



**Centre for Mental Health, Mental Health Foundation, Mind,
Rethink Mental Illness and Royal College of Psychiatrists**

**Health and Social Care Bill House of Lords Second Reading Briefing
11 October 2011**

Introduction

Our five organisations have come together to produce a joint briefing on the Health and Social Care Bill. We welcome the principles in the Bill of patient and public involvement and integration in health and social care and are pleased that the Government has enhanced these principles since the Futures Forum report earlier this year. This briefing focuses on our remaining concerns about the Bill, as well as the opportunities it presents to improve the support offered to people of all ages with mental health problems.

The Bill must be informed by the needs of everyone using health and social care services, including those with mental health conditions. Too often health care reform is oriented around physical health services, leaving mental health services to be 'retro-fitted' to systems that do not reflect their needs.

Debate on this Bill must reflect the views of patients and their priorities, and must also acknowledge the economic reality. Trusts and local authorities are having to make difficult decisions about how to prioritise their budgets, and people with mental health problems are concerned about potential or very real service closures, the loss of relationships that have been built with professionals, and further problems in accessing services including increases to waiting times.

The Bill also includes important changes to the 1983 Mental Health Act, which governs the use of compulsory powers to treat people with mental health conditions. We support many of these changes but are calling for two specific amendments in relation to the Mental Health Act. Our organisations are all members of the Mental Health Alliance and are acting on behalf of that Alliance.

‘Parity of esteem’

The Government’s mental health strategy, *No Health Without Mental Health*, makes a welcome pledge to give services for mental health ‘parity of esteem’ to those addressing physical health needs. We believe that the Bill should stipulate that the Secretary of State, National Commissioning Board, clinical commissioning groups and all the other newly established bodies not only have this principle in mind throughout their work, but also have a duty to show how they acted upon it.

Achieving parity of esteem will require further work alongside the Bill on the way mental health services are commissioned. The development of a tariff for mental health services has been slow, and continues to lag even further behind for services for children and young people. This leaves mental health services especially vulnerable to cuts in spending. It is also, however, an opportunity to develop a system of payment based on the outcomes services achieve for people, not just levels of activity. It is therefore crucial that the tariff is developed alongside the creation of robust and measurable outcome indicators that reflect the needs and wishes of mental health service users.

Integration

Integration of services is especially important for people with mental health problems, many of whom need support from a range of agencies at one time as well as ongoing support over periods of time that responds to their fluctuating needs.

Integration within the health and social care system has been strengthened in the Bill since the Futures Forum report was published in June. However the Bill could go further in promoting integration in its broadest, and most cost-effective, form.

Clinical commissioning groups (CCGs) should be required not just to ‘have regard to’ **Joint Strategic Needs Assessments** (JSNAs) but to ‘demonstrate’ that their commissioning plans are seeking to address the physical health, mental health and social care needs of their local populations. The NHS Commissioning Board should have a duty to provide regular guidance to CCGs and local authorities on how to achieve this. Commissioning plans can only cater for the most vulnerable in society if the assessments they are based upon accurately reflect the prevalence of illness and needs of those people.

We strongly support the additional powers the Bill has conferred upon **Health and Wellbeing Boards** (HWBs) to influence CCGs’ plans. To be truly effective, however, we believe HWBs should have the power to pull commissioners from different sectors, including those in ‘health related services’, to work together and where necessary pool budgets to support people whose needs transcend organisational boundaries. We

would also encourage the addition of health-related services to HWB membership, including for example police, schools, housing and debt/money advice services.

Integration between **locally and nationally commissioned services** needs to be addressed in the reformed NHS. Health care within prisons and some secure services will be commissioned nationally. It is crucial that CCGs retain responsibility for people in prisons and secure services from their local areas while they are incarcerated, and that CCGs are incentivised to commission for the whole of a person's 'care pathway' and held to account for achieving outcomes throughout that process.

Services need to be commissioned in an integrated manner. One way of achieving this is for people using those services to be meaningfully consulted during the commissioning process. Currently, the Bill merely requires the NHS Commissioning Board and CCGs to "secure that individuals to whom the services are being or may be provided are involved whether by being consulted or provided with information or in other ways". Such duties are wholly inadequate and will allow the NHS Commissioning Board and CCGs – should they choose to – to engage in non-meaningful consultation with users of services.

Competition

While Government statements on the role of competition and the importance of collaborative work have been welcome, it remains unclear how this translates into the Bill. Clarity is required on how Monitor will operate, the role of EU competition law and how collaboration and integrated services can be promoted and assured.

Fragmentation and loss of specific services to providers who may not provide medical training can also seriously compromise the training of the next generation of doctors. We therefore believe that while clinically appropriate choice is important for patients, competition between providers can be disruptive in many areas of care, particularly when dealing with complex co-morbidities. Competition must be used with extreme care, and only where it can be shown to clearly benefit patient care and does not undermine the delivery of integrated care and training.

Public Health and inequalities

We welcome the Government's significant commitments to improving public health, reducing health inequalities and taking a preventative approach to healthcare, which recognize the impact of social factors on mental health. However, mental health hasn't been given due consideration in the Department's public health plans. We still need to see significant progress against use of alcohol amongst people with mental health problems, against physical health inequalities for people with mental health problems, and against early intervention for the most vulnerable families.

We need strong mental health outcome indicators in the Public Health Outcomes Framework as well as robust, evidence-based guidance for commissioners on how to achieve this for mental health.

The Bill places a duty on CCGs to obtain advice from public health experts but there is no explicit duty on CCGs to 'promote' public health. Such an omission could render the delivery of public health outcomes significantly less likely, with CCGs free to act without regard to the wider public health needs of the populations they serve.

We welcome the announcement that the Futures Forum will be exploring this issue in further detail and seek assurances from the Government on how it will ensure the NHS continues to make a contribution to public health and prevention.

Duties should also be placed on CCGs to ensure they demonstrate to the NHS Commissioning Board how their proposed, and executed, plans address the reduction in health inequalities.

Mental Health Act

We support most of the changes to the Mental Health Act proposed in the Bill, in clauses 35 – 42. We are concerned, however, that changes to the provisions for **statutory aftercare** for people who have been subject to compulsory care risk watering down the rights such people have to free care for as long as it is required. In particular, the Bill proposes to separate the current **joint** duty on the NHS and local authorities in England to provide aftercare, enabling each to separately decide to stop providing those services when it thinks they are no longer necessary. This risks leaving some people without necessary support and at increased risk of relapse and rehospitalisation. It also goes against the grain of the Government's desire for integration of services, as well as providing a false distinction between health and social care which patients themselves do not recognise. We believe that safeguards are needed to ensure that both the NHS and local authorities have to consult with each other before withdrawing from aftercare agreements.

We also believe that the Bill presents an important opportunity to address a weakness in the system for **supervised community treatment (SCT)**. SCT allows for a mental health patient living in the community to be compulsorily required to take their medication, regardless of whether or not they are able to make decisions about care and treatment for themselves. The numbers of people on SCT have exceeded all expectations since it was introduced in November 2008 and, without any consideration of capacity, it is possible that people will continue to be subject to compulsion for long periods when it may no longer be necessary. We believe the Bill should amend the Mental Health Act to add a test of impaired decision-making to the criteria for the use of SCT. This would ensure parity with patients with physical health problems who are able to make choices about their care and treatment, improve the responsiveness of services to the current needs of patients and make more efficient use of resources by focusing SCT on those who need it most only for as long as it is necessary in their case.

Collective patient involvement

In its current form, the Bill will maintain the status quo of NHS service design and planning which do not harness patient and carer expertise. Without meaningful involvement of patients collectively in fundamental decisions about the design of services, the potential of the principle of 'no decision about me without me' to positively influence the NHS will be limited.

We therefore wish to see the introduction of patient and carer expertise to the duties on commissioning bodies and Monitor to 'obtain advice' in discharging their functions. Currently, they must obtain advice only from expert 'professionals'. We see this form of 'collective' patient involvement as distinct from the role of local Healthwatch organisations, which have a much broader role in shaping strategic commissioning and providing feedback to commissioners.

Clinician involvement

We believe that work to improve patient care does not just take place in a clinician's own place of work. Developments in terms of service improvement, clinical standards, research, and education and training also come about because clinicians and others are able to contribute their time and expertise to work outside their own organisations for the benefit of the wider NHS.

However, because of the understandable pressures of service delivery, there is increasing difficulty in clinicians being afforded time by their employers to participate in activity outside their own organisation on behalf of the wider NHS. This applies to work developing clinical guidelines and setting standards, ensuring research ethics, providing education curricula and assessments, and providing expert clinical advice for a range of regional or national bodies including the Department of Health itself. Most national bodies report they finding it increasingly hard to secure clinician input to their work.

We would therefore wish to see the Bill contain a duty on employers to facilitate staff involvement in work on behalf of the wider NHS outside their own organisations.

About us

Centre for Mental Health, the Mental Health Foundation, Mind, Rethink Mental Illness and the Royal College of Psychiatrists are working together to inform debate about the Health and Social Care Bill from the perspective of mental health services and those who use them.

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