Consultation of RCPsychiS Members – Mental Health Services in National Care Service Proposal

- **Which healthcare services do you think have been enhanced from being delegated to IJBs?**
- **Which healthcare services do you think have not benefited from being delegated to IJBs?**
- **What aspects or functions of currently delegated healthcare services need to be continued in the NCS, which need to be changed or removed, and why?**
- **What other functions for planning and delivery should be included in the NCS that would lead to better outcomes?**
- **As services transfer to the NCS, what risks do you foresee and what do you think may need to be in place to ensure oversight of clinical and care governance for services which will be the responsibility of the Care Boards?**
- **What are your immediate thoughts or concerns about the proposals and how community healthcare might change as a result?**
- **What other opportunities do you see for improving outcomes for our communities accessing support and services as part of the development of the NCS?**

RCPsych in Scotland – General Views

The RCPsych in Scotland has substantive concerns about the potential impact current proposals for the inclusion of mental health services within a National Care Service will have for patient safety and care, as well as recruitment and retention of the psychiatric workforce. We believe there is insufficient detail in these proposals for the College to support such a major system change. Within any service it is critical that mental health is viewed in parity with physical health, and we are concerned that these proposals will create significant barriers to achieving this. Our members do not believe there is enough evidence provided in the proposals to ensure patient outcomes will be improved and may even worsen because of a lack of joined up care. We have set out our detailed concerns in this submission and welcome the opportunity to further engage with Scottish Government as to the integration of care services to ensure clinical needs are met and patient safety remains.

- **Clinically-led services and ensuring the needs of the most vulnerable are met**
- **Relationship with physical health services**
- **Experience of integration & lessons learnt**
- **Risks**
- **Governance structure & principles**

Clinically-led services and ensuring the needs of the most vulnerable are met

We are deeply concerned the current proposal that all mental health services move to the National Care Service erects a barrier between mental and physical health care, to the potentially significant detriment of patients in both services

There is a risk that the 'Getting It Right For Everyone' (GIRFE) approach proposed for the National Care Service overlooks the specialist needs of people with severe mental illness (SMI) because of its focus on meeting the more generalist population needs. There needs to be continued recognition that people with SMI have specific needs that can be met only in a specialised clinical mental health context. This reflects that there is a vast difference between mental wellbeing services and services in the community which provide for those with mild mental ill health and specialist secondary and at times tertiary, community mental health services. Whilst it is important that there is easy access for those who need access to wellbeing services and support where necessary, it is critical that Secondary Care Mental Health Services are aligned with other Health services, in order that the needs of our most vulnerable are met, to further reduce stigma and to support parity of physical and mental health. As the lead clinicians for a population with severe and enduring conditions, we would strongly recommend that from the outset, a clear definition and understanding of what mental health care and treatment is and who provides it is needed before any decisions on structural change are made.

Most Mental Health teams depend on Psychiatric leadership and responsibility in terms of governance and service delivery. People with lived experience tell us that they value the contact with their consultant psychiatrist as key to their recovery and support. Removing mental health services from NHS structures and systems that enable clinical input to decisions about governance and service delivery puts patients' safety at risk. In order to ensure mental health services are able to deliver care and treatment to the nation's most vulnerable individuals, enshrining the principles of care, meeting clinical need and empowering clinical capabilities as part of the 'Getting It Right For Everyone' (GIRFE) approach must be a priority.

Relationship with physical health services

Mental and physical health are fundamentally linked. Research has consistently shown that individuals with severe and enduring mental ill health die 10-20 years earlier than the general population. Furthermore, it is well recognised that physical health problems significantly increase the risk of developing mental

health problems. Nearly one in three people with a long-term physical health condition also has a mental health problem.

As doctors, psychiatrists require access to clinical facilities (including diagnostics) and close communication with other medical colleagues to provide holistic care to patients. Moving mental health services away from the NHS structurally will sever vital links and create blocks in a system that should enable seamless communication between mental and physical health professionals. Doctors and other clinicians also operate within different professional codes, data, record keeping and legal obligations from social care, and these need to be recognised. Changes to shared record keeping would change the nature of medical confidentiality and this would need to be addressed legally under a new system.

Mental health cannot and should not be seen in isolation from physical health but rather as one. Creating further barriers by separating the two within different systems would without doubt risk patients' safety and best outcomes. People with severe and enduring mental illness in the community require access to dieticians, physiotherapists, smoking cessation, diabetes specialists and a range of other interventions accessible through primary or acute care which can make a real difference to a population who die young because of chronic physical disease. Disconnecting secondary care mental health care from physical health services will make access to such care harder and further entrench health inequalities for people with mental illnesses.

Mental health care and treatment is delivered across a range of settings from specialist inpatient units sometimes located within general hospital settings to standalone specialist inpatient units and community mental health teams all the way to clinics delivered within local primary care settings. There is a danger that framing all mental health services as 'community health' impacts the recognition of and resourcing for specialist mental health care and minimises the complex needs of people with mental illnesses.

Additionally, mental illness has long struggled to be treated with parity of esteem to physical illness. The proposal to single out Mental Health Services, Services for People with Neurodiverse Conditions and Dementia for a move into the NCS feels like a retrograde step and deeply stigmatising to people who access these services and for the specialist mental health practitioners who work within them. There is a very real risk that this conveys a message that the needs of the people who access these services are not as deserving of the prioritisation afforded those with physical health conditions.

Experience of integration & lessons learnt

The College is concerned that the NCS proposals insufficiently recognise the lessons learnt from previous system change. Our members' experience of integration and IJBs varies considerably across the country and specialties. A lack of joined up working, and structures for on-the-ground clinicians/staff to feed into and develop joint understanding, have been cited as common issues, as have clinical governance structures.

Members feel that structural changes alone cannot deliver change in care outcomes. Space to collaborate, to engage and to take collective decisions both

physically and culturally is critical. Teams which are clinically led to the benefit of patients, and therefore having a strong clinical voice alongside social care/community providers and people with lived experience would ensure that the specialist clinical needs of those with severe mental illness could continue to be met beyond the implementation of structural changes

There is a perceived lack of understanding within the current IJB structures of the range of mental health needs within the population, and examples of people unfamiliar with the clinical needs of those with severe mental illness having responsibility for making critical decisions around how best to provide this care. Assurances that this would not be the case and a clear structure for how clinical governance will apply in mental health services operating under the proposed new structure is critical. Furthermore, we are concerned that the proposed model drives a one-size-fits-all approach to the detriment of local care for local need.

To ensure there is buy-in to deliver the proposed changes, proposals would need to be effectively communicated with assurances around how these changes will be different from previous rounds of restructuring. Also, the very process of restructuring is hugely expensive, significantly disruptive and usually confusing and distressing to staff and patients alike. Outcome needs to be very important indeed to justify such change at this time. We need to see how the new model would be constructed, how it would be designed for mental health settings, and how services would retain the principle of clinical specialists meeting clinical need with sufficient resources. As noted in earlier sections, it is important to recognise that specialist care from psychiatrists will continue to be provided for in health board auspices, connections to other clinical professionals and services must be retained and strengthened.

The system is currently under extreme pressure and will be for some time because of the increasing demand for specialist mental health services. We also recognise the immense challenges within social care. This makes it immensely difficult for clinical stakeholders and frontline clinicians to free up time to have their voices added to the consultation and co design process. This risks, developing services which are clinically undesirable and unsafe.

Risks

As highlighted in our response to the initial NCS Consultation, any proposed structural change **must** recognise the current context of an unprecedented level of demand, low morale, workforce gaps and change fatigue within mental health services. Services are being pushed to the brink and we have significant concerns that further large-scale structural change will hinder rather than boost services ability to deliver safe patient care. It is important to acknowledge that we currently have a service that is stretched to the limit with a workforce that is demoralised and fatigued. A large scale structural change in this context risks wide spread systemic failure and a direct risk to patient safety, as well as risk of exodus of staff from the service.

Major structural change, coupled with a perceived removal from the NHS to an already stigmatised profession, carries a high risk of negatively impacting recruitment and retention into the profession at a critical juncture. Psychiatry is currently facing a workforce crisis with General adult psychiatry having the

highest number of consultant vacancies nationally. Any action that can be interpreted as devaluing the profession will negatively impact the stream of people either wanting to become a psychiatrist or remain one. By moving psychiatry and mental health into a separate system we risk stigmatising psychiatry further and therefore enhancing the view that it is different from other medical specialties.

There would also be significant implications for the training of doctors in Mental Health.

We do not believe workforce planning for specialist mental health care should be rolled into this new structure. While there needs to be better integration of hospital and community settings, mental health professions such as psychiatry will still operate within inpatient health board settings, and have their clinical governance retained in those structures. This mental health workforce requires immediate intervention to boost future numbers in future right now.

Meaningful change is needed now rather than after a complex and complicated transition to new structures. Current initiatives needed to address immediate and medium-term issues, such as a national transitions strategy to address delayed discharges and the development of quality standards for mental health care, should not be put on hold or slowed down while these proposals are taken forward.

Governance structure & principles

As expressed in our response to the initial NCS consultation, without further detail on the commissioning process, the principles on which it would be conducted and the clinical input into these processes, it is impossible to critically analyse these proposals.

The clinical regulations and standards set by professional bodies, and how these would intersect with regulation and scrutiny developed based on these principles, have not been made clear. Nor were the different definitions of risk between social care and health care, and how to ensure health care practitioners continued to be judged by a systems-based definition of clinical risk. Clinical risk is very different to the risk management systems in social care, with the system taking responsibility for clinical failures rather than the individual. Retaining this is critical to ensure the wider service's obligation to ensure the right training and resources were there to provide the right care was retained

We believe that frontline practitioners, psychiatrists as well as senior clinicians and service managers must be strongly represented on Care Boards. In doing so, the frontline service providers and user's experiences could inform the development of services in a practical, outcomes-focused way

There are also no additional principle setting an expectation to meet the needs of all Scots, including those with more severe conditions. These are the people who, without the right regulatory oversight, could be left behind by these changes.