Royal College of Psychiatrists
Consultation Response

DATE: 6th October 2010

RESPONSE OF: THE ROYAL COLLEGE OF PSYCHIATRISTS

RESPONSE TO: Liberating the NHS – *Commissioning for Patients*

The Royal College of Psychiatrists is the leading medical authority on mental health in the United Kingdom and is the professional and educational organisation for doctors specialising in psychiatry.

We are pleased to respond to this consultation. This consultation was prepared by: Dr Neil Deuchar, Dr Nick Kosky, Chris Fitch and Richard Meier.

This consultation was approved by: Dr Laurence Mynors-Wallis (Registrar)

For further information please contact: Claire Churchill on 020 7235 2351 ext.6293 or e-mail cchurchill@rcpsych.ac.uk

Response to *Commissioning* for patients- a consultation on proposals

Responsibilities

Scope of GP commissioning:

Q3a: In what practical ways can the NHS Commissioning Board most effectively engage GP consortia in influencing the commissioning of national and regional specialised services and the commissioning of maternity services?

The Royal College of Psychiatrists believes that the NHS Commissioning Board should work with GP consortia to produce a description of:

(i) the nature and extent of population health needs and patient presentations that are currently being made to primary care in their consortia area;

(ii) the clinical strategies that are currently being employed to address these at a consortia level;

(iii) the clinical strategies and organisational arrangements that could be employed at a regional and national level.

When producing this description, two practical considerations with regard to mental health need to be made.

Firstly, many patients with serious mental illnesses have complex health and social care needs. Meeting these needs often requires intervention not only from specialist mental health services but also from local social care agencies, primary care services, voluntary sector organisations, and networks of peers,

friends and family. Consequently, a risk may exist for some patients that specialist mental health services (which are often of low volume and high cost) are commissioned at regional and national level, while other services (of higher volume and lower cost) are commissioned at the level of the GP consortia. This could mean:

(i) mental health patients with complex needs may 'fall between' GP consortia and the NHS Commissioning Board;

(ii) local GP consortia may not fully understand or consider the needs of such patients when commissioning services in their area (including joint commissioning with local authorities);

(iii) patients could receive uncoordinated or fragmented care, or inappropriate 'out of area treatments' (with sizeable financial and social inclusion implications);

The Royal College of Psychiatrists therefore recommends that attention needs to be given to whether *local* specialised services may need to be commissioned for some groups of patients with complex needs (e.g. patients with schizophrenia who need key rehabilitation/recovery services). Where properly implemented, such services could introduce cost-savings, as individuals with complex needs often engage with multiple services but with minimal co-ordination between them, leading to inefficiency and ineffectiveness.

Secondly, descriptions of the nature and extent of population health needs should take into account the likelihood that people with serious mental illnesses are often *not* on a GP practice register. For example, in some areas, we know that over half the people with serious mental illness in a GP registrant population do not appear on the GP register and consequently do not receive physical health care services. This inequality in access to services can contribute to the premature mortality of people with serious mental illnesses (ranging from 10–25 years depending on locality). Commissioning incentives

which narrow this gap are therefore required both to improve the information to commission services at a local, regional and national level, as well as bringing people with the most complex needs into primary care. Practical ways in which this could be achieved include the NHS Commissioning Board and GP consortia working to create clinical networks of primary and social care professionals. These networks could link with public health bodies and users and carers, who can draw on existing knowledge (such as that in a Joint Strategic Needs Assessment) to scope and describe the local health and social care requirement.

The Commissioning Board must also ensure that universities and NHS training structures will interface with the proposed new system so that teaching and training of undergraduate and post-graduate professionals can be fully supported with minimal disruption during any transitional periods. Thought will also need to be given to how professionals in training can move between jurisdictions in the UK and how revenue flows from consortia to universities and teaching hospitals (in respect of Service Improvement for Training and funding for original research, for instance). Many academic posts are currently supported by NHS Trusts and if they are uncertain of their revenues they will be loathe to continue their investment in these posts, meaning checks and balances may need to be introduced into the system to prevent destabilisation of innovation.

Q3b: How can the NHS Commissioning Board and GP consortia best work together to ensure effective commissioning of low volume services?

Low volume services should be commissioned based on care pathways which set out a framework of:

(i) assessment standards;

(ii) evidence-based interventions;

(iii) outcomes to be assessed;

(iv) the timeliness of assessment and intervention.

Guidance needs to be provided as to the skills and competencies required of the professionals who undertake the assessment and interventions.

The Royal College of Psychiatrists and the Royal College of General Practitioners welcome the opportunity to lead the development of such pathways and make them available as templates upon which commissioners could plan local services.

Q3c: Are there any services currently commissioned as regional specialised services that could potentially be commissioned in the future by GP consortia?

Some mental health services could be commissioned at a more local level. This will need to be decided by GP consortia and the NHS Commissioning Board based on:

(i) the prevalence of the condition in the local population (which could span several GP consortia);

(ii) the extent to which meeting complex patient needs requires a physical service base (e.g. therapeutic communities, mother and baby units, eating disorder units or residential adolescent units).

(iii) whether the strategic overview and development of such service types across England could be maintained in a localised organisational arrangement.

This could include the commissioning of services for people with learning disabilities, particularly if complications such as epilepsy, challenging behaviour or long term physical conditions exist. Offender health and special hospital services should continue to be commissioned at the regional and national level.

Q3d: How can other primary care contractors most effectively be involved in commissioning services to which they refer patients, e.g. the role of primary care dentists in commissioning hospital and specialist dental services and the role of primary ophthalmic providers in commissioning hospital eye services?

No comment.

Relationship between consortia and individual GP practices:

Q3e: How can GP consortia most effectively take responsibility for improving the quality of the primary care provided by their constituent practices?

There are at least three ways in which GP consortia can drive up the overall quality of mental and physical primary health care:

(i) ensuring GPs have the skills and confidence to deal with patients with common and serious mental illnesses in primary care settings;

(ii) the implementation of care pathways as described under Q3b;

(iii) addressing the specific issues of patients with serious mental illnesses, long-term conditions, and medically unexplained symptoms.

GP skills

People presenting with mental health conditions constitute 25% of the daily workload of every GP. We believe that (a) at least one member from every GP practice team should have had mental health training; (b) each consortium should have a Mental Health Lead which could oversee this and other training needs (see Q5a); (c) GP mental health specialist leadership could be strengthened through existing structures (such as the National Leadership Council); (d) post-graduate qualification in mental health should be made available to GPs.

Care pathways

Primary mental healthcare is largely related to persons suffering mild, moderate or (in some cases) severe depression, anxiety and other conditions historically referred to as common mental health problems. GP consortia should ensure that (i) care is being provided in line with commissioned pathways including NICE guidance for the relevant conditions into clinical practice (including NICE guidance on physical health problems where a mental health condition is associated with this); (ii) outcomes are evaluated using indices and instruments that have been established (for instance as part of the Improving Access to Psychological Therapies programme); (iii) incentives and levers to existing measures of quality improvement such as the Quality Outcomes Framework are used to shape pathway implementation, and by Commissioning for Quality and Innovation (CQIN) is used to drive upstream interventions, primary prevention and public wellbeing.

Consortia must ensure that there are sufficient mental health clinicians including psychiatrists, therapists and support workers to deliver the pathway. The consortia should use aggregated data on, for example, employment, to demonstrate the public health and economic impact of their constituent practices' activity.

Outcome measurement

All practices should use a care pathway determined outcome measurements. The RCPsych should also be consulted to ascertain whether it could play a role in terms of data collection and analysis. For example, an outcomes quality network for mental health could enable consortia to compare their performance with one another in the context of robust and fair outcomes data. The Royal College of Psychiatrists already undertakes benchmarking with mental health services across the country. Data could be used to populate data-packs for individual GP and psychiatrist appraisals. This would align the goals of the local and wider NHS to the aims and objectives of individual practitioners, and also further integrate outcomes data into quality systems in both GP practices and MHFTs.

Referral mechanisms

Particular consideration also needs to be given to the commissioning of psychological therapies. Where complex presentations are made to primary care, referral to a primary care contractor providing access to primary care psychological therapies (often referred to as IAPT) may not be appropriate, with direct referral to other levels of the stepped care model (in which IAPT is integrated rather than an end point) often being in the patient's best interests (e.g. referral to a CMHT whose patients will have access to a psychiatrist or a more multi-disciplinary team).

Patients with serious mental illness (SMI)

As noted in Q3a, work is required to ensure GP practice registers of people with serious mental illness adequately reflect the prevalence of these conditions in the local area. This will avoid inadvertent exclusion of such patients from care. It will also assist with meeting wider care quality and efficiency improvements including those for elderly patients with dementia.

Long-term conditions (LTCs)

The relationship between mental health and LTCs such as diabetes, coronary heart disease (CHD), COPD, bowel cancer and others should be more clearly articulated in: (i) the QOF and other high risk register arrangements; (ii) treatment procedures that standardise assessment, harmonise medicine management, and therefore enhance effectiveness and safety; so that (iii) care planning for such patients routinely involves mental health assessment and management in the primary care setting. The rationale for this includes evidence that people with, for example, diabetes are more likely to present with, again for example, diabetic crises if they suffer co-morbid depression. Managing the depression would therefore save time and money incurred in managing the diabetes.

Medically unexplained symptoms (MUS)

Explicit clinical strategies are required to prevent inappropriate usage by such patients of medical and surgical outpatient and inpatient services. Such strategies should be a major part of every local QIPP programme and will require investment in ensuring access to psychiatrist and psychologists. Evidence exists that up to 50% of outpatients and 20% of inpatients have MUS resulting in significant personal and social costs.

Q3f: What arrangements will support the most effective relationship between the NHS Commissioning Board and GP consortia in relation to monitoring and managing primary care performance?

If adequately developed and deployed, the use of the Mental Health Clustering Tool (MHCT) can provide a core tool for monitoring and assuring primary (and secondary) care performance. This becomes stronger and more meaningful if aligned to a suite of outcome indicators for different broad areas of mental healthcare (see answer to question 33 in the College's response to 'Transparency in Outcomes' framework).

Using PbrMHCs commissioners can identify what should happen for whom. Procuring mental healthcare consequently becomes: (i) much more business-like (and therefore attractive to stewards of public funds); and (ii) a basic minimum standard exists of what a patient can expect from being placed on a certain pathway is achieved (which aids patient empowerment through the passage of reproducible information).

Primary care performance may also need aligned incentives, for instance shared audits with secondary care.

Q3g: What safeguards are likely to be most effective in ensuring transparency and fairness in commissioning services from primary care and in promoting patient choice?

The use of regularly published and agreed pathways and outcome data would help drive up clinical quality, consistency, and equity. If sufficiently detailed information were available, this could be used to enable patient choice. It would be advantageous to develop clinical dashboards for clinicians, practices, and mental health teams.

<u>The role of the NHS commissioning board</u>

Q3h: How can the NHS Commissioning Board develop effective relationships with GP consortia, so that the national framework of quality standards, model contracts, tariffs, and commissioning networks best supports local commissioning?

Accountable Officers in each of the GP consortium should be encouraged to identify a Mental Health Lead for that GP consortium (or share one a lead with another consortium). This Mental Health Lead will need to work with consortium or regional commissioning support to ensure the principles of best practice mental health commissioning are embedded into behaviours and

processes in consortia. Mental Health Leads should be encouraged to form a network, whether regionally or nationally, to share and develop best practice, and organisations such as the RCPsych and RCGP can assist with their coordination. GP consortia must ensure that they have access to a specialist advice and ensure that primary and secondary care develop a pathway rather than an artificial commissioner/provider split.

Q3i: Are there other activities that could be undertaken by the NHS Commissioning Board to support efficient and effective local commissioning?

The College believes that a mental health commissioning framework should be developed by the NHS Commissioning Board and other partners led by clinicians through involvement of the Royal Colleges:

(i) This framework should be based on a set of agreed principles of mental health commissioning including, for example:

(a) patient at the centre;

(b) evidence-based interventions;

(c) use of pathways of care;

(d) reducing the gap between prevalence and identification;

(e) reducing mortality and morbidity;

(f) early recognition and access;

(g) alignment with public health and social care;

(h) critical mass of activity necessary for programme budgeting, marginal analysis and demonstration of value for money and return on investment;

(i) assembly of a critical mass of senior level specialist expertise at GP commissioners' disposal;

(j) linking QIPP, CQUIN, quality accounts, QOF;

(k) consistent alignment of service provision and evaluation with NICE Quality Standards and outcomes frameworks;

(ii) care pathways should be provided as templates for local adaptation (Q3b above);

(iii) agreed monitoring arrangements for the implementation of the pathways.

Since PbRMHCs currently relate largely to "working-age adults" and the elderly, the NHS Commissioning Board would need to encourage work to develop the methodology for other ages.

The NHS Consortium Board must also describe the links that need to be developed within different parts of healthcare and across different agencies to enable GP commissioners to work alongside local authorities. An example of this might be of how operations within and across Tiers 5 and 6 Personality Disorder services, offender health systems and medium security could become integrated so that cohorts of patients with complex clinical and forensic needs might be repatriated into local and/or regional systems. Another might be the coordination of commissioning and usage of services requiring supra-regional or national arrangements (such as high security and residential therapeutic communities for personality disorder)

Organisational form

Establishment of GP consortia:

Q4a: What features should be considered essential for the governance of GP consortia?

(i) financial transparency;

(ii) internal audit function and lay scrutiny;

(iii) published commissioning specifications;

(iv) explicit links between population needs and commissioned services;

(v) benchmarking across country on: cost; services provided; outcomes achieved.

Forming consortia

Q4b: How far should GP consortia have flexibility to include some practices that are not part of a geographically discrete area?

We do not believe there should necessarily be a barrier to a GP practice geographically distant from the consortium joining it. However, we do feel that special arrangements might have to be in place to ensure it receives the same standard of mental health service contracted by the rest of the consortium. This is particularly relevant to emergency mental health inputs such as Crisis Resolution and Home Treatment Teams (CRHTTs).

Mental health can rely heavily on coordinated community care, GP consortia could helpfully align with Local Authority configurations.

Q4c: Should there be a minimum and/or maximum population size for GP consortia?

Yes, in order to achieve economies of scale. Most services being commissioned do not require each local area to reinvent pathways of care. The maximum size will depend on the need to work with local authorities and major providers but could be done on a federal model within a larger consortium.

Freedoms

Freedoms, controls and accountabilities:

Q5a: How can GP consortia best be supported in developing their own capacity and capability in commissioning?

There are multiple ways:

(i) developing a mental health commissioning framework (see Q3i);

(ii) improving GP mental health education (see Q3e);

(iii) ensuring robust governance (see Q4a);

(iv) Care pathways populated by evidence-based interventions could drive radical improvements across areas covered by several GP consortia. Examples of this include transcending age boundaries for young people with early psychosis; standardising psychiatric liaison functions for Acute Foundation Trusts (including mental health input for LTCs and MUS); delivering the National Strategy and Quality Standards for dementia; driving best practice across the MH acute care pathway (and reducing admissions and shortening length of stay); and standardising clinical decision making to best practice in complex and intractable cases, thus reducing the potential for out-of-area placements;

(v) Mental health specialist psychiatric expertise at the level of each GP consortium and within the NHS Commissioning Board is viewed as key. This would ensure that services are provided seamlessly across the mental health spectrum;

(vi) GP leadership - GPs interested in leading mental health commissioning will need to work to acquire the necessary knowledge. This will be achieved through formal and informal learning of good commissioning practice for mental health, learning disability, substance misuse and dementia. This should incorporate not just clinical aspects, but also the mechanics of commissioning at various levels of the overall system (including programme budgeting; marginal analysis; return on investment; value for money; procurement; standard contracts; call-off contracts; levers/enablers such as CQIN, revalidation and cost-effectiveness analysis; and individual personal budgets).

(vii) A "Commissioning Pack" for mental health needs to be produced for GP commissioning consortia: (a) outlining and explaining all types of services; (b) clarifying for GP commissioners pathways of care; (c) contributing to methodology for clinical quality review by commissioners of providers; (d) capturing the effectiveness of alternative solutions and interventions chosen by patients exercising individual budgets; (e) helping establish demonstrable improvements in health and wellbeing of mentally unwell and other populations through the use of outcome measures (Q5e); (f) undertaking clinical and economic analysis on behalf of GP consortia of the operational reconfiguration of inpatient populations and hospital structures required to achieve the objectives of QIPP; (g) designing primary prevention strategies for specific conditions (e.g. postnatal depression); and (h) designing, in consultation with public health colleagues, community interventions for health and wellbeing; evaluating the impact on communities of primary preventative and wellbeing initiatives.

Q5b: What support will GP consortia need to access and evaluate external providers of commissioning support?

GP Consortia will need guidance to ensure their quality assurance parameters and mechanisms are consistent with those of colleagues (as set out by CQC and Monitor). It is likely that systems to enable this in mental health are not as developed as in other areas of clinical commissioning activity. Consequently, the expertise of organisations such as RCPsych and the NMHDU will be essential, as will a commissioning pack (see Q5a) in which to make, sustain and extend these connections.

Managing financial risk:

Q5c: Are these the right criteria for an effective system of financial risk management? What support will GP consortia need to help them manage risk?

No, because financial risk in mental health commissioning often comes from: (i) lack of clarity about currency; (ii) lack of clarity about the functions and added value of different types of clinician or mental health professional; (iii) 'returns on investment' often being equally manifested in *non*-mental health parameters (such as housing and employment outcomes); and (iv) only relatively recent initiation of economic impact analysis of service types (for instance early intervention) and models of approach (for instance primary prevention of postnatal depression or resilience building for children and families at home and at school).

A mechanism for PbR predicated on mental health clusters is still subject to piloting. GP consortia will therefore need a great deal of support from healthcare commissioning services and other sources of intelligence and strategy (such as NMHDU, RCPsych, and RCGP)to ensure investment and procurement risks are minimised, at least in the early stages of the process.

Transparency and fairness in investment decisions:

Q5d: What safeguards are likely to be most effective in demonstrating transparency and fairness in investment decisions and in promoting choice and competition?

We believe that safeguards are about ensuring 'right care' is not denied to patients and that the wishes and choices of patients are not over-ridden by (i) inappropriate mechanisation of care; (ii) a lack of patient or carer voice; or (iii) inadequate financial planning and procurement.

The respective Royal Colleges are ideally placed to furnish commissioners with specific advice about the components of right care, and also the characteristics of providers most appropriately placed and staffed to provide it. The RCPsych accredits many aspects of care (including, for example, ECT services, inpatient care, and therapeutic communities).

Finally, quality premiums do have face validity but need to be based on outcomes that are fair for both patients and commissioners, and also relevant to the local characteristics of the population for which mental health services are being commissioned. Although year-on-year improvement within an organisation is usually posited to be more significant than comparisons between them, comparisons are inevitable and should therefore be conducted on a 'like for like' basis.

Accountability to patients and the public:

Q5e: What are the key elements that you would expect to see reflected in a commissioning outcomes framework?

Some outcomes are fairly simple and direct. However, others are often far more complex. For example, in inner city areas with ethnically diverse populations it is appropriate for GP consortia to take account of service change characteristics based on Single Equality Strategies when commissioning mental health services.

The RCPsych has recently suggested an outcomes suite (see Q33 of our response to the *Transparency in Outcomes* Consultation). The use of outcomes is essential in service accountability.

Q5f: Should some part of GP practice income be linked to the outcomes that the practice achieves as part of its wider commissioning consortium?

There needs to be incentives to encourage successful commissioning. How such incentives might work and who receives them needs fuller consultation.

Q5g: What arrangements will best ensure that GP consortia operate in ways that are consistent with promoting equality and reducing avoidable inequalities in health?

All GP consortia should be able to describe the demographic characteristics and sociological derivation of their populations. This will enable them to make adjustments within frameworks of best commissioning practice for mental health to meet the specific needs of the population.

For example, an inner city group of practices may wish to work in conjunction with homeless services and employ outreach staff such that the physical and mental healthcare needs of hard-to-reach sub-populations are better addressed. Financial incentives may well exist to attract a critical mass of such practices to operate in this way.

Case-studies are emerging of good practice in relation to the development of other sorts of partnerships, aimed at de-stigmatising and encouraging pathways into care for young persons, and consortia can learn about and adopt similar modus operandi in the pursuit of prevention and earlier intervention for youngsters with, or at risk from, mental illness.

Health and Wellbeing Boards, HealthWatch and Patient Participation Groups can all work with consortia and individual practices to improve the awareness of socioeconomic deprivation as antecedents to psychological ill health and enable action to address this through public mental health initiatives. Evidence of collaboration of this nature could itself represent a proxy for quality in commissioning.

Patients and the public

Partnership:

Q6a: How can GP consortia and the NHS Commissioning Board best involve patients in making commissioning decisions that are built on patient insight?

Commissioning must actively and meaningfully consult and involve representatives from the population it wishes to serve. For urban settings, this must include hard-to-reach groups such as asylum seekers, the homeless, the chronically severely unwell and offenders. Having heard from these groups, commissioning should encourage processes and systems that enable balances

of legitimately differing perspectives to be resolved between users, carers and providers in everyday clinical practice. The litmus tests of success in this endeavour is not so much engagement with services (although this is important at the outset). Instead it is the acquisition of recovery and citizenship on the part of patients who become emancipated from being defined solely as 'service users'. Commissioning must therefore also ensure that (i) employment, education and/or voluntary activities exist for all; and (ii) that patient expertise and peer mentorship is used where appropriate to provide interventions.

The significance of this approach is that it is drives prevention and partnerships. Involving Health Watch and Patient Participation Groups (Q6c) becomes an essential condition to the commissioning process, links with LAs, and forms the bedrock of an approach which is as concerned with the antecedents of mental ill health as treatment itself.

Mental health is well-placed to champion multi-professionalism in mental health commissioning. This is because practitioners tend to operate in a culture of multidisciplinary teams in which consultants often have leadership roles.

Q6b: How can GP consortia best work alongside community partners (including seldom heard groups) to ensure that commissioning decisions are equitable, and reflect public voice and local priorities?

This has been addressed in Q6a.

Q6c: How can we build on and strengthen existing systems of engagement such as Local Health-Watch and GP practices' Patient Participation Groups?

Both must ensure input for individuals with mental health experience, including both those with ongoing illnesses and those who have recovered.

Q6d: What action needs to be taken to ensure that no-one is disadvantaged by the proposals, and how do you think they can promote equality of opportunity and outcome for all patients and, where appropriate, staff?

Variability in experience, knowledge, skill and focus is likely to exist both within GP practices *and* across GP consortia. Since the mechanics of commissioning for mental health are in their infancy, there therefore exists potential for GP commissioners to adopt a path of least resistance – procuring by block contract, for example. This would represent a missed opportunity.

We believe the risk of this is can be mitigated by a commissioning framework. This should be set and quality assured by the NHS Board with regional or other local coordination.

Q6e: How can GP practices begin to make stronger links with local authorities and identify how best to prepare to work together on the issues identified above?

This can be achieved through (i) solutions based on the needs of 'citizens' as well as 'patients'; (ii) programmatic approaches to commissioning with unified GP and Local Authority leadership; (iii) single commissioning strategies for Brighter Futures; (iv) full engagement with personalisation and self-directed support; (v) Total Place-based models of public sector commissioning; (vi) evaluation against outcomes and decommissioning where there is no evidence

of impact; (vii) shared financial and operational risk; (viii) working with social enterprises to build resilience across populations; and (ix) single, lean governance mechanisms.

Q6f: Where can we learn from current best practice in relation to joint working and partnership, for instance in relation to Care Trusts, Children's Trusts and pooled budgets? What aspects of current practice will need to be preserved in the transition to the new arrangements?

There is considerable research on joint working and partnership, and it would be very helpful for the Department of Health to summarise this to inform better integrated working. Joint Strategic Needs Assessment (JSNA) is poorly supported by public health professionals and agencies in some areas. This is because proficiency is lacking in the need to prioritise mental health and specialist learning disability commissioning.

Some mental health-specific JSNAs have been developed by a joint PCT/LA Health and Wellbeing Teams, and these are examples of good practice.
In other areas, local Mental Health and Learning Disability Partnership Boards (established between PCTs and MHTs with multiagency representation) have been part of informing and scrutinising the findings of specific population health needs assessments and these partnerships and working models should similarly be preserved.

Other health and care professionals:

Q6g: How can multi-professional involvement in commissioning most effectively be promoted and sustained?

This can be promoted and sustained through joint-working by the relevant Colleges, national or regional bodies and allied social care professions. Practice

staff other than doctors will bring vital insight and expertise to the table – not only in terms of mental health issues but also, importantly, with regard to proper arrangements for the physical healthcare of mentally unwell patients. Foundation Trusts should also consider placing staff within consortia. Although this may present certain conflicts of interest, anecdotal evidence suggests that integrated approaches to commissioning work rather better than combative ones, so agreements at source between commissioners and providers would be an important pursuit.

A joint team of mental health specialists and commissioning consortia should evaluate and inform the strategic development of integrated care pathways for psychological therapies. This should be underpinned by patient and carer participation and development.

It will also be important for the Boards of GP consortia to consult or, if necessary, include other professionals groups, such as Directors of Nursing and Chief Pharmacists as well as representatives from the Local Authorities, to ensure multi-professional and multi-agency leadership of decision-making.

October 2010

NB: *The responses in this submission are numbered Q3a – Q6b. These numberings directly relate to the different chapters of the Commissioning for Patients document, then to each of the specific questions raised within them. For example, Q3a provides our answer to the first question raised in Chapter 3 on Commissioning for Patients is on Responsibilities. Similarly, Q6b provides our answer to the last question of Chapter 6 on Partnership.*