range of mental health services dipped during

Covid and that it has, by and large, gone back to pre-pandemic levels, but not for psychiatry services. Do you have any views on why the number of psychiatry appointments has decreased while other services have recovered to their pre-pandemic levels?

**Stephen Boyle:** You are right, Mr Coffey. I think that you are referring to exhibit 2, in which we set out the change in activity across a range of mental health specialisms between October to December 2017 and the end of last year. As the committee would expect, and as it will have seen from previous reports on NHS activity, there was a considerable drop in activity but—this is largely consistent with what we reported in previous NHS overview reports—it recovered across a range of specialisms.

On the specifics of psychiatry—again, colleagues might want to say a bit more about this—it has been one of the key specialisms with recruitment and retention challenges. We note in the report that, because there are so few specialists in the area, some NHS boards recruit from one another to meet provision. Perhaps, as part of workforce considerations, a longer-term review is required of how people come into the specialism and how they are retained, and, as part of that, a costed workforce financial plan is needed across the piece to ensure consistency of service provision across specialisms.

Eva Thomas-Tudo might want to say a bit more.

**Eva Thomas-Tudo:** Psychiatry is one of the areas in which the availability of information is very limited. The number of appointments is published, but there is no information about the number of referrals, waiting times, how long people are waiting and so on. It is difficult to say why the number of appointments is going down. It is likely that the challenges with recruitment and retention that the Auditor General has set out are one of the reasons for it but, without further information, it is difficult to come to a judgment about it. For instance, we do not know whether the number of people being referred has decreased or increased, but the Royal College of Psychiatrists has told us that demand is high. It has done some specific pieces of work in Glasgow, I think; we have not been able to see the data, but it tells us that demand is high.

**Willie Coffey:** There is a really interesting table in the report about access to services through digital means. As usual, it highlights quite a difference across Scotland in whether consultations are digital or face to face. I was taken by the NHS Ayrshire and Arran figure being the highest in Scotland for face-to-face consultations. Will you offer us a few ideas on what is going on there? Why is the situation so varied across Scotland? Is there any observed impact on the difference between face-to-face and digital consultations?

**Stephen Boyle:** The why element is the harder part to answer. What we have set out in exhibit 3 is the variation in psychological therapy that takes place across Scotland. You are right to highlight that Ayrshire and Arran has the highest figure for face-to-face consultations, at 86 per cent of all recorded appointments. At the other extreme, we have NHS Orkney, with virtual appointments at 94 per cent. The most important thing about it is that, consistent with Government strategy, patients have choice about how they receive psychological therapies.

From focus group commentary, we found that there was no universal picture from the people to whom we spoke. Some said that a virtual appointment was what they wanted, as it increased the speed with which they were able to access services. However, other people said that it was not right for them and that they got much more benefit from a face-to-face consultation. The primary path has to be that patient choice is seen in the access to the service that they want.

Why the situation is what it is is the more limited component of the information that is available to us. It might be an area that the committee could look at, should you decide to explore it further.

**Willie Coffey:** Do you see that mixed hybrid model of face to face and digital continuing for the foreseeable? Do you see it becoming the norm that there is a choice available to people? It sounds as though it is not really a choice but a necessity to provide digital access.

**Stephen Boyle:** I will say a wee bit more and, again, Christine Lester and Eva Thomas-Tudo might want to say something further.

We currently have an audit under way on digital exclusion. Given the pace of change in the provision of public services, whether in accessing mental health services or other services, it is important that the move to digital service provision goes at the right pace and respects the different choices and benefits that come with digital and face-to-face models. The Accounts Commission and I will report to the committee on that in early 2024.

I will stop there, as Eva or Christine might wish to say more.

10:00

**Christine Lester:** Access to digital might account for some of that. For example, people may not have the means to access digital services because they do not have broadband or the infrastructure around them, or they might not be able to because of a language difficulty or

something like that, so maybe face-to-face consultations are better for them in those instances. Digital exclusion is a big issue, and, as Stephen Boyle said, we are doing work on whether it is equal across the board, which it definitely is not, even geographically, never mind the other inequalities that we have mentioned.

It is about choices first, but if a person is in a crisis they want what is quickest, and sometimes digital intervention might be quicker than face-to-face intervention, although I do not have any evidence to support that.

**Willie Coffey:** I was just looking at the table in your report again, and it shows that the pictures in Orkney and Shetland are almost opposite to each other on digital or face to face; they seem to be polar opposites. In the Western Isles, the number of telephone and video appointments is incredibly high compared with the number of face-to-face ones. There are even differences between rural settings and the islands; there are very different pictures. Anyway, I will leave that query for another time.

My last question relates to another point in your report. In paragraph 29, you say that the Government issued its planning guidance to IJBs as part of its plans for improvement in mental health and wellbeing care services and that we expected a further publication in April 2022, but it has not yet appeared. Can you offer some more comments on that, and tell us when we might expect it?

**Stephen Boyle:** You are right, Mr Coffey. I will pass that question on to Christine Lester, given the Accounts Commission's role in overseeing the work of IJBs. However, I will say that—as we have touched on a number of times—although guidance and strategies are important, giving clear guidance on what is to be delivered, how it is to be delivered and evaluated, and the information that is to be collected underpins what is needed for IJBs and other service providers to take the next step to effectively implement strategy ambitions.

**Christine Lester:** Integration joint boards have the job of commissioning services that are then delivered by health and social care partnerships, which are then staffed by councils, the third sector and the NHS—depending on which strand they come from—and we can see the difficulty in doing that.

However, IJBs definitely have a role in drawing everything together, because the money goes into the pot and then they can decide how it will be best spent in their locality. It could be spent on housing or managing transitions between child and adolescent services to adult services—children and adolescents become adults eventually. IJBs have a role in that, but the delivery of it is through the workforce of the local authority and the NHS, and we have issues with workforce and workforce planning in that area, as we have alluded to.

**Willie Coffey:** Do you have a date for the publication of the guidance?

**Christine Lester:** I do not have a date.

**Eva Thomas-Tudo:** We do not know when the guidance will come out but, as you said, it was due last year as part of the commitment to establish the primary care mental health and wellbeing services by 2026. The guidance was to be on measuring outcomes from those services, so we would like it to be published either as a separate document—as originally planned—or built into another delivery plan that the Government is planning at the moment. We recommended in paragraph 30 of the report that that should be published as soon as possible.

**Willie Coffey:** Good.

**Christine Lester:** I will just say something about measuring outcomes. It is very important that the outcomes measured are those of individuals and not the outcomes that the service feels it can deliver. That is crucial in mental health provision, above everything else.

A case may involve something quite simple, such as dealing with anxiety, but as it is about the outcome for the individual it is incredibly difficult to measure that, and we are still trying to get to grips with how to audit it. Between us, along with Public Health Scotland, we are doing some work to get a bit more of a handle on real-life outcomes, as opposed to audited financial outcomes and so on.

**Willie Coffey:** For years, have we just never asked people how they feel about the treatment and services that they have had?

**Christine Lester:** There is a stigma attached to speaking about mental health. Mr Simpson asked about the one in four figure and said that it might mean that several people in this room suffer with mental health problems. That might be true, but there is a stigma attached to talking about it; it is not like having a broken leg or a sore hip. We need to recognise that and be open about it.

**Stephen Boyle:** We risk overcomplicating these things. Christine is right—the issue is whether the outcome made a difference to the person who received the service. If it did, we can say, "Great—we'll continue doing that." Alternatively, we can take an evaluative approach and ask, "What different things can we do?" Those are the next steps that we have talked about.

It is inevitable that work will have to be done across partners—across the Scottish Government, councils, health boards and so on. That is easy to

sign up to, but it is also vital that those bodies have a clear shared plan and shared accountability.

**Christine Lester:** I would like to provide a wee bit of anecdotal evidence. Self-directed support is a welfare payment. When I was involved in that in Moray, we had a client who used their self-directed support payment to buy a fish tank to put fish in. That solved their anxiety problem—it gave them something to get up for in the morning. That was their outcome, which worked for them. It was also a great use of public funds, because it lasted as long as the fish, at which point the person went and got more fish. Genuinely, that is the sort of thing that makes a difference to people's lives, because it gives them a reason to get up in the morning and something to look forward to, as well as helping them to relax. That is the level of outcomes that we should really be looking at.

**Willie Coffey:** That is a lovely story to share with the committee—thank you.

**Christine Lester:** I hope that it helps.

**Willie Coffey:** I thank everyone for their responses to those questions.

**The Convener:** I am afraid that I am going to bring us back to the institutional architecture and all that. One of the things that I take from the report is the question of where the IJBs are in all of this. There is a lot of attention on the health boards' outcomes and the local authorities' outcomes, but the IJBs are supposed to straddle the work of those bodies and to pull it together and integrate it. Will you say a word or two about the conclusions that you drew from the work that you did on the role of the IJBs?

**Stephen Boyle:** I will give a brief answer, but I am sure that Christine Lester will have more to say.

The report makes it clear that the accountability seems mismatched. Although the funding is commissioned through to the IJBs, accountability with regard to the Scottish Government's funding direction still seems to rest with the health boards. That needs to be resolved if IJBs are to be an effective pillar in relation to how public spending can be delivered more effectively.

**Christine Lester:** IJBs are not funded directly; their funding comes from the local authorities and the NHS boards, and it has to trickle through into their commissioned services. Therein lies another difficult problem, because IJBs, in working to commission services on an annual budget, need to look ahead three to five years. When we audit councils and IJBs, we ask them for medium and long-term financial planning, but they have to do that with an annual dollop of money. When the money goes to the IJB, it is supposed to be used in a way that is specific to that locale. Where I live, the situation would be very different.

Are the IJBs held accountable? I am not sure about that. I think that it is a very difficult and complicated arrangement that is not well understood. Having been at committees here before, I struggle to see any change in the understanding of what an IJB can do and is able to do. There is no doubt about it; some very keen thinking needs to be done about the IJBs, and whatever follows in the next iteration, because things cannot be done in the future as they are being done now.

**The Convener:** I think that IJBs were described in Parliament just last week as being quite a mixed bag. I do not know whether you have discerned this from your auditing work, but is it the case that, in some areas, the IJBs are accountable and are working well, whereas in others they are not? You do not need to name any, but do you get the sense that there are different performances in different parts of the country?

**Christine Lester:** I think so, but the fact is that they face different challenges and work within different communities. Some smaller local rural communities, for example, are much more focused on coming together and working together to help with the challenges in that location. I was thinking about remote and rural areas in particular, but actually, inner-city areas are the same. You just have to look at some of the community work that is being done in Dundee.

IJBs are very different. By their very nature—there are 31 of them—they cannot help but be different, and therein lies the challenge. However, there is a challenge around workforce planning and leadership, too. How do you find 31 leaders to deal with that environment day in, day out? It is very difficult.

**The Convener:** Maybe—or maybe not. Ultimately, if we are creating these institutions and if Parliament is legislating to set up a way of delivering services, we should expect the leadership that is necessary to drive that forward to be in place. I guess that that is what we, as the Public Audit Committee, expect, too.

**Christine Lester:** The focus of the Accounts Commission's strategy is to look very much at leadership going forward, and whether we have the available workforce and a way of recognising these things.

**The Convener:** Good.

I am conscious of the time, and we still have some important areas to cover. As we are on the topic of local government, I will ask quickly about the Verity house agreement. Auditor General, I will start with you. Can you give us your assessment

whether that agreement will make a difference to the delivery of mental health services?

**Stephen Boyle:** I am probably not in a position to reach a view on that yet. We have seen a statement of intent from the Scottish Government and COSLA on funding and accountability, and there is talk of a fiscal framework. From what I understand, much work needs to happen before it, and how it will operate in practice, can be set out more clearly over the next few months.

I look forward to seeing further detail on the agreement, but what I will say is that, if it acts as a template for more accountability in relation to where decisions are taken, that could be helpful. Perhaps I can link that back to today's report, in which we have set out what is a cluttered, unclear and complex governance and accountability landscape. If the agreement helps to bring clarity to how services will be delivered and the associated accountability, we would welcome that. However, as I have said, I look forward to seeing more detail.

**The Convener:** Thanks.

Christine Lester, will the Accounts Commission monitor the Verity house agreement and its outcomes?

**Christine Lester:** I do not really think that that is our role. That said, we are looking very carefully at the agreement and speaking to local authorities about it and, again, the prospect of a fiscal framework would be very welcome in terms of what we have already discussed about commissioning services for the longer term and being able to sustain them over a period greater than 12 months.

**The Convener:** That was helpful.

Turning again to progress towards improving mental health services, can you tell us a bit more about the support that the Scottish Government has been providing to NHS boards to help them meet their psychological therapies waiting time targets, as highlighted in the report?

**Stephen Boyle:** Yes, I can, convener, and I will also bring in Leigh Johnston to give a bit more detail.

Overall, as we have set out in paragraph 45, the waiting time for psychological therapies has a 90 per cent target attached to it. We go on to develop that in exhibit 5, in which we show that, to date, none of the NHS boards has met that target, to varying degrees.

The support that is provided is set out in paragraph 47. Tailored support has been provided to some NHS boards. In relation to NHS Grampian, for example—this goes back to the point that we discussed with Mr Coffey—we note that the availability of specialist individuals can impact on the performance of the health board in the round. Again, it comes back to the need for a workforce plan and longer-term plans in the future, as well as actions in the short term.

I will pass over to Leigh Johnston, who might have something further to share with the committee.

10:15

**Leigh Johnston:** I do not have much to add. I will just say that, obviously, the support was tailored to the areas that received it, so it was based on local circumstances and needs and was very much focused on reducing the waiting times for people who had been waiting the longest.

In the NHS Grampian case study, we give an outline. Some improvements were delayed, because the board waited a long time for a director of psychology to help with them. The board also faced challenges with the quality of the data that supported the psychological therapies output. The board has since tried to improve that by implementing a new system for gathering more robust data, which will give it better insight into what is going on.

**The Convener:** You mentioned Grampian, but Tayside is also highlighted in the report. Tayside has been the subject of not just local but national interest, because of some tragic cases of people completing suicide, for example. In that case study, you characterise things as making "good progress". Subsequent to the Strang report, an oversight and assurance group was put together to ensure that the health board was implementing the Strang review recommendations—there were, I think, 51 of them. I read the oversight and assurance group report when it came out in January, and my reading of it was that it echoed some of the points that Strang had made, in that there was an overreporting of progress by NHS Tayside in the area. I think that, on 17 of the 51 recommendations, the group took issue with the health board's view of how well it was doing. Basically, it said to the board, "You're not making the progress that you are stating that you are making."

Do you want to reflect on that issue, given that it is mentioned in the report?

**Stephen Boyle:** I would be happy to.

In case study 4, we set out the history of mental health service provision in NHS Tayside, including the very well-documented challenges that the health board was having, the challenges in relationships with service users and the local community, and Strang's review of services, which was followed by the independent oversight. We

tried to set out a fairly factual assessment of the current circumstances and progress. Although there has been progress in some areas, it is perhaps worth recording that we note that there are also areas where little progress has been made in respect of governance and public performance reporting—which perhaps speaks to the point that you are making—and that there is still work to do to build trust with communities who use the service.

We have an audit role in some of this. We continue to track the progress that the board is making through the annual audit, and we are reflecting on when the best time would be to undertake further parliamentary reporting on that, alongside opportunities that exist in our wider NHS overview reporting. The audit role is one component. Of course, accountability for progress rests with the health board and its accountable officer and with the IJB and its local authority partners.

As for how best to characterise the situation, I would say that there has been progress in some areas, but there is still important work to do. We have looked to set that out fairly factually in the case study in the report.

**The Convener:** I appreciate that response.

We are pressed for time. I will bring in Willie Coffey, followed by Sharon Dowey, and then I will bring in Graham Simpson if we have time.

**Willie Coffey:** I have a question about the target that 10 per cent of front-line health spending should be on mental health services by 2026. There is a lack of clarity about what counts as the front line and what counts as mental health services, and we need clarity if we are to properly report on that target. Where are we with that? Are we making any progress in making things a bit clearer so that boards can report for us?

**Stephen Boyle:** I will do my best to set out the position for the committee. We cover the issue in paragraph 67 of the report, which states that the Government's ambition is that

"by 2026, ten per cent of front-line health spending by NHS boards should be on mental health services".

NHS boards were required to set out their current percentage in their delivery plan for the current year—boards give returns on their intentions to the Scottish Government annually. However, that resulted in confusion, because the Scottish Government and boards did not have an agreed or shared definition of front-line mental health spending, so the Government is carrying out a review so that it can better define in its guidance what it considers to be front-line spending.

Eva Thomas-Tudo might want to say a bit more about the progress towards the 10 per cent target. There are some signs of things going back slightly in relation to an overall assessed definition, so there is some work to do on the definition and on progress towards the overall target.

**Eva Thomas-Tudo:** As the Auditor General said, the current percentages were originally expected to be provided as part of boards' submissions for their annual delivery plans, but, given the confusion about definitions, that work is on-going. The Scottish Government is working with boards to get the trajectories in place. We had hoped to see that information just before we published the report, but, unfortunately, it did not come through in time. We hope to see those trajectories in place in the new few weeks.

**Willie Coffey:** I look forward to that.

**The Convener:** The deputy convener, Sharon Dowey, has some questions.

**Sharon Dowey (South Scotland) (Con):** Good morning. Paragraphs 77 and 78, on page 41 of the report, raise concerns that pressure on staff is increasing because of high vacancy and turnover rates and difficulties in filling vacancies. The report cites a national shortage of psychologists, and it says that

"vacancies for general psychiatry consultants are the highest of all medical and dental consultant roles in Scotland"

and that

"Vacancies for mental health nurses have more than doubled between March 2017 and March 2023, and the turnover rate has reached a record high."

What action is the Scottish Government taking to support NHS boards that face those issues?

**Stephen Boyle:** Eva Thomas-Tudo can talk about the actions that the Government is taking, what is planned and the timescales for that, but I will say two things first. There needs to be a comprehensive workforce plan so that health boards, the Government and their partners can work towards the delivery of the strategy. You are right that our report builds on the views of those who provide adult mental health services and say that the system is under real strain. We set out some vacancy and turnover rates and the fact that very specialist people are in short supply, so health boards are competing for those skills. Ultimately, that has an impact on the services that patients are looking for, and it perhaps speaks to regional variation, which we have already covered this morning.

**Eva Thomas-Tudo:** As Stephen Boyle said, there needs to be a workforce plan. The Scottish Government plans to publish, this autumn, a workforce action plan alongside the delivery plan for the new mental health and wellbeing strategy. We have not seen the plan yet, so we do not know

how detailed it will be, but we hope to see details of how the Government will tackle the really challenging position in relation to vacancies, and the workforce position in general.

It is also worth mentioning that, although specialist roles are critically important, and a plan to address vacancies absolutely needs to be in place, establishing innovative roles can help to ease pressure on specialist services, including in mental health and wellbeing services in primary care. Our report gives examples of where boards are employing people in newer roles to address such recruitment challenges.

**Sharon Dowey:** Your report says that, during the audit,

"The Royal College of Psychiatrists also raised concerns that most NHS boards rely on locums who are not consultants to fill vacant consultant psychiatry posts."

Do you know the extent to which that is happening? Has an assessment been made of any risk that it could present?

**Eva Thomas-Tudo:** We do not have that detail. The Royal College of Psychiatrists raised that concern to us and highlighted it as being a challenge, so it will have the detail on that.

**Sharon Dowey:** You also mentioned the workforce plan, and we are waiting for the report on that to come out. I am always interested in whether the workforce plan equals funded places at universities and colleges. Do you know why not enough students are coming into mental health nursing? Seemingly, there has been an increase in funded places, but we still cannae get enough people in.

**Stephen Boyle:** That is an important area for the health system to resolve. Our report touched on the fact that NHS Education for Scotland is involved in tackling the issue, which is the important next step. The areas of promotion to prospective students, and of engaging their interest and changing their behaviours, will all have to be considered. Our report sets out the circumstances that the system currently finds itself in and is alert to. The effectiveness of the next steps, and what the planned steps might be, will be part of the action plan. Again, the committee might want to explore that area of interest directly with those NHS bodies.

**Sharon Dowey:** I will move on to plans and strategic direction, How realistic are the Scottish Government's commitments to increase the mental health directorate's budget by 25 per cent and to ensure that 10 per cent of the front-line NHS budget is spent on mental health by 2026, given the financial constraints that your report highlights?

**Stephen Boyle:** You are right that to say that we have highlighted the financial constraints that the Scottish budget faces. Indeed, we have done so in many of our recent reports over the past 18 months or so. It will come down to the prioritisations that the Government wishes to make and to parliamentary consideration of the budget. Whether that is consistent with the aims of increasing mental health service provision in primary care settings or the target for 10 per cent of the NHS budget to be spent on such provision will all have to be balanced. Those are the levers that the Government and the Parliament have at their disposal as they set priorities.

As we touched on in our earlier discussion, it is clear that other parts of public services risk not being prioritised while health spending is. Over many years, our NHS overview reporting has said that the system as it currently operates is not sustainable, so public sector reform has to move at a faster pace.

Building on Christine Lester's earlier point, we have to move from reform being a reactive part of the system to there being more preventative spend that requires NHS councils, IJBs and third sector providers to come up with a fundamentally different plan than the one that we currently operate.

That all goes back to choices and priorities. Making further progress will require prioritisation that might not favour other parts of public spending.

**Sharon Dowey:** That goes back to your comment that difficult decisions that will need to be made.

We note that, this autumn, the Scottish Government expects to publish a delivery plan and a mental health workforce plan that will set out how and when the priorities in the mental health and wellbeing strategy published jointly with COSLA will be achieved. Do you have an update on the timings for the publication of those documents?

**Stephen Boyle:** I do not think that we do. The most up-to-date information that we have is that it will be in the autumn. I assume that the committee will be very keen to see that the plans are consistent with the findings and recommendations that we make in our report.

**Sharon Dowey:** What more could the Scottish Government, alongside its health and social care partners, learn from NHS England to improve its financial, workforce and operational data in relation to mental health services? You refer to that in paragraph 98 on page 47.

10:30

**Stephen Boyle:** In the report and in other audit work that is under way, we try to evaluate where there are options for applied learning from what has been done in other jurisdictions. The one caveat that I would make before I say a bit more—Leigh Johnston might want to say more about how NHS England is operating—is that we have not seen a perfect model. Although we draw on NHS England and one of our case studies from Trieste, in Italy, about the provision of services, we note that there is not a perfect set of circumstances for the provision of high-quality adult mental health services. What we have seen in England, though—Leigh can say more can say more on this—is that its use of data is further along than we have seen for primary care in NHS Scotland. We know that NHS Scotland speaks to its colleagues in NHS England to bring some of that learning back and see whether it can that be applied successfully and effectively here in Scotland.

**Leigh Johnston:** Building on what Stephen Boyle said, it is important to recognise that NHS England still faces a number of data quality and completeness issues. The situation is not perfect, but NHS England is collecting a greater range of data than we currently have on spending and activity across a range of different services, inequalities, and the recovery rate for people who have engaged in psychological talking-type therapies. We are trying to say in the report that we could possibly learn something from NHS England in terms of the range of different data that it currently collects and the different types of things that it is looking at.

**The Convener:** We are very tight for time. Graham Simpson, you can have the final question, if it is very quick.

**Graham Simpson:** Thanks, convener; it will be quick. It concerns something that we have not touched on yet, which is the cost of drugs to treat people with mental health problems.

I read recently that there has been an explosion in the use of antidepressants. There are now up to 1 million adults in Scotland who are on antidepressants, which almost gets us to the one-in-four figure that we mentioned earlier. There is a huge cost to all that, and I wonder whether you have done any analysis of that.

**Stephen Boyle:** I recognise the reference that you make to the cost of antidepressants, and we have seen some commentary on that over the past couple of weeks.

As we said, we did not focus on individual conditions during this audit, but what we have set out in paragraph 75 shows what was perhaps not the expected result. Spending on mental health medicines in a community setting fell in real terms from £117 million in 2017-18 to £90.4 million in 2021-22. At the same time, we are seeing an increase in the number of items that are being prescribed. That is consistent with the point that you make, and it leads us to an interim conclusion—we have not done any audit work or have any evidence on this—that the cost of medicines for some conditions has fallen, but the scale of access is still high and increasing.

**Graham Simpson:** So, the cost of the medicine is falling, but the number of people using it may have risen.

**Stephen Boyle:** Yes.

**Graham Simpson:** That may be something that we should look at.

**The Convener:** Thank you, Auditor General, for the evidence that you have led this morning, along with Leigh Johnston, Eva Thomas-Tudor, and Christine Lester from the Accounts Commission. I thank you all very much for giving us your time and your thoughts and reflections, and for giving us some very useful evidence that we will now consider in deciding what next steps we want to take on this hugely important area.

May I say, Auditor General, that I think that this is one of the strongest reports that you have produced, certainly in my time as the convener of the Public Audit Committee. It is very clearly driven by the evidence and has reached some pretty stark conclusions that I think all of us, as members of the Scottish Parliament, will need to reflect on. Thank you very much indeed.

10:34

*Meeting continued in private until 11:25.*

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