

Royal College of Psychiatrists

Consultation Response



DATE: 27th Sept 2010

RESPONSE OF: THE ROYAL COLLEGE OF PSYCHIATRISTS

RESPONSE TO: *Liberating the NHS: Increasing Local democratic legitimacy in health*

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 Max Henderson, and it was prepared by Richard Meier in the College Policy Unit.

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

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Q1. Should local HealthWatch have a formal role in seeking patients' views on whether local providers and commissioners of NHS services are taking account of the NHS Constitution?

The College supports the strengthening of patient involvement. We assume that the reference to patients' views will cover those of carers and of advocates for patients. Particularly for people who lack capacity and whose illness involves impaired cognitive functioning the involvement of these people where appropriate is central and should not be left to chance but made explicit and actively promoted.

The College also supports, in principle, the funding and promotion of 'local consumer champions' such as the envisaged local HealthWatch groups which might be able to put pressure on commissioners to ensure that, for example, the very low availability of psychotherapy therapies (despite their being recommended in NICE guidance for a variety of mental health conditions) is addressed.

Although past patients can be sometimes more reflective having been through the system than those in the midst of using services, it is vital that at least some of those service users and carers who local HealthWatch consult are currently in a relationship with services as they are developing, rather than trying to address aspects of the sometimes poor experiences of care they had a number of years ago.

There is a danger of believing that by involving only people who welcome the opportunity, and are well enough, to attend workshops and focus groups that effective consultation and communication has taken place. There is a risk that instead of a realisation of the Government's commitment to ensuring that there is a strong local voice for patients that one ends up with simply a local voice for strong patients (with users of psychiatric services, or patients with

particular conditions, in competition with users of other services and their support groups). It is essential that membership has a balanced representation of patient interests with physical and mental health being equally represented. One possibility might also be that HealthWatch are only granted a mandate to act when a, certain number, or proportion, of patients have similar concerns.

Q2. Should local HealthWatch take on the wider role outlined in paragraph 17, with responsibility for complaints advocacy and supporting individuals to exercise choice and control?

See response to question 1, but in principle, given the broad functions anticipated for HealthWatch, it would make sense for local groups to take on these responsibilities. Furthermore, by engaging with complaints, they will be better informed as to the nature of problems in their area and the organisational culture of the health and social care provision in the local area.

Q3. What needs to be done to enable local authorities to be the most effective commissioners of local HealthWatch?

The College is concerned that there is the clear possibility of a conflict of interest should the local HealthWatch wish to voice criticism of the local authority which funds it (and that local HealthWatch might therefore refrain from criticism of the local authority for fear of not being retained by it). Paragraph 19 seems to make passing reference to this but does not adequately suggest a solution. This needs to be addressed.

The College suggests it would be helpful to have health commissioners and even providers in the selection process when allocating local HealthWatch contracts. Whist the process should be led by the Local Authority, input from health bodies would promote joint working and ownership of the outputs from HealthWatch.

Q4. What more, if anything, could and should the Department do to free up the use of flexibilities to support integrated working?

The consultation (paragraph 23) recognises that the take-up of opportunities for joint commissioning and pooled budgets has been limited due in part to the differential terms and conditions of service which are a major hindrance to more effective integrated working, and the differential regulation and performance management of health and social care.

While these agencies must be pressed in the direction of integrated working – and the bringing together of the regulators in the Care Quality Commission should improve this – the College believes that that further work should be carried out to examine why (over and above the reasons put forward above) such integration has proved so unappealing.

Q5. What further freedoms and flexibilities would support and incentivise integrated working?

Please see response to question 4.

Q6. Should the responsibility for local authorities to support joint working on health and wellbeing be underpinned by statutory powers?

Yes.

Q7. Do you agree with the proposal to create a statutory health and wellbeing board or should it be left to local authorities to decide how to take forward joint working arrangements?

We agree with the proposal for a statutory base because only then do we consider that the impetus will be provided to iron out the difficulties that stand in the way of integration. Furthermore, having uniformity of model across the

country would assist in sharing learning, and hopefully benchmarking activities.

Q8. Do you agree that the proposed health and wellbeing board should have the main functions described in paragraph 30?

Yes.

Q9. Is there a need for further support to the proposed health and wellbeing boards in carrying out aspects of these functions, for example information on best practice in undertaking joint strategic needs assessments?

Yes. It will be important that adequate training (and funds to provide it) is available for GP consortia so that they can contribute as effectively as possible to all aspects of the commissioning cycle (not only the JSNA).

Other support would include:

- health economics expertise (of particular benefit in areas that cross traditional planning boundaries, such as health/social care and primary/secondary care)
- knowledge and expertise regarding the mental health care in people with physical disorders

Q10. If a health and wellbeing board was created, how do you see the proposals fitting with the current duty to cooperate through children's trusts?

No comment

Q11. How should local health and wellbeing boards operate where there are arrangements in place to work across local authority areas, for example building on the work done in Greater Manchester or in London with the link to the Mayor?

No comment

Q12. Do you agree with our proposals for membership requirements set out in paragraph 38 - 41?

With the addition of representatives from local HealthWatch, such a membership may well provide an opportunity for those committed to providing excellent mental health services to be heard, influence decisions and promote mental health-friendly policies more broadly. The College welcomes the prominence given in the consultation to the role of the Director of Public Health within the membership of these boards.

Q13. What support might commissioners and local authorities need to empower them to resolve disputes locally, when they arise?

The College suggests it would be helpful to have benchmarking of Board activities, in particular with regards to joint commissioning and pooled budget arrangements, or indeed indicative targets. This might allow broader perspectives to be included to help address local differences of opinion.

Q14. Do you agree that the scrutiny and referral function of the current health OSC should be subsumed within the health and wellbeing board (if boards are created)?

Yes, to avoid duplication and bureaucracy.

Q15. How best can we ensure that arrangements for scrutiny and referral maximise local resolution of disputes and minimise escalation to the national level?

Bolstering the role of HealthWatch on the Health and Wellbeing Board may help lessen contentious commissioning plans being brought before the Board.

Q16. What arrangements should the local authority put in place to ensure that there is effective scrutiny of the health and wellbeing board's functions? To what extent should this be prescribed?

Again, there seems to be potential for conflict of interest here, given that representatives from the local authority will be part of the membership of the health and wellbeing board. It is unclear how the local authority could be expected to scrutinise a body whose membership it partly comprises? As stated previously, the College feels that having representatives of local HealthWatch on these boards would be beneficial in this regard.

Q17. 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, the public and, where appropriate, staff?

No comment.

Q18. Do you have any other comments on this document?

The formation of a National Public Health Service is welcome. 'Public health' however is not defined, and it would be helpful to have this clarified. The emphasis on research, analysis and evaluation is welcome as is the clear statement that funding will be ring-fenced. We also welcome the fact that clear directions will be given as to how this money should be spent. It is imperative

that in its desire to give local areas their autonomy difficult or expensive but necessary initiatives - such as those relating to early intervention to prevent mental illness - are not abandoned for quick wins that will have a lesser impact on population health over the longer term. We also feel that psychiatrists are well-placed to offer advice to health and well-being boards regarding the bridge between the childhood antecedents of later adolescent and adult mental health problems. If we are to adopt a meaningful approach to public mental health in terms of identifying cause and prevention, early developmental problems in children need to be explicitly recognised as early warning signs and intervention seen as more likely to reduce the personal, familial and societal health burden.

Overall, the College has concerns about the pace of change and therefore urges the Government to be flexible as to the timetable. To bring about the integration of health and social care at such a time of significant financial pressures may simply fail and involve waste of energy and money as well as threaten front line delivery to patients if it is forced too quickly. So while we support a statutory base for joint social and healthcare, we believe that the findings from research as to why it has not succeeded (where it has not) and what the present barriers might be should inform any proposed solutions.

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