



Health and Social Care Bill 2011 Royal College of Psychiatrists Second Reading Briefing House of Commons



Introduction

The Royal College of Psychiatrists approach to health reform is fundamentally based on how it will affect the care, welfare and treatment of the one in four people with mental health problems.

The College has welcomed the following aspects of the Health and Social Care Bill: putting the patient at the centre of care, the focus on clinical outcomes, increased involvement of clinicians in commissioning (with a corresponding reduction in management costs), ring-fenced money for Public Health and the aspiration for joined up social care and public mental health outcomes.

¹ However, we remain concerned about how the scale and the pace of change may impact on the care and, in particular, the continuity of care that can be given to patients with mental health problems. We are particularly concerned that in some areas the new GP consortia will not yet have developed the skills or expertise to support mental health commissioning and believe that there needs to be engagement of specialist clinicians from the outset.

We will also want to be sure as the reforms progress that, in the reorganisation brought about with this Bill, the valuable and previously agreed policy initiatives are not lost. The Bradley reforms to the criminal justice pathway for people with mental health problems is one example, the dementia strategy another. We recognise however that the reforms give opportunities for redesigning services to eliminate waste and duplication and we welcome the chance to have a role in this.

Key areas outlined in this briefing include:

- **Need for specialist clinical expertise in commissioning (1)**
- **Importance of protecting the needs of patients with severe and complex mental disorders (1.22)**
- **Need for clarification regarding fears that close working between clinicians may lead to accusations of conflict of interest (3)**
- **Concerns about further roll out of 'Any Willing Provider' given recent evidence from some mental health services (4)**

Health and Social Care Bill 2011

Key areas for the College

The Royal College of Psychiatrists is the leading medical authority on mental health in the United Kingdom and the Republic of Ireland and is the professional and educational organization for doctors specializing in psychiatry.

1. Commissioning and clinical expertise

1.1 Issue

Part 1 of the Health and Social Care Bill sets out the framework for the reformed NHS by establishing GP Consortia and the NHS Commissioning Board. The majority of services will be commissioned by GP Consortia with a number of specialist services, such as secure psychiatric services, being commissioned by the Commissioning Board.

We are concerned to ensure that the newly-established bodies are able to commission mental health services effectively so that high-quality services are provided to all that need them.

2 In order to achieve this we believe, along with all the other Medical Royal Colleges including the Royal College of General Practitioners, that clinical commissioning must involve a close working relationship between GPs and specialists. Furthermore, in order to meet the needs of those mental health patients with particularly complex difficulties – a group of patients for whom care is costly and about whom GPs will have relatively little knowledge – the role of psychiatrists in advising commissioners will be vital.

1.2 Why specialist clinical expertise is necessary

1.2.1 To ensure efficient, coordinated care

The Nuffield Trust¹ has documented international research¹ which shows the importance of specialist involvement:

*‘The US experience shows that holding risk-bearing budgets can motivate doctors to deliver efficient, coordinated care that reduces avoidable and repeated admissions to hospital. However, to achieve this, **the groups had to ensure that primary and specialist doctors cooperated closely** and were able to invest in a range of high quality and innovative services that offer alternatives to hospital care, particularly for older patients with chronic conditions.’²*

1.2.2 To protect the needs of patients with severe and complex mental disorders

People with mental illness range widely from those with common mental disorders, such as anxiety, depression and addiction problems, to those with severe and complex disorders,

¹ The Nuffield Trust is one of the leading independent health policy charitable trusts in the UK.

<http://www.nuffieldtrust.org.uk/aboutus/index.aspx?id=37>

² <http://www.nuffieldtrust.org.uk/publications/detail.aspx?id=145&PRid=756>

such as schizophrenia and bipolar disorder. Among them are groups with very specific diagnoses and specific needs who are not always well understood or for whom adequate services have been lacking, for example those with borderline personality disorders, dual diagnosis (both serious mental health problems and addiction problems) and learning difficulties.

We believe that without specialist clinical expertise in commissioning, there is a danger that services for patients with severe and complex services will be adversely affected. Although this group of patients is smaller in number than people with common mental disorders, the cost of treatment is significantly higher. We are concerned that this could make them a lower priority for GP consortia.

1.3 What we are doing: The Joint Commissioning Panel for Mental Health (JCP-MH)

The College has collaborated with the Royal College of GPs and other leading organisations in mental health to set up a Joint Commissioning Panel for Mental Health. The Royal College of General Practitioners strongly support the JCP-MH, and a working link exists with the RCGP's Centre for Commissioning.³

The Panel will exist to provide current and future commissioners with knowledge, skills, tools, evidence and insight. It will publish briefings, launch a practical framework for mental health commissioning, and bring together and help commissioners, users and survivors, clinicians, carers, managers and others deliver the best possible mental health services.

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1.4 What needs to happen

The Bill sets out duties for both the Commissioning Board (Clause 19 (13G)) and GP consortia (Clause 21 (14O)) to 'obtain appropriate advice' in carrying out their functions. The Bill also places a duty on the Board (Clause 19 (13P)) and GP Consortia (Clause 21 (14Z)) to publish annual reports.

We welcome these provisions as an acknowledgement from the Government that there needs to be wider professional input in to decision making, but we believe that some of the duties as drafted in the Bill are ambiguous and need to be strengthened. We will be seeking amendments to the duties and would welcome clarification at 2nd Reading on the following questions:

- What will this duty to obtain advice mean in practice?
- What do the Government envisage as 'appropriate advice'?
- Will there be guidelines setting out how often advice needs to be obtained?

2 Concerns about close working between clinicians being seen as a conflict of interest

2.1 Issue

³ http://www.rcgp.org.uk/centre_for_commissioning.aspx

The College is seeking clarification on a potentially dangerous issue whereby clinicians may feel that they will be accused of breaking Competition Law by working collaboratively over service issues.

It will be critical in the new system that clinicians (both GPs and psychiatrists) feel able to work closely to improve local services. We are concerned about a situation where providers who have been unsuccessful in bidding for services may cite the close working between clinicians as a conflict of interest.

2.2 What needs to happen

We would welcome commitments from the Government to outline safeguards to ensure that local clinicians working together to improve services will not be accused of breaching Competition Law.

3. Meeting the needs of the whole population including hard-to-reach groups

3.1 The Issue

4 We believe that in order for GP Consortia and the NHS Commissioning Board to meet the needs of the whole population then it will also be necessary to strengthen the current proposals to assess need and engage with hard-to-reach groups.

We also welcome the duties on GP consortia (Clause 21, 14N) and the NHS Commissioning Board (Clause 19, 13F) to reduce inequalities regarding access and outcomes. There is vast evidence to show that people with mental health problems and learning disabilities encounter serious inequalities daily in terms of their health, life chances and inclusion.⁴⁵

As discussed in point 1, the involvement of psychiatrists and other mental health specialists, including service users and carers in commissioning is essential and will be an important lever in ensuring that the needs of these patients are addressed. However, it is not the answer alone. We believe that the Government also needs to address two key areas:

3.2 Robust needs assessments

3.2.1 Issue

A Joint Strategic Needs Assessment (JSNA) describes a process that identifies current and future health and wellbeing needs in light of existing services, and informs future service planning taking into account evidence of effectiveness. Joint Strategic Needs Assessment identifies “the big picture” in terms of the health and wellbeing needs and inequalities of a local population.

4 [http://www.rcpsych.ac.uk/pdf/Fair%20Deal%20manifesto%20\(full%20-%201st%20July2009\).pdf.pdf](http://www.rcpsych.ac.uk/pdf/Fair%20Deal%20manifesto%20(full%20-%201st%20July2009).pdf.pdf)

5 <http://www.rcpsych.ac.uk/pdf/No%20Health%20without%20mental%20health%20the%20Evidence.pdf>

Currently JSNAs are undertaken by the local authority. The Bill sets out a joint responsibility for producing JSNAs between local authorities and GP consortia.

There are already concerns about the effectiveness of local authorities to ensure the JSNAs reflect the true prevalence of mental health problems and the needs of their populations.⁶⁷⁸⁹ There is a danger that simply expecting GP consortia (with no prior expertise in this area) to undertake these JSNAs will replicate the problems which local authorities have encountered.

3.22 What needs to happen

We believe that a duty should be placed on GP consortia to demonstrate that in the course of their JSNA they have focused in particular on the views of vulnerable people and hard to reach groups, those with complex medical and social care needs and those experiencing exclusion.

GP consortia must do more than draw up estimates from the number of people on GPs Severe Mental Illness Register (since many people with serious mental illnesses are often not on a GP practice register for severe mental illness) or by simply extrapolating from the Survey of Psychiatric Morbidity Among Adults Living in Private Households.

The NHS Commissioning Board should be required to make expertise available to GP consortia to ensure that the standard of JSNAs – in regard to particular groups about which data has historically been difficult to gather – is high.

GP consortia should be required to demonstrate that they have reserved a sufficient proportion of its management budget to buy in expertise to ensure that the standard of its JSNA in regard to ascertaining a truer picture of prevalence and needs in relation to mental illness is high, and that they demonstrate that this

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3.3 Engagement

As well as assessing need, it is also important that there is a duty for consortia to properly engage with some of the most vulnerable and marginalised groups in society - including asylum seekers, homeless people, young people from disturbed families, prisoners, those in debt or who are unemployed, people from some minority ethnic groups, victims of domestic violence and elderly people with dementia.

In the College's response to the White Paper (Equity and Excellence: Liberating the NHS) we wrote: "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."¹⁰

⁶ <http://jsnaonline.org/2008-9/Hull%20Summary%20JSNA%20271008.pdf> (for example, p28)

⁷ www.ic.nhs.uk/webfiles/Services/in%20development/jsna/Calderdale2.ppt

⁸ <http://www.cambridgeshire.nhs.uk/downloads/Your%20Health/JSNAs/Mental%20Health%20JSNA.pdf> (for example, p11)

⁹ <http://www.norhtynesidejsna.org.uk/wp-content/uploads/2010/11/Autism-Adults.pdf> (for example, p9)

¹⁰ <http://www.rcpsych.ac.uk/pdf/Final%20response%20to%20Call%20for%20evidence%20on%20Commissioning.pdf>

In the Government's Recent Command Paper, Liberating the NHS: Legislative Framework and Next Steps,¹¹ the Government responded by saying: 'A number of respondents emphasised the importance of ensuring that GP consortia not only listen to patients and handle their complaints, but also respond to people's views and feedback and that they seek out the views of those who may not be using current services. Turning Point called for "a duty to be placed on GP consortia to engage with communities to ensure they know, and more importantly know how to meet, the needs of people not only accessing their services currently but those in the wider community they will be responsible for". Advocacy Partners Speaking Up described how "independent advocacy can be involved too at earlier stages of the commissioning process, reducing the causes of complaints, fostering a culture of public participation and patient voice, service innovation and collaborative working". The Bill will therefore place a duty on GP consortia and the NHS Commissioning Board to ensure that people who may receive a service are involved in its planning and development, and to promote and extend public and patient involvement and choice.'

We do not feel that the answer above adequately addresses the issue and believe that there should be a duty on the consortia to actively engage with hard to reach groups in their community rather than simply a duty to engage with those people who are already receiving or are in contact with services. This will ensure that they have a sufficient awareness of the needs in the community when making commissioning decisions.

4. Concerns about the effect of 'Any Willing Provider' on mental health services.

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4.1 Proposals in the Bill

Chapter 2 of the Bill, in particular Clause 61 will further roll out the Government's service provision model 'Any Willing Provider'. 'Any Willing Provider' (AWP) is a model for providing healthcare where patients can select who provides their care from a list of those willing to offer it and that meet certain standards.

The Government's aim in introducing 'Any Willing Provider' is to promote choice and competition in the NHS. The Royal College of Psychiatrists support choice and competition where they can stimulate innovation and, importantly, drive up the quality of mental health care.

However, we are very concerned about the crude potential use of the concept of 'any willing provider' and we have evidence from addictions services (see 4.2) to suggest that the current model has involved frequent retendering, with decisions often made on price over quality and which has led to service fragmentation, disruption to continuity of care, and loss of integration of care pathways.

4.2 Evidence from addiction services

In 2009, The Specialist Clinical Addiction Network (SCAN), a Department of Health funded network of addictions services, carried out a survey in to retendering.¹² Some key themes emerged from the survey:

¹¹ Department of Health; Liberating the NHS: Legislative Framework and Next Steps; p.63

¹² <http://www.scan.uk.net/docstore/scanBites20.pdf>

4.21 Cheapest bidder rather than highest quality

The SCAN Survey found that there is a growing concern that cost is the main driving force for decision-making to the exclusion of other considerations.

A core concern with the practical implementation of the Any Willing Provider model has been that some commissioners have purchased services solely on the basis of cost, leading to “negative auction” in which many services are willing to reduce cost to unsustainable levels in order to win contracts. This process has, in some cases, led to the purchase of services of dangerously poor quality.

The Nuffield Trust has also pointed out that international evidence shows that price competition in hospital care is associated with a reduction in quality of care.¹³

4.22 Service Fragmentation

We are particularly concerned to avoid fragmentation of services with several providers delivering different aspects of a care pathway – these providers constantly changing as services are retendered. The retendering of services from one provider to another risks poor continuity of care for those recipients of care who have long-term conditions and who would therefore be subject to numerous transfers of care as the treatment provider changes hands. Competition alone without quality can lead to system which is highly complex and difficult for providers and service users to understand. There have been many occasions where the frequent re-tendering of services has been highly disruptive for patients.

4.23 Care-Pathways

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There is a real danger that if a multiplicity of providers are delivering different aspects of the care pathway, patients may fall between gaps in services. The SCAN survey found that the retendering process is widely perceived to be disruptive to both patients and staff, and appears to place little importance on continuity of care.

There is widespread concern that patients are falling through gaps during the retendering process and there have been reports of untoward clinical incidents as a result of poor continuity of care and lack of effective clinical governance procedures.

4.24 Education and Training: Brain drain

The SCAN survey found that staff are reported to be suffering from low morale, with some being lost from services due to lack of job security or anxiety about changing terms and conditions of employment. The time and resources involved in preparing for the bidding process itself is putting additional pressure on teams, not to mention the recruitment processes for new and replacement staff.

Training posts are reported to be threatened, as some new service models are unable to provide this aspect of workforce development, nor has training been included in most of the tender specifications. Training may be viewed as an expensive ‘optional extra’ when costing services and achieving ‘value for money’.

Worryingly, trainees caught in the middle of a retendering exercise run the risk of not completing their required period for accreditation in the addiction speciality essential for CCT and career progression.

¹³ <http://www.nuffieldtrust.org.uk/pressarea/index.aspx?id=1141>

The process of retendering has also been criticised. Many respondents to the SCAN survey refer to a lack of clarity of the criteria being used to judge the bids..

There has also been an absence of rationale when awarding bids or decommissioning seemingly well-functioning services. Staff have been baffled by not being shortlisted when they had recently achieved Foundation Trust status. Contracts have been awarded to services whose staffing and service models do not appear to be appropriate for the local patient population.

4.3 What needs to happen

Some mental health services have already seen the introduction of the Any Willing Provider model and the evidence has shown serious problems around service fragmentation, decisions made on cost over quality, the disruption to continuity of care, and loss of integration of care pathways.

We believe it would be a disaster if this experience was repeated across mental health services. We will be looking at amendments to the legislation to protect against these concerns. We believe that there should be an acknowledgement that commissioning should include commissioning for integration, continuity, and training delivery in addition to outcomes.

5. Changes to the Mental Health Act

5.1 Issue

Clauses 30 to 37 of the Bill make changes to the Mental Health Act. In the main, these changes are being made to bring the Mental Health Act in line with the new legal framework of the NHS. Clause 273 changes the rules on compulsory treatment of patients in the community, known as supervised community treatment (SCT).

5.2 Clause 30

Clause 30 relates to the Secretary of State's power to approve doctors ("section 12 doctors") as having special experience in the diagnosis or medical treatment of mental disorder. The Secretary of State is also responsible for approving doctors and other professionals as approved clinicians for the purposes of the Act.

Currently doctors approved under section 12 of the Mental Health Act and Approved Clinicians obtain their approval from Strategic Health Authorities. SHAs have appointed multi-professional panels (medical, in relation to section 12 approval) to ensure required competencies are proven, high standards are set and are similar across England.

Clause 30 gives the Secretary of State the power to give the authority to grant approval to the NHS commissioning board, Strategic Health Authority or other body or bodies. No further details are given. The College is concerned to ensure that bodies granting approval are independent of commissioning consortia and of provider organisations and that there is relevant professional input into the approval process.

5.3 Clause 273

Clause 273 changes the rules on when the compulsory treatment of patients in the community (supervised community treatment SCT) needs to be approved by a second opinion appointed doctor (SOAD).

The College welcomes clause 273. The provision will permit capacitous patients subject to a community treatment order to consent to the treatment recommended by their doctor, should they wish, without the need for a statutory second opinion doctor to agree (this is the same provision as for detained patients). This will both strengthen safeguards and reduce costs. It will free up second opinion doctor time which should enable the Care Quality Commission to provide second opinion doctors, at the required time, for patients who lack the capacity to consent. Furthermore, it will mean that if capacitous patients, who have been consenting to treatment, change their minds, they will have the right to a second opinion doctor before being forced to have the treatment (other than in an emergency).

6. Public health

6.1 The Issue

9 The Royal College of Psychiatrists welcome the priority given to public health in the Coalition Health Reforms backed up by ring-fenced local authority funding. The Department of Health is currently consulting on their public health proposals and the College is preparing a response to this. We welcome the creation of Public Health England and the devolution of public health powers to local authorities, led by Directors of Public Health. The Bill sets out the framework for these reforms in Clause 25, 26, and 27.

Historically, public health strategies have concentrated on physical health and overlooked the importance of both mental illness and mental well-being. It is vital that local authorities take account of the vast evidence for public mental health promotion (see 6.2) when allocating funding.

6.2 The evidence

In October 2010, the Royal College of Psychiatrist produced No Health Without Public Mental Health: The Case for Action. This report set out the vast evidence showing why public health strategies cannot afford to ignore mental health. Mental illness is associated with greater risk of physical illness, and physical illness in turn increases the risk of mental illness.

- Premature death: people with schizophrenia and bipolar disorder die on average 20 years earlier than the general population, largely owing to physical health problems
- Smoking: people with mental disorder smoke almost half of all tobacco consumed and account for almost half of all smoking-related deaths. Rates of smoking on in-patient mental health units are 70%, compared to 21% in the general population
- Death from cancer and heart disease: people with depression have a significantly worse survival rate from cancer and heart disease

- Long-term physical conditions: people with two or more long-term physical illnesses have a seven-fold greater risk of depression
- Alcohol: excessive consumption of alcohol is associated with higher levels of depressive and affective problems, schizophrenia and personality disorders as well as with suicide and self-harm.

6.3 The benefits of promoting public mental health

Promoting mental health can bring great health, social and economic benefits across all sectors of society. Public health not only considers the prevention of illness but also the wider promotion of mental well-being. Mental well-being is fundamental to a good quality of life and the productivity of individuals, families and communities. Its impact is felt across education, employment, criminal justice, participation in public life, social behaviour, physical health, recovery from mental and physical illness, and life expectancy. It is therefore an issue to be addressed by all government departments and areas of policy.

6.5 Concerns with the current proposals

Integration of public health into local government should provide opportunity to influence the social and environmental determinants of good mental health and to look at the causes of both mental and physical ill health in an integrated way. So, for example, local policies on housing, transport, open spaces, and alcohol licensing and pricing all affect people's mental and physical health.

But there is a real danger that the proposed separation of public health from the NHS, both financially and organisationally, will mean the NHS no longer sees 'health' as its responsibility, only health care, and it will focus on treating ill health, not preventing it. GP-commissioning consortia should have incentives to invest upstream. But if public health funds are held separately and the responsibility for health improvement and prevention sits with local authorities, it is not clear who will make such investments, particularly at a time when funding will be under pressure.