

About Us:

Mental Health Aberdeen is a local association which provides 16 services across Aberdeen and Aberdeenshire for people with mental health problems. These include telephone information helplines, counselling, community support services, carers' support, befriending and housing support. We also seek to influence policy at both local and national level, and to promote positive mental health. We are committed to involving service users and carers, and promoting Recovery.

Mental Health Aberdeen is a registered charity in Scotland, No. SCO 12306 and a company limited by guarantee and registered in Scotland No. 100864

Annex G Consultation Questionnaire

The case for change

Question 1: Is the proposal to focus initially, after legislation is enacted, on improving outcomes for older people, and then to extend our focus to improving integration of all areas of adult health and social care, practical and helpful?

Yes No

Comments On balance we feel it would be better if , once legislation is enacted, it covers all areas of adult health and social care. Our reasons are:

- Concern that implementation of this legislation in respect of the younger age groups could be seriously delayed, deliberately or by default.
- It could be confusing to have two different systems running at the same time, especially where the groups overlap, e.g. for people with a disability who reach the age of 65.

If it is decided to implement the change only for older people in the first instance, as a pilot, it should be for a fixed period and there should be a specified timetable for rolling out the changes for all other adults. There should be a quick independent evaluation of how it is working, carried out, for example, by a University Department and not by a local authority or other interested party.

Outline of proposed reforms

Question 2: Is our proposed framework for integration comprehensive? Is there anything missing that you would want to see added to it, or anything you would suggest should be removed?

Yes No

Comments

National outcomes for adult health and social care

Question 3: This proposal will establish in law a requirement for statutory partners – Health Boards and Local Authorities – to deliver, and to be held jointly and equally accountable for, nationally agreed outcomes for adult health and social care. This is a significant departure from the current, separate performance management mechanisms that apply to Health Boards and Local Authorities. Does this approach provide a sufficiently strong mechanism to achieve the extent of change that is required?

Yes No

Comments We hope so, This is certainly different and makes a good deal of sense. We are acutely aware of past difficulties in getting Health services and Local Authority social care services to work productively together. Areas of contention have included finance, power and control, leadership and joint decision making. For effectiveness and cost reasons, however, this approach has to work. Strong, clear legislation and leadership are required.

Question 4: Do you agree that nationally agreed outcomes for adult health and social care should be included within all local Single Outcome Agreements?

Yes No

Comments At present SOA's sometimes differ from national policy and lead to inconsistencies between levels. Agreed outcomes should be for longer than a year to allow progression towards longer term goals. They should be written in plain English, which can be easily understood by all relevant parties.

Governance and joint accountability

Question 5: Will joint accountability to Ministers and Local Authority Leaders provide the right balance of local democratic accountability and accountability to central government, for health and social care services?

Yes No

Comments Yes, Hopefully! Hopefully this will also contribute to greater consistency across different areas of Scotland. It is, however dependent on people's willingness to work together. There could otherwise be real difficulties if Health Boards and Local Authorities have differing views, or if different parties are in power at local and national level.

Question 6: Should there be scope to establish a Health and Social Care Partnership that covers more than one Local Authority?

Yes No

Comments There could be advantages in this provided there is the full backing of all parties and a proven ability to co-operate and work together. One issue would be how to decide on respective contributions to the shared budget which would be seen to be equitable.

Question 7: Are the proposed Committee arrangements appropriate to ensure governance of the Health and Social Care Partnership?

Yes No

Comments We are not sure about this, but their operation needs to be audited

Question 8: Are the performance management arrangements described above sufficiently robust to provide public confidence that effective action will be taken if local services are failing to deliver appropriately?

Yes No

Comments

Question 9: Should Health Boards and Local Authorities be free to choose whether to include the budgets for other CHP functions – apart from adult health and social care – within the scope of the Health and Social Care Partnership?

Yes No

Comments Yes, but only after the process has bedded in for adult health and social care, and only if there are sound and transparent reasons for doing so. This should not be allowed to impact adversely on the main reason behind the legislation.

Integrated budgets and resourcing

Question 10: Do you think the models described above can successfully deliver our objective to use money to best effect for the patient or service user, whether they need “health” or “social care” support?

Yes No

Comments It is possible. The key lies in whether or not the full budget is transferred. There must be transparency and monitoring of the budgets by an independent agency, before the legislation is passed and for at least 3 years after the changes take effect.

Question 11: Do you have experience of the ease or difficulty of making flexible use of resources across the health and social care system that you would like to share?

Yes No

Comments No experience of ease of using flexible budgets, but some of problems!

The last major reorganization of Health and Social care budgets for people with mental health problems came with the closure of psychiatric hospitals and hospital wards. At that time statistics were not kept in a form which allowed a public check on whether or not the full hospital savings were released. We are very clear that they were not, but found it difficult to provide evidence of the extent of this problem.

One of us was on a multi-organisation working group planning a specific community service to replace the previous hospital based service. An external consultant had made recommendations as to the nature of the service needed and had identified the costs of the existing service. The money released was considerably less than this. The reasons given included, for example, that the running costs of the building could not be fully released as even an empty building has running costs; and that costs of staff time where staff were working some of their time in the unit and some in another part of the hospital could not be included at all as the hospital would still have to employ them. Yet when the building was sold, not only were the proceeds not released to other mental health services, which was expected, but the “running costs of an empty building” were not released. And when the wards in which the members of staff had spent the other part of their time were closed, the staff costs were again not released.

At another phase of the process the Health Board was releasing money only where it could be shown that new facilities enabled long stay patients to be discharged from hospital and/or prevent their readmission. Occupancy in these facilities was closely monitored for a period of years after the money was transferred. This provided a perverse incentive to social work departments to:

- Set up expensive facilities in order to get as much money as possible transferred to their budget.
- Earmark long stay patients in hospital wards for a new project to be developed, and not to refer them to vacancies in existing projects even where this would have allowed them to be discharged sooner.
- Ensure that the new projects were fully occupied before referring to the older, cheaper projects, especially when budgets were tight.

This distorted the market and led to financial and staffing problems for the

voluntary organizations which had set up projects on a shoestring budget at an earlier date.

This time it is essential that the transfer of budgets is transparent and complete. The budgets for different patient/client groups need to be identified, so that it is possible to track changes in funding of those services, such as mental health services, which have traditionally been “Cinderella Services”. Hopefully the fully shared budget will overcome some of the perverse incentives resulting from transferring money from one budget to another, but there is still the transfer to the shared budget to be watched.

Question 12: If Ministers provide direction on the minimum categories of spend that must be included in the integrated budget, will that provide sufficient impetus and sufficient local discretion to achieve the objectives we have set out?

Yes No

Comments This is one essential requirement towards ensuring that full budgets are transferred. There is also a need for full budgets before and after the transfer to be made public. It is essential that there is full transparency throughout the process.

Jointly Accountable Officer

Question 13: Do you think that the proposals described here for the financial authority of the Jointly Accountable Officer will be sufficient to enable the shift in investment that is required to achieve the shift in the balance of care?

Yes No

Comments It is essential for the Jointly Accountable Officer to have the financial authority described, and to be able to take decisions without referring back up the line. Whether or not it is sufficient will depend on the calibre of the JAO.

Question 14: Have we described an appropriate level of seniority for the Jointly Accountable Officer?

Yes No

Comments The jointly Accountable Officer definitely needs to have authority, and therefore needs to be a very senior appointment, recognized and respected by both Health and Local Authority . He/She will need to be financially experienced and competent, and willing and able to act autonomously. There could be advantages in recruiting someone from a business background to the role.

Professionally led locality planning and commissioning of services

Question 15: Should the Scottish Government direct how locality planning is taken forward or leave this to local determination?

Yes No

Comments There should be scope for local variation, but there is also a need for central government to set basic parameters and expectations, as described in paragraph 7.5. Above all the needs of the care recipients must be paramount rather than the politics of power between Health Boards and Local Authorities or between Local and National authorities.

Question 16: It is proposed that a duty should be placed upon Health and Social Care Partnerships to consult local professionals, including GPs, on how best to put in place local arrangements for planning service provision, and then implement, review and maintain such arrangements. Is this duty strong enough?

Yes No

Comments We are unclear as to whether or not the third sector is included among "local professionals", but it is important that they too are consulted.

It is also important that timescales are put in place for each stage of the process

Question 17: What practical steps/changes would help to enable clinicians and social care professionals to get involved with and drive planning at local level?

Comments We trust that the third sector is included amongst the “social care professionals”, but note with concern the reference in para. 7.10 to working “with our partners in the NHS, local government and the professional organisations to agree the “landscape changes”” needed for professionals to be able to participate effectively. Voluntary Organisations provide a significant proportion of the social care services, and must also be included.

There will be a need for training in the new approach, and this should be made available across the board, including to the voluntary sector.

It is not only GP’s who have issues in relation to workload and availability of time. This is also a major issue in the voluntary sector. We suggest that all those who are not already paid from the Health and Social Care budget should be funded for their contribution to locality planning.

Cross visiting between localities and areas could help to generate ideas and spread good practice.

Question 18: Should locality planning be organised around clusters of GP practices? If not, how do you think this could be better organised?

Yes No

Comments GP’s should be involved, but should not be the leading power. In our experience GP’s vary greatly in their awareness of the services provided by social work departments and the third sector. Our experience of GP fundholding was that it could take many years for a decision to be reached – we provided a partially funded “pilot” counselling service for 11 years before a final decision as to its future was made.

It is also our experience, from a period when the organisation of Aberdeen City Council services was divided into smaller localities, that these were too small, and services became fragmented as a result. Larger organisational entities are more accountable and more effective. It makes sense for specialist services to be more centralised. In Aberdeen, we would suggest that the local authority Area would be a suitable size for planning, though we appreciate that it may be more appropriate to split local authority areas both in large rural areas, such as the Highlands and Islands, and in the larger cities like Glasgow.

Question 19: How much responsibility and decision making should be devolved from Health and Social Care Partnerships to locality planning groups?

Comments Locality planning groups should have a responsibility to produce local plans within a given time frame, and to propose these to the Health and Social Care Partnerships. The HSCP's should retain the final decision making and accountability.

Question 20: Should localities be organised around a given size of local population – e.g., of between 15,000 – 25,000 people, or some other range? If so, what size would you suggest?

Yes No

Comments The appropriate size of localities in terms of population will vary enormously between sparsely populated rural areas and large cities. The localities should be organised around natural communities rather than population size.

Do you have any further comments regarding the consultation proposals?

Comments

It is vital that there is a proper external assessment of the impact of the changes, and that this should be carried out as soon as is practicable after the changes are implemented. If there are problems a lot of damage can be done to individuals in the system within a very short time. The review should have consistent parameters across areas.

A key factor in the success or otherwise of the changes lies in the amount of money which is transferred to the budget. We are unclear about who will determine this, but feel it is important for the minimum budgets concerned to be defined centrally.

It is important that there is transparency throughout. Realistic figures of spending before and after the changes should be publicly available. There will be likely to be a tendency to downplay current spending, as in the closure of psychiatric hospitals, so the method of defining the budgets for reporting should be determined centrally.

Do you have any comments regarding the partial EQIA? (*see Annex D*)

Comments

Do you have any comments regarding the partial BRIA? (*see Annex E*)

Comments