LETTER FROM DR KEVIN WOODS, DIRECTOR GENERAL OF HEALTH AND CHIEF
EXECUTIVE OF NHS IN SCOTLAND, SCOTTISH GOVERNMENT TO CONVENER OF THE
PUBLIC AUDIT COMMITTEE, 7 DECEMBER 2009.

Thank you for your letter of 9 November raising issues on antidepressant prescribing and resource transfer following the Committee’s consideration of the Overview of Mental Health Services Report. I offer the following responses to the issues raised.

Anti-depressant Prescribing

Q. What progress are boards making towards achieving the HEAT target of reducing anti-depressant prescribing?
Q. What efforts are you planning to promote better achievement of this target?

This target was established with the objective of improving the health service response to depression and anxiety in recognition of the evidence of the significant incidence and prevalence of these disorders, the growing use of antidepressants and the recommendation that psychological therapies be more widely available.

The target has been significant in improving our knowledge and understanding of the care and treatment of those with depression and anxiety and in exploring the wider issues related to this very complex area of care. It is clear that setting the target has enabled a number of improvements to be made and we continue to regard it as a helpful measure. Further we will continue to monitor and track it in conjunction with the work we are taking forward to increase access to therapies, which is aligned with our commitment to set an access target for psychological therapies for 2011/12. Wider work in hand on this is set out below.

The defined daily dose per capita of antidepressants (percentage change) since 2006 is shown in the following table:

<table>
<thead>
<tr>
<th>Year Ending</th>
<th>Scotland % change</th>
</tr>
</thead>
<tbody>
<tr>
<td>30-06-2006</td>
<td>2.08%</td>
</tr>
<tr>
<td>30-09-2006</td>
<td>2.86%</td>
</tr>
<tr>
<td>31-12-2006</td>
<td>4.22%</td>
</tr>
<tr>
<td>31-03-2007</td>
<td>4.38%</td>
</tr>
<tr>
<td>30-06-2007</td>
<td>5.16%</td>
</tr>
<tr>
<td>30-09-2007</td>
<td>6.08%</td>
</tr>
<tr>
<td>31-12-2007</td>
<td>6.04%</td>
</tr>
<tr>
<td>31-03-2008</td>
<td>5.50%</td>
</tr>
<tr>
<td>30-06-2008</td>
<td>4.80%</td>
</tr>
<tr>
<td>30-09-2008</td>
<td>4.18%</td>
</tr>
<tr>
<td>31-12-2008</td>
<td>4.06%</td>
</tr>
<tr>
<td>31-03-2009</td>
<td>4.13%</td>
</tr>
<tr>
<td>30-06-2009</td>
<td>5.21%</td>
</tr>
</tbody>
</table>

The table shows that in 2008 the percentage change was on the decrease. However the last quarter showed a slight rise.

Information regarding the number of people on antidepressants is not currently collected so we do not know whether the number of people taking antidepressants has increased. The table shows the amount of antidepressants prescribed, so increases can be attributable to the same number of people staying on an antidepressant for longer or the same number of people receiving a higher dose.
Since setting this target, there has been a growing research consensus that most of the increase in the Defined Daily Dose (DDDs) of anti-depressants is caused by a relatively small group of people taking their medicines for a longer period. This may be clinically appropriate. Given these uncertainties, we have encouraged NHS Boards to use the target to drive improvements in evidence based prescribing of antidepressants and improvements in access to non-drug treatments, rather than seeing the delivery of the target as an end in itself.

Our focus has been on supporting NHS Boards to deliver these underpinning improvements and action taken has included:

- Setting up the Mental Health Collaborative, which supports NHS Boards and their key partners to deliver the improvements in evidence based prescribing of antidepressants and improved access to non-drug treatments. It delivers this through funding dedicated time in NHS Boards to focus on improvement work; providing training in tools and techniques that have a track record of improving services; supporting Boards to then apply those techniques to this area of work and enabling effective sharing of knowledge across Scotland about what is and isn’t working to deliver improvements;

- Establishing Integrated Care Pathways for mental health in line with National standards and supported and accredited by NHS Quality Improvement to monitor and report on NHS Board’s progress. A key milestone for development and implementation of ‘foundation level’ accreditation was set for September this year and all NHS Boards met this level; and

- Creating capacity for improved access to evidence based psychological therapies.

Q. What efforts are underway to ensure that patients can access other treatments across Scotland such as psychological therapies and leisure services?

NHS Education for Scotland (NHS NES) is working in partnership with the Scottish Government’s Mental Health Division to provide, and broker the provision of, training in evidence-based interventions which are effective for depression, e.g. Cognitive Behavioural Therapy (at both certificate and diploma level), other psychological therapies and Mindfulness.

Access to psychological therapies is being improved by ensuring that resources are used effectively by delivering only evidence-based care. This work is being complimented by guidance from the Mental Health Collaborative on how to set up a service so that it minimises any unnecessary waits. This guidance will use the lessons learnt from reducing waiting times in the acute sector and apply it to the mental health context.

With NHS NES we have produced The Matrix - a Guide to delivering evidence-based Psychological Therapies in Scotland - which gives advice to NHS Boards on the issues involved in the delivery of evidence-based psychological interventions, including strategic service planning, training standards, and adequate levels of supervision. A Psychological Therapies Group has been set up to oversee the implementation of the advice in ‘The Matrix’, its continuous updating, and to expand its coverage to other key priority areas in mental health.

NHS NES is resourcing ‘Psychological Therapies Training Co-ordinator’ posts in NHS Boards to provide the educational infrastructure necessary to ensure training and supervision is well-organised, sustainable, and has maximum service impact. Good quality psychological therapies supervision is essential for the delivery of evidence-based care. NHS NES has developed competence-based psychological therapies supervision training, which is being rolled out on a ‘training for trainers’ basis across Scotland.

In partnership with us, NHS NES has supported or commissioned training in a number of evidence-based therapies, including:
We are funding a Psychological Interventions Team (PIT), to be hosted within NHS NES, which will carry a portfolio of responsibilities related to patient pathways and referral criteria and to increasing access to evidence-based psychological therapies.

We are also funding 2 pilots to help improve access to self-help therapies for people with mild to moderate depression or anxiety. *NHS Living Life* is run by NHS24 and involves 5 regional NHS Board pilots; and the “*WISH*” pilot (Widening Access to Self Help) is hosted by NHS Greater Glasgow and Clyde and involves 3 other regional Boards.

**Q. What work is being carried out to assess the appropriateness of prescribing levels?**

NHS Boards are using some of the additional capacity funded by the Scottish Government through the Mental Health Collaborative to support work on assessing the appropriateness of prescribing levels. Examples include:

- NHS Greater Glasgow and Clyde has appointed a full time pharmacist who is leading work with GP Practices to audit current antidepressant prescribing practice, identify areas for improvement and provide support to then deliver these improvements. To date, detailed audits have been undertaken with 8 practices and improvement support provided to address key issues identified;

- NHS Grampian has undertaken a detailed analysis of the prescribing behaviour of a sample of more than 30 GPs, assessing close to a thousand consecutive practice attendees. This highlighted that inappropriate antidepressant prescribing occurred in less than 1% of those treated;

- NHS Ayrshire and Arran is developing a comprehensive data extraction tool that obtains detailed information about prescribing and patient review patterns from primary care IT systems. This data is then used to identify key areas for improvement;

- NHS Borders is working with a number of practices to look at current prescribing practices including the number of people receiving antidepressants, appropriateness of use including whether prescribed at the correct dose, and compliance rates with drug therapy; and

- NHS Forth Valley is auditing all GP practices to look at compliance with their guidance on the drug treatment of depression.

The Mental Health Collaborative also hosted a key event on the 3rd December 2009 which brought together representatives from NHS Boards involved in this work to enable effective exchange of good practice across Scotland.

The Mental Health Collaborative has also commissioned work from the University of Edinburgh's Centre for Population Health Sciences in collaboration with the University of
Aberdeen to interrogate the Primary Care Clinical Informatics Unit database which sits with Aberdeen University and is funded by NHS Scotland Information Services Division/the Scottish Government. This database uploads anonymised GPASS practices data from across Scotland and therefore covers approximately 1/3 of the Scottish population.

The research questions addressed by this study aim to clarify:

- the proportion of patients in a representative sample of Scottish practices who start taking an antidepressant over a year;
- The dose and duration of that treatment;
- the proportion of antidepressant prescribing accounted for by medium and longer term prescribing;
- The influence of the following factors in prescribing practice: patient age, sex, physical co-morbidity, deprivation and GP practice;
- The duration of treatment for those patients stopping antidepressants;
- The proportion of patients taking antidepressants for conditions other than depression and anxiety;
- The proportion of amitriptyline prescribing accounted for by chronic pain and other conditions rather than depression.

This work will report in Spring 2010.

It is also worth noting that all NHS Boards, with the current exception of Western Isles, have Prescribing Advisers who monitor the use of medicines including antidepressants by GP practices using data collected by NHS National Services Scotland via PRISMS and produce feedback reports for GPs. Prescribing Advisers will use this information to monitor compliance with locally agreed evidence-based formularies. Another aim is to reduce variation between prescribers. This is in addition to Information Managers in the Mental Health Collaborative who use PRISMS to monitor antidepressant prescribing against the HEAT target ensuring that it is monitored in the same way across the country.

Q. What work is being carried out to better understand why levels of anti-depressant prescribing are continuing to rise?

There is a growing research consensus that suggests that most of the increase DDDs is caused by a relatively small group of people taking their medicines for a longer period, rather than an increase in people starting a drug for the first time. Recent publications of note include work by Moore et al (2009) which examined data from the General Practice Research Database. This analysis concluded that the rise in antidepressant prescribing is mainly explained by small changes in the proportion of patients receiving long term treatment. It is clinically appropriate for some people to be on antidepressants longer term. However, Moore et al highlight that we don’t yet know whether the increase in the proportion of people on longer term prescriptions represents:

- appropriate prescribing for those with a chronic and relapsing disease; or
- a failure to discontinue antidepressants in those with a milder illness; or
- both of the above.

Evaluation of a ‘Doing Well’ site in Renfrewshire showed that intervention can support and sustain “rational” antidepressant use (minimal use in mild depression but support for concordance with medicines in severe depression). Although the amount of antidepressants prescribed continued to increase, the increase was consistently less than the average increase across Scotland. Comparing June 2003-04 with June 2006-07 showed that the average rate of increase across Scotland was 12.9%, whilst the rate of increase in Renfrewshire was 3.8%

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Q. Can you explain what factors influence the variation in anti-depressant prescribing?

In a large Scottish study of 983 practices, Morrison et al. (2009) found a 4.6-fold difference between the first and ninth deciles of antidepressant prescribing, standardised for registered patients' age and sex composition.

A multivariate model was used to examine factors associated with prescribing. This concluded:

- Significantly higher prescribing than expected was associated with limiting long-term illness, deprivation, urban location and a greater proportion of female GPs in the practices.
- Significantly lower prescribing than expected was associated with single-handed practices, higher than average practice list size, a higher proportion of GP partners born outside the UK, practice location in remote rural areas, a higher proportion of patients from minority ethnic groups in the practice and higher mean GP age. A weak relationship was found between increased numbers of psychologists employed in an area and lower prescribing levels.

These factors explained approximately half of the variation in prescribing levels across Scotland.

The research also considered whether there was a link between levels of antidepressant prescribing and the quality of care delivered. In line with other research, no association was found between the quality of care and levels of antidepressant prescribing. However, caution needs to be taken around the interpretation of this finding as the quality of care is difficult to measure and the quality markers used were limited to available data. Therefore, the measures used may not fully reflect the actual quality of care delivered.

All of this work clearly demonstrate that a great deal of work has been done and continues to be done to improve both our understanding of and responses to depression and anxiety. It has been particularly helpful to have been able to discuss this target along with other mental health issues with NHS Boards and their partners through the twice yearly performance management reviews. Letters issued to NHS Boards following visits set out any action points for follow up. This target has also been frequently raised through the Ministerial led annual reviews with each NHS Board. This has highlighted the priority we attach to improving care and support for this group and ensured engagement by NHS Boards at the very highest levels.

Resource Transfer

Q. How does the Scottish Government account for the disparity in resource transfer levels across Scotland?

Arrangements for resource transfer between NHS Boards and local authorities have been in place since 1992, and were initiated to allow NHS Boards to make payments to local authorities, to help meet the cost of projects that enable people to move out of hospital and into more appropriate care in the community.

The specific level of resource transfer in each instance is determined by agreement locally, with funding being provided to support transfer of an identified service provision from the NHS to local authorities, rather than following the individual. Disparity in the level of transfer can be

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accounted for in part by the fact that, historically, resource transfer was linked to long-stay bed closure programmes for which different NHS Boards and local authorities had different starting positions. In some areas a relatively low level of resource transfer may indicate a lower level of activity for which transfers are made but this should be interpreted with caution given the different starting points referred to.

Ultimately, the level of resource transfer is a matter for agreement between NHS Boards and their council partners. The Scottish Government recognises its role in enabling and supporting effective working arrangements between partners in health and social care and is taking steps to further improve resource transfer arrangements as described below.

In more general terms however, the Scottish Government is currently undertaking a review of care services for older people in particular – the Reshaping Care of Older People programme – which includes a review of funding and wider resource issues in the context of partnership working across health and social care. Furthermore, the Joint Improvement Team (JIT) has, since 2004, worked directly with local health and social care partnerships across Scotland to provide practical support and additional capacity to deliver better health and social care services to those who need them.

The JIT’s work focuses on equipping partnerships with the tools and knowledge to enable them to fully account for their use of resources, management of staff and the care delivered through joint services, or services that are jointly managed. This involves working jointly in the field with partnerships to improve outcomes through, for example, addressing local issues with delayed discharge, developing sustainable approaches to healthcare provision, through intermediate care, telecare, and managed care networks, improving the mechanisms behind commissioning of services, and facilitating much greater user and carer involvement.

Q. What action is the Scottish Government taking to promote and monitor resource transfer across Scotland?

The Scottish Government, with NHS Scotland and COSLA, recognised earlier this year that greater clarity around resource transfer arrangements, and any issues arising from these, would be helpful. In response, a working group has been established with membership from the Scottish Government, NHS Scotland and local government. The group will report to the Ministerial Strategic Group on Health and Community Care, which is chaired by the Minister for Public Health and Sport, early in 2010. The report will offer advice on ensuring that current resource transfer arrangements work efficiently and effectively, and to the greatest benefit of service users.

Work is also currently underway to develop an Integrated Resource Framework (IRF) which will encourage the understanding and improved management of the pool of resources for health and social care. The Scottish Government will be looking for evidence from the four IRF test sites – in Tayside, Highland, Lothian and Ayrshire and Arran – regarding mechanisms for more effective sharing of resources.

Q. How do you monitor that funds being transferred are being directed to the appropriate services?

The Scottish Government requires NHS Chief Executives to assure appropriate use of allocated budgets, including any resources transferred to local authority partners. It is therefore primarily the responsibility of individual partnerships to work within the framework set out and to agree arrangements which ensure that they can discharge that accountability effectively.

The Scottish Government is committed to the principle and benefits of strong partnership working, as demonstrated by the introduction of the Single Outcome Agreement arrangements, and the National Performance Framework. Whether resources are located
within NHS or local authority budgets, it is important to ensure that monies are committed to the best possible outcomes for individual service users.

On a more specific note, we have this year introduced a Community Care Outcomes Framework which partnerships can use to help manage their health and social care resources to best effect.

Q. How do you ensure that funding closely matches services requirements in each area?

As described previously, appropriate provision of services in the community is a matter for discussion and agreement between NHS Boards and local authorities. NHS Boards remain accountable for resources that are transferred, and the Scottish Government expects individual Boards to ensure that they are involved in the planning and review of services.

Q. How are you encouraging more joined-up working between NHS Boards and local authorities around how funds should be allocated?

The Scottish Government, NHS Scotland and COSLA are working together to develop an Integrated Resource Framework to support partners in achieving effective planning and use of resources. We are also working together through the working group mentioned above to look for ways to ensure that the current resource transfer arrangements work as smoothly as possible.

We have also taken the opportunity afforded by our Annual Review process to bring joint commitments and joint working between NHS Boards and their community planning partners into the spotlight. We have offered Boards the opportunity to highlight and discuss their progress with the SOA commitments they have made with council (and other) partners beyond the scope of the NHS discrete activities, thus articulating the role of government in supporting and promoting partnership working at the local level.

Q. Have you looked at alternative models for funding, for example, it was suggested in evidence that a single financing system would be more appropriate?

We will examine the work of the group which is looking at resource transfer arrangements as well as the results of the IRF test sites to see if improvements can be made. As part of the work on the IRF we have also commissioned work to gather evidence on which types of funding arrangements work well elsewhere which combined can be used to further improve NHS and local authority practice.

LETTER FROM CONVENER OF THE PUBLIC AUDIT COMMITTEE TO DR KEVEN WOODS, DIRECTOR GENERAL OF HEALTH AND CHIEF EXECUTIVE OF NHS IN SCOTLAND, THE SCOTTISH GOVERNMENT, 9 NOVEMBER 2009

At its meeting on 7 October the Committee took oral evidence on the AGS report, Overview of Mental Health Services, from a number of NHS Boards and their partner Local Authorities. A copy of the Official Report of that meeting can be found at the following link:
http://www.scottish.parliament.uk/s3/committees/publicAudit/or-09/pau09-1502.htm#Col1230

The Committee further considered the report at its meeting on 4 November and agreed to write to you on a number of issues that emerged during the evidence session. The Committee would be grateful for a response to the following questions.

Resource Transfer
The Committee noted from Audit Scotland’s figures (AGS Report, Exhibit 14, page 31) that resource transfer by NHS boards to local authorities to support community mental health services, per head of population, varies significantly between boards. The Committee queried lower transfer rates in Fife, Lanarkshire, Lothian, and the Western Isles. In particular, the Committee highlighted the difference in the figures per head in Lanarkshire and Greater Glasgow, given that both areas have a similar demographic makeup.
How does the Scottish Government account for the disparity in resource transfer levels across Scotland?

What action is the Scottish Government taking to promote and monitor resource transfer across Scotland?

How do you monitor that funds being transferred are being directed to the appropriate services?

How do you ensure that funding closely matches services requirements in each area?

How are you encouraging more joined-up working between NHS boards and local authorities around how funds should be allocated?

Have you looked at alternative models for funding, for example, it was suggested in evidence that a single financing system would be more appropriate?

Anti-depressant prescribing

Audit Scotland highlights in its report that the anti-depressant target ‘does not take account of initial prescribing levels in each NHS board. It is also unclear what the correct rate of prescribing should be and whether reducing the rate of prescribing is always appropriate.’ (AGS Report, paragraph 104, page 25).

The Committee was particularly interested in the figures that show that anti-depressant prescribing has increased in recent years, in spite of the HEAT target to reduce anti-depressant prescribing.

- What work is being carried out to assess the appropriateness of prescribing levels?
- What work is being carried out to better understand why levels of anti-depressant prescribing are continuing to rise?
- What progress are boards making towards achieving the HEAT target of reducing anti-depressant prescribing?
- What efforts are you planning to promote better achievement of this target?
- Can you explain what factors influence the variation in anti-depressant prescribing?
- What efforts are underway to ensure that patients can access other treatments across Scotland such as psychological therapies and leisure services?