
Thank you for your letter of 22 January outlining the issues I agreed to follow up after my evidence to the Public Audit Committee on 13 January.

The information requested is set out in the following Annexes, and in respect of the questions specifically related to NHS Lanarkshire, these have been provided and approved by the Board’s Accountable Officer.

Annex A: Early Interventions
Annex B: Resource Transfer
Annex C: Monitoring anti-depressant use
Annex D: Older Adult Psychiatrists
Annex E: Response to questions related to NHS Lanarkshire

ANNEX A

EARLY INTERVENTION

The committee asked for details setting out the policy and resources invested in early years education and improved parenting in those aged 0-5. It also asked for details of:

- Initiatives implemented over the past 5 to 6 years to improve parenting and early years education, and whether the Scottish Government is increasing investment in such initiatives; and
- The family nurse initiative and initiatives related to school based nurses.

The following material covers a range of activities and a strategy that goes beyond improving mental health. It is worth noting that, while there are wide health benefits from early intervention, the strategy is not particularly aimed at making an impact on serious mental illness later in life. There is not an evidence base for such an impact.

The Early Years Framework which is described below is largely delivered through Community Planning and therefore covers a range of budgets and accountability arrangements. It will be brought together through Single Outcome Agreements (SOA). It is for local authorities to allocate their resources as they see fit and in line with their Single Outcome Agreements. However, early years provision is a key priority for the Scottish Government and CPPs were asked to give it high priority when developing their SOAs. Where there is a direct allocation of funding through NHS Boards, I have brought that out in the text.

The Early Years Framework

The Early Years Framework was launched on 10 December 2008 and demonstrates the commitment of the Scottish Government and local
government (through COSLA) to giving every child the best start in life. It is increasingly evident that inequalities in health, education and employment opportunities are passed from one generation to another. The earliest years of a child’s life give us the opportunity to break this cycle through prevention and early intervention. The Getting It Right For Every Child (GIRFEC) programme is the methodology that will enable community planning partnerships (CPPs) to deliver the Early Years Framework.

The Framework covers the interests of children pre-conception to the age of 8 years and will have a 10 year horizon.

**Support for Parents and Practitioners**

The Early Years Framework identifies ten elements of transformational change to achieve the objectives of the framework, and parenting is one of the key elements identified. The framework is about building parents’ confidence and capacity to be the best parents they can be for their children, with the support of good quality public services. In terms of supporting parents, the Scottish Government is looking for better use to be made of universal services to identify and meet the needs of parents.

We are supporting NHS Lothian, by investing £500,000 to help them develop their parenting strategies and employ parenting co-ordinators. The aim is for them to have a co-ordinated menu of evidence based parenting interventions, and to have a coherent approach to training, through a multi-agency approach.

We have invested £300,000 in Barnardo’s Scotland to develop a group based parenting programme for vulnerable, young first time mothers. The pilot phase begins in April and there will be external evaluation. The aim is to produce a manual and training programme so it can become part of the menu of parenting interventions local areas will select.

NHS Health Scotland is currently developing an Early Years section on its website, that will encompass a virtual learning environment, where multi-agency practitioners can share practice and access a central point for comprehensive information on child health and wellbeing from pregnancy up to age 8. The aim is to provide a supportive environment for practitioners, supplemented by conferences and themed learning events.

NHS Quality Improvement Scotland has been funded to develop and support the delivery of a framework to allow equitable access to care for vulnerable families (0-3). The framework is due to go out to consultation shortly, and has been developed using a multi-agency steering group and is aimed at helping agencies put the key principles and values of GIRFEC into practice.

The Scottish Government launched a new marketing campaign, to convey the value and importance of parenting in the first 3 years of life – specifically through talking to, reading to and playing with your child. The Play Talk Read Marketing Campaign is encouraging and highlighting the crucial nature of
communicating with your child in the very early years and gives practical tips to parents on easy ways of doing this. Relationships are key to a child’s development and the home learning environment in early years has a huge influence on educational outcomes. The campaign has a broad appeal to include all parents and carers from teenagers to mid-forties.

Support is provided to families experiencing relationship difficulties through funding the two national family support organisations, Relationships Scotland and Scottish Marriage Care. Funding is also provided to 13 local Family Mediation services. This family support work aims to reduce conflict and heal relationships where possible, and where it is apparent that parental relationships have broken down irretrievably, to support parents in developing child contact and maintenance arrangements which protect the health and best interests of children.

Total funding for Family Support organisations for 2009-10 is £1.786 million, which will remain the same for 2010-11.

The Scottish Government also provides funding to voluntary sector services to provide a range of support services for parents. In 2009/10 this amounted to just over £494k.

These organisations include Parentline Scotland, Parenting Across Scotland, Home-start, Parent Network Scotland (who provide training/classes for parents to help them deal with difficult behaviour, general parenting skills etc.) and One Parent Families Scotland. Parentline Scotland also provides a free confidential helpline to parents which offers support, information and advice.

**Workforce**

We are working towards our own common core of skills covering the entire workforce who work with children, young people and families. These skills will not only highlight what everyone should have in common, but also equip the workforce with the necessary ability to deliver our aspirations within policy: to transform outcomes for children and families. In the summer of 2010 stakeholders will be invited to populate and agree the common core. They will then be asked to reflect on their own educational frameworks to ensure the core is adequately covered.

**Community Nursing**

Health visitors/Public Health Nurses work as part of multi-disciplinary, multi-agency teams to support parents and identify risks to health. Health visitors have an important role in helping families and communities to secure successful outcomes for themselves. We remain committed to maintaining their vital contribution to the health of vulnerable groups including children, families and teenagers.
Health visitors will continue to provide a universal service to children as laid out in Health for all Children (Hall 4). Families who require additional support will be referred to the appropriate service.

Health visitors determine the nature and frequency of contacts beyond the core Hall 4 programme on the basis of each individual family’s needs. In practice this means that families who have greater needs and are more vulnerable will receive a higher level of support and, subsequently, will have a greater level of contact with health professionals. However, we acknowledge that all young families need support and will take steps to ensure these needs are met.

We have established a new Scotland wide Modernising Community Nursing Board which will support NHS Boards to meet community care needs through a development approach that will provide high quality person centred care. The aim is to ensure patient safety by building capacity, capability, sustainability and flexibility in the community nursing workforce in Scotland.

Health for All Children (Hall 4)

Hall 4 guidance issued by the Scottish Government in 2005 sets out the programme of routine screening, surveillance and health promotion checks which every child should receive. We are currently in the process of developing a Chief Executive Letter, for NHS Boards, that reinforces the principles set out in Hall 4 within the new policy environment focussing on early years.

Play

The Scottish Government is investing £4 million in a programme ‘Go Play’ over a two year period with the aims of helping the play sector in Scotland grow and offering increased opportunities for play for children in Scotland aged 5 to 13 years. ‘Go Play’ is being managed and administered by Inspiring Scotland, a venture philanthropy organisation, that uses money and skills to improve the lives of Scotland’s most vulnerable people. Inspiring Scotland is committed to delivering work that has a measurable impact and uses robust evaluation to find out what is working so everyone involved can build on success and improve results.

Preschool education

Funding for pre-school education, childcare and the programme formerly known as Sure Start are all now included within each local authority’s annual local government finance settlement. Sure Start’s aims and objectives of supporting families of very young children 0-3, particularly the most vulnerable and deprived, have been subsumed into the overarching early years framework.

There is a Concordat commitment to expand pre-school education and the Scottish Government is aware of the benefits of pre-school education in terms of building the foundations for school and developing social and life skills. This
is why the entitlement to free pre-school education for children aged 3 and 4 increased to 475 hours per annum from August 2007.

The entitlement broadly begins from the term after the child’s 3rd birthday. The exact dates are set out in *The Provision of School Education for Children under School Age (Prescribed Children) (Scotland) Order 2002*. Local authorities have a duty to provide free pre-school education for all eligible children whose parents wish them to attend. It is for local authorities to decide exactly how to deliver this annual hours entitlement based on local needs and circumstances.

We are making solid progress with delivering the Concordat commitment to expand pre-school education. The expansion to 475 hours is in place and we are working with local authorities to further extend entitlement to pre-school education.

**Family Nurse Partnership**

The Scottish Government, via the NHS, is investing £1.6m to fund the testing of this early intervention programme in the City of Edinburgh over the next 3 years, supporting first time teenage parents and their partners. It is hoped the project will support 145 teenagers over this period, until their child reaches the age of 2.

The model is based on the work of Professor David Olds from the USA and has over 30 years of evidence base. The model is currently being tested in England jointly across 50 Primary care and Local authority sites and the two recent evaluations have shown early signs of success.

The aim of the model is to:

- improve pregnancy outcomes;
- improve child health and development including future readiness for schools; and
- improve parents' economic self-sufficiency.

The approach is a preventive programme, benefiting children and families who have the poorest outcomes i.e. mothers with low psychological resource. It is a structured home visiting programme, delivered by family nurses and is licensed, with fidelity measures to ensure replication of the original research.

The key to its success is often attributed to the relationship between client and nurse and the fact that it focuses on the strengths within the teenager and her family.

The programme will be evaluated after the three years, and any learning from this will contribute to the review into Modernising Community Nursing.

**Health & Wellbeing in Schools Project**
The Committee also requested information on nursing in schools. We are currently piloting a project to tackle health inequalities using a multi-agency team to increase healthcare capacity in schools. The project directly responds to the recommendations of *Equally Well, the Report of the Ministerial Task Force on Health Inequalities*.

Our plans are to increase the range of nursing and other healthcare support available to school-aged children and young people. Other healthcare support may include, for example, mental health workers, physiotherapy and speech and language specialists.

Four demonstration sites (NHS Ayrshire and Arran, Forth Valley, Grampian and Lothian) and their partners have begun to test a range of new models of care. The new practice models will not only harness existing skills but develop and shape new roles to offer effective care to children, young people and their families. It should also provide opportunities for teachers and school staff to be proactive in identifying those who are particularly vulnerable or have complex needs.

Funding from the Scottish Government’s Equally Well Programme of just over £1.1m has already been provided to test these new models of practice, with a further £1m available in 2010/11. Figures recently published show an increase of 16% from 2007 to 2009 in the number of whole-time equivalent school nurses in Scotland. The project is focusing on communities that have a high number of vulnerable children and young people. The project is about supporting children and young people to make choices that will help them be healthy and feel well and supporting them when things are not right. Taking steps to feeling healthy and good about themselves will increase their life confidence as well as helping in academic achievement.

For example, Mental Health Advisors in the demonstration sites are taking a whole-school approach to develop children and young people’s participation in addressing their own health and emotional wellbeing. Health Care Support workers have now taken on screening and surveillance which has enabled the integrated teams to focus on early intervention prevention initiatives at key transitional stages for the most vulnerable children and young people ensuring that individual plans are in place to meet their needs.

The work of the demonstration sites will be evaluated to ensure transfer of information nationally.

**Getting it right for every child (GIRFEC)**

GIRFEC is the Scottish Government’s child-centred approach to overall children’s services. It aims to improve working across the boundaries of education, social work, health, police and the third sector so that the child and family experience one team to support them. Under the GIRFEC approach children and young people should no longer be referred on from one professional to another but receive a service personalised to their needs. GIRFEC requires services to be streamlined and simplified to remove
complexity, duplication and overlap. This will bring business benefits, freeing up resources, as well as improved outcomes for children and young people. GIRFEC focuses on the needs of each child as a whole by adopting an approach that is based on partnership, shared language and common tools supported by a single system for identifying, assessing, and planning to address children’s needs.

GIRFEC means considering:

- **Culture** – strong leadership is required across agencies and areas to coordinate adoption and development of the approach. Support for staff in developing their working practices is also essential;
- **Systems** – adapting systems and language to accommodate information-sharing requirements, and so on. The development of eCare to include the GIRFEC model will help support local services in this area; and
- **Business processes** – matching policy and practice with GIRFEC core values.

GIRFEC is currently being implemented in various ways across nine community planning partnership areas:

- Highland, Lanarkshire (North & South together), Edinburgh (focusing on whole system change);
- Dumfries & Galloway, Clydebank (West Dunbartonshire), Falkirk (focusing on children and young people experiencing domestic abuse);
- West Lothian (focusing on chronology in an electronic environment); and
- Angus (focusing on adult services).

The funding for these pathfinders and learning partnerships comes from the Scottish Government’s Children, Young People and Social Care budget.

**Next Steps**

Going forward, we will:

- Engage with Community Planning Partnerships to understand how they are working to improve outcomes for children and young people and to encourage them to progress the GIRFEC approach alongside the early years framework.
- Produce an implementation guide by Spring 2010 which will draw on lessons learned to date, and provide tools and guidance on establishing and developing GIRFEC.
- Develop eCare systems for safe, secure and targeted information sharing across disciplines and authority boundaries.
• Build in the GIRFEC approach across all Scottish Government work where it impacts on children and families, including the development of adult services.
• Give further consideration to how GIRFEC fits within inspection and performance management systems and structures, as well as self evaluation

ANNEX B

RESOURCE TRANSFER

The Committee asked for a response to specific questions relating to NHS Lanarkshire’s situation and Annex E sets out a response to these which should be considered also within the context of my evidence on 13 January and the policy context set out in my earlier letter to the Committee of 7 December 2009.

In that respect, it is important to note that resource transfer guidance states that the level of resources to be transferred is matter for local negotiation. In Lanarkshire, as with every other NHS Board, the levels were agreed between the NHS and the local authorities concerned and were based on joint planning arrangements to take account of the responsibilities being transferred between the agencies for individual patients. As I said in my evidence, different NHS Boards had different starting points and it will also be the case that some NHS Boards have not transferred as much responsibility to local authorities as others and continue to provide services themselves to people in the community with mental health problems.

The Committee also asked about the transfer of resources on a multiple NHS Board and local authority basis for patients previously accommodated in national specialist institutions it may be helpful if I explained what happened when the Royal Scottish National Hospital at Larbert closed.

A specific sum of money was identified per patient for resource transfer which was then passed to the NHS Board which would assume health responsibility on discharge. These Boards would then liaise with their local authority partners to make the placement in their community. So, to quote the example of a Kilsyth resident as mentioned in the Committee hearing, NHS Forth Valley would transfer a specified sum to NHS Lanarkshire who would then agree a care plan with North Lanarkshire and transfer the appropriate resource. NHS Forth Valley had a project lead who played into all these discussions and ensured resolution of any problems taking account of individual patients’ needs.

ANNEX C

MONITORING ANTI-DEPRESSANT USE

The Committee asked what information is available on how other nations monitor anti-depressant prescribing compared to Scotland; whether other
nations can track the number of patients involved; and whether they are expressing similar trends in anti-depressant prescribing.

Comparison of antidepressant prescribing between countries is complex and care needs to be taken not to draw unsubstantiated conclusions by simply looking at headline figures. The difficulties in drawing any meaningful conclusions from the data are caused by:

- The detection rate for depression varying significantly between countries. This will impact on levels of antidepressants prescribed, as countries with higher detection rates are likely to have higher levels of treatment;
- Significant variations in the proportion of those diagnosed who then go on to get a treatment of any type;
- Differences in the way that antidepressant prescribing is measured including numbers of prescriptions written, number of prescriptions dispensed, the volume of antidepressants prescribed or the volume of antidepressants dispensed. The Scottish HEAT target measures the volume of antidepressants dispensed; and
- A lack of clarity on the appropriate level of antidepressant prescribing, so even where we can report directly comparable data, there is often insufficient information available to interpret whether any given variation is caused by more or less effective practice.

Given all of the uncertainties that exist around this data, it is worth highlighting again that this target has driven considerable work to improve evidence based prescribing of antidepressants and improved access to non-drug treatments, examples of which were provided in my previous response.

Having highlighted that, considerable care needs to be taken in drawing interpretations from comparative data. I can confirm that there have been marked increases in antidepressant use in many Western countries including the other three UK jurisdictions. In the following sections, I provide information on data availability across the UK, comparative UK data around antidepressant prescribing and information on international variations and trends.

**Antidepressant data availability and trends across the UK**

In the United Kingdom, General Practitioners can extract data from their local system to identify the number of people issued with a prescription for antidepressants, but none of the UK jurisdictions have systems in place to collate this information above practice level. We in Scotland have a system that captures data nationally from approximately a third of GP practices and we have commissioned an analysis of this information which should be available in the Summer of this year.

Similarly, as with the rest of the UK, we do not have data about the number of people who are dispensed antidepressants, but we will be able to do this once CHI number (unique patient identifier) is on 100% of prescriptions. This is
currently at approx 80% coverage. Northern Ireland is taking a similar approach and are currently at 90% coverage.

All four UK jurisdictions have data in respect of the number of prescriptions dispensed for antidepressants in a given time period. The following graph shows the comparison. However, care needs to be taken in interpreting this data as it does not control for the length of the prescription. So one GP who is prescribing a patient antidepressants one month at a time for three months would show as three prescriptions, whereas another who prescribes three months in one go will show as just one prescription. In reality the same amount of drug is prescribed in both these scenarios – but one shows as three times as many prescriptions as the other.

Notes

1. population estimates are all taken from ONS so that they have all been handled the same but discrepancy with Scotland’s GROS data are quite large which raises some concerns around accuracy of per capita figures.
2. prescribed items data are taken from 4 different sources which means that, potentially, the data has been calculated/ processed/ subject to different rules 4 different ways, and therefore is potentially not comparable.
3. data does not control for differences in length of prescription (i.e. 28 days and 60 days prescriptions both just show as one prescribed item)

In relation to the total amount of antidepressants prescribed (DDDs), all four UK countries collect this information and the following graph shows comparative figures for England, Scotland and Wales.
This graph shows Scotland's DDDs per capita as higher than England and Wales, though the rate of increase over the last three years has been less in Scotland. This is in comparison to the first graph detailing the numbers of prescribed items for antidepressants, which shows England and Scotland at similar levels and both countries considerably lower than Wales and Northern Ireland.

I have previously highlighted to the committee that DDDs are impacted not just by the number of people who are prescribed antidepressants but also by the dosage and duration of the prescription. The limits of the current data mean that we do not know whether the difference in DDD levels is due to more people receiving antidepressants and/or prescribing at a higher dosage and/or prescribing for a longer duration. Further, the data does not allow us to draw any conclusions on the appropriateness of the prescribing, it may be that the higher level of DDDs per capita in Scotland is clinically appropriate.

In relation to duration of prescribing, from a quality perspective, knowing how long people remain on the drug is important. NICE guidelines state that individuals should remain on an antidepressant for 6 months following remission of the depression. Research based on sampling indicates that compliance with this is very low, but none of the UK countries are able to routinely report on this information. Increased compliance with NICE guidelines would lead to higher levels of DDDs. Unfortunately, data is not available to enable us to compare duration of prescribing between Scotland and the rest of the UK.

International trends and variations in antidepressant prescribing

When comparing levels of antidepressant prescribing internationally, it is important to take into account the following:

1. Proportion of those diagnosed with depression varies significantly between countries. In effect, there may be training and cultural reasons why a primary care doctor may not recognise
depression in a presenting case. This will impact on the amount of antidepressants prescribed – as clearly countries who detect more depression are likely to have higher levels of treatment. There has been a significant focus on depression in Scotland, through both the GP contract and other local policy initiatives, combined with work to address stigma and encourage people to seek treatment and we believe that means that in Scotland the treatment gap will be smaller than in other countries.

The following is taken from “Integrating Mental Health into Primary Care – A Global Perspective” – World Health Organisation. The recognition of mental disorders in primary care by primary care workers is low to moderate at best. There is considerable variation across countries with the proportion of depression detected by treating physicians varying between 21% and 74%. The UK data is at the higher end at 70%.

| Table 1.4 Recognition as a psychological case of current ICD-10 disorders by treating physicians |
|-----------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|
|                                    | Depression                        | Generalized anxiety disorder      | Somatization disorder            | Any diagnosis (except harmful use of alcohol)* | Harmful use of alcohol            |
| % recognized                       | % recognized                       | % recognized                       | % recognized                       | % recognized                       | % recognized                       |
| Rio de Janeiro, Brazil             | 44                                | 32                                | 43                                | 36                                | 0                                 |
| Santiago, Chile                    | 74                                | 61                                | 89                                | 74                                | 98                                |
| Shanghai, China                    | 21                                | 20                                | 12                                | 16                                | 45                                |
| Paris, France                      | 62                                | 60                                | 66                                | 47                                | 46                                |
| Berlin, Germany                    | 57                                | 55                                | 56                                | 56                                | 14                                |
| Mainz, Germany                     | 56                                | 65                                | 96                                | 60                                | 29                                |
| Athens, Greece                     | 22                                | 13                                | 11                                | 17                                | 0                                 |
| Bangalore, India                   | 46                                | 35                                | 31                                | 40                                | 0                                 |
| Verona, Italy                      | 70                                | 74                                | 100                               | 75                                | 10                                |
| Nagasaki, Japan                    | 19                                | 23                                | 0                                 | 18                                | 4                                 |
| Groningen, Netherlands             | 60                                | 59                                | 75                                | 51                                | 31                                |
| Ibadan, Nigeria                    | 40                                | 67                                | 33                                | 55                                | 33                                |
| Ankara, Turkey                     | 28                                | 26                                | 34                                | 24                                | 21                                |
| Manchester, United Kingdom         | 70                                | 72                                | 100                               | 63                                | 7                                 |
| Seattle, United States of America  | 57                                | 47                                | 80                                | 57                                | 12                                |
| Total                              | 54                                | 46                                | 64                                | 49                                | Not available                     |

2. There will also be a difference between the proportion of those diagnosed who then go on to get a treatment of any type. We do not have data showing the gap between diagnosis and treatment – but the “Integrating Mental Health into Primary Care – A Global Perspective” – World Health Organisation Report does provide some estimate of the gap between number of people with a particular illness and how many of those receive treatment of any type. A review of
mainly high-income countries highlighted that, across the countries studied, on average 56% of numbers predicted to have depression received no treatment.

<table>
<thead>
<tr>
<th>Mental disorder</th>
<th>Median treatment gap (percentage)</th>
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</thead>
<tbody>
<tr>
<td>Schizophrenia and other non-affective psychotic disorders</td>
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</tr>
<tr>
<td>Depression</td>
<td>56</td>
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<tr>
<td>Dyathymia</td>
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<tr>
<td>Bipolar disorder</td>
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<tr>
<td>Panic disorder</td>
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<td>Generalized anxiety disorder</td>
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<tr>
<td>Obsessive compulsive disorder</td>
<td>60</td>
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<tr>
<td>Alcohol abuse and dependence</td>
<td>78</td>
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</tbody>
</table>

A recent study in Europe (Kohn et al, 2004) found that just under half (48%) of people defined as being in need of mental health care were receiving formal services. This was in contrast to 92% of people with diabetes who have used services for their condition.

The above highlights how difficult it is to do meaningful comparisons based on pharmaceuticals dispensed – which is further compounded by differences in how the data is collected in different countries. However, the Public Audit Committee were interested to know whether other counties have also seen rises in antidepressant prescribing – and though we cannot do direct comparisons - we can confirm that marked increases in antidepressant use have been reported in many Western countries since the early 1990s. Rises in antidepressant use have been reported in Scotland\(^1\), England\(^2\), France\(^3\), Germany\(^3\), Italy\(^4\), Holland\(^5\), Scandinavia\(^6\), Iceland\(^7\), Canada\(^8,9\), United States\(^10\), and Australia\(^11\).

In Canada, antidepressant prescriptions rose 238% between 1981 and 2000\(^8\), a rise which may have been largely accounted for by a rise in the prevalence (but not incidence) of depression\(^9\). In the USA, consultations for depression rose by 70% between 1987 and 2001 (representing a relative increase in the number of primary care rather than psychiatry visits), and over the same period the total antidepressants prescribed increased by 116\(^12\). Antidepressant use increased in Iceland by as much as 8.6 times between 1975 and 2000 and 3.9 times between 1989 and 2000. This increase was associated with modest rises (2% per annum) in outpatient service use for depressive disorders\(^7\).

**Anti-depressant prescribing references**

1. Munoz-Arroyo R, Sutton M, Morrison J. Exploring potential explanations for the increase in antidepressant prescribing in Scotland using secondary


ANNEX D

OLDER ADULT PSYCHIATRISTS
The Committee asked what proportion of psychiatrists specialise in older adult psychology to support the statements given in the evidence that this had increased. We have assumed the Committee means to ask about the proportion in older adult psychiatry, rather than psychology.

Figures provided by NHS Information Statistics Division show that in 1999 there were 43 older adult psychiatric consultants in Scotland; there are now 67. An increase of over 55% in 10 years. The proportion of consultants specialising in older adult psychiatric services in relation to the total number of psychiatric specialists currently stands at 11%.

ANNEX E

RESPONSE TO QUESTIONS RELATED TO NHS LANARKSHIRE

Q1. Has the limited resource transfer in Lanarkshire had any impact on the development of mental health services?

The short answer is no. This is because all funding, whether through Local Authority, NHS or resource transfer, is used to support a whole health and social care system.

Our joint future plans and integrated mental health service strategy moving forward are not founded on transferring resources across agencies but much more about using aligned mainstream resources to achieve better outcomes for the client group.

The historical resource transfer monies made available recurrently by NHS Lanarkshire to the two local councils is seen as one strand of existing funding alongside other mainstream sources of funding to fund jointly agreed community care priorities.

It should be stressed that the level of resource transfer was agreed between NHS Lanarkshire and North and South Lanarkshire Councils. This recognised the level of resources in mental health services in place in Lanarkshire prior to 1992 and the cost of providing redesigned health and social care services in the community.

Q2. What steps has NHS Lanarkshire taken to improve acute mental health services in Lanarkshire? In particular, what progress is being made with the new mental health unit at Monklands Hospital?

Significant service redesign work delivered via the partnership arrangements with service users and local authorities has enabled a measurable shift in the quality of mental health services in Lanarkshire. This is in line with the priority placed by the Board on investment in mental health services.
Since 2006, £3.79m has been invested in service developments across adult; old age; forensic; psychology and CAMHS services. Through the same period an additional £1.7m has gone into improvements in specialist regional inpatient services, for adolescents (£207,000) and medium secure care (£1.5m). More than £2.6m of additional ring fenced funding has also gone into enhance substance misuse services. Two new capital developments to support patients with complex needs will open this year at Coathill Hospital, Coatbridge (£4.9m) opening in May 2010 and Caird House, Hamilton (£8.14m) opening in December 2010.

With regard to the proposed new mental health unit in North Lanarkshire the original timescale for taking forward the business case process from Initial Agreement (IA), to Outline Business Case and through to Full Business Case was August 2009 to November 2010. This would be subject to the necessary approvals and finances being available. Thereafter construction would have started in 2011 and completed in 2013.

The Initial Agreement for the new mental health inpatient unit located in North Lanarkshire was approved by the NHS Board in August 2009. Within the IA the decision was still to be taken on whether the unit would be located at Monklands or at Wishaw General Hospital.

The development of the Initial Agreement was informed by extensive stakeholder involvement including local authorities, services users, carers and staff, to establish the appropriate number and configuration of beds for adults; acute functional over 65; acute organic over 65; substance misuse and intensive psychiatric care.

In recognition of the changing economic position the Board requested that Scottish Government consideration of the Initial Agreement be deferred to enable the opportunity to scope options for continued investment in mental health services. The Board recognises that due consideration will require to be given to the uncertainty of future capital and revenue availability.

The Board remains committed to achieving the strategic aim of delivering a single integrated inpatient facility in the north and in the south. The pace of the implementation will however be determined by the future availability of capital and revenue funding.

The Board will take a decision once the scoping work has been completed on the options for delivering the necessary investment in workforce expansion in services such as CAMHS, psychological therapies and old age psychiatry, alongside the significant additional capital and revenue investment associated with our capital development aspirations. At this stage it is clear that a phased approach to timing will be required.

Q3. Has the decision to retain existing Accident and Emergency facilities had an impact on mental health service provision?
As set out in the “A Picture of Health” consultation process the plans for acute mental health services were designed around one unit for North and one unit for South Lanarkshire. The unit in South Lanarkshire was agreed as Hairmyres whilst a decision was yet to be taken as to whether the North unit would be located on the Wishaw or Monklands sites.

Following the consultation on “A Picture of Health” it was agreed that the mental health unit for North Lanarkshire would be sited at Monklands Hospital. At that stage it was intended that Monklands Hospital would be a Level 2 hospital with available space on the site for a new mental health unit.

With the retention of Monklands Hospital as a Level 3 hospital, initial planning work identified that the development of a 130 bed unit would be extremely challenging on an already congested site. The footprint required for the new mental health unit is considerable as a consequence of its proposed ground floor and single room design. As part of the development of the Initial Agreement for the mental health unit it was agreed that further consideration would be given to whether the unit should be based at Monklands or at Wishaw.

Q4. Were mental health and other health service provision in Lanarkshire designed in the context of the previous plans for the reconfiguration of Accident and Emergency services?

Yes. The answer to question 3 above provides the context for the planned provision of mental health services as outlined in the “A Picture of Health” consultation.

Q5. What plans are there for investment in Monklands hospital and when will it take place? What is planned and at what cost, and how much of this related to mental health services?

In the last two years (2008/09 & 2009/10) NHS Lanarkshire has spent £4m on improvements to Monklands Hospital infrastructure. We have plans in place to invest a further £15m in Monklands Hospital over the next three years commencing in 2010/11. This investment will focus on the infrastructure of the hospital while improving clinical areas.

During the first year of the investment programme work will include alterations to the hospital to allow concentration of inpatient haematology beds for NHS Lanarkshire. These are currently sited at Wishaw and Monklands Hospitals. The concentration of inpatient haematology beds at Monklands Hospital formed part of the “A Picture of Health” consultation and approval for this was confirmed following the A&E review in 2008.

Work is ongoing to identify investment priorities for the following two years and the current mental health facilities will be included in this assessment process.
The Initial Agreement setting out a more fundamental redevelopment of Monklands Hospital is still being considered and will have to be set in the context of the uncertain economic environment for the medium term.

Q6. What mental health services will be delivered from the new Airdrie Health Centre. When will this facility be opened to the public, and what mental health services will be available?

NHS Lanarkshire received approval of the Full Business Case for the new £27m Airdrie Health Centre from the Scottish Government on 27 January 2010, along with confirmation that the necessary capital funding will be available.

We are now proceeding to contractually commit to this project with GSARP (Graham Street Airdrie Retail Portfolio) (updated name of developer). A detailed programme is now being worked up to provide timesframes for the various stages of this development from demolition through to completion of the construction.

Based on previous work undertaken we expect the facility to be open to the public in early 2012.

The health centre will be used by nine different GP practices along with a number of primary care and community-based services. The centre will serve around 50,000 patients from across the town.

Two community mental health teams will transfer from the Adam Avenue Clinic into the new health centre. These include the Community Outreach team, which deals with chronic and enduring mental health conditions and the Focused Intervention team, which deals with a range of other mental health conditions including anxiety. The new centre will increase opportunities for closer working between the two teams and social work, which will also transfer to the new centre, as we move towards a more integrated set up.

Q7. If additional resource transfer takes place in Lanarkshire, will this affect investment by the Health Board, in mental health services?

There is wide agreement between COSLA, Scottish Government and the NHS that the current system of resource transfer requires extensive review to reflect modern practice.

This review is looking at future arrangements rather than trying to unpick historical agreements. The emphasis will be on integrating resources across partnerships and moving away from cost shunting between agencies.

As long stay institutional closure programmes in Lanarkshire are largely complete, there is virtually no NHS provision of long stay hospital care and therefore no scope for additional resource transfer. Any change to previously agreed levels of historically based resource transfer would obviously diminish
NHS Lanarkshire’s current pattern of investment and would significantly impact on the capacity and quality of clinical care.

Q8. Staffing levels in NHS Lanarkshire for both acute and community services is below the Scottish average. Why is this the case, what steps are being taken to address staffing levels and what impact do they have on the provision on mental health services across Lanarkshire?

Staffing levels in NHS Lanarkshire are below the Scottish average as a consequence of the fact that past allocation formulae have placed Lanarkshire below the Scottish average in funding (conversely, of course, some NHS Boards will be above the average). As a result, Lanarkshire has below average indicators in nearly every area and the level of mental health staffing is a reflection of this. Nevertheless, the Board has endeavoured in recent years to increase its expenditure on mental health services as set out below.

The new NRAC allocation formula puts Lanarkshire above the average for Scotland. So as the Scottish Government incrementally moves NHS Boards towards the NRAC target, there is an opportunity for further investment into mental health services.

In recent years significant improvements have been made in staffing levels across all disciplines, which in turn results in enhancements to service capacity and quality (see response to question 2). NHS Lanarkshire has developed community mental health teams designed to better meet the needs of people with enduring mental health problems as well as improving capacity and capability to provide focussed interventions for people with mild to moderate mental illness.

These community-based developments have been essential to support the rationalisation of in-patient accommodation by lessening dependence on institutional care. This has freed up resources for direct investment into improvements in community-based services. Since 2006 this has amounted to investment of £3.793m allowing the creation of an additional 96.26 whole time equivalent posts in mental health.

Within Child and Adolescent Mental Health, NHS Lanarkshire is recruiting to an additional 7.3 new whole time posts including clinical psychology, child and family Reach Out service, primary mental health team and mental health clinicians. This is with the support of funding received from 2009/10 of £126,000 from NHS National Education for Scotland and £213,000 through the Scottish Government’s National Delivery Plan.

NHS Lanarkshire is also continuing to make the most of existing staffing resources by shifting the balance of care to the most appropriate services. For example:

- From hospital-based to community-based services through the ongoing retraction from Hartwoodhill Hospital.
- Towards increased provision of psychological therapies by training existing community psychiatric nurses in this area.

Thank you for giving evidence at the Public Audit Committee meeting on 13 January on the Auditor General for Scotland’s report entitled “Overview of Mental Health Services”. The Official Report of the meeting is available at the following link: [http://www.scottish.parliament.uk/s3/committees/publicAudit/or-10/pau10-0101.htm](http://www.scottish.parliament.uk/s3/committees/publicAudit/or-10/pau10-0101.htm)

You offered to write to the Committee on a number of issues raised during the evidence session and for ease of reference I have listed these below.

**Early Intervention**

The importance of early intervention and its impact on children’s mental health, particularly, the investment in early years education and improved parenting in those aged 0-5, were highlighted during the evidence session. You offered to provide the Committee with a note setting out the policy and resources invested in that area. (Public Audit Official Report Cols 1423-1424). The Committee would be grateful for that information and specifically requested information on the following.

- Details of initiatives implemented over the past 5 to 6 years to improve parenting and early years education, and whether the Scottish Government is increasing investment in such initiatives?
- Details of the family nurse initiative and initiatives relating to school-based nurses.

**Resource Transfer**

The Committee had a number of questions about the levels of resource transfer in Lanarkshire compared to Greater Glasgow and Clyde, and you offered to provide the Committee with a note on issues relating specifically to Lanarkshire’s situation (Public Audit Official Report Col 1432).

The Committee would be grateful for this note. You also offered to provide information on how resource transfer was handled on a multiple health board and local authority basis for those patients who were previously accommodated in national specialist institutions (Public Audit Official Report Col 1433).

Due to time constraints, it was agreed that if the Committee had any further questions relating to this area, they would do so in writing and I have attached a list of further questions the Committee had at Annexe A.

**Monitoring anti-depressant use**

The Committee was interested in how anti-depressant prescribing is monitored in Scotland and how Scotland compares to other nations in this area. An ongoing concern is that daily dosage levels are known, but not the numbers of patients involved. (Public Audit Official Report Col 1450-1451)

- What information do you have on how other nations monitor anti-depressant prescribing compared to Scotland, and in particular,
whether other nations can track the number of patients involved and whether they are expressing similar trends in anti-depressant prescribing?

**Older Adult Psychiatrists**

In evidence, the Committee was informed that the proportion of psychiatrists specialising in older adult psychiatry had increased to reflect the proportion of older adults with mental illness. (Public Audit Official Report Col 1454)

- What proportion of those psychiatrists specialise in older adult psychiatry?

**Annexe A**

Questions related specifically to NHS Lanarkshire

1. Has the limited resource transfer in Lanarkshire had any impact on the development of mental health services?

2. What steps has NHS Lanarkshire taken to improve acute mental health services in Lanarkshire? In particular, what progress is being made with the new mental health unit at Monklands Hospital?

3. Has the decision to retain existing Accident and Emergency facilities had an impact on mental health service provision?

4. Were mental health and other health service provision in Lanarkshire designed in the context of the previous plans for the reconfiguration of Accident and Emergency services?

5. What plans are there for investment in Monklands hospital and when will it take place? What is planned and at what cost, and how much of this related to mental health services?

6. What mental health services will be delivered from the new Airdrie Health Centre. When will this facility be opened to the public, and what mental health services will be available?

7. If additional resource transfer takes place in Lanarkshire, will this affect investment by the Health Board, in mental health services?

8. Staffing levels in NHS Lanarkshire for both acute and community services is below the Scottish average. Why is this the case, what steps are being taken to address staffing levels and what impact do they have on the provision on mental health services across Lanarkshire?