FINANCE COMMITTEE

Tuesday 29 October 2002
(*Morning*)

Session 1

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FINANCE COMMITTEE
20th Meeting 2002, Session 1

CONVENER

*Des McNulty (Clydebank and Milngavie) (Lab)

DEPUTY CONVENER

*Elaine Thomson (Aberdeen North) (Lab)

COMMITTEE MEMBERS

*Brian Adam (North-East Scotland) (SNP)
*Mr David Davidson (North-East Scotland) (Con)
*Mr Tom McCabe (Hamilton South) (Lab)
*Alasdair Morgan (Galloway and Upper Nithsdale) (SNP)
Mr Jamie Stone (Caithness, Sutherland and Easter Ross) (LD)

COMMITTEE SUBSTITUTES

Mr Keith Harding (Mid Scotland and Fife) (Con)
Mr Keith Raffan (Mid Scotland and Fife) (LD)
Andrew Wilson (Central Scotland) (SNP)

*attended

THE FOLLOWING ALSO ATTENDED:

Mr Ian Doig (Adviser)

WITNESSES

Jim Brown (Scottish Executive Health Department)
Dr Lindsay Burley (NHS Scotland Board Chief Executives Group)
Dr James Dyer (Mental Welfare Commission for Scotland)
Colin McKay (Scottish Executive Health Department)

ACTING CLERK TO THE COMMITTEE

David McGill

SENIOR ASSISTANT CLERK

Terry Shevlin

ASSISTANT CLERK

Gerald McInally

LOCATION

The Chamber

Scottish Parliament

Finance Committee

Tuesday 29 October 2002

(*Morning*)

[THE CONVENER *opened the meeting in private at 10:36*]

10:51

Meeting continued in public.

The Convener (Des McNulty): Before we proceed to agenda item 2, I should say that we have received apologies from Jamie Stone and from David Davidson, who will join us later.

Mental Health (Scotland) Bill: Financial Memorandum

The Convener: Agenda item 2 concerns the financial memorandum to the Mental Health (Scotland) Bill. I welcome our witnesses. Dr James Dyer is director of the Mental Welfare Commission for Scotland and Dr Lindsay Burley is chair of the NHS Scotland board chief executives group. The committee has received short written statements from the witnesses, who may now wish to make brief opening statements.

Dr James Dyer (Mental Welfare Commission for Scotland): I thank the committee for giving me the opportunity to give evidence. I do not want to say much by way of an opening statement. My submission concentrates on the financial memorandum as it affects the Mental Welfare Commission for Scotland. Perhaps the organisation is unusual in being content with the memorandum; indeed, that may be sufficiently unusual as to merit some explanation.

Our response to the memorandum is largely explained by the fact that we were consulted by the Executive and submitted a fairly detailed business case on the extra financial costs to the commission that will arise from 2004 because of new and extended duties under the bill. We also made a business case on the need to replace our information technology system, which will be a one-off cost to be split between 2003-04 and 2004-05. External consultants assisted us in preparing the detailed business case for the replacement. In the financial memorandum, the Executive appears to have accepted our business cases, which is why I say that the commission is content, as far as we are directly concerned.

If members wish to ask questions about other aspects of the memorandum, I would be happy to try to answer them. I do not know whether the committee wants me to restrict my comments to the commission.

The Convener: We will deal with that when we come to questions. Dr Burley, do you wish to make a brief opening statement?

Dr Lindsay Burley (NHS Scotland Board Chief Executives Group): I thank the committee for giving me the opportunity to attend the meeting. First, I must declare what might be seen as a conflict of interests. I was a member of the Millan committee and am therefore signed up the principles that are inherent in the Millan report.

I have sought views from my colleague chief executives of boards throughout Scotland. I have received views from only about half a dozen colleagues, so there was not a lot of information, but my brief written submission outlines areas of concern that were flagged up. They include training, the number of available specialist staff, services and advocacy. The main concern was the number of available specialist staff, particularly in psychiatry. There is a concern that the tribunal system may pull staff who are already stretched and in short supply away from services. Others have raised that issue, too. People may be concerned less about money and more about the availability of staff.

Elaine Thomson (Aberdeen North) (Lab): Will the witnesses expand on the bill's financial implications? I was pleased to hear Dr Dyer say that there has been effective consultation and that he thinks that his case has been taken on board. His submission refers to a "modest reduction in costs", which is also nice to see. In which areas might there be increases or reductions in costs? Will there be increases or reductions in salaries or in respect of premises, for example?

Dr Dyer: The issue of replacing the IT system aside, costs will largely be reflected in salaries. Around 70 per cent to 80 per cent of the commission's costs are staff costs. We will need to increase the number of our staff to deal with the increased responsibilities that will arise from the bill. For example, there will be broader inquiry responsibilities, including the publication of reports on whether recommendations of our inquiries have been addressed. There will also be broader visiting responsibilities and an increased range of situations in which commission-approved second opinions on treatment are required. Visiting patients subject to conditional discharge and community-based compulsory treatment orders will be new and there will be appearances before the tribunal when we have remitted cases to it. Those are some areas in which our work load will increase. We have costed that increase using unit

costs for different functions and different members of staff in the commission.

There will be a modest reduction in costs in two areas. First, there will be a reduced role in review of detention. The Executive intends that the commission will retain its power to discharge people from compulsory measures. However, with the development of tribunals, the commission will be able to use that power much more selectively. Therefore, we will carry out fewer reviews of detention directly, a factor that we have built into the costing.

There should also be a reduction in the number of situations in which emergency detention is carried out without the consent of a mental health officer as, under the new provisions, there will be less emergency detention. The intention is that there will be more direct entry to 28-day detention rather than emergency detention, on which the current provisions rely heavily. Therefore, there will be fewer situations in which detention occurs without consent and less work for us in following up and making inquiries into those situations. That will mean a small reduction in our work load.

Elaine Thomson: Would you like any financing aspects to be changed? Do any concern you or are you content with them?

Dr Dyer: I would like to comment on two matters. I am concerned about the allocation for local authorities. I know that the committee will take evidence from the Convention of Scottish Local Authorities and that it is up to COSLA to deal with the issue directly, but the Mental Welfare Commission for Scotland simply wants to point out that local authority spending on mental health services starts from a low base—8 per cent of what the health service spends on mental health services, according to the memorandum. We have seen too many patients suffering delayed discharge in hospital because local authority facilities and services are not available for them or indeed for patients who are out of hospital on leave of absence, for example. Such patients have a poor quality of life, which could be improved by more community services.

To take another example, current legislation makes social circumstances reports by mental health officers mandatory in certain circumstances. Our forthcoming annual report will point out that such reports are being provided in only 50 per cent of cases, despite being mandatory. That says something about the availability of current MHO services, which will need to be significantly expanded to meet the bill's requirements.

It is important that the tribunals are adequately resourced. There have been problems south of the border, where mental health tribunals are already in place. Seven patients were recently successful in a human rights case that they brought because of delays in appeals being heard by tribunals. The main reason for the delays was inadequate medical staffing of the tribunals. The patients were successful in their case and may be able to get compensation as a result.

The amount that, according to the memorandum, will be provided for psychiatrists is not too bad. The figure covers both those who will sit on the tribunals and those who must be available to go to tribunals that are considering the cases of their patients. However, other things may not have been factored in. For example, there will be a need for extra consultants to implement the provisions of the bill. The Royal College of Psychiatrists projected a requirement for somewhere between 18 and 28 additional consultants, but 29 consultant posts in Scotland are unfilled at the moment. There is therefore a need to recruit more consultant psychiatrists. I do not know whether a cost has been factored in for expanding the training grades to allow for that recruitment.

11:00

Brian Adam (North-East Scotland) (SNP): I have a technical question. Why has the Executive allowed only £1 million for the commission's £1.108 million computer? Is there a concern that, if the contingencies that the commission has allowed for are required, money might need to be taken from service provision?

Dr Dyer: We are fairly relaxed about that, as a 10 per cent contingency was built into the IT figure. As Brian Adam has correctly pointed out, the total estimated cost was £1,108,000, whereas the allocation given in the financial memorandum is £1 million. I am confident that the commission would be able to negotiate with the Executive if the figure were in fact to creep over the £1 million mark.

Brian Adam: Are there no worries that services might need to be cut in order to ensure that the commission has the hardware?

Dr Dyer: No. We are happy to accept the round figure of £1 million and negotiate if unforeseen problems arise.

Brian Adam: Both Dr Dyer and Dr Burley have rightly identified the potential problems over the availability of specialist staff. However, the submissions from some of the professional bodies not only highlight that difficulty but mention that there might be insufficient funding for the number of staff that the Executive projects will be needed as a consequence of the bill. Would Dr Dyer and Dr Burley care to comment on the funding that has been made available to pay for the additional

medical health officers? I know that one local authority has written to us to state that it pays £30,000 a year for an MHO but that only £25,000 is made available to it for that purpose. Similar comments have been made to us about the health service side by the Royal College of Nursing Scotland and the British Medical Association.

Dr Dyer: Others will be able to comment in more detail on the specific costs of MHOs, for example. I would prefer to limit my comments to saying that the bill will clearly not work properly unless enough funding is provided to supply the necessary number of MHOs, whose responsibilities will increase significantly under the bill. One would need to turn to COSLA or the Association of Directors of Social Work for a precise answer to that question, but the issue is certainly important. As I indicated, there is a serious strain on the current MHO service.

Brian Adam: There is a national health service side to the question as well as a local authority side. My recollection is that MHO status within the NHS came with an entitlement to early retirement. Obviously, that comes with a cost. Will Dr Burley comment on that?

Dr Burley: Let me return to that issue once I have commented on the initial question, which was about the amount of money set aside for the implementation of the bill. One of the issues, which Dr Dyer has alluded to, is that mental health services are not always as well resourced as they might be. Staff are not as well tooled up for current mental health legislation as they might be. I do not want to be an apologist for the Scottish Executive, but I think that the difficulty lies in teasing out which problems are connected to the new legislation and which are legacy problems, as it were. I am not qualified to comment on what the pensions implications might mean to the service.

Dr Dyer: There may be confusion about two different uses of the term "mental health officer". The first use applies to someone who is appointed by a local authority to undertake certain functions under current mental health legislation. At present, that is restricted to specially trained social workers. It is intended in the bill that the term will continue to be restricted to social workers who are fulfilling the mental health officer function.

In the past, consultant psychiatrists also had what was called mental health officer status, which gave them certain benefits in relation to pensions. That enabled them to retire somewhat earlier than others in the health service. However, that provision has now stopped for new entrants. I forget exactly when it stopped, but it was something like eight to 10 years ago, although people who had the benefit before it was stopped continue to enjoy it. Those are two quite different uses of the term "mental health officer".

The Convener: I want to pursue Dr Burley about the additional costs for extra psychiatrists and for the training of other staff. The BMA thinks that the £1.5 million additional funding linked to psychiatrists is probably only half the amount that will be required. The BMA also cast up concerns about the fact that, under the heading "The principle of reciprocity and plans of care", the financial memorandum makes available only an additional £2 million to a budget of £557 million. From her experience and understanding of the health service, does Dr Burley think that the BMA has identified areas of real concern?

Dr Burley: Yes, there are areas of real concern. However, going back to what I said before, we need to ask to what extent such concerns come from the new legislation and the important issues such as reciprocity that it will introduce. There are areas of concern right now, such as delayed discharges, which Dr Dyer mentioned, and the general financing and resourcing of the quite complex packages of care that enable people to move from institutional settings into the community. Obviously, the bill is not just about detaining patients. In fact, there will be little or no difference between the needs of some detained patients and those of some voluntary patients.

The bill highlights some of the existing problems within the service. Speaking as a board chief executive, I can say that there will be some real tensions. There are other priorities that we must fund through our allocations. It is perhaps unfair to suggest that all the problems are connected with the new legislation. Some of them arise from the fact that we are slowly—but perhaps not quickly enough—coming to terms with the needs of people with mental health problems as we have closed some of our institutions.

Alasdair Morgan (Galloway and Upper Nithsdale) (SNP): Would it be fair to say that Dr Burley is implying that some of the costs in the financial memorandum would be accurate—or perhaps a reasonable estimation—if the system was working at present, which is not in fact the case? We clearly have a large number of vacancies in various fields, which means that we are not training people and/or that we are not paying them enough. Therefore, it will never be good enough simply to make assumptions about figures that are based on projecting forward the existing situation with an extra work load. If we cannot make the existing system work, the new system will suffer from exactly the same problems, but perhaps in spades. The BMA submission says in relation to the NHS cost:

> "One could take the cynical view that it will not be possible to spend the £1.5 million allocated".

Is that a valid criticism?

Dr Dyer: I am not so concerned about the figures projected to meet the increased costs arising from the bill in relation to psychiatrists. However, figures from the information and statistics division of the Common Services Agency for September 2001 showed that 29 consultant posts were vacant in Scotland. There is clearly a need to deal with that, as well as to meet the requirements of the bill.

The principle of reciprocity says that, if people are to be deprived of their freedom by being made subject to compulsory measures, there is a parallel duty on services to ensure that appropriate services are provided for them. The Mental Welfare Commission would suggest that it is not consistent with that principle for a local authority to charge people for services that they are receiving as part of a compulsory care plan. If that view were accepted, moneys would have to be built in to allow people to have the costs waived for services, such as residential or nursing home accommodation, that they were compelled to receive and were not receiving by choice. That is relevant to section 23 of the bill, which allows local authorities to charge for services.

The Convener: You have given us one or two questions that we may want to put to the Executive during the next phase of evidence.

I would like to pick up on the issue of accommodation. Your submission suggests that the increase in the commission's staff will require increased accommodation. The projections that you have built in are linked to whether there is space in your existing building, but you also highlight the fact that relocation could be expensive. How expensive would it be?

Dr Dyer: Thank you for picking up that point, although it is difficult to answer your question precisely. We moved to our current accommodation in Argyll House in 1997, because we needed more space. We have now fully occupied our existing space; we had to expand somewhat to deal with duties under the Adults with Incapacity (Scotland) Act 2000, for example. With the anticipated increase in staffing to meet the requirements of the Mental Health (Scotland) Bill, we would certainly need more space.

As my submission says, I hope that we could find extra space within Argyll House. The costing in the submission assumes that if space were to become vacant we would be able to occupy it. The costing becomes much less predictable if that is not possible and we need to relocate the whole office elsewhere. At present, I am unable to make any projection as to what that would cost. The Executive's relocation exercise would presumably be relevant in those circumstances and it might be necessary to relocate the commission outside Edinburgh. If that should prove necessary, the cost would have to be negotiated at the time, so it is hard to predict. However, the commission would wish to remain in its current base if that was at all possible.

Brian Adam: The bulk of the money in the financial memorandum is being allocated to local authorities. The financial memorandum does not say whether that money will be ring fenced or exactly how it will be dealt with. I imagine that the Mental Welfare Commission will have some views on that, which it would be interesting to hear.

I note that Dr Burley commented on advocacy. I know that patient representatives have raised concerns about whether money for advocacy services should be ring fenced within NHS budgets and how that might be dealt with. Could you comment on that?

11:15

Dr Dyer: There are a lot of arguments for ring fencing the money. Those areas where money has been hypothecated in one way or another seem to have fared better than mental health has in recent years. Sir Roy Griffiths, the architect of the Government's approach to community care, said in his 1990 report to the UK Government that, if money for community care were not ring fenced, the scheme would be a three-wheeled wagon. I think that local authority spending on mental health services is something of a three-wheeled wagon. As I said, we are talking about 8 per cent of what the health service spends on mental health and we know that there are serious deficiencies in the current service. Local authorities have historically given priorities to areas such as criminal justice and children, where there seems to be a stronger statutory drive to the provision of services. I would therefore support the argument for ring fencing money for mental health community care.

Dr Burley: I shall start by commenting on advocacy. There has been quite a thrust on us in the health service, and on local authority partners, to develop advocacy services. Money has been made available for that, in relatively small sums, but it is important nonetheless. I can say, speaking from my experience in the Scottish Borders area, rather than about the whole of Scotland, that we have focused our growing advocacy services around people with mental health problems and learning disabilities.

On ring fencing, I shall broaden my answer, as Dr Dyer did, from advocacy to mental health services in general. The question is a delicate one. On the one hand—I am speaking as a board chief executive on behalf of my colleagues—we do not usually ask for everything that is passed to us to be ring fenced, as that gives us very little flexibility.

On the other hand, our accountability lines as chief executives of health boards are directly to the Scottish Executive health department and those lines can enable a direction of spend even without ring fencing.

That is not the case for local authorities. There have been issues throughout the country about the way in which moneys are used in local authorities. The mental illness specific grant is an example of ring-fenced moneys coming into local authorities that has made a difference to the way in which services are provided. The change is relatively small, however, compared with the overall spend on mental health services.

I am choosing my words with care, because it seems a little bizarre to say that we are not sure that we would like everything to be ring fenced in the health service, but that it might be handy if the money were ring fenced at local authority level. The arguments reflect the different lines of accountability.

We recognise the legislative changes that are coming about, not only through the Mental Health (Scotland) Bill, but through the joint future and other aspects of the work of the Scottish Parliament and Scottish Executive. More joining up, aligning and pooling of budgets is expected and the Scottish Executive is giving more direction to health and local authorities together to ensure that they deliver specific objectives. We are aware of that shift.

Brian Adam: The Millan committee representatives who appeared before the Health and Community Care Committee made it absolutely clear that they wanted the advocacy money ring fenced within the health service, although the current arrangements do not specify that. Is that fair comment, if you are wearing another hat?

Dr Burley: I declared my interest at the beginning of the meeting. As a member of the Millan committee, I am signed up to that principle. I am here to represent views across the health service. I hope that that is understood.

Mr David Davidson (North-East Scotland) (Con): I apologise for being late; I had travel problems.

Dr Burley talked about provision in the round of mental health services in the community, of which advocacy is obviously a part. As a chief executive, would you say that what is being made available currently is what you would like to deliver? Is sufficient money being offered to enable the implementation of your model for delivery?

Dr Burley: I am in favour of significant change in the way in which we deliver services in the community. My experience in Borders NHS Board—I am not necessarily speaking for the whole of Scotland—is that we are continuing to make progress in the right direction, which includes ensuring that people who use the services have a much greater say in the way in which those services are delivered. We have a long way to go to ensure that primary care services, specialist mental health services and local authority services work together to deliver a good and responsive service to the people who need it. That applies as much to other groups of people as it does to people who have mental health problems. Much of the issue is about organisation, partnership and how people work together.

There are significant money issues in relation to the provision of much of the support that is available for the small number of people who suffer from serious and enduring mental illness. There are cases of our not being allowed to move people from hospital settings into the community; the problem is resources, although we are moving in the right direction. There are also issues about the ways in which different professional groups and organisations work together and share goals.

Mr Davidson: The bill's financial memorandum indicates that, in the year 2004-05, the NHS will receive an increase of £0.5 million for more mental health assessments. At the moment, people who suffer from conditions such as eating disorders must wait as long as nine months for assessment. During that time, the physical condition of many such sufferers becomes critical, which often has an effect on the amount of mental health support that they require. Is the increase sufficient to cover all—not just those relating to eating disorders—needs? Is it a reasonable sum of money that will enable demand to be met?

Dr Burley: I have already suggested that we need to tease out the cost of implementing the bill as opposed to the cost of making up for shortfalls in services, which our previous conversation was about. I am well aware of some of the issues that relate to highly specialised services for disorders such as eating disorders. In some such cases, we are unable—either individually, in different parts of Scotland, or collectively across several regions—to offer appropriate services for relatively small groups of people. It is difficult to tease out whether the money that has been allocated is sufficient to implement the bill, rather than to make up for an existing shortfall.

The theme that has emerged from the evidence that has been received on the bill relates to the potential additional stress that the bill's enactment might place on services that are stretched. In some places, services such as those for eating disorders are particularly stretched.

Mr Davidson: I am sorry that I missed part of the evidence that Dr Dyer and you gave.

The cost of implementing the bill does not involve simply the cost of implementing legislation; rather, it is necessary to ensure that it will be possible to deliver what the bill demands be made accessible and available to patients in Scotland—I note that both witnesses are nodding in agreement. Given that, the Finance Committee has a responsibility to ensure that the proper figures hit daylight and that people know the real costs, which are the costs of implementing the necessary services, rather than just the costs of implementing the legislation. In your professional opinion, do the figures in the financial memorandum stack up?

Dr Dyer: It is difficult to give a precise answer to that question. I sympathise with the sentiment of David Davidson's question. Under the bill, someone who is already in contact with the psychiatric service will have the right to ask for an assessment. The service will be required to oblige—the bill contains that new duty—unless it has good reason for not doing so, which it can state in writing.

At present, much of the psychiatric service operates without a waiting list, which it must do because psychiatric illness tends to present acutely. It is not like a hip operation, for example, for which people can wait some time, although they have often wait too long. However, some parts of the psychiatric service have unacceptably long waiting lists, for example child and adolescent services in some areas. David Davidson mentioned services for eating disorders, and there are also long waits to see psychologists for psychological contribution to assessment or treatment. There are deficiencies in those areas, which might need to be addressed if the aspiration of the bill is to be properly fulfilled. In my position, I cannot say whether £500,000 is enough for that; I can say only that the figure would bear close scrutiny. Others who have more expertise might comment.

The Convener: You referred earlier to the Griffiths inquiry and its aftermath, in which it took a long time for local authorities' service developments and resources to gear up for the care responsibilities that were transferred to them from the health service. We might have a situation in two or three years in which local authorities find that they have to engage in a substantial catch-up exercise in order to pick up the responsibilities that will be transferred to them by the bill, specifically on the introduction of compulsory treatment orders. It is perhaps disturbing that we have not had more responses from local authorities to identify issues that are relevant to that.

Is it possible to quantify what might be required to meet aspirations and improve the quality of services that are delivered by the NHS, or is that an issue that the committee can only highlight?

Dr Dyer: I appreciate the question. The issue is a major one for local authorities because sections 20 to 22 of the bill will place substantial responsibilities on them. Those sections also provide great opportunities for authorities to play a more meaningful role in the care of people who have mental disorders and, to some extent, in the prevention of disabilities that result from mental disorder. Local authorities will have to ensure that services are available that will minimise the effects of mental disorder and which will allow people to live lives that are as normal as possible.

In the face of that, one would expect local authorities to have made detailed costings so that they could comment on the adequacy of the figure. The total figure for the continuing costs to local authorities is £13 million, which according to my calculation equals £400,000 per local authority. That is the average figure—authorities obviously vary in size—but it does not seem to be enough to meet the substantial requirements and opportunities that will be presented by the bill.

The Convener: Do you have anything to add, Dr Burley?

Dr Burley: I do not feel able to answer for the local authorities but, as Dr Dyer said, the sum—when it is divided throughout Scotland—is not a lot of money given the responsibilities that local authorities will be taking on.

The Convener: I want to pursue the matter of compulsory treatment orders, which will require people to take treatment in communities. That will require a lead agency and the co-operation of other agencies—including those within local government—across the boundaries between local government and the health service. The same will perhaps be true in relation to advocacy. It all seems to be quite complicated and potentially costly. Has any modelling been done on the administration of compulsory treatment orders and what that will mean in relation to the resources that will be required?

11:30

Dr Dyer: I do not know what modelling the Executive has done on that. It must have done some in order to arrive at the figure of 45 full-time equivalent new MHOs, for example.

The number of people on CTOs will be fairly limited. I guess that there would be only a few hundred people who might otherwise be detained in hospital but who, under the principle of least restrictive intervention, could be made subject to CTOs and remain at home or wherever they are in the community. However, there will be a limited

number of people for whom that treatment will be appropriate.

I say that partly because of my experience of extended leave of absence in Scotland. I, with others, studied people who had been on leave of absence for longer than one year, but I am struggling to remember the number of people who were on leave of absence for longer than a year. At the end of 1994, the figure was—I think—about 190. If we project that figure into the future, I guess that there will be between 200 and 400 people on CTOs. However, that is not to say that CTOs will not give rise to significant costs. It is clear that there will be people who will need—quite apart from the wider local authority responsibilities that I mentioned—intensive treatment support and monitoring if they merit compulsory measures. It is very important that CTOs are adequately resourced.

I know that some users and organisations fear that CTOs will be used as a cheap alternative to compulsory admission to hospital, and that NHS boards might try to save money by reducing the number of available beds and use CTOs instead, but it would be entirely inappropriate to use CTOs in that way. They should be used to increase patients' freedom in that they will not have to be admitted to hospital. However, that can be done only if patients receive a proper range of treatment and support in the community.

Alasdair Morgan: The BMA has quoted the Royal College of Psychiatrists' estimate that between 18 and 28 additional consultant psychiatrists will be needed to implement the provisions of the new act. The BMA suggests that even if there were only 18 additional consultant psychiatrists, the amounts that are included in the package as detailed in the financial memorandum would not be sufficient. Two questions arise from that. First, do you accept the range of 18 to 28 additional consultant psychiatrists? If so, do you agree with the BMA that there is not enough money to pay for those psychiatrists?

Dr Dyer: I have to declare an interest. I was a member of the Royal College of Psychiatrists working group that produced that estimate; therefore I can say that the estimate was produced as conscientiously as possible. The working group considered all situations in which psychiatrists would have extra work from tribunals through sitting as medical members of tribunals, preparing reports and attending tribunals to discuss patients. Although various assumptions were made, it was reasonable to estimate that there will be a need for 18 to 28 additional consultant psychiatrists.

I do not believe that the projected cost will differ from that in the memorandum by as much as the BMA's evidence states. The suggested figures of £1.5 million for the extra cost of psychiatrists' patients being before tribunals and £0.65 million for psychiatrists sitting on those tribunals might be quite reasonable.

Mr Davidson: I return to Dr Dyer's answers to a previous question about giving patients the choice to move into community-based care, in which he expressed concern about whether that choice can be delivered. Has your experience of, and knowledge gained from, committees on which you have sat given you any knowledge of the number of psychiatric professionals at nursing level and above that would have to be attached to community practices, for example, in order to implement what you suggest?

Dr Dyer: I am afraid that I cannot answer that. The Mental Welfare Commission has not quantified the number of extra nurses, doctors and psychologists that it would take to do that job: that is not the commission's role.

However, our annual reports point out that there are people on leave of absence, for example, who suffer from poor quality of life. They might get their depot medication and a visit from a community psychiatric nurse every few weeks, but they have little to do apart from sit in their houses and look at the walls. They do not have appropriate activities or services that would improve their quality of life. It is clear that it would be costly to bring the service up to scratch while having to meet the extra costs that will be occasioned by implementation of the bill.

The Convener: We have reached the end of our questions. I thank both witnesses for their written and oral evidence. The committee will in due course report its findings to the Health and Community Care Committee, which is the lead committee for the bill.

We will take a short break while the next set of witnesses gets ready.

11:37

Meeting suspended.

11:43

On resuming—

The Convener: I welcome witnesses from the Executive. We are joined by Jim Brown, head of the public health division; Colin McKay, manager of the Mental Health (Scotland) Bill team; and Andrew Mott, who is also from the Mental Health (Scotland) Bill team. I thank them for attending and give Jim Brown the opportunity to make a short opening statement before we proceed with questions.

Jim Brown (Scottish Executive Health Department): In developing the bill's policy and the bill itself, the Executive has sought to consult

as much as possible and to be as inclusive as possible in that consultation. That philosophy applied to the development of the Millan report and to the consideration that has been given to that report—which manifested itself in last October's policy statement—and the development of the bill.

I head a multi-sectoral and multi-agency mental health reference group, which seeks to bring together the various interests that are involved in the development of the bill. That approach enables us to get a feel for the views of the community and of the voluntary and statutory sectors. The same philosophy has been extended as far as possible to the development of the financial memorandum.

11:45

Brian Adam: How confident are you that you will be able to spend the money that has been allocated, considering the current difficulties in recruiting social work staff and the significant shortfalls in consultant psychiatrists and other related professions? Have you considered phasing in the introduction of the various measures to ensure that you can fill the posts that you hope to create?

Jim Brown: That will be a matter for ministers. We are proceeding on the assumption that the bill will not be commenced before April 2004. Whether that is done on a phased basis will depend on the readiness of our preparations. As I indicated, we are consulting the various interests about development and implementation of the bill. Part of my division is now focusing on implementation issues and is consulting about the resources that will be necessary. Work force issues were raised in the submissions to the committee and in evidence from the previous witnesses. We are carefully considering those issues and we are aware of the potential pitfalls and implications that must be considered, including the work loads of psychiatrists and mental health officers.

Brian Adam: Given that there are concerns about the number of staff that will be required to implement the bill in its current form—the number that has been allowed by the Executive is not high enough, according to some submissions that we have received—can you give us an Executive view as to why the figures in the bill are adequate?

Jim Brown: In terms of mental health officers, we have consulted closely the Association of Directors of Social Work and we established a group to consider such issues. The group had several meetings and the ADSW helped us to arrive at the estimate of 45 additional mental health officers.

I offer clarification on a point that has been made. One of the submissions from local authorities indicated that the average cost of a mental health officer would be £35,000. Our estimate is that it would be £55,000 and the estimate in the financial memorandum reflects that.

Brian Adam: I think that that submission stated that the cost would be £30,000 and that the authority thought that the Executive's figure was £25,000.

Jim Brown: Our figure is £55,000 per officer.

Alasdair Morgan: I will ask a supplementary to that question. The consequence of the bill in various areas will be expanding demand for certain types of service, such as psychiatry and social work services. We cannot fill existing vacancies and I believe that the solution is to increase training provision and/or to increase salaries. Am I correct in assuming that, leaving aside one-off training, there is no allowance within the proposals to increase on-going training provision so that we can produce more psychiatrists, or to increase salary levels so that we attract and retain more of them?

Jim Brown: The committee might know that a general review of work force issues in the national health service is being undertaken by the Executive. As a pathfinder project in that exercise, a mental health work force group has been established, which is considering training, recruitment and associated issues.

Alasdair Morgan: The result of that consideration, however, is hardly likely to be a reduction in the cost of the bill, is it?

Jim Brown: That consideration will certainly not result in a reduction of costs. That is why we estimate, taking account of the helpful submission from the Royal College of Psychiatrists, that there will be a need for 15.5 additional psychiatrists.

The main point on which we differ from the Royal College of Psychiatrists is the number of daily cases that the psychiatric member of a tribunal would be able to cope with. The Royal College of Psychiatrists estimated that such a member could cope with one case per day, but we estimate that they could cope with two.

Alasdair Morgan: I admire the increase in productivity.

For the purposes of the estimates that you have produced, what is the cost of an additional psychiatrist?

Jim Brown: The cost of an additional psychiatrist is £100,000.

The Convener: I apologise to committee members; I must go and do something else, but my deputy convener, Elaine Thomson, will take over.

Mr Davidson: We have heard evidence that the Executive's money will flow out on a certain date and, as you said, on an expanding basis. What about the pre-commencement costs of training existing staff? I ask that on the back of Alasdair Morgan's question. If you are going to deliver a service, somebody must be there in advance, trained and ready to deliver it. From the evidence that we have received, there is concern about money being available ahead of the date that is mentioned in the bill. How will you bridge the gap?

Jim Brown: The memorandum indicates that training for non-local authority staff will commence in the current year, for which we have allowed £750,000. We have allowed £700,000 for local authority training in 2003-04. The intention is to introduce the training programmes before the bill is commenced.

Mr Davidson: Have you come to an agreement with the various bodies that the funds that are being offered are sufficient to deliver? Those bodies do not seem to agree with you. Do you have evidence that you have held discussions?

Jim Brown: Yes. We have done our best to produce estimates in consultation with relevant interests. We noted the submission from the Royal College of Nursing, for example, that the figures may be inadequate; it is open to us to re-examine the figures if that is the case, but the idea is that new training courses or new aspects of training could be assimilated into existing training courses.

Mr Davidson: The new commission that is being set up for all the professional health bodies across the UK is concerned about continuing professional development, or CPD. That issue is raised in the RCN's submission and it is being raised elsewhere in idle chat at the steamie. Where does CPD come into the bill? There is not much point in having a one-off upgrade when all the professionals are obliged to undertake CPD. Is anything built into the figures for that?

Jim Brown: Not precisely, but once the bill has fully commenced it will be necessary to reflect that.

Mr Davidson: Before they sign up to CPD or to any new training to take a step forward in their careers, professionals tend to look at what is going to happen over the next three years and ask, "Will I have to take time off? Will the training affect my earnings? Will I benefit because of it? Will it give me more skills? How intensive will the CPD be?" Should clearer comments not have been made about that?

Jim Brown: Those are the kinds of issues that we hope to address as part of our work towards implementation.

Mr Davidson: Could you report on your discussions with the voluntary sector?

Jim Brown: The voluntary sector—for example the Scottish Association for Mental Health and advocacy interests—is represented fairly extensively on the group that I chair. Voluntary organisations have had the opportunity to be involved in the development of the bill and to make representations on the financial implications as they understand them.

Mr Davidson: What do you understand those financial implications to be?

Jim Brown: The financial memorandum reflects our best estimate of the cost considerations and implications of the bill.

Mr Davidson: Do your consultees accept those figures?

Jim Brown: We have sought to take account of representations and submissions that have been made to us. I cannot say honestly that all interests would accept the figures that are set out in the memorandum.

Alasdair Morgan: Is it assumed that the local authority would meet all the costs of the care package of someone who was subject to compulsory care in the community? Would that person be expected in certain circumstances to meet some of those costs?

Colin McKay (Scottish Executive Health Department): The financial memorandum does not assume that people will pay for services. It is hard to predict what services would be included in a compulsory treatment order and how those would be paid for. When we drew up the financial memorandum, the issue of free personal care was being developed.

The issue of people being charged for services that they are compelled to receive has been raised with us and we are considering it. The bill provides for local authorities to charge for services, but regulations may limit that power—just as they limit personal care charges. Relatively few people would pay for services that they are compelled to receive under a compulsory treatment order. Most people with severe mental illness do not have significant funds, so it would not be realistic to charge them. Some services in the treatment package may not be charged for in any case. Any income from charging recipients of compulsory treatment orders for services would make no material difference to the global figures.

We are considering in principle whether people should be charged for services that they are compelled to receive. There is concern that, if services are provided free only to those who are subject to compulsory treatment orders, that may create a perverse incentive for subjecting people to compulsory treatments. It may also encourage people to refuse services, so that they may

receive services without paying for them. We need to work through such issues. We are aware that there is concern about people being charged for services that they are compelled to receive, but we believe that that will happen quite rarely.

Alasdair Morgan: Is the working assumption in the financial memorandum that local authorities would meet all the costs of care under compulsory treatment orders?

Colin McKay: Local authorities would meet the costs of local authority services. The NHS would also contribute. Care packages have been costed on the assumption that local authorities would meet the total cost of those.

Alasdair Morgan: You may have heard the previous witnesses discuss the arguments for and against ring fencing the extra money that will be made available to local authorities. What are your views on that issue? What measures would you use to determine how much money should be allocated to each local authority?

Jim Brown: At the moment, there is a presumption that resources would not be ring fenced. However, it is for ministers to take a view on that issue. Our working assumption is that the general allocation procedures for local authorities would apply.

Alasdair Morgan: The formulae for allocation are quite complex. Will they have to be reviewed in the light of the new commitments or obligations that the bill will place on authorities? Will you need to reconsider how much money is allocated to specific authorities, or will you continue to rely on the existing formulae?

Jim Brown: Our assumption is that the general grant-aided expenditure formula will continue to apply.

12:00

Brian Adam: I presume that the Arbuthnott formula will be applied to the money for the NHS.

Jim Brown: That will be the case.

Brian Adam: What level of savings for the NHS do you expect, given that more people are to be dealt with in the community? As the bulk of the measures appear to move money and people towards care in the community, there must be a saving for the NHS. I realise that reciprocity—I am struggling to get my tongue round that word—will have implications for the NHS, but what savings do you expect as a result of people moving into the community from institutional care?

Colin McKay: It is difficult to disaggregate the small number of people who might be on community-based orders. Our estimate of the number of people who will be on community-based orders is not much at variance with Dr Dyer's estimate. The changes will be a small part of the broader changes of moving people out of hospital and into the community. Most of the changes will happen outwith the bill's mechanisms and on a voluntary basis. One difficulty is that, in the health service, moving out one or two people does not necessarily make a saving because it might not allow a ward to be closed, or perhaps more people will be moved in.

If community care—in broader terms—is better developed and resourced, it should be possible for more people to be treated in the community and not in a hospital, which should ultimately create a saving for the NHS or, at least, allow the NHS to put money into other services. However, we do not think that the specific change of having a few people on compulsory treatment orders will realise an identifiably large saving for the NHS.

Brian Adam: How do you plan to finance the one-off capital costs? Will you use traditional procurement methods? Will the money for local authorities go by grant or by permission to borrow?

Jim Brown: The details are to be considered but, to use your expression, we will use traditional methods.

Mr Davidson: I want to return to the Arbuthnott formula approach to NHS care. If patients are to be put back into the community, primary care trusts and mental health services will be out there doing their bit. Is there any correlation between the projected demand in a region and funding under the Arbuthnott formula? Will the Arbuthnott formula be retuned to allow for the fact that in some areas—the north-east is an example—the demands on the service might increase and those extra demands might not fit with the extra amount from Arbuthnott? How will NHS boards apply for sufficient funding to deliver the principles of the bill if they are underfunded through Arbuthnott?

Colin McKay: The additional costs of the changes that the bill will make to the relationship between the NHS and local authority mental health services are probably insignificant, given the context of the wider changes to community care. The bill links into broader changes, such as the greater development of community care and more joint working between the NHS and local authorities. Many of the bill's mechanisms are designed to facilitate those changes.

Although the bill's procedures are based on the ideas of joint working and community-based services, the bill will not cause those changes, because the provisions for compulsory care and treatment will not affect the vast majority of mental health service users. I think that of around 30,000 hospital admissions a year, about 1,000 are

compulsory admissions under the Mental Health (Scotland) Act 1984. So, the broad sweep of changes to the configuration of mental health services is probably at one remove from the changes that will be introduced by the bill. We have not particularly reformulated any of the formulations to take account of the bill.

Mr Davidson: So, if by chance, because of a pocket of difficulty, the bill leads to an increased demand for services in a health board area, the health board will just have to find the finance for that out of general funding.

Colin McKay: Yes, out of general funding and the increases in general funding that have flowed through the general settlements to the NHS in recent years.

The Deputy Convener: It looks as if we have worked our way through most of the questions that we wanted to ask you this morning. Thank you for coming along and answering the committee's questions so well.

The committee will now prepare a draft report that will go to the Health and Community Care Committee for discussion. We will discuss the draft report at the next Finance Committee meeting, on 5 November.

Items in Private

The Deputy Convener: As we agreed earlier, the committee will now move into private session. [*Interruption.*] Sorry, I am advised that the final item on the agenda is to agree whether we wish to discuss in private certain items at our next meeting—specifically lines of questioning on the draft budget and the Homelessness etc (Scotland) Bill and discussion of the draft report to the Mental Health (Scotland) Bill. Are we agreed?

Members *indicated agreement*.

The Deputy Convener: Thank you.

Finally, I remind members that there will be a meeting this afternoon of the cross-cutting review group on regeneration as delivered through the voluntary sector. The first evidence-taking session will be this afternoon at 3.30 in Cannonball House, with Hugh Henry, the Deputy Minister for Social Justice.

Brian Adam: Is that meeting for all committee members?

The Deputy Convener: Sorry, it is only for members who are on the regeneration cross-cutting review group.

Brian Adam: That is why at least two members were looking puzzled.

Mr Davidson: I have an Audit Committee meeting at 2 o'clock, but I will do my best to attend the meeting. I think that I am on that group, am I not? I presume that that is why I got the papers.

The Deputy Convener: I do not know.

Meeting closed at 12:07.

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