

Royal College of Psychiatrists Consultation Response



DATE: 27th Sept 2010

RESPONSE OF: THE ROYAL COLLEGE OF PSYCHIATRISTS

RESPONSE TO: *Liberating the NHS: regulating healthcare providers*

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 Neil Deuchar, 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. Do you agree that the Government should remove the cap on private income of foundation trusts? If not, why; and on what practical basis would such control operate?

The College agrees that the Government should remove the cap on private income of foundation trusts. Mental Health Foundation Trusts (MHFTs) may need to concentrate on delivering social care to patients – employment, housing and leisure activities are all widely agreed to be fundamental to recovery. They may do this by forming partnerships with other organisations which, in turn, can be formal or informal. The advantages of formal arrangements are that funds and risk can be shared and care pathways can be harmonised within a unified organisation. MHFTs may also wish to generate or receive income from a variety of other sources that may be distinct from GP/LA commissioned activity: examples include user-led organisations, intellectual property rights arising from patents on innovations, fees for training packages. Income for consultants undertaking independent practice in association with the FT (for instance preparing court reports for existing or new patients) and income from compensation claims (in order to offer rehabilitation after brain injury, for example). Capping such income therefore limits the scope for MHFTs to be innovative, entrepreneurial, and address breadth and quality of care in partnerships with others.

Q2. Should statutory controls on borrowing by foundation trusts be retained or removed in the future?

The degree to which MHFTs may wish to borrow depends on their integrated business plans (IBPs). If a strategy exists to invest in a development in order to improve or replace outdated or inappropriate estate or cater for a cohort of complex patients currently treated inappropriately elsewhere, borrowing may be deemed by the Board as an appropriate financial strategy for capital

generation. If care for specific groups of patients is centralised around expertise (in support of which there is psychiatric evidence) then capital investment may be substantial and statutory controls over borrowing limits may constrain the ability of a MHFT to meet patient needs. However, since - as the consultation itself notes - no foundation trust has yet taken a loan from the private sector for a significant capital investment, it may be that there is no need for such loans. An alternative path might be to increase the statutory borrowing limits and review them on a periodic basis.

Q3. Do you agree that foundation trusts should be able to change their constitution without the consent of Monitor?

The College believes that statutory controls should be removed whilst at the same time ensuring there is adequate governance and accountability to support decision-making. As long as a MHFT is licensed by Monitor as being legally constituted, it seems sensible to enable it to alter its constitution under the stewardship of their boards and governors in order that it can respond quickly and efficiently to changes in market forces or the advent of new business opportunities.

Q4. What changes should be made to legislation to make it easier for foundation trusts to merge with or acquire another foundation trust or NHS trust? Should they also be able to de-merge?

The College believes that foundation trusts should be able to merge and de-merge as appropriate without undue disruption to staff and service provision. If a board team is successful and places a MHFT in a strong position to acquire another organisation, it seems sensible to retain the board without the need for re-elections or re-appointments, since this retains the team and the constitution that provided the strength for the development. The only proviso to this would be that if a MHFT acquired a markedly different portfolio to that to which it is used (for instance community services) there needs to be a

mechanism to ensure adequate and appropriate expertise and experience is added to the board. That said, the quicker and easier this can happen, the better.

Q5. What if any changes should be made to the NHS Act 2006 in relation to foundation trust governance?

Part of the rationale for a MHFT is the links it can establish and grow with a local community with which it works in partnership to improve the mental health and wellbeing of that community. Staff-only membership could undermine this. Boards of governors should be constituted by a range of stakeholders – for MHFTs these include not only patients and carers but also a wide variety of other stakeholders such as GPs, LAs, employment and housing agencies, schools and other educative agencies, the police and the courts. Increasing the accountability of a MHFT to its governors depends on ensuring that governance structures work well.

Q6. Is there a continuing role for regulation to determine the form of the taxpayer's investment in foundation trusts and to protect this investment? If so, who should perform this role in future?

Monitor should remain as an independent economic regulator but can extend its remit to oversee financial probity and diligence in all sorts of organisations contracted by the NHS to provide health services. This could include autonomous, semi-autonomous or independent trading arms of FTs such as user-led and staffed workshops and other social purpose vehicles working in an integrated but independent fashion with the FT.

Q7. Do you have any additional comments or proposals in relation to increasing foundation trust freedoms?

No comment

Q8. Should there be exemptions to the requirement for providers of NHS services to be subject to the new licensing regime operated by Monitor, as economic regulator? If so, what circumstances or criteria would justify such exemptions?

In order to be licensed by Monitor, MHFTs will need to have been registered with the CQC, thus assuring quality of services in the licensing agreement. Adult social care would be exempt from the requirement to license because pricing structures need to be deregulated in order to stimulate the market where choice may currently be limited. If choice is to be extended to specialist mental healthcare, it would be important to enable MHFTs to deploy care within best-practice tariffs but demonstrate greater efficiencies (and better outcomes) in order to manage competition successfully.

Q9. Do you agree with the proposals set out in this document for Monitor's licensing role?

Yes. However, while the separation of its role from that of the CQC's regarding quality is welcome, close collaboration between Monitor and the CQC will be required.

Q10. Under what circumstances should providers have the right to appeal against proposed licence modifications?

As a general principle, the College considers that providers should have the right to appeal. However, if this is to be restricted, then providers should at least have the right to appeal if they can demonstrate consistently good outcomes (and any partnerships on which these outcomes may be predicated) in the arena in which it is intended to impose licensing modifications or if Monitor were to require a Trust to provide services (in order to promote competition or to safeguard continuity of services) which were uneconomical to the Trust.

Q11. Do you agree that Monitor should fund its regulatory activities through fees? What if any constraints should be imposed on Monitor's ability to charge fees?

The College believes that central funding would be more cost-effective.

Q12. How should Monitor have regard to overall affordability constraints in regulating prices for NHS services?

Quality, Innovation, Productivity and Prevention (QIPP) themes for mental health include reducing admissions through more robust management of the acute care pathways by crisis resolution/home treatment teams. It should therefore be the case that desired changes to practice are incentivised by pricing structures, indices and contracting schemes that reward reduction of, or productivity gains in, bed usage rather than reference costs related to occupied bed days. Similarly, many psychiatric liaison schemes are now working with acute FTs to identify, prevent the admission of, and affect the prompt discharge of persons with medically unexplained symptoms; contracts that reward bed occupancy similarly offer perverse incentives. Tariff structures that do not take into account co-morbidities and the contribution of physical and mental health conditions to each other will similarly damage the relationship between pricing structures and desired clinical practice. Overall affordability constraints are mitigated by ensuring the inclusion of basic minimum standards and evidence based interventions in tariffs.

Q13. Under what circumstances and on what grounds should the NHS Commissioning Board or providers be able to appeal regarding Monitor's pricing methodology?

If these factors are not taken account of, either the NHS Commissioning Board or providers (or, for that matter, the relevant Royal College) should be able to

appeal. Equally, if Monitor uses its licensing powers to require Trusts to run services which may be economically unviable.

Q14. How should Monitor and the Commissioning Board work together in developing the tariff? How can constructive behaviours be promoted?

Joint-working between these bodies should be based on principles of good partnership working: open discussion at all stages; engagement of broad clinical advice and reference; extend the parties working together to include social care, clinicians and professional bodies (i.e. break away from the two bodies alone developing the tariff).

Q15. Under what circumstances should Monitor be able to impose special licence conditions on individual providers to protect choice and competition?

The powers that Monitor will have to impose special licence conditions on individual providers underline the importance for Trusts to be able to collect data on outcomes in order to be able to clearly and unequivocally demonstrate that its outcomes against domains of effectiveness, experience, safety and equitability are superior to competitors and that patients, GPs and other customers are routinely making use of such information in their decision making – since without such outcomes data, it will be all the harder to argue against impositions made by Monitor.

Q16. What more should be done to support a level playing field for providers?

If there is to be a level playing field for all providers, then there must be a mechanism to avoid private provider's cherry-picking financially viable services when Monitor is requiring NHS providers to deliver financially unviable services

as part of its License. Monitor defines mandatory services for NHS providers, though does not appear to do so for non-NHS providers.

Q17. How should we implement these proposals to prevent anti-competitive behaviour by commissioners? Do you agree that additional legislation is needed as a basis for addressing anticompetitive conduct by commissioners and what would such legislation need to cover? What problems could arise? What alternative solutions would you prefer and why?

There needs to be a balance between concern about anti-competitive practice and a need to ensure that commissioners commission seamless pathways of care, whether or not different interventions are provided by competing providers.

Q18. Do you agree that Monitor needs powers to impose additional regulation to help commissioners maintain access to essential public services? If so, in what circumstances, and under what criteria, should it be able to exercise such powers?

Additionally regulated mandatory services in mental health could include activities where there is clear evidence for effectiveness but unacceptable variation in provision. One example would be psychiatric liaison services.

Q19. What may be the optimal approach for funding continued provision of services in the event of special administration?

In general, provision of services no longer offered by a provider in administration should be tendered to another organisation with a good track record in the relevant area of provision. Since this may have to happen

quickly, this might be an area where the concept of a “preferred provider” might be retained.

Q20. Do you have any further comments or proposals on freeing foundation trusts and introducing a system of economic regulation?

No comment

Q21. 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?

It is clearly vital to decide on appropriate suites of outcomes so that Monitor is able to regulate and improve quality and safety by way of an economic system that requires certain basic minimum standards of best practice and behaviours (evidence-based and values-based practice respectively) and which can be stipulated as mandatory by way of additional licensing requirements to ensure equity of access and provision for groups of people who, in mental health arenas, are often hard to reach.

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