

Royal College of Psychiatrists

Consultation Response



DATE: 6th October 2010

RESPONSE OF: THE ROYAL COLLEGE OF PSYCHIATRISTS

RESPONSE TO: Health Select Committee – Call for evidence on Commissioning

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.

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Response to call for evidence on Commissioning

Summary

- The Royal College of Psychiatrists welcomes increased involvement of clinicians in commissioning but believes that there should be co-commissioning between specialists and GPs and not GPs alone. Psychiatrists have considerable expertise in mental health service delivery and need to be key players in developing innovative and cost effective services.
- Mental health 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.

- Commissioners have to ensure that they retain a focus on:
 - hard to reach groups;
 - patients with complex mental health problems who would not be subject to national commissioning but require often expensive care and may be overlooked in favour of high volume, low cost case.
- Commissioning needs to ensure that research and teaching are protected.
- The College welcomes the focus on outcomes. Commissioners must ensure that outcomes are for the whole population on GP lists and not just those identified on chronic disease registers.

Specialist Services

What arrangements are proposed for commissioning of specialist services?

1. The Royal College of Psychiatrists believes that the NHS Commissioning Board will need to 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.
2. All services should be commissioned based on care pathways which set out a framework of: (a) assessment standards; (b) evidence-based interventions; (c) outcomes to be assessed; (d) 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.
3. Two considerations need to be made with regard to mental health. 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);
4. We therefore recommend that attention needs to be given to whether *local* specialised services 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. Offender health and special hospital services should continue to be commissioned at the regional and national level.
 5. Importantly, any decision to commission specialised services at a *local level* will need to be decided by GP consortia and the NHS commissioning Board based on (a) prevalence of the condition in the local population (which could span several GP consortia); (b) 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); and (c) whether the strategic overview and development of such service types across England could be maintained in a localised organisational arrangement.
 6. Furthermore (as described in more detail in 11 and 12), the commissioning of low volume specialised services should be based on care pathways which set out a framework of: (a) assessment standards; (b) evidence-based interventions; (c) outcomes to be assessed; and (d) 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.
 7. 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.

2. Clinical engagement in commissioning

How will commissioners access the information and clinical expertise required to make high quality decisions about the shape of clinical services?

8. There are at least four ways:
 - (i) through promoting and sustaining multi-professional involvement;
 - (ii) ensuring that commissioners have the skills and confidence to make decisions about services providing mental health care;
 - (iii) providing information to allow commissioners to implement care pathways;
 - (iv) developing an overall suite of outcome measures;
9. Firstly, multi-professional involvement in commissioning can be most effectively 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 professional 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.

10. Secondly, there is an opportunity to improve GP skills in mental health. 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; (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.
11. Thirdly, information on care pathways needs to be provided to all commissioners. 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 (a) 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); (b) outcomes are evaluated using indices and instruments that have been established (for instance as part of the Improving Access to Psychological Therapies programme); (c) incentives and levers to existing measures of quality improvement such as the Quality Outcomes Framework (QOF) are used to shape pathway implementation, and Commissioning for Quality and Innovation (COIN) 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.
12. To provide the information needed to meet this goal, a "Commissioning Pack" for mental health needs to be produced for GP commissioning

consortia. This should: (a) outline and explain all types of services; (b) clarify for GP commissioners the pathways of care; (c) contribute to methodology for clinical quality review by commissioners of providers; (d) capture the effectiveness of alternative solutions and interventions chosen by patients exercising individual budgets; (e) help establish demonstrable improvements in health and wellbeing of mentally unwell and other populations through the use of outcome measures; (f) help undertake 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 Quality Innovation Productivity and Prevention (QIPP); (g) help design primary prevention strategies for specific conditions (e.g. postnatal depression); (h) assist the design, in consultation with public health colleagues, of community interventions for health and wellbeing, and (i) assist with evaluation of the impact on communities of primary preventative and wellbeing initiatives.

13. Fourthly, all practices should use care pathway determined outcome measurements. The RCPsych should 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 Mental Health Foundation Trusts.

How will commissioners address issues of clinical practice variation?

14. Firstly, 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, the potential exists 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.
15. Secondly, GP Consortia will need guidance to ensure their quality assurance parameters and mechanisms are consistent with those of colleagues (as set out by Care Quality Commission 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 NMH DU will be essential, as will a commissioning pack in which to make, sustain and extend these connections.

16. Thirdly, in addition, 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.
17. Fourthly, 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. 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. Using Payment by Results Mental Health Clusters 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.

How will GPs engage with their colleagues within a consortium and how will consortia engage with the wider clinical community?

18. See above.

3. Accountability for commissioning decisions

How will patients make their voice heard or their choice effective?

19. 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.
20. 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.
21. The significance of this approach is that it drives prevention and partnerships. Involving Health Watch and Patient Participation Groups becomes an essential condition to the commissioning process, links with Local Authorities, and forms the bedrock of an approach which is as concerned with the antecedents of mental ill health as treatment itself.
22. 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.
23. Both Health Watch and Patient Participation Groups must ensure input for individuals with mental health experience, including both those with ongoing illnesses and those who have recovered.

What will be the role of the NHS Commissioning Board?

24. See above.

How will commissioning interface with the Public Health Service?

25. The setting up of health and well-being boards – underpinned by statutory powers – is an effective structure to achieve joint working across health, social care and public health. These boards should include Directors of Public Health as this would provide a mechanism whereby commissioning will interface with the public health service at the local level. Members of GP consortia will require sufficient training in mental health to ensure they are able to influence debates and discussions about appropriate public health interventions. This will help ensure that public mental health is adequately addressed in the joined up commissioning plans devised by health and well-being boards.

How will commissioning interface with Health Watch?

26. GP consortia will be held to account by local HealthWatch groups. HealthWatch should take-over the complaints advocacy services currently run by the NHS, resulting in GP consortia/commissioners being held to some account for the quality of the services they provide, while supporting service users and carers in their healthcare choices.

4. Integration of health and social care

How will any new structures promote the integration of health and social care?

27. Firstly, there is also 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.

28. Secondly, GP practices can make stronger links with local authorities by: (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.

29. Thirdly, Joint Strategic Needs Assessment 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 Primary Care Trust/Local Authority 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 Mental Health Trusts 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.

What arrangements are proposed for shared health and social care budgets?

30. No comment.

What will be the role of local authorities in public health and commissioning decisions?

31. Local authorities will play a major role in this through the role set out for them in the proposed health and well-being boards. As regards public health, money ring-fenced for local public health budgets (under the Directors of Public Health) should be further ring-fenced for public mental health strategies and interventions. In terms of commissioning, only if members of GP consortia are given both sufficient training in mental health and the requisite training in the needs assessment functions currently carried out by PCTs, will those commissioning mental health care be able to adequately contribute to the joined up commissioning plans across the NHS, social care and public health which the newly-created health and well-being boards will be responsible for.

5. Other issues

32. 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.

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