

Royal College of Psychiatrists Consultation Response



DATE: 19th February 2010

RESPONSE OF: THE ROYAL COLLEGE OF PSYCHIATRISTS

RESPONSE TO: Strengthening National 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 response has been completed by the Registrar at the Royal College of Psychiatrists, Professor Sue Bailey.

This consultation was approved by: Dr Ola Junaid-Associate Registrar

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Strengthening National Commissioning

The Royal College of Psychiatrists is pleased to respond to this consultation. In summary we welcome the initiative and wish to remain actively involved in the process. We believe there needs to be representation from the Royal College of Psychiatrists on the new body.

Consultation questions

Question 1- In the proposed changes, we are recommending a single group to advise Ministers on nationally commissioned specialised services. Do you agree to combining this advice into one group? If not, why not?

Overall the Royal College of Psychiatrists agree with the proposal to combine the two roles into a National Commissioning Advisory Group (NCAG) which would make recommendations directly to ministers. The author of this response, on behalf of the Royal College of Psychiatrists, was involved in the latter stages of the Carter review and believes the above proposal is in line with the thinking of that review and Lord Carter's recommendations and steps forward.

The whole consultation document places a very heavy emphasis on technologies (whether new devices or new medicines). This does not capture the reality of all interventions, especially in the field of mental health, where the psychological therapies are of great importance. Therefore we hope this area will be adequately represented in any future NCAG group (40% of contacts with Primary Care are because of mental health problems). At the "threshold criteria" for nationally commissioned services there are discreet populations with very complex and rare psychiatric conditions across the life span that have attached to them high cost and high disease burden where the evidence base for effective combined physical and psychological treatments, set in a social context are rapidly evolving.

With respect to the proposals outlined on page 11 of the consultation document, paragraphs 1.7, 1.8, 1.9 and 1.10 whilst seeing the sense of these proposals the very nature of these expensive new treatments for a small group of patients will attract public and media attention and therefore the proposed set of actions will need to demonstrate ethical validity and that there has been appropriate discussion and understanding across both the NICE process, the NCAG process and the proposed Innovation Pass.

Question 2: We have proposed the expertise of NCAG will need and have suggested that the Secretary of State appoints the Chair and members of SCAG. Do you think this is right? Is there other expertise we should include?

We would wholeheartedly welcome greater involvement of patients and lay representation but it needs to be acknowledged that delivering true lay representation and empowered patient participation is a challenging task. In this specific regard, due attention should be given to the fact that a significant number of NCG current commissioned services (and it is unlikely that this will change) provide specialist assessment, care, treatment and interventions for children and adolescents. This should be reflected in the lay and patient representation as should any other stage of the lifespan or any other group with particular vulnerabilities, disadvantage or risk of inequality.

Given the importance of robust and informed commissioning architecture and best implementation and delivery of specialist services the enhanced representation from commissioners and those with fit for purpose health economics expertise is to be welcomed. The proposed SHA representation opens up the opportunity to improve seamless pathways of care for patients across nationally commissioned services, linking into regionally commissioned services and out on into PCTs.

The expertise which seems to be most obviously missing on the proposed NCAG list is an ethicist who can test each and every process for ethical validity. Within the NCAG group is "clinical", clinical is an unclear term. As a current member of the NCG I recognise that Royal Medical Colleges are represented across the broad range of specialties throughout medicine and The Royal College of Psychiatrists would not wish to see this representation diminished but would accept those chosen to sit on the new group are appointed through an open and transparent process. They should have demonstrable fit for purpose skills, capacity for innovate thinking and be firmly linked into their specialist professional body. There at present seems to be ambiguity in this area which needs clarification and it may be appropriate for discussion to take place at the Academy of Medical Royal Colleges.

Finally in terms of the composition of the group there is no specific mention of third sector NGO representation. In a climate where we are moving towards social enterprise, including for those patients that have rare conditions this would seem to be of importance. This may be subsumed under lay representation but I would argue they are not the same thing.

Question 3: We believe that the proposed changes will build on and strengthen the implementation of Professor Sir David Carter’s review of specialised services commission arrangements and will provide a stronger and more robust process for national commissioning. Do you have any other suggestions for strengthening national commissioning?

Stronger emphasis on follow through, on measuring the patients benefits impact of having a nationally commissioned service on:

1. The patient group itself
2. Quality of life of patient and their carers
3. Increased skill set of staff and how this increased knowledge and skills should have add on benefit to link to services whether regionally commissioned or services commissioned at the level of the PCT i.e. each learning from the other along the pathway of commissioning.

I have raised other points relevant to question 3 in response to question two.

Question 4: In the accompanying impact assessment we have attempted to estimate the likely cost and benefit of the new proposals Do you agree with our estimate of the likely costs and benefits? If not please indicate and provide evidence, where possible, of any areas of disagreement.

I am aware that the impact assessment, in attempting to estimate the likely costs and benefits to the new proposals did use a case scenario model. In reviewing the economic evaluation the clear advantage is consolidation of decision making about existing national commissioning of highly specialist services into the single new body, NCAG. It is easy to see the benefits to patients in terms of real equality of access to high costs technologies, especially in respect of regional variation of patient access (this is a particular issue in mental health). It is also easy to see an achievable reduction in administration costs.

I would share the views in the summary “by extending the scope of national specialised commissioning to consider a small number of additional technologies which may be suitable for nationally commissioned specialised services will have uncertain financial consequences.” I am not an expert in this field but I think that the summary statement that the net impact of these proposals on NHS spending on treatment is estimated to be zero is as stated “subject to great uncertainty” and would suggest that the trend would be for cost implications in the short term to rise but with a case to be made for medium and long term gain.

Question 5: Please identify the impact the proposals in this document might have from the perspective of ethnicity, age, gender, gender reassignment, sexual orientation, religion or belief or socio economic considerations? If there is a negative impact what proportionate measures could address those issues?

While the quality impact assessment screening appears to be thorough the only way to be sure about this is for there to be very careful ongoing monitoring. There are known particular vulnerabilities in the field of mental health with respect to ethnicity where we know that access to services is more challenging. We know that there are inequalities in access to services at a local and regional level and therefore would assume these would have a knock on effect at national level. There are particular sensitivities in the field of mental health where users and mental health services are far more vulnerable to the vagaries of extant socio economic circumstances. Therefore I would like to see a robust proposal within this consultation for how the equality impact assessment will be continually monitored and how the NCAG group would be expected to respond if it is found that there are identifiable inequalities. In the field of nationally commissioned mental health services there is the added pressure of the involvement of other government departments, i.e. nationally commissioned services who deal with mentally disordered offenders where unlike any other branch of medicine the patients are coercively detained under the Mental Health Act therefore this needs particularly careful monitoring.

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