OFFICIAL REPORT
AITHISG OIFIGEIL

Public Audit Committee

Thursday 14 December 2023

Session 6

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CONTENTS

Col.
DECISION ON TAKING BUSINESS IN PRIVATE 1
SECTION 23 REPORT: "ADULT MENTAL HEALTH" 2

PUBLIC AUDIT COMMITTEE
33rd 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:

Dr Alastair Cook (Scottish Government)
Gavin Gray (Scottish Government)
Caroline Lamb (Scottish Government)

CLERK TO THE COMMITTEE

Lynn Russell

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Public Audit Committee

Thursday 14 December 2023

[The Convener opened the meeting at 09:00]

Decision on Taking Business in Private

The Convener (Richard Leonard): Good morning. Welcome to the 33rd and, I assume, last meeting of the Public Audit Committee in 2023.

The first item on our agenda is a decision on whether to take agenda items 3, 4 and 5 in private. Do we agree to do so?

Members *indicated agreement.*

Section 23 Report: "Adult mental health"

09:00

The Convener: The main item for the committee is agenda item 2, which is further consideration of the joint Accounts Commission and Audit Scotland report on adult mental health.

We have already held a series of round-table evidence sessions, as well as having a session with the Auditor General and his team. This morning, we are pleased to welcome witnesses from the Scottish Government to give us their response to the evidence that we have already taken and to answer some of the questions that we have.

I am pleased that we are joined by the accountable officer, Caroline Lamb, who is the chief executive of NHS Scotland and the director general of health and social care in the Scottish Government. Alongside the accountable officer, we have Gavin Gray, who is the deputy director of improving mental health services, and Dr Alastair Cook, who is the principal medical officer in the mental health division of the Scottish Government.

Before we get to our questions, I invite Caroline Lamb to make a short opening statement.

Caroline Lamb (Scottish Government): Thank you for the invitation to provide evidence to the committee. We welcome the opportunity to discuss such an important topic. Colleagues in our mental health directorate worked closely with Audit Scotland as it produced its report on adult mental health. It is comprehensive, clear and wide ranging, and we recognise the issues that have been raised.

Alongside that, we have engaged widely with a range of partners as part of the development of our mental health and wellbeing strategy, the delivery plan and the workforce action plan, of which I am sure you are all aware. Our delivery plan set out the specific actions that we intend to take over the coming months, many of which address some of the issues raised in the report. Therefore, actions in both plans cover a wide spectrum of areas. They recognise that action is required across Government to address the underlying causes of poor mental health, as well as ensuring provision of the right support for those who need it.

We have rightly set out an ambitious strategy, but we are acutely aware of the deeply challenging financial situation that we find ourselves in. Despite record investment in the national health service, there are significant financial challenges across health and social care. The committee will

be well aware of those being a result of increased pay settlements, increased demand, inflation, rising energy costs and the continuing impacts of Covid and Brexit.

Despite that context, there has been an overall increase in spending on mental health, which we expect spending on mental health to be well in excess of £1.3 billion this financial year. I know that the committee will want to explore the impact of that spend in more detail, but we have made significant progress. For example, we are investing £51 million in our community mental health and wellbeing fund for adults, developing and rolling out the world-leading distress brief interventions programme, and exceeding our commitment to fund more than 800 additional mental health workers in key areas.

That said, we know there is still much to do, and we are keen to explore all that with you in more detail.

The Convener: Thank you very much indeed. I think that you alluded to it, but, for the record, I ask you whether you accept all the key messages and recommendations in the report.

Caroline Lamb: Yes, we do.

The Convener: You also spoke of financial challenges. We will get to those in more detail in the course of the meeting, but I have a question about the announcement in the past couple of weeks of another in-year budget cut to mental health services, which follows on from the in-year cut announced as a result of the emergency budget review last November, which was of the order of £38 million. The cut this year is £29.9 million.

The joint report states:

> "Increasing the availability of mental health and wellbeing services in primary care could help to prioritise prevention and early intervention and decrease pressure on specialist services."

How will the recently announced cuts, which include a reprofiling of mental health and primary care programmes, impact on those services?

Caroline Lamb: We are absolutely committed to improving mental health services, but we have to balance our budget. Despite the cuts and reductions in budget that you alluded to, we are spending more than twice the amount on mental health than we were spending back in 2021, so there has been a substantial increase in the investment in mental health services.

I can discuss that with you in some detail. My colleagues might want to speak about some of the measures that we have been taking in primary care. We have made significant investments in prevention and early intervention in primary care. Our support to NHS 24 is included in that overall primary care provision.

We will continue to invest, but we are doing that in the context of a very challenging financial climate. As a result of that, we need to be clear. The recommendations from Audit Scotland and the work that we have been doing on data will ensure that we are able to assess the impact, be clear about the difference that that huge additional investment is making and focus on ensuring that we get the best value possible from the large sum of money that we are investing.

The Convener: Presumably, you concede that taking nearly £30 million out of the budget, on top of taking £38 million out of it last year, will have an impact on services.

Caroline Lamb: It is obviously disappointing to have to reduce any budget. As I said, that is set in the context of an extremely challenging financial climate and the need for us to ensure that we can balance our budget. We have to make very difficult decisions. That does not take away from the fact that we are still investing substantially and that we need to ensure that that huge investment is deployed in the best possible way.

The Convener: So, what spend has been postponed—I think that that was the expression used in the letter to the Finance and Public Administration Committee—from the mental health transformation fund?

Caroline Lamb: The committee will be aware that we have had to step back and pause a little on our commitment to spend more money on mental health workers in primary care.

Gavin Gray might want to comment on some other areas of detail.

Gavin Gray (Scottish Government): The other areas that we have had to pause development on, rather than stopping activity that was already happening, are more about not proceeding with things that were planned. There was investment planned in forensic mental health services on the back of the independent review, which we are pausing. We are looking at how we can work with the system to make better use of the services and optimise what is in the system. That is the other significant area in which we have paused work that was planned.

The Convener: Is there not a bit of an implementation gap? The Government's stated position is that it will increase mental health funding by 25 per cent and that 10 per cent of all NHS front-line spending will be on mental health, but things seem to be going backwards, not forwards, on both fronts.

Caroline Lamb: I come back to the point that we are working in an extremely challenging

financial climate. I am sure that the committee wants us to ensure that we are spending the money that we spend in the best possible way. A lot of our work is about ensuring that we have the data and intelligence to enable us to understand where systems are doing well and where there is room for improvement in what systems do within the existing package of resources. It is also about ensuring that that money is deployed as well as it possibly can be.

The Convener: We will get on to data and evidence shortly.

One of the clear recommendations of the report that we are discussing concerns the fact that there is a great inequality in the impact of mental ill health. In one of the evidence sessions, we considered the impact on the minority ethnic community and other marginalised groups. Will taking money out of the mental health services budget not also have a disproportionately unequal impact on the communities that are most marginalised and probably most dependent on mental health services?

Caroline Lamb: We are clear that poor mental health does not have an equal impact across all communities. We are also clear that the cost of living crisis and the stress that is involved in people trying to manage their budgets adds to the impact of poor mental health and creates mental distress. A lot of our work has been focused on trying to support not only alleviation and prevention but early intervention in those areas. Much of our work on data with Public Health Scotland is also designed to ensure that we can be clear about the impact that we have and that we can use that information to address inequalities that we might see.

Gavin Gray might want to add something to that.

Gavin Gray: As the Audit Scotland report recognises, we have made a big commitment, across the directorate, on how we support equalities. We consulted our equality and human rights forum during the development of the delivery plans and the strategy. In the context that Caroline Lamb set out, we are trying to identify in the delivery plans the areas where we really need to make progress. We have tested that with a lot of equalities groups.

We also published comprehensive equality impact assessments against both the delivery plans, and we continue to work with people with lived experience from all of the equalities groups to ensure that what we are doing is having an impact. We will involve those groups closely as we develop the plans and as we implement them, so that we can keep making progress. As Caroline Lamb said, we understand the disproportionate impact that mental health issues have.

Dr Alastair Cook (Scottish Government): In addition, work on which we have been able to make new investment—particularly through the community mental health and wellbeing fund for adults, which is mostly landing in the third sector—has been specifically targeted towards inequalities and the relevant groups, which have been asked to look specifically at additional services and additional supports as a priority. Inequalities have been at the forefront of work on making changes around earlier intervention and prevention.

The Convener: There is a joint Convention of Scottish Local Authorities-Scottish Government mental health and wellbeing strategy that refers to the specific needs of minority ethnic groups. However, during the course of our inquires, we have been told that there is no action in the accompanying delivery plan to provide culturally sensitive mental health services. Can you explain why that is?

Caroline Lamb: As Gavin Gray has already explained, we work with equalities groups to develop the delivery plans.

The Convener: Those groups have said to us that a plan does not exist.

Gavin Gray: The boards and local authorities that are delivering services are all subject to the public sector equality duty. Through our engagement with the boards and through the annual delivery planning process, we ask what boards are doing on equalities to meet the needs of different groups. We do that not only on mental health, but across the board. We are setting the policy intent, but the boards that are delivering the services need to get into that level of detail.

As Caroline Lamb said, we are trying to establish data to better understand what is happening with those groups so that we can have conversations to ensure that delivery is happening. There is a lot involved in that, and we are constantly trying to understand what is happening and then work with those who are delivering the services to ensure that they are delivering for the groups that they need to deliver for.

The Convener: We will get into more detail about the data gaps and some of the evidence that we have taken around that, but the question is not so much whether you are talking to various groups or not, but what the outcomes are.

Caroline Lamb: Sorry, but we need to be clear that it is for local systems to assess the needs of their populations, as Gavin Gray said, and it is for them take into account the clear inequalities across the system to determine how they best take forward the actions that are in the plan.

The Convener: So, are you saying that when a Scottish Government and COSLA joint strategy is developed, it is all down to what happens at a local level; there is no Scottish Government oversight of that?

Caroline Lamb: No. As Gavin set out, we are setting the direction clearly, and we are also working very closely with Public Health Scotland so that we have enhanced data to monitor progress against delivery. However, I think that you would agree that it is important that local systems, which have local understanding of their local populations, are able to determine what is required in their particular circumstances.

The Convener: Again, I go back to the point that I made earlier, which is that the Scottish Government made increasing mental health funding by 25 per cent to ensure that 10 per cent of all spending on the NHS front line is on mental health services a priority. I would therefore expect the Scottish Government to take some responsibility to ensure that those outcomes are being met.

09:15

Caroline Lamb: That is exactly what we are doing. In September, we published our core mental health outcomes framework and our specification for psychological therapies. We are asking boards to self-assess their delivery against those standards. We are also working with Public Health Scotland so that we have the data to measure delivery and, as I said earlier, identify the systems that are doing well and the systems that have room for improvement.

The Convener: Before I bring in Willie Coffey, I want to ask you about a proposal that was put to us by the Mental Health Foundation. It said that, in order to tackle mental health inequalities, there ought to be an assessment of the impact on mental health of all Government decision making. Do you accept that that is worth exploring?

Caroline Lamb: We could explore that proposal, absolutely. As I said in an earlier answer, mental health and mental distress are not just for the health and social care portfolio. The factors that impact on mental health run across all sectors of society, including the areas where Government has an opportunity to intervene, so we would need to consider the issue in relation to decision making across Government.

Willie Coffey (Kilmarnock and Irvine Valley) (SNP): The convener led on some finance-related questions that I was hoping to touch on, but I would like to return there. The Public Audit Committee is interested in following the public pound. Caroline Lamb, you mentioned the £1.3 billion investment in mental health services. The Auditor General's report clearly shows that there has been a significant increase in funding for the directorate in recent years but, as the convener mentioned, there have been cuts to various parts of the service. What impact does that ebb and flow of being allocated more money and then facing cuts have on you in delivering those services? Does it mean that you have to delay things? Do you have to cancel work? What are the real impacts, and what are the effects of the spending changes?

Caroline Lamb: As I explained earlier, we have been substantially increasing funding in mental health—it has doubled since 2020-21. In that context, the impact of having to make reductions is more about slowing down work that has not yet started. We are able to do that because we have been on a trajectory of increasing funding. Although it is disappointing to have to slow things down, it means that we are able to protect all the work that has already been put in place and protect the funding for our health and social care partnerships and our NHS boards to carry on delivering the services that are already in place.

Willie Coffey: You are confident that you will not lose the intention to fund certain initiatives, but you might have to slow them down.

Caroline Lamb: We are committed to continuing to deliver against the delivery plan, but we, and I as accountable officer, also have to deliver a balanced budget. That means that our ability to invest in everything that we want to invest in is challenged.

Willie Coffey: You mentioned the distress brief intervention programme, as did the Auditor General in his report. Will you tell us a wee bit more about that? Is there a concern that we have removed dedicated funding for that, or is it continuing? Are the recommendations from the DBI programme being taken forward?

Caroline Lamb: I will come to Dr Cook on the detail but, from my perspective, we are continuing to fund the central components of that DBI programme, particularly the work that NHS 24 does on that. We have been clear with local systems since the start of that programme that they would need to embed that in their financial planning.

Dr Cook: I am happy to cover that. The DBI programme was very clearly set up with an end point, and the pilot programmes had initial investment that allowed them to get things off the starting blocks. That will come to an end at the end of March 2024. We now have, I think, 29 out of the 31 health and social care partnerships live, with a target to get them all live by March 2024, so we are on track to do that. There will be continued funding for the DBI national programme, which

allows people access through NHS 24 and the police and ambulance services, as well as some central support for the local areas. All the areas that have had temporary funding now have plans in place to continue the service beyond the end of that initial central funding.

Willie Coffey: That is good to hear.

To turn to our third sector colleagues, the committee has had many round tables, and we always hear pleas about sustained funding for three or five years. SAMH was no different in calling for a shift to a five-year statutory minimum contract length. Caroline Lamb, how confident are you that we can get to such a place? Year in, year out, the committee hears pleas for funding to be sustained for three or five years. Are we able to get anywhere near to doing that?

Caroline Lamb: I absolutely accept how difficult it is for organisations to manage and operate efficiently and well on funding that is almost hand to mouth. The challenge for me as the portfolio's accountable officer is that, in order to move to such longer-term funding, we need more assurance around the annual nature of our own funding. For example, at the moment, it is challenging to understand how much we will get in Barnett consequentials. We would all like to move towards at least having indicative budgets and giving third sector partners a bit more security on that.

Willie Coffey: Do you give three-year indications of funding? Do you try to do that and then have to pull back?

Gavin Gray: For some, the smaller amounts have a proportionally bigger impact, so we do what we can with our third sector partners to recognise that and to give them as much assurance and comfort as possible. As Caroline Lamb said, that is always subject to a caveat about the parliamentary budgeting processes, but we try our best to give as much comfort and protection as we can to VOX Scotland and other organisations that give us the voice of lived experience.

Willie Coffey: We hope to get there one day, convener, on what is a big and important issue.

Caroline Lamb, an issue that came up in our discussions was how to demonstrate positive outcomes and benefits from our significant investment. Good examples are in the Auditor General's report and were heard during our round-table sessions. How do we capture a bit more of that? It is easy to focus on the problems—funding variations and so on—but how do we capture those positive benefits in the area of adult mental health?

Caroline Lamb: That brings us back to our work with Public Health Scotland. In one of your earlier evidence sessions, you heard from Richmond Davies about the work that that organisation is taking forward to ensure that we have better data. We have quite a lot of data in the acute hospital sector but, as I have said to the committee on previous occasions and in different contexts, we struggle a bit more on data from the community and social care and primary care sectors. However, over the past couple of years, we have made huge progress in starting to improve that. Public Health Scotland has on-going work to do that.

We are also working to ensure that we can gather information on satisfaction levels. Gavin, will you say something about the satisfaction survey?

Gavin Gray: Again, that is something that we have been very aware of. We know that a lot of collection happens locally—I think that Tracey McKigen and others said in their evidence that information is collected for certain schemes—but we have not done that systematically at a national level, so one of the commitments that we will look at this year in our delivery plan is a patient satisfaction survey, which would tie in with that and give us national as well as local oversight.

As I have said, we engage with a lot of organisations such as VOX Scotland, and we have a diverse experiences advisory panel, which means that we take the views of lived experience when we develop policy. However, there has been a gap. We need something at the end of treatment, so that we can understand what people's experiences are and feed that in with all the other, more quantitative data that we have. As I said, we have a commitment to deliver that next year.

Willie Coffey: Other members will have questions about data collection issues, and the convener covered the impact of the emergency budget review a wee moment ago. My final question is for Caroline Lamb. Are our NHS boards on track to meet the commitment that, by 2026, 10 per cent of front-line health spending will be on mental health?

Caroline Lamb: That is difficult for me to say. Audit Scotland's view was that we are not on track to meet that commitment. In the context of a very challenging financial position, it is difficult for me to say absolutely that we will be on track. The commitment was for around 10 per cent of NHS spending, but it is important to recognise, as Audit Scotland did, that this is not only about the spending that goes through the NHS. Work on prevention and early intervention is very important in improving mental health, so a lot of our investment has been in communities and in the

third sector. We must look at the whole spend, rather than focusing on the NHS part of that.

Willie Coffey: Will you still track that?

Caroline Lamb: We are tracking and monitoring that with health boards.

Willie Coffey: If we ask you again in a year's time, will we be able to get closer to knowing whether that is on track?

Caroline Lamb: Absolutely.

The Convener: On that point, how do you respond to the evidence that we were given by Dr Srireddy from the Royal College of Psychiatrists in Scotland, who said:

"We made the shift, we shut the asylums and we have moved into the community—but then we kind of lost interest."—[*Official Report, Public Audit Committee*, 16 November 2023; c 18.]

Caroline Lamb: I do not at all think that we have lost interest. The work that we have been doing to invest in the community—and in the acute sector—recognises that the key to improving mental health services is having the right workforce and skilled people to support folk who need services. Alastair Cook might want to comment, but I can take psychiatry as an example. We have significantly increased the number of psychiatry training places at the same time as investing very significantly in the workforce who give early intervention support in the community, so I do not think that there is any way in which we can be said to have lost interest.

The Convener: The Royal College told us about the reliance on locums and other members are going to ask about the workforce plan.

Dr Srireddy also said that governance has been a real challenge and spoke of fragmentation. You may not agree, but his view and his members' perspective was that mental health was, in his words, an "afterthought".

We also have a pretty clear message in the report from the Auditor General and the Accounts Commission, in which key message 3 says:

"The system is fragmented, and accountability is complex, with multiple bodies involved in funding and providing mental health services. This causes complications and delays in developing services that focus on individuals' needs."

Those are quite serious charges. How do you respond to those?

Caroline Lamb: I do not recognise the picture that is being painted. I accept, as we have just discussed, that we are directing funding to third sector organisations as well as through primary care and through NHS boards, which can sometimes look difficult to navigate, but we are absolutely following the principle of getting it right for everyone. We look to ensure that our systems put the person at the centre and that we make it as easy as possible for people to navigate those systems.

Gavin Gray, do you want to add to that?

Gavin Gray: Regarding the visibility of mental health, we work with a number of director general colleagues. Mental health is one of the priorities in the annual delivery plan guidance and in our medium-term planning, so we work continually with colleagues to ensure that it has visibility. We are aware that people are concerned. We have always tried to get parity between physical and mental health and continue to push on that.

We have recognised some of that in the delivery plan, given the complexities of the system that we deal with for everything from the forensic right through to the light-touch information and wellbeing advice that we give. There is such a broad range of partners and interactions in that. It can be difficult and, as Caroline Lamb said at the start of the meeting, we accept the challenges that exist at times in accessing systems. That is slower than we would like, which is why, again, we have actions in there that are aimed at how the systems interact and how the digital offers link with primary care community support.

09:30

We have made advances around psychological therapies and child and adolescent mental health services by establishing specifications and getting a consensus about what good support looks like. That is one of the things that we want to do more on for community and adult secondary mental health services over the next year or two. We want to establish a better picture of what good services should look like so that we can build on that and address some of the issues.

Caroline Lamb: I want to return to the point about mental health being an afterthought. As DG, I assure the committee that mental health is absolutely not an afterthought. As Gavin Gray said, we include the mental health priority objectives in our annual delivery plan guidance for NHS boards, and, when we meet NHS boards to complete their performance reviews, which we do regularly, we include folk from the mental health team so that we look not just at performance in urgent and unscheduled care, planned care and cancer but at how boards are doing in mental health.

Dr Cook: I want to pick up on the perception of there being a lack of attention on adult mental health services. I think that we would acknowledge that, to an extent, Dr Srireddy's point about that is justifiable. In the past while, there has been a huge focus in the interaction between Government

and local systems around the psychological therapies and CAMHS waiting times initiatives. That might have led to a perception that adult services were getting less focus and attention.

As we have moved into the current process with the mental health and wellbeing strategy that has been published, the delivery plan and the publication of the core mental health standards, we are very much trying to rebalance the thinking in the system so that, while still recognising that waiting times for child and adolescent mental health services and psychological therapies are hugely important, we recognise that other things are really important, too, and need more attention as we go into the next phase.

The Convener: The Auditor General has obviously chosen to produce the report on adult mental health services because it is a matter of public interest.

Caroline Lamb, I will take you back to your initial response when I put to you the evidence that we had taken from both the Royal College of Psychiatrists in Scotland and the Auditor General. At 9 o'clock, you said that you accepted all the key messages in the report. However, before the clock got to half past 9, you were distancing yourself from the very clear message that there is a view, which has been reinforced in all the round-table evidence sessions that we have had, that the system is fragmented and that there are issues around accountability in the system. Do you not accept any of that?

Caroline Lamb: No. I have said that I absolutely accept that people sometimes find it very complex to navigate the system. Some systems are better at joining things up than others. One of the things that we need to do is to learn from the way in which the best systems approach it. That is very much grounded in our work on getting it right for everyone and ensuring that the person is at the centre of what systems do, rather than individual aspects of the system. I am sorry if something that I said implies that I do not recognise that. We know that we have challenges, and we are working across systems to address that, but it is not a single homogeneous picture, either. Some systems are better at this than others.

The Convener: Without batting in defence of homogeneity, we are looking for a bit of consistency, and there seems to be a very mixed picture across the country. That is why, as a committee, we wonder whether you have thought about some of the evidence that we took, in which there was a concern about the legal framework that integration joint boards, for example, operate in. Are you considering reviewing the governance arrangements to see whether they can be simplified, be made more effective, provide better value for money and be more accessible to the people who need the services?

Caroline Lamb: I have two things to say in response to that. First, we absolutely recognise the need for consistency, which is why we publish the core mental health standards and look for self-assessment against those standards.

Regarding IJBs, the committee will be aware that we have been working with COSLA on the development of the national care service, which is intended to create far more consistency and to address some of the governance barriers to delivering primary care services in communities, primary care and the acute sector.

The Convener: Is the Government looking at primary legislation or at making changes to the oversight and delivery model?

Caroline Lamb: As part of the development of the national care service, we have been working with COSLA to ensure that we can put national oversight in place, while also simplifying or removing some of the barriers to getting those seamless systems in place.

The Convener: I think that the answer to my question is no. Although that will be mopped up as part of the national care service review, you do not necessarily expect any fundamental reform of the architecture of adult mental health services.

Caroline Lamb: We are talking about the architecture for our integration joint boards, which is absolutely at the centre of the national care service review that we are working on with COSLA.

The Convener: Are you saying that you think that that is working well?

Caroline Lamb: I am not saying that. I think that there is a lot of room for improvement, which is one of the things that the national care service will look at.

The Convener: I go back to a point that I alighted on very briefly, which is based on the evidence that we took from the Royal College of Psychiatrists. You seem to paint a picture of things going pretty well, but we were told that the system is hugely overreliant on locums. Do you have a strategy for tackling that?

Caroline Lamb: I accept that there is an overreliance on locums. Our strategy for tackling that has been to increase the number of psychiatry training places. Alastair Cook can say more.

Dr Cook: A lot of work is going on to improve recruitment and retention. We are trying to improve international and domestic recruitment. Retention is also a big issue.

Psychiatry has historically been one of the more difficult medical specialties to attract doctors into and we went through a spell of struggling to fill core training places. For the past three or four years, we have had a 100 per cent fill rate for core training, but that training takes a minimum of six years and most people take eight or nine years to complete it because of various different options or because of part-time working, so that will take time to filter through.

Increasing the number of core training places in the past few years has been successful, in that we have filled those places, but the next phase, as those core trainees come through into higher training places, will be to ensure that we keep them in Scotland and bring them into the Scottish workforce. Our working group, which includes the Royal College of Psychiatrists, NHS Education for Scotland and others, is working to achieve that.

The Convener: Do you have a shared perspective on the scale of the challenge?

Dr Cook: Absolutely.

The Convener: Okay. Thank you.

I invite the deputy convener, Sharon Dowey, to put some questions.

Sharon Dowey (South Scotland) (Con): The report highlights a number of issues with the availability and quality of data and recommends that

"The Scottish Government and Integration Joint Boards (IJBs) should ... urgently progress work to improve the availability, quality, and use of financial, operational and workforce data"

to improve planning, information sharing and monitoring of the quality of services and patient outcomes. How is the Scottish Government addressing the gaps in data to enable more informed planning and decision making?

Caroline Lamb: Data sits at the heart of a lot of what I have been talking about so far. We are working closely with not just Public Health Scotland but our e-health and digital leads across boards, to ensure that the systems that are in place accurately capture data on mental health activity, which feeds into data on cost.

Gavin Gray has told you about some of our work on people's experience of services. That work continues, and it is at the core of a lot of what we are trying to do not just in relation to mental health but in understanding where activity happens in the community and in primary care, so that we can accurately capture and report on that. It is important, as you said, that that data is reflected back to local systems, so that they can see how they are doing, including how they are doing against other systems, so that they can identify opportunities for improvement.

Gavin, do you want to add anything?

Gavin Gray: The other side of that is in planning. We have talked about the annual delivery plan and the medium-term delivery plan. As we have said, mental health is one of the 10 priorities, so we get reports back on what the local mental health plans look like and how those sit with workforce projections and plans. We look at all of that collectively in order to identify any other national gaps—things that we need to do—and to inform our regular engagement with mental health leads in each board. We do that primarily at board level, but there is good representation from IJBs—a lot of the functions are delegated to them so, often, the mental health lead is a chief officer or has delegated responsibility.

We try to use those mechanisms to understand what the tensions are in planning. Then, in effect, we use that to agree with the boards what national help they need—where we can support them in areas where they might be struggling. For example, we have done a lot to improve waiting times for CAMHS and psychological therapies. When board performance does not look so good, we have those conversations with them to identify what the barriers are. We have a team of professional advisers who support to boards to improve.

Caroline Lamb: Is it also worth saying something about the benchmarking work?

Gavin Gray: Yes. We talk about that in the delivery plan. For the past couple of years, we have invested in UK benchmarking, so we get data that allows boards to look at various things such how bed numbers and staffing numbers compare not just across Scotland but with comparable services in the rest of the UK. That is very much driving improvement at the moment. We pay the membership fee for that and the boards engage in that activity.

We have focused on adult services, CAMHS and the three events that are planned at the start of next year. We are sharing that intelligence and planning with mental health leads, so that boards can consider what works, what different models look like and how they can learn and use that intelligence to develop and improve their own services.

Sharon Dowey: I will come back to some of that in a wee bit.

During the third round-table evidence session, Public Health Scotland explained that it holds

"robust data on in-patient mental healthcare".—[*Official Report*, *Public Audit Committee*, 23 November 2023; c 20.]

However, the equivalent data does not exist for adult mental health services in the community. Can any lessons be learned from the way in which

data is currently gathered for secondary care, to improve the availability and quality of adult mental health data in primary care settings?

Caroline Lamb: Yes, absolutely. As I have said to the committee, one of our challenges is that, although we have good data in the acute sector, otherwise the situation is more complex, because many more organisations are involved in that activity in primary care—including more than 900 general practices—and, more broadly, in the third sector in the community. However, Public Health Scotland has been working broadly with us on primary care data, because the situation also applies in other areas of activity. That work is on-going and we are committed to ensuring that we get that picture of activity on adult mental health no matter where that takes place. That is important to us.

09:45

Sharon Dowey: You spoke about collecting a lot of data, and you mentioned the UK benchmarking. How readily available are all those reports for us to see how well we are doing?

Gavin Gray: The benchmarking information that we disseminate is not published at the moment, because boards use it primarily as an improvement tool. We talk to the boards about that, and, through the process next year, we will look at whether we can publish anything from it.

On what we are trying to do with PHS, Dr Richmond Davies talked about the CAMHS national data set when he was here, and getting that individualised data will allow us to interrogate information in a much stronger way. That is going to be part of the regular publication.

On the back of the strategy, we have set out outcomes, which Dr Davies also talked about. Having established the outcomes framework, we are doing the work on the evaluability assessment. We had another meeting about that this week with PHS, so we are on track with that. We will publish a much broader range of information that will give a much broader overview beyond the waiting times targets for the two services. It will give a much broader picture against the outcomes that we set out in the strategy.

As Caroline Lamb said a couple of times, we are looking how we can measure against the core mental health standards to get better information and quality in order to get a more standardised view across the boards. Those are the main areas that we are looking at publishing. We will bring out more on that over the next year.

Sharon Dowey: You spoke about all the information that comes from different bodies. Did you say that you have 900 or so GPs? Do they all feed into one system so that you can get a report, or does everybody have individual systems?

Caroline Lamb: We predominantly use two systems in GP practices in Scotland, and we have a single system that PHS is able to use to—this is not very technical—suck data out of those systems. We continue to work to ensure that the data that goes into those systems is coded consistently, so that we are comparing apples with apples rather than apples with pears.

Across general practice, we have made huge progress not only in relation to the data extracts, which are relatively straightforward, but the quality assurance of the data in those systems. That is why, as you heard from Dr Davies, we are confident that we will be able to make those improvements to the data that we have.

Sharon Dowey: Is work being done to ensure that everybody uses the same system? One complaint that I have heard from consultants when I have been out talking to them is the fact that the boards have different computer systems, so if patients go between boards, they have to spend hours on telephones to get information. Is any work being done to ensure that everybody uses systems that speak to each other?

Caroline Lamb: The short answer to that is yes. A lot of work is being done to ensure that we can move towards having patient records that contain all the data about an individual. In some cases, that is about ensuring that all boards are using the same version, because, certainly for the patient management system, almost all boards use the same system. With technology the way that it is these days, the issues are less about being able to join up those systems than about making sure that the data is equivalent and that it is recorded consistently across systems.

There is also a need to manage concerns around information governance. People legitimately need to understand and be confident about who is able to see their information, and be confident that it is being used in the right ways. Work on that is on-going under our digital health and care strategy.

Sharon Dowey: Are there any timelines for when everybody will be using the same system? That would obviously help the mental health of GPs, consultants and patients.

Caroline Lamb: Yes. It is less about using the same system than about ensuring that we are able to get consistent information from the same systems. There is incremental progress towards that. We have described some of the on-going work, and that work will continue. Again, some of that is dependent on investment.

Sharon Dowey: So, we are not working towards having the same system—it is just about data collection.

Caroline Lamb: We need to be careful with regard to having the same system, because it is not about having one massive IT system—historically, those do not tend to go too well. It is about ensuring that we are able to render up and make available data from those systems in a way that is easy for people to understand.

I will give a simple example, which is Covid driven. As part of the vaccination programme, we were able to pull data from different systems, but make it available to individuals so that they could get their own vaccination record.

Sharon Dowey: The report also states:

> "The Scottish Government and health and social care partners should learn from NHS England, which publishes more detailed information on mental health services regularly."

It says that the NHS England data is not complete and that there are still issues there, but it also says that

> "information is now routinely published on service activity and performance, spending and inequalities."

Do you plan to learn from NHS England? What measures can you implement from there?

Caroline Lamb: We are absolutely committed to improving the data that we have and to being able to publish more of it. As Gavin Gray said, we are also undertaking benchmarking work to ensure that we are able to compare ourselves with NHS England. We are keen to learn from all systems—not just in NHS England but in NHS Wales and outwith the UK—what works well for people.

Gavin Gray: The two systems are a bit different, so we cannot directly lift from the NHS England system, but our analysts and the teams at Public Health Scotland are looking at what is available elsewhere and how that can be factored into the thinking about what we do and the work—as we have talked about—that we are taking forward.

We are working with PHS to ensure that we can publish more regular and wider information on outcomes. That is the intent in the strategy and the delivery plan, and that is what we will be working towards next year.

Sharon Dowey: What, in the NHS England system, is different from our system that means that it can report the data just now?

Gavin Gray: There is a lot around the way in which the systems operate. Alastair Cook may want to come in on that.

Dr Cook: The big difference is commissioning, to be frank. In order for mental health trusts to justify to their clinical commissioning groups certain activities that they are doing, it is necessary for them to get that data. It adds a lot of bureaucracy to NHS England that we do not have in NHS Scotland, but it means that there is more data produced, collected and monitored.

We can learn from that system, but I hope that we can do it without having to introduce such a bureaucratic commissioning layer in order to make it happen.

Sharon Dowey: I come to my final question. Has the Scottish Government provided funding to NHS Education for Scotland to develop the mental health workforce statistical publication? That was also mentioned in the report.

Caroline Lamb: Yes.

Gavin Gray: It is part of the considerations in the budget for this year, so we will discuss that with the minister as part of the prioritisation for next year.

Sharon Dowey: So no funding has been given to it as yet.

Gavin Gray: Not this year.

Caroline Lamb: However, NHS Education for Scotland continues to produce the statistical publication. As Gavin Gray said, there is also a question around how NHS Education for Scotland best uses its resources, and what it can do in terms of efficiencies to enable it to further develop that publication within resources. That is part of the work that we will be doing with it in relation to value for money.

Sharon Dowey: The report provides some detail about a piece of work that is intended to "significantly improve" the availability of mental health workforce data. There may, therefore, be implications for mental health if we do not put the money in. The phrase "spend to save" is being used just now. We need to ensure that the data that we get ensures that the money that we put in gives us the right outcomes. Are there implications if we do not provide the money for that piece of work?

Caroline Lamb: We need to be careful not to automatically assume that every extra bit of work needs extra money. There might be things that we would want NHS Education for Scotland to prioritise over other things in order to ensure that we are able to get access to the data that we want. We are very keen to improve that statistical report, but we need to have a conversation about what that means in the context of the overall resource budget that is made available to NHS Education for Scotland and how that is deployed.

The Convener: Okay. Thank you. In order to move things along, I invite Graham Simpson to put some questions to you.

Graham Simpson (Central Scotland) (Con): I will follow up on what Sharon Dowey asked about. She covered the NHS England mental health dashboard, which I have had a look at. I am sorry if you feel that it is too bureaucratic, Dr Cook. You can come back in on that, but to me, it provides very useful information. It follows progress, which is what this is all about. That links into what Mr Coffey asked about. It is about following the money and seeing what progress has been made. That is what the dashboard is all about. It used to be called the mental health five-year forward view dashboard, which is a bit of a mouthful. The website, which anyone can look at, says that it

“brings together key data from across mental health services to measure the performance of the NHS”.

Should we not be doing that here?

Dr Cook: To be clear, I think that that is what I said. We should be trying to do something like the dashboard. However, the process that led to the ability to deliver it in England has resulted in the bureaucracy that I referred to. That is about the whole process of clinical commissioning, as the contracting between the commissioning groups and the delivery bodies has introduced a whole layer of administration. One of the side effects of that is the dashboard, which is a great thing and something to which we should aspire, but it would be great to have that without having to add in that whole extra layer of administration. That is the point that I was trying to make.

Graham Simpson: I am all in favour of doing things simply, rather than introducing bureaucracy. Are you basically saying that you would like to have a Scottish mental health dashboard? I put that question to Dr Cook and Caroline Lamb.

Caroline Lamb: Yes. As we have described, we are working really hard with Public Health Scotland to try to ensure that we can get all the data on a consistent basis across Scotland. I do not know whether every trust in England is able to make data available for the dashboard, but we would certainly want to ensure that we are being consistent across Scotland so that we can compare like with like and make fair comparisons. It is really important that we make that data available so that local systems can see how they compare with other systems and, therefore, identify their opportunities for improvement.

Graham Simpson: What timescale are you working to?

Caroline Lamb: For us, the dashboard is about pulling together the data and the indicators against the core mental health standards. Public Health Scotland is working on that at the moment, and I think that it is talking about next summer.

Dr Cook: Late 2024, I think—yes.

Graham Simpson: You think that something will be up and running by next summer.

Caroline Lamb: We are hoping to get something up and running. Generally, when we get into publishing new sets of data, we first make them available as management information so that they are seen by local systems, which have an opportunity almost to quality assure them locally. Public Health Scotland also has a set of processes that it needs to go through to ensure that the data is statistically correct before it is published. We generally provide such data as management information first, and we move to publication after that.

Graham Simpson: The key thing about the dashboard is that anyone can look at it.

Caroline Lamb: Exactly. That is where we would like to get to.

Graham Simpson: From what you have said, that will be possible, but not until after next summer.

Caroline Lamb: Yes.

Graham Simpson: When will it be possible?

Caroline Lamb: I would need to discuss that with Public Health Scotland, given its timeframes for doing the assurance around published data, as opposed to management information.

Graham Simpson: Initially, it will just be for you. You and your colleagues will be able to look at it, but the public will not.

Caroline Lamb: It will also be available to local systems so that they can understand how they are doing.

Graham Simpson: It is really important that it is available to the public so that we have total transparency.

Caroline Lamb: I absolutely agree. It is just that Public Health Scotland, as the statistics regulator, has some processes that it needs to go through, and I would need to ensure that it is happy before I start giving timescales.

10:00

Graham Simpson: When I looked at the dashboard, the other thing that I came across was that, down in England, they have what are described as mental health hubs. They seem to exist across England and they are aimed at staff. Have you come across them?

Dr Cook: Not specifically. There are lots of mental health hubs of various sorts. If they are specifically about staff wellbeing support, I note that we have established staff mental health and wellbeing support systems in every board in Scotland. They were significantly accelerated and expanded as we moved into the pandemic, and they are on-going. In every board area, psychologists are available to support staff wellbeing. We also have a mental health and wellbeing hub for staff, which is for Scotland.

Graham Simpson: That is a national thing.

Dr Cook: Yes.

Graham Simpson: Okay. It might be similar.

Dr Cook: It might be.

Graham Simpson: Maybe you can go away and have a look at that. They seem to be dotted around England.

You will have been following the evidence, and you have read the report. In pretty much every evidence session, we have asked about the model that exists in Trieste in Italy. Dr Cook knew that I was going to ask about that. It can be described briefly as a "one-stop shop", if you like. It is open 24 hours a day, seven days a week, and people do not need an appointment—they can just call in. Pretty much every witness that we have had has said that that is a good model. Do you agree?

Dr Cook: Yes, although there is a "but", as you might expect. We have to see it in context. Trieste is a city with 200,000 people. It had a mental health hospital that had 2,500 beds. The changes were made at a time when there was a radical political leadership together with a visionary clinical leadership, and they were able to do something that other places have simply not been able to do. They closed 95 per cent of their beds at a swipe. Can you imagine us coming in and suggesting that to the Scottish Parliament? It is unthinkable that that would not be opposed. They then managed to retain those resources to manage those very extensive community services.

We have admired them. When we were developing our community mental health services in Scotland, a number of colleagues went over to Trieste to look at and learn from the model there, and the lead clinicians from Trieste have been relatively frequent visitors to Scotland, which is probably why their model has been picked up as one that people in Scotland are interested in. Our systems have learned from it, but we have not been in a position where we could resource 24/7 community hubs in the same way. We rely on general practice out-of-hours services in the out-of-hours period, but we have been able to put mental health supports into those wider services to expand that. Our 24/7 services have remained a bit hospital based.

There are aspects that we have not been able to progress nearly as far as they did in Trieste, but we have learned from the model. It is perhaps ironic to talk about Trieste at the moment, because all the current literature is, in effect, about saving the Trieste model. It is under huge threat at the moment because of financial and political opposition to it. It is a great example to learn from, but it is not directly applicable in our context. However, as I said, it would be nice.

Graham Simpson: It would be nice if we could have a Scottish version. It may not be exactly the same, because everywhere is different. Maybe you could be that visionary clinical leader that you described, Dr Cook.

Caroline Lamb: As Alastair Cook described, it is sometimes hard to lift and shift models from one system to another when they do not operate in the same context. The NHS 24 mental health hub is an attempt to provide initial contact that can signpost people to other systems. NHS 24 also employs skilled clinicians to deal with mental health risks.

We need to consider what the best approach for Scotland is, learn from lots of other systems and think about how we align that with the increasing use of NHS 24, particularly in urgent and unscheduled care. Is that fair, Alastair?

Dr Cook: Yes—that is helpful. In the 1960s and 1970s, people were not able to consider digital innovation, but it might be one of the keys to help us to unlock the issue with rurality, for instance. The Trieste model could not work without being place based. People had to go to the community hub. Through digital, we might be able to look to virtual hubs, albeit that they would have to be backed up by people being able to get face-to-face help.

Graham Simpson: That is correct. Not everybody could use such a system.

I asked about the Trieste model partly because it sounds like a good one. However, my reasons also go back to the convener's question about the system being fragmented. I am not sure whether you agreed that the system is fragmented, Caroline, because you said two different things. However, if we accept that we have a fragmented system and that people fall through the cracks, we can see that that leads to the amount of mental health work that the police have to pick up. That is another matter that the committee has been exploring.

You will know, because you have heard it from the police, that the vast majority of their time is taken up dealing with people who have mental

health issues. A lot of that time is taken up sitting in hospitals when they could be out on the beat dealing with crime. That is not a good situation. We heard from NHS Lothian that things are a little bit better in its area. That health board has a system in place that helps to prevent police from sitting in hospitals, but that is just NHS Lothian. In other parts of the country, including my area—I represent Central Scotland, which includes Lanarkshire—that system is not in place. In Lanarkshire, we have had situations in which entire shifts of police were sat in accident and emergency. That is ludicrous, is it not? If we had somewhere that police could take some people with mental health issues—not everybody—that would free them up. That has to be better, has it not?

Caroline Lamb: Yes.

Dr Cook: We are doing a lot of work with Police Scotland on that. We absolutely acknowledge the problem and we have been working with the police on the report that His Majesty's Inspectorate of Constabulary in Scotland published recently.

We mentioned the availability of clinicians in NHS 24. There has been work to develop an enhanced pathway that enables the police to contact the NHS 24 mental health hub in situ from where they are with an individual and, we hope, avoid the need to convey the person to hospital in the first place. A lot of local work is also going on in liaison groups with local hospitals and the police. The NHS Lothian approach, which you picked up on, is an example. In fact, NHS Lanarkshire has also been working really hard on that, and I think that it was picked up in the Audit Scotland report. The board has done some joint work with the police on reducing conveyance to hospital and it has achieved a 73 per cent reduction in that conveyancing rate through joint working with the police and the mental health emergency assessment service there. The mental health assessment service works.

I am not saying that the example that you gave is untrue, because these things do happen and people end up spending their whole shift in a hospital. However, when that happens, there is a missed opportunity audit with the police to look at what could have been done differently to try to avoid that. I know that that is happening in Lanarkshire, and work is also going on in other places. I think that we had some reports from the police this week in which they said that they are starting to see a difference.

We had a very well-attended workshop at Tulliallan two weeks ago, at which all the boards and mental health systems were represented. We are committed to carrying on working with the police to improve joint risk management, which is crucial, as there are sometimes different perceptions of risk. An individual who presents to the police in distress may be regarded by the mental health service as safe because they are well known to it and they have a care plan in place, but the police may feel uncomfortable leaving that person there. Better joint management of that risk could lead to further improvements.

Having the police sitting in emergency departments for long periods waiting for mental health assessments to be done is something that we want to remove from the system completely.

Graham Simpson: It is good to hear that you had that session at Tulliallan. Is that because you want to get to a position Scotland-wide where the police have somewhere that they can refer people to?

Dr Cook: Absolutely—

Graham Simpson: The key thing is that they will be able to do that at all times of the day.

Dr Cook: We already have that with the mental health hub, whereby there is an opportunity to refer someone on to local services that function 24/7. However, it is about taking that further so that it is not just a phone line. In many places, community psychiatric nurses are involved in working directly with the police on triage. We are looking to develop all those models where we can.

Graham Simpson: It is not about being able to phone somebody; it is about being able to take the person somewhere and freeing up police time. I gave the example from Lanarkshire because I speak to the police in Lanarkshire. When I say that entire shifts of police have been in A and E, it is because they have been there. I accept that there is now a local arrangement whereby, if things are getting particularly desperate, the police will phone the NHS and say, "Look, can you give us a hand here?"

Dr Cook: That arrangement should not be in place only when things are desperate. It should exist all the time.

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

The Convener: Thank you very much. Graham Simpson mentioned case study 2 in the report. Can I ask you about case study 4, which is not Trieste but Tayside? There have been some pretty catastrophic failures in the approach of the mental health service in NHS Tayside. The experience of people at Carseview in particular produced some very harrowing personal tragedies for families. What information can you give us about current adult mental health services in NHS Tayside?

Caroline Lamb: As you will be aware, we escalated NHS Tayside because of its performance on mental health, so we continue to

keep those services under review. Gavin can give you the latest information.

Gavin Gray: We worked closely with NHS Tayside last year. An independent oversight group that was led by Fiona Lees produced a report on NHS Tayside's mental health services. On the back of that, changes were made to the delegation arrangements. I had a lot of discussions with the previous and current ministers, and with the leadership at NHS Tayside. There was a meeting with the chairs of the IJBs last week. The plan is in place and there is a lot more scrutiny locally of progress.

We are also keen to promote engagement with local lived-experience groups, which have been very involved. We have close contact with them on trying to ensure that there is transparency and oversight of progress on the reporting. There is definitely a way to go, but there is a commitment locally on delivery against the plan that has been set out.

10:15

The Convener: This goes back to at least 2018; I remember raising the matter in Parliament back in the spring of 2018. The last time I spoke to families with lived experience, they were still perplexed, at best, that insufficient progress appears to have been made and that people are still not getting access to the services that they need. Do you recognise that picture?

Caroline Lamb: As Gavin Gray said, we escalated the board, and we continue to work with it. Obviously, we have had a change of leadership in NHS Tayside; on the back of that, we have been clear about the priorities for Tayside. I was up there a few weeks ago with the minister doing the annual review, and we continue to maintain our focus. It is clearly important that Tayside is able to move forward and make positive change, and we continue to support the board in trying to do that, but I absolutely accept that, on the ground, people are not seeing change as quickly as they want.

The Convener: In the interests of time, I will move things on and invite Colin Beattie to put some questions to you.

Colin Beattie (Midlothian North and Musselburgh) (SNP): I will cover access to mental health support and services. Caroline Lamb said earlier that—if I remember correctly—spending on mental health had doubled since 2021, but the Auditor General highlights in his report that many people find accessing support and services to be "slow and complicated". What are you doing to deal with that?

Caroline Lamb: As I said, we have been focused on making sure that we are investing in and supporting services in relation to avoiding mental health issues and in relation to early intervention—we are trying to prevent issues or to intervene early. That includes the work on distress brief interventions that we have touched on, and the support that we have been giving to local authorities to ensure that counselling services are provided in all secondary schools.

I have also talked about NHS 24's mental health hub, which is taking about 2,500 calls a week. That service was established in 2020 and has dealt with about 300,000 individuals since then. We have also touched on how we are trying to make digital services—computerised cognitive behavioural therapy and other opportunities—available to people.

We have invested a lot in trying to improve access while making sure that access is available in various ways, because it is not a one-type-suits-all situation. One of our challenges is to make sure that people are aware of what is available. We have been working with primary care teams on a toolkit that can be used to point people towards available services.

Gavin Gray: Guidance on available support was issued to primary care last year, and we will continue to look at that. If it needs to be updated or we need to recirculate it to make sure that GPs are aware of it, we will try to do that. We recognised that in the delivery plan, and there is a specific commitment in there, as I mentioned, to taking a person-centred approach across all the areas that Caroline Lamb has talked about, in order to make sure that people are able to access what they need more easily. That will be a priority for us, and we will work with partners to do that next year.

Colin Beattie: My response is that it appears, from the Auditor General's report, to be the case that despite all the initiatives that you talk about, people are still having difficulty in accessing a complicated system. What is going to happen in the future, over and above what you have stated, to address that concern?

Dr Cook: I can come in on that. This is a complex story that we need to work through. Some really positive aspects include the fact that our population is now much happier than it was 15 or 20 years ago to talk about mental health, to recognise mental health issues and to come forward and seek mental health support.

We are developing multiple ways for people to access services. Far more people are being seen for their mental health problems, and they are being seen in a better and more holistic way. It is not the case that one just gets antidepressants or

does not; there are psychological therapies and lots of other different services available. We do things a lot better, but not to the extent to which demand has increased over the years.

We need to find ways to develop services that allow people to easily access lower-level support, which will mean that more specialist services will be able to focus their attention on those with the highest levels of need and the most complex issues. That is where we are at the moment with regard to our strategy and delivery plan: we are trying to get the balance right between those two very difficult calls on current capacity.

Colin Beattie: Therefore, the bottom line is that we do not yet have a strategy in place to deal with the feedback on concerns about the complexities of access to services.

Dr Cook: I argue that we have the strategy but we do not yet have delivery, because we do not have the capacity.

Colin Beattie: On another facet, in committee evidence sessions concerns have been raised about use of digital services, which Caroline mentioned. Is the Scottish Government still committed to giving people a choice in how they access services so that no one is forced to use a digital service?

In part, that arises from rural concerns. People who live in the country are away from population centres and, generally, from the sort of facilities that might be beneficial to them. They have to travel long distances for some services, so there might be pressure on them to use digital services rather than travel to the city for face-to-face services. How are you going to handle that? Digital services are not right for everybody.

Caroline Lamb: I absolutely agree with you—digital is not right for everybody. Digital services have huge benefits and many people find that they are very comfortable with them. Our satisfaction rates with computerised cognitive behavioural therapy, for example, are very high, at about 83 per cent. It works really well for some people by allowing them to quickly access help and support, but it will never be something that everybody wants.

We also have to accept that people in some areas of the country are digitally excluded, and that some demographics are not as comfortable with using digital as others. Therefore—as, I think, Alastair Cook said earlier—we absolutely need to ensure that we are always able to offer face-to-face services. However, if people are comfortable with digital services and find them helpful, that takes pressure off face-to-face services, so it is a really valuable resource for us and for people.

Colin Beattie: Will people will still have a choice, for sure?

Caroline Lamb: Yes.

Colin Beattie: Are there plans in place to understand better the demand for psychiatry services and to address the significant related workforce challenges?

Dr Cook: We have begun to address a number of the challenges, as was said in previous answers. Certainly, on understanding demand, a lot of the improvements that we make around data and data collection will be helpful.

On the psychiatry workforce, the work that we are doing on recruitment and retention, which I mentioned earlier, to increase the number of trainees at the beginning and, through that, to increase the number at consultant level, will contribute to improvement. It is also important to acknowledge that psychiatry is a small part of a very big multidisciplinary workforce and that looking at how we can best deploy the workforce that we have, and the workforce that we might have, through peer support and bringing psychology graduates into the mental health workforce, for example, can contribute to improvement.

Colin Beattie: How difficult is it to recruit into the workforce?

Dr Cook: It is extremely difficult in certain areas and at certain times. The trainees who complete getting to consultant level are snapped up immediately into jobs. A number of jobs that are vacant are filled by locums; we are looking at support for locums as part of our work.

Colin Beattie: Will the Scottish Government

> "publish a costed delivery plan ... setting out the funding and workforce needed to establish and accommodate primary care mental health and wellbeing services across Scotland by 2026"

in accordance with the Auditor General's recommendations?

Caroline Lamb: We have published part of the delivery plan against the mental health and wellbeing strategy. The data work that we are doing is about gaining a better understanding of where the money that we are spending is having the best impact. That work will feed into our developing a delivery plan that looks at services and how they interface with each other across Scotland.

Colin Beattie: What timescale are we looking at for that?

Gavin Gray: The commitment in the delivery plan is for us to produce a report on progress around November next year.

Colin Beattie: Next year?

Gavin Gray: Yes—in November 2024.

Colin Beattie: Okay. Thank you.

The Convener: A particular occupational group that we have not yet spoken about explicitly is community link workers. When Christiana Melam from the National Association of Link Workers gave evidence to the committee on 16 November, she basically said that link workers feel quite undervalued in the system, and cited their not even being listed as a group to be consulted in relation to statutory guidance for the Health and Care (Staffing) (Scotland) Act 2019. Caroline, what is your view on the role of community link workers?

Caroline Lamb: The community link worker role is enormously valuable, especially in our more deprived communities. The Scottish Government has recently intervened to provide additional financial support, in the context of a very challenging financial climate, to support on-going provision of community link workers in Glasgow. Community link workers are really important, particularly when we think about some of the underlying causes of mental distress in relation to the cost of living and so on. They are absolutely a valued part of the whole workforce family across health and social care in Scotland.

The Convener: I do not know whether you were sitting watching that 16 November evidence session with a cheque book in your hand, because the rise in funding for community link workers was announced at the same time as we were taking evidence on that issue.

Caroline Lamb: I never have a cheque book in my hand.

The Convener: Can I just clarify something for the record? We spoke at the beginning of the meeting about the £29.9 million cut, which would have an effect on primary care services and community link workers as part of that whole network. Are those community link worker positions protected from the likely cuts that are coming down the track?

Caroline Lamb: Community link workers are funded through the primary care improvement fund rather than specific mental health money, so they are part of the overall move to increase the number of members of multidisciplinary teams in primary care. As I have said, the position for the current year is extremely challenging. You will note that the consequentials that are coming as a result of decisions that have been made by the UK Government in the autumn statement were in the order of £230 million, of which £220 million was non-recurrent, which leaves £10 million that is recurrent into next year. We are looking at a very challenging position going into next year, but the community link workers funding comes, on the whole, through the primary care improvement fund.

10:30

The Convener: I will finish up by asking a little bit more about the funding situation, but I have another question before I get to that. You mentioned that many mental health issues are not, at the end of it, directly your responsibility as the director general of health and social care, but are a function of inequality in society, of economic and social deprivation, and of a lack of access to services. Will you tell us a bit more about what the Government can do, or is doing, to take a more whole-system approach to the matter?

Caroline Lamb: Many of the policies that were set out in the policy prospectus and in the mandate letters to the cabinet secretary are focused on poverty and reducing inequality. The child poverty payment is a classic example. All those policies contribute to alleviating some of the economic conditions that influence not just poor mental health but poor physical health. Although they are levers for the broader Scottish Government, the health and social care system can make a huge contribution.

All our health boards have been developing their roles as anchor institutions. That involves considering how they can support employment in their local communities, use the money that they use to buy goods and services—their procurement—to grow wealth in local communities, and use their estate in their contribution to the green agenda. Although there are things for which we do not have the levers, there are also ways in which we can ensure that we make best use of the money that we already spend to help to drive wealth building in local communities.

The Convener: That is the community wealth building model, is it not?

Caroline Lamb: Absolutely.

The Convener: Can you give us reassurance that that is not just a passing fad and that it will be part of the approach to health and social care?

Caroline Lamb: It is absolutely not just a passing fad. On the employment aspect, you will be well aware of the challenges in recruitment in health and social care. Identifying and growing our own workers in local communities and bringing into employment people who might not have thought of a career in health and social care, or people who might be economically inactive at the moment, are key priorities for all our NHS boards.

The Convener: I will take us back to one of the fundamentals that we have discussed a few times this morning. Do you believe that NHS boards are on track to meet the target of 10 per cent of all front-line spending being on mental health services?

Caroline Lamb: As I said, we continue to work with NHS boards to monitor that, not only by setting the priorities for annual delivery plans but by monitoring, through our performance meetings with them, what boards deliver against those priorities. We face a couple of tricky financial years ahead, so we need to ensure that we capture the spend not just through NHS board budgets but across communities and primary care.

The Convener: When I see a figure of 10 per cent being set out as a goal in Government policy, I do not see that as just being about amounts; I see it as also being about proportions.

Caroline Lamb: Yes.

The Convener: In other words, that might mean a shift from some areas of current expenditure in acknowledgment that mental health is a growing issue that should be a central part of the national health service's work, perhaps in a way in which it has not historically been a part.

Caroline Lamb: I hope that we have reassured you that we see mental health as a key priority for our NHS boards. We will continue to work with them and to monitor proportions of spend exactly as you have identified.

Graham Simpson: Are all the boards committed to delivering the 10 per cent figure?

Caroline Lamb: All the boards are absolutely committed to making sure that they deliver against our core mental health standards and that they provide good services. We will continue to monitor exactly how the spend profile looks.

Graham Simpson: That is not what I asked. Are they committed to the 10 per cent figure?

Caroline Lamb: Yes, and my belief is that boards understand—

Graham Simpson: All the boards?

Caroline Lamb: —that that is the direction of travel.

Graham Simpson: It is not the direction of travel. There is a national target for spending 10 per cent of the budget on mental health services. Much of the delivery of that will come through health boards and IJBs—

Caroline Lamb: And IJBs, exactly.

Graham Simpson: —which we have not asked about today. Are all the boards committed to it?

Caroline Lamb: Yes, I believe that they understand that that is absolutely—

Graham Simpson: You believe that they are?

Caroline Lamb: Yes.

Graham Simpson: So, if they are, they will surely report back to you, and then you can monitor whether they are on track.

Caroline Lamb: As I said, we are working through the process of continuing to monitor that, and part of that is ensuring that we capture all the spend, which is another of our data challenges.

Graham Simpson: You said earlier that it was difficult for you to track that.

Caroline Lamb: One reason why it is difficult is that we are ensuring that we capture all the spend. We have already identified that we have not been as good at capturing activity in mental health as we need to be, so we are working on that. The ability to allocate spend against that area of activity is linked to that difficulty.

Graham Simpson: Data and following the money to see what is happening have been constant themes, but we have not been doing them well enough, have we?

Caroline Lamb: I absolutely accept that we have a lot of room for improvement, which is why we are so focused on being able, as you say, to be clear about what we are spending and what we are getting for that spend.

The Convener: I will finish with a fairly straightforward, I think, question. The COSLA and Scottish Government mental health strategy was published after the Accounts Commission and Audit Scotland reports came out, and the committee is very interested to know when you will publish a progress report on where you are with the commitments in the delivery plan and, in particular, when you will report back on the workforce action plan. Again, for the avoidance of doubt, we have been told by a number of witnesses that there is—to quote their expression—a "workforce crisis". When is there likely to be a progress report?

Gavin Gray: On the commitment around the delivery plans, we talked about them being renewed in around 18 months, but between now and then, as we have said, we will continue to report progress on a number of areas. There will be regular publication of workforce statistics and of stuff that we already publish, and we will also publish new wider information on outcomes, which we want to get into the public domain. That will give a sense of the progress that is being made.

The Convener: Yes. To go back to a point that Graham Simpson made earlier, we recognise that some of the data is required for management

purposes, but the committee would strongly support the maximum amount of data being in the public domain so that people can understand what is going on and follow implementation of the policy and delivery of outcomes.

We have come to the end of our evidence session. I thank Alistair Cook, Gavin Gray and Caroline Lamb for being with us this morning. In particular, I thank you for coming to the committee room. Quite a few of our evidence sessions have been with people who have joined us remotely, which is not always easy. You might be surprised to learn that technology sometimes fails, although, on the whole, we have had really good evidence sessions.

Thank you very much for the time that you have given us this morning and for being so willing to answer the questions that we have put to you.

10:39

Meeting continued in private until 11:20.

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