

Royal College of Psychiatrists

Consultation Response



DATE: 14th Jan 2011

RESPONSE OF: THE ROYAL COLLEGE OF PSYCHIATRISTS

RESPONSE TO: *Liberating the NHS: Greater choice and control*

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. The lead author for this consultation was Dr Laurence Mynors-Wallis and it was prepared by Richard Meier from the College Policy Unit.

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Final response to Liberating the NHS: *Greater choice and control*

Q1. How should people have greater choice and control over their care?

How can we make this as personalised as possible?

It is important that in discussions about choice it be recognised that many patients both with physical and mental health problems may be limited in their choice of providers by a range of practical considerations.

Most patients want to be treated by a high quality service with swift access times, close to home. If these conditions are met, many patients will choose a local provider. The first priority for the NHS must be to use the monitoring of outcomes to drive up standards of all NHS organisations. If this does not occur, socially disadvantaged patients will in effect be discriminated against (since they are more likely to attend local services) whereas those less socially disadvantaged – and who tend to be more likely to avail themselves of information and to make choices accordingly – will opt to travel further away.

In terms of how people should have greater choice and control over their care, healthcare professionals should make a point of asking/reminding patients about the choices available to them at each decision point along the care pathway. This should be embedded into clinical practice.

Q2. Which healthcare services should be our priorities for introducing choice of any willing provider?

The first priority for implementing “any willing provider” should be for those services in which there are currently significant discrepancies in quality and outcomes. This will help ensure that those providers providing care that is of less good quality will either have to increase their standards or as a result of choice will be providing less care.

In considering the implementation of “any willing provider” it will be important not to destabilise existing health structures. There is a danger of cherry-picking services that are seen as profitable, leaving services - e.g. those providing for long term conditions -receiving poorer funding and not attracting innovative managers.

All providers should be encouraged, where possible, to provide accessible services, close to the patient’s home. This does not need a new range of what may be disparate and fragmented services. It will need to be recognised that with dispersal of services that there may be losses of economies of scale which will increase the cost of some services.

As mental health services are currently configured, there is sometimes little scope for choice as one service may have a single consultant in the community and a separate consultant for inpatient services.

With an increasing number of services looking to set up triage services as well as roving assessment teams there will be further restrictions of any choice being available; this will also be the situation for in-patient services. For inpatient services there is the added problem of bed availability and within a Trust there is often no choice.

Q3. How can we offer greater choice of provider in unplanned care?

To have meaningful choice of emergency provision in mental health would mean duplication of service and be very expensive to deliver. However, such a set-up could be tried in urban centres as a pilot in order to see whether it is feasible and/or desirable.

Q4. What would help more people to have more choice over where they are referred?

The availability of information is crucial. It will be expected that providers will have well designed websites which have approved accredited outcomes documented on them. Those providers regularly used by GP consortia would have accessible information to enable patients to make an informed choice.

Q5. Which choices would you like to see in maternity services and which are the most important?

Given the importance of postnatal support to women's emotional well-being and also to infant mental health, we support the extension of choice in regards to postnatal care, but would stress that there is little point in providing choice if, for example, health visiting and community midwifery services are so short-staffed that people cannot exercise the choice that has been extended to them.

We would also welcome increasing the range of peer support available to new mothers; however, such provision would need to be additional to what is being providing currently rather than a replacement for it.

Q6. Are these the right choices for users of mental health services, and if not why not?

Patients with mental health problems should have the same opportunities for choice as others. There needs to be recognition that those services provided in the patient's home may provide less opportunity for choice than those services to which patients may choose to travel. Mental health services are at present often restricted within geographically based community mental health teams.

There should be a choice within a service about which clinicians patients see e.g. a choice of psychiatrist, community psychiatric nurse and psychologist.

Patients requiring specific psychological interventions may within individualised care plans be able to choose a range of interventions for their mental health problems e.g. patients should be offered a choice of physical healthcare treatments, psychological interventions and social interventions. At present, choices are often limited by the availability of such services. The new commissioning arrangements must work to ensure that the full range of NICE approved services are being delivered by local providers.

Patients detained under the Mental Health Act should have a choice as to which hospital they wish to be admitted, recognising that if they choose to be detained in hospital far away from where they are living this may make transfer back into the community more problematic. However, these patients often spend a significant amount of time in hospital and therefore it is important that they have a choice of ward. For this to be made a reality there would have to be greater supply of beds to ensure a reasonable chance of access to a hospital. If it is deemed that a patient does not have the capacity to make informed choices, high quality advocacy will need to be made available.

Patients should have a choice about whether their continuing follow-up be through their GP, primary care team or whether they wish to remain in contact with the specialist service.

Patients who have been seen by mental health services should be able to have swift and easy access back to those services without having hurdles placed in their way.

Q7. When people are referred for healthcare, there are a number of stages when they might be offered a choice of where they want to go to have their diagnostic tests, measurements or samples taken. At the following stages, and provided it is clinically appropriate, should people be given a choice about where to go to have their tests or their measurements and samples taken:

- At their initial appointment - for example, with a GP, dentist, optometrist or practice nurse?
- Following an outpatient appointment with a hospital consultant?
- Whilst in hospital receiving treatment?
- After being discharged from hospital but whilst still under the care of a hospital consultant?

It would seem to be self-evident that most patients being referred for investigations would prefer it to be done immediately following their consultation and if this is not possible then patients would expect a balance to be struck between timeliness of the investigation and ease of access.

Q8. Are there any circumstances where choice of where to go for diagnostic testing would not be appropriate, and if so what are they?

No comment.

Q9. Would you like the opportunity to choose your healthcare provider and named consultant-led team after you have been diagnosed with an illness or other condition?

There should be no difficulty about which healthcare provider mobile patients attend. The issue of a consultant-led team raises the question as to why patients can't choose to see a named nurse or psychologist as well as a named consultant within the team.

Many patients may choose to have more frequent access to mental health care professionals of whatever discipline. There should be a clear recognition within this consultation that choice is always going to be limited by resources, or patient expectations will be raised beyond a level which can be afforded.

Many services currently operate at capacity and choice will be limited by availability.

Q10. What information and/or support would help you to make your choice in this situation and are there any barriers or obstacles that would need to be overcome to make this happen?

Information and support needs to be on availability and outcomes and patient and carer experience.

Q11. Is there anything that might discourage you from changing your healthcare provider or named consultant-led team - for example, if you had to repeat tests, wait longer or travel further?

No comment.

Q12. What else needs to happen so that personalised care planning can best help people living with long term conditions have more choice and control over their healthcare?

The following needs to be in place for personalised care planning to be a success:-

1. Sufficient numbers of appropriately-trained community nurses
2. Patient access to information about the range of opportunities available for their condition
3. Swift access to specialised advice as necessary.

4. Co-ordination with voluntary and third sector groups
5. Integration of health, social, physical and mental health care
6. Support for carers

Q13. What choices are most important to people as they approach the end of their lives? What would best help to meet these?

A major issue for people with dementia is that a disproportionately low minority are able to die at home with dignity. Many patients die in institutions or after transfer to a general hospital. Support for end of life care at home for people with dementia is complex. Good national examples exist.

Q14. We need to strengthen and widen the range of end of life care services from which patients and carers can choose. How can we best enable this?

No comment

Q15. Carers may sometimes feel that they themselves have no choice when the person they care for chooses to die at home. How should the respective needs and wishes of patients and carers be balanced?

The place of death should be agreed as part of an Advance Care Plan with adequate discussion between all parties when capacity is present. Carers and patients should be clear what is involved long before actual end of life decisions need to be made.

Q16. What sort of choices would you like to see about the NHS treatment that you have? Treatment could mean therapy, support for self management, medication or a procedure like surgery.

For common mental health disorders it is recognised that best treatment is often through a stepped care approach. This means that to some extent choice is limited reflecting that steps with less intensive interventions are often successful in bringing about recovery. The individual patient however may wish to start treatment at a more intensive level rather than the lower levels which may involve self-help and watchful waiting.

Q17. How can we encourage people to take more responsibility for their health and treatment choices?

If care plans are drawn up in the context of real partnership it is more likely that patients will follow the care plan. Similarly, if care plans are owned by the patient and ideally written in the first person these are more likely to be implemented because they are care plans drawn up by the patient for themselves rather than by the professional.

Shared healthcare decisions

Q18. How do we make sure that everyone can have a say in their healthcare?

See Q17.

Q19. How can we make sure that people's choices can reflect their different backgrounds - whether ethnic, religious or any other background that could affect their healthcare preferences?

Informed choice in shared healthcare decisions depends crucially on the availability of accessible information. The NHS needs to ensure that there is high quality information made available in a variety of formats.

Q20. How can we make sure that carers and the families of patients and service users can have a say in decisions about the healthcare of the people they support, where appropriate?

There needs to be an acknowledgement of the balance between supporting carers in their desire to be involved in the care of their relatives and friends and protecting the autonomy of adult patients with capacity. Best practice can be taught, particularly with patient and service user led training.

Q21. How can we support the changing relationship between healthcare professionals and patients, service users, their families and carers?

This can only be done by culture change not only amongst professionals but also by patients, carers and the public. Patients and carers must always be listened to but it will not always be possible to meet their demands.

Q22. What needs to be done to ensure that shared decision making becomes the norm? What should we do first?

With their longstanding commitment to 'recovery', mental health services are perhaps more advanced than other health services in the practice of shared decision-making. Psychiatrists and other healthcare professionals working in this field have much to offer in terms of leadership and expertise when it comes to ensuring that shared decision-making becomes standard practice.

Q23. Should healthcare professionals support the choices their patients make, even if they disagree with them?

Patients with capacity do not have to accept the advice given by healthcare professionals. There is often a range of treatment options and healthcare professionals should support patients in making sensible choices. Healthcare professionals would not be expected to deliver an intervention which they believed was inappropriate; however, in these circumstances it is likely that the patient will choose a different healthcare professional for at least a second opinion.

Q24. What sort of advice and information would help healthcare professionals to make sure that everyone can make choices about their healthcare?

No comment

Q25. How can we encourage more people to engage in advance care planning about their preferences for the care and support they receive – for example, when they are approaching the end of their life?

Where illnesses are progressive such as dementia there is a progressive and subtle change between expectations of maintaining skills and independent living and a realisation that decline is in progress. Although not dissimilar to cancer medicine the duration of the decline can be very long and although it is difficult to draw up a meaningful advance care plan very early in the course of dementia progressive introduction of discussion about deterioration may well lead to effective planning for the later stages.

Q26. Would you welcome a chance to engage in advance care planning before you become ill – for example, when you go for your mid-life Health Check – rather than after a diagnosis of a life-threatening condition?

No comment

Q27. How could training and education make choice and shared decision making a part of healthcare professionals' working practices?

Training that will make a difference should be patient and carer led training. Real stories can have a powerful impact when considering change. This is a real opportunity to involve patients and carers in the training of healthcare professionals.

Q28. How can we help people to learn more about how to manage their health?

A clear part of the role of healthcare professionals should be to help the patients learn more about how to manage their health. It should be expected this aspect of care be included in care plans as a way of avoiding dependency.

There are many other ways in which patients may learn to manage their own health and the voluntary sector can have a clear role to play.

Q29. What help should be available to make sure that everyone is able to have a say in their healthcare?

It is important when dealing with people with dementia or learning difficulties that information is presented in a succinct and understandable way. Information need not be simplistic but may need to be given repeatedly.

Q30. Who would you like to go to for help with understanding information and making decisions and choices about your healthcare, or that of someone you support?

No comment.

Q31. How can we make sure that carers' views are taken into account when the person they support makes a healthcare choice?

When patients lack capacity, carers' views should always be taken into account. This is easier when carers have power of attorney or deputyship but, in general, there should be an expectation that carers' views will be taken into account, unless there are particular documented reasons why this is not thought to be appropriate.

Q32. What information and support do carers, parents, guardians and those with powers of attorney or deputyship need to help others to make choices or to make choices on others' behalf?

See Q31

Q33. What information and support do voluntary sector and patient-led support groups need so that they can continue to help people to make choices about their healthcare?

Voluntary sector and patient-led support groups should be trained in use of advocacy. This is a particular skill and the availability and expertise is often of variable quality across the country. The importance of advocacy is that it enables the patient to articulate their own decisions; it is important that this is not overridden by well-meaning advocates.

Q34. How can people be encouraged to be more involved in decisions about their healthcare?

No comment.

Q35. Would decision aids be a useful tool for healthcare professionals and their patients and service users? Are there any barriers to their use?

No comment.

Q36. How should people be told about relevant research and how should their preferences be recorded?

Developing research should be incorporated into NHS approved information about treatment. NHS Evidence could develop its website so that there is a simple description of key recent research in the diagnostic groups e.g. if there is a paper demonstrating a new drug treatment for depression then a plain English and simple summary could be made available on the NHS Evidence website.

Q37. How can we encourage more healthcare professionals to use Choose and Book when they make a referral?

No comment.

Q38. How can we encourage more healthcare providers to list their services on Choose and Book?

No comment.

Q39. How else can we make sure that Choose and Book supports the choice commitments in chapter 2?

No comment.

Q40. Do you agree with the proposed approach to implementing choice of named consultant-led team? What else would you suggest needs to be done?

There needs to be a balance between patients being referred to a named consultant led team and waiting times. This needs to be made explicit to the patient and healthcare professionals should not be penalised for breaching waiting times.

There needs to be some protection of specialised expertise for those individuals that particularly require it.

Q41. Do you agree with the proposed approach to establishing a provider's fitness to provide NHS services? What other criteria would you suggest?

See Q 43

Q42. Should this approach apply uniformly to all providers, no matter what size, sector and healthcare services that they provide? For example, should a small charity providing only one healthcare service to a very localised group of patients be subject to the same degree of rigour as a large acute hospital that delivers a range of services to a regional catchment of patients?

See Q 43

Q43. Do you agree that an "any willing provider" directory should be established to make it easier for commissioners to identify providers that are licensed and have agreed to the NHS standard contract terms and conditions?

There are significant problems with the concept of any willing provider:-

1. The potential breakup of pathways of care. This has clearly been seen within addiction services where providers provide different sections of the pathway. This makes it difficult for clinicians, patients and carers

alike to navigate their way through an often complex system of different providers

2. Non-NHS any willing providers often come and go when different organisations obtain the tender. Again there is difficulty for healthcare professionals to advise patients which providers are available if there are frequent changes. It will be important to commission for continuity and integration.
3. There is a danger with any willing provider of engaging in a Dutch auction in which quality is sacrificed for cost
4. The suggestion from the consultation is that “any willing provider” is not expected to provide ongoing care. This could mean that services may be set up to just provide assessment services and refer back to the mainstream services.
5. Any increase in “willing providers” will also affect training markedly. There will be no obligation on other providers to participate in training or teaching.

Q44. The White Paper indicates that the Government will explore the potential for introducing a right to a personal health budget in discrete areas. Which conditions or services should be included in this right?

The introduction of personal health budgets needs to be carefully thought through. The College welcomes the use of pilots to inform the process. Personal health budgets do have the potential for having significant benefits for some patients. There is also the potential for unintended consequences e.g. closure of services which may not have enough people attending them. Also, individuals making unwise non-evidence based choices may still need to access healthcare.

Safe and sustainable choices

Q45. How can we make sure that any limits on choice are fair, and do not have an unequal effect on some groups or communities?

GPs and hospital clinicians have long used forms of rationing often based on severity of illness to determine access to interventions. The fact that an intervention is NICE-approved does not mean that it is necessarily financially affordable to everyone who wishes to access.

Q46. What do you consider to be the main challenges to ensuring that people receive joined-up services whatever choices they make, and how should we tackle these challenges?

A major challenge will be to ensure that it does not add increasing bureaucracy and the burden of collecting more data.

Q47. What do you consider to be the main risks to the affordability of choice and how should we mitigate these risks?

No comment

Q48. How far should we extend entitlements to choice in legislation and hold organisations to account against these?

Legislation will be a blunt tool and there is a danger that NHS money will be spent on legal bills rather than on providing care.

Q49. Where no specific right to choice applies, how can the Board best encourage GP consortia to maintain and extend the choice offer?

No comment.

Q50. What is the right mix of measures to encourage GP consortia to offer appropriate choices to their populations?

No comment.

Q51. What is the best way to gather patient feedback about the extent to which commissioners have put in place choices?

No comment.

Q52. Are the responsibilities of organisations as outlined enough to:

- ensure that choices are offered to all patients and service users where choices are safe, appropriate and affordable?
- ensure that no-one is disadvantaged by the way choice is offered or by the choices they make?

No comment.

Q53. If you do not get a choice you are entitled to, what should you be able to do about it?

No comment.

Q54. What are the main risks associated with choice and how should we best mitigate these risks?

Any system of choice must take account of the need for training and research in order to guarantee the sustainability and improvement of future services. Ideally, it would be hoped that those services engaged in academic activities would be the ones that would be chosen preferentially by patients. However, it

is vital that systems do not have unintended adverse impacts on academic activities.

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