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The College

Comments of the Royal College of Psychiatrists on the NHS White Paper: *Working for Patients*

General

The Royal College of Psychiatrists supports the government's aim "to raise the performance of all hospitals and general practitioners to that of the best." We would want to include also "all other health services such as community based services." However we are not convinced that the government's proposals would achieve this aim and we agree with all the comments made by the Joint Consultants Committee in their evidence to the Social Services Committee. *The College believes that such very drastic, expensive and untried changes should first be evaluated at a regional or district level before any general introduction.*

It is quite illogical that a document which strongly supports the principle of audit should also be advocating the general introduction of management and administrative practices which have not yet been evaluated. Some of the changes proposed, e.g. the internal market and competitive pricing and charging, have been introduced in the USA and have resulted in a large increase in administrative and financial control for their implementation. It seems certain that the administrative costs for the National Health Service in the United Kingdom will be more than doubled if the White Paper is introduced.

The extra money which will be needed for these administrative developments should be separate from and extra to the money required for clinical services. The principles of "audit" and "best value for money" should be applied as rigorously to these administrative procedures as to clinical procedures.

The actual style and content of the White Paper and the Working Papers cause us further unease. Their treatment of the complex issues involved is superficial and leaves a great deal unsaid. What has been launched, with great public razzmatazz and expense, is more of 'an artists impression' of a new building rather than any serious architectural drawings or specifications. The citizens of the United Kingdom deserve better than this before they and their Parliamentary representatives are required to make decisions which will affect their health services for many years to come.

Service issues

The proposals so far circulated may have very great significance for the planning and delivery of psychiatric care.

The nature of a 'core service' is referred to in Chapter 4 of the main document. *The College reiterates its view that 'core services' must include all aspects of a psychiatric service* (except for those for rarely occurring conditions). In particular, there must be no dividing off of 'acute' services from 'chronic' services. They are indivisible and must be provided locally on a district basis. This point was emphasised in our response to the Griffiths Report *Community Care: Agenda for Action*" (Royal College of Psychiatrists, 1988). Such a service will require a close integration and co-operation between hospital clinicians, general practitioners and community services. *Our College believes that the proposed contractual system will lead to a fragmentation of services to patients and we were interested to see that the Royal College of Physicians holds the same view.*

In Working Paper 2(2.3) the list of core services is "not intended to be regarded as definitive", "it will be for each district to consider, in the light of its own particular circumstances, what its core services should be." It is not clear whether these 'circumstances' will be financial ones or based on the needs of the population. Psychiatric illness is universally common, its exact prevalence depends upon the nature and age of the population. *Every district in the United Kingdom must have a psychiatric service covering both acute and long-term care which is designed to meet the needs of its local population of all ages.*

In particular, provision must be made for those districts with a large population of homeless or itinerant people. They have a considerable degree of psychiatric and physical morbidity. The numbers of such people passing through the district in the course of a year is considerably higher than the number at any given point of time. Consequently numbers calculated on the basis of a census may seriously underestimate the total number of patients that may require treatment.

The cost of a patient's stay in hospital depends a great deal on its duration. This in turn often depends upon the provision of appropriate facilities for the

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patient after discharge. Thus the efficiency of emergency services and the cost of the fixed payment, negotiated by a district with a self-governing hospital, will depend upon the provision of efficient community-based facilities.

The existence of such facilities is just mentioned in 4.15 but they are not otherwise discussed. Day hospitals are not mentioned at all. The implicit model of the White Paper seems to be one of the general practitioner and the hospital. The total health care system has been quite neglected, but without it the guarantee of immediate admission cannot be sustained nor can the fixed cost of care by the hospital.

For psychiatric patients other external factors may affect length of stay; for instance, a patient admitted under a court order may continue to be detained even when the consultant believes that the patient is fit to be discharged if the court or the Home Office regards the patient as a potential risk to the public.

Research from our College (1988) has shown that demands on psychiatric services and on in-patient beds are related to indices of social deprivation in the population – The Jarman Indices. It is unfortunate that this index has not been included in the RAWP calculation. The Jarman Index must be considered when the district's psychiatric needs are being planned.

The relationship between the GP and the psychiatric services

For those general practitioners operating on a budget, the fixed cost approach to out-patient services (Working Paper 3, 3.5–3.7) may well lead to 'perverse incentives' for the hospital either to set a high fixed charge in advance or to under-investigate and thus 'make a profit'. For psychiatry, many of the investigations involve further interviews with the patient and his or her family and other inquiries rather than just technical procedures. The proposed scheme does not easily take in to account the fact that many psychiatrists are now visiting general practitioner surgeries regularly for the purposes of referral and/or consultation and that many patients are referred initially to psychiatrists by other sources e.g., social work departments, other specialists, educational authorities and the Courts.

Many psychiatric patients who require out-patient care only may also be a considerable burden on a general practitioner's resources. Some of these patients will require continued supervision, e.g. by a community psychiatric nurse, and continued medication which may be expensive, and very often they will suffer from physical illnesses which they will be inclined to neglect. *The College is concerned that such patients may be seen as an excessive burden on a general practitioner's limited budget.*

There is no mention of day hospital care in the entire White Paper. This form of care is becoming increasingly important especially for patients with long-term psychiatric problems. Such patients would be a considerable burden on the general practitioner's budget. *The College's opinion is that all psychiatric day hospital care should be financed from the District Health Authority Budget.*

In respect to in-patient care, Working Paper 3 (paras 3.2–3.4) makes no mention of patients suffering from psychiatric illness. The great majority of psychiatric in-patient admissions are urgent admissions which cannot be delayed. In addition, hospital Accident and Emergency Departments see a considerable number of patients requiring psychiatric assessment and care. Both these groups are presumably outside the scope of a general practitioner's budget.

Management issues

The College supports the view of the Joint Consultants Committee that the proposed management framework and systems will:

(i) not be in place for many years
(ii) will be extremely costly
(iii) must be evaluated and pilot schemes established before any general adoption.

The College is particularly concerned about the degree of control which District Health Authorities will be able to exert on the range of services provided by self-governing hospitals. We note that serious reservations on the same issue were expressed by the National Association of Health Authorities in their evidence to the Social Services Committee. They state that the negotiating power of District Health Authorities may not be powerful enough and that the self-governing hospitals will "start to drop uneconomical services and inevitably concentrate on productive/profitable services at the expense of services, say for the elderly and the chronic sick". The National Association of Health Authorities lists a number of 'key' questions and concerns which need to be answered and these are:

"Lower cost treatment arranged with another district could have higher cost to patients and families in terms of travelling distance.
Is patient choice likely to increase or decrease with the existence of pre-determined contracts?
How will GPs or the DHA be able to judge outcomes in terms of quality?
To what extent will price dominate to the detriment of quality?
Will hospitals concentrate on profitable services which are in demand by purchasers of care outside the locality at the expense of local people?"

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The Institute of Health Services Management have made similar comments. We would strongly support these reservations. *Our College considers that no hospital should agree to accept self-governing status until and unless these and other questions are clearly answered. We have written to all our Members to this effect.*

There is one particular point on which we would comment. Under the Mental Health Act 1983 in England and Wales, managers have a duty to hear appeals against compulsory detention. The managers concerned are non-executive i.e., not the officers of the Health Authority. This has worked well and has given managers considerable insight in to clinical practice and problems. *The College doubts whether the slimmed down numbers of managers under the new proposals will be able to cope with this important work.* To use people from outside the management structure would, in our view, reduce its importance and its value to patients and management.

Audit

The College, like all other Royal Colleges, strongly supports the introduction of medical audit into health care. We have set up a Research Unit on funds contributed by our own Members to further this aim.

Audit must be seen as an important educational exercise and should be closely related to research. Research should influence audit procedures which should in turn suggest new topics for research. Audit can best develop where there is time both for teaching and research. Regular routine reviews can become superficial and uncritical. *The College considers that every full-time consultant will require at least one session a week to devote to audit and extra funds will be needed for collecting and analysing information* (the routine information as collected at present using the Körner indices are generally not adequate for clinical audit, but may suggest areas for inquiry).

To be effective, audits must tackle sensitive and often painful issues, e.g. postoperative deaths, suicides in hospital. To do this properly requires confidence between professionals both about the quality of the audit and about the way in which the information will be used. We agree that the results of audit should be published but are somewhat concerned by the fact that (para 4.2e) "relevant parts of both the forward programme and the annual report (of the District's Medical Audit Advisory Committee) could be made available to other Health Authorities considering placing contracts within the District". We are concerned that managers on short-term contracts and negotiating contracts for their self-governing hospitals may suppress or dilute the findings of clinical audit if they are unfavourable.

The College believes that some regular multidisciplinary forum for auditing management is badly needed and should complement the auditing of medical and clinical procedures. The current language of management is quite extraordinarily lacking in self-criticism.

Education and research

Both these topics are given scant attention in the White Paper and Working Papers. We can only agree with the comments made by the National Association of Health Authorities that "the cursory treatment of teaching and research issues is a serious flaw in the White Paper. The National Health Service depends crucially for the quality of its care on high standards and excellence in basic and clinical research and training".

In the original document *Working for Patients*, training and research were assigned precisely two paragraphs. In the paragraphs about the functions of Regions there was no mention of their extremely important teaching functions. In the paragraphs about consultant contracts there was no mention of their teaching obligations.

The Working Papers are hardly any more reassuring. The Regions have been awarded a very important function i.e. "funding training and research in all hospitals to remove their costs from pricing provisions" (Working Paper 2 para 4.2). This seems to suggest that teaching and research is regarded as a 'regional extra' on the Health Service as a whole. This is not at all reassuring nor is the statement (4.7) that "hospitals must not cut back on postgraduate training in order to achieve immediate cost reductions if the long-term effect will be poorer standards of *service*" (N.B. *not of training*). Thus service needs are commercially paramount and it will be the responsibility of the Regional Health Authority to ensure that this does not happen and to fund postgraduate training directly where necessary. Paragraph 4.7 then goes on to say that "a way of doing this would be for the Regional Health Authority to contract with individual hospitals or groups of hospitals to provide appropriate training programmes". It is not clear what is meant by a "programme". At present, courses are often funded in this way, but it is a fundamental basis of postgraduate education that all hospitals must be staffed to a great extent by trainees working in posts and programmes approved by the appropriate College. The holders of the new staff grade posts must receive continued education. In the future, it will become even more important to provide continuing education for consultants.

The self-governing hospitals may set particular difficulties:

(i) it is likely that the individually negotiated salaries of senior medical staff will increase the disparity

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between health service and university staff with consequent erosion of academic activities

(ii) the range of patients may be reduced

(iii) it is possible that the hospitals could hire doctors to work in the service in posts which are not recognised for training and that such posts may come to predominate over posts recognised for training by the appropriate Colleges. Thus self-governing hospitals may opt out of training and concentrate entirely on service provision along the lines followed currently by the majority of private hospitals.

Every hospital of any size must be seen as a training hospital. The costs, in our view, must be built into the system and not seen as an extra provided by the Region.

Consultant appointments and contracts

The College was pleased to see that teaching duties and responsibilities are included in the consultant's contract (Working Paper 7, para 2.6) as well as participation in medical audit. *In our view, a full-time consultant will require a minimum of two sessions per week to fulfil his or her teaching and audit duties and responsibilities.* Consultant staffing for service and teaching provision should be calculated on this basis. For psychiatrists there are extra demands on their time from the work connected with the Mental Health Act (for example, Mental Health Review Tribunals, Second Opinion Procedures, and Court Work) and for the need to serve on other important Committees such as the Mental Health Act Commission and the Health Advisory Service, both of which prefer to make the use of doctors who are still in active clinical practice.

Review of contract

We appreciate the need for reviews of job descriptions, but we are anxious to ensure that a consultant continues to work within the overall guidelines carefully laid down by the College. These include staffing levels, size of population to serve, number of available beds and other matters which are of great importance to the work, effectiveness and continued education of the consultant. The College Regional Adviser must be consulted if there is any dispute or doubt on these matters.

Appointment procedures

The College is strongly opposed to the participation of managers as members of appointment committees. We have had evidence that this can lead to serious distortion in the selection process and have recently issued guidance on this matter to our Members (Royal College of Psychiatrists, 1989).

Distinction Awards

The College does not want to comment in detail on the changes in Distinction Awards procedures, but would want to make the following points:

(i) Those who have distinguished themselves in research and in academic medicine must not be overlooked. Their contributions to the National Health Service are essential to its survival and growth. There are already many monetary disincentives to entering academic and research fields in the United Kingdom.

(ii) The presence of managers on medical distinction award committees should be reciprocated by the presence of senior doctors on the committees awarding performance increments to managers.

Questions to be asked

How will contracts between a District Health Authority and a self-governing hospital ensure that core services for the District are provided and will not be discontinued unilaterally?

What information will be required by Districts for making decisions as to which core services will be provided? In the case of a District omitting a particular service, how will the District obtain it?

For psychiatric patients, the following factors other than the clinical state of the patient can affect the cost of care:

(i) teaching and research activities of the hospital (cost per day and possibly length of stay)

(ii) capital cost of hospital building and equipment (cost per day)

(iii) community services (length of stay)

(iv) legal decisions affecting discharge (length of stay).

How will pricing either in Health Authority contracts or in GP budgets be arranged to take account of these factors and protect both the quality of patient care and the continuing education and research activities of a hospital?

What arrangements and calculations will need to be made in order to implement the proposal (Working Paper 2, para. 4.2) that "Regions fund training and research in all hospitals, to remove their costs from pricing provisions."?

April 1989

Membership of the Royal College of Psychiatrists Working Group on The Government's Review of the NHS

Chairman Dr J. L. T. Birley, *President, The Royal College of Psychiatrists*
Members Dr D. G. Fowlie (*Chairman, Social and Community and Rehabilitation Psychiatry Section*), Dr A. R. M. Freeman (*Secretary, Public Policy Committee*), Dr A. Gath (*Registrar, The Royal*

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College of Psychiatrists), Dr D. Kelly (*Medical Director, The Priory Hospital*), Dr S. A. Mann (*Member, Executive and Finance Committee*), Professor J. Watson (*Professor of Psychiatry, Guy's Hospital*)
In attendance: Mrs Vanessa Cameron (*Secretary*), Ms Deborah Hart (*Assistant Secretary*)

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Trainees' forum: How to survive in management

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On 23 January at the Winter Quarterly Meeting 1989, one week before publication of the White Paper on the Review of the NHS, the Trainees' forum, entitled 'How to Survive in Management', took place. The decision to devote this forum to management issues was taken in September 1988 at the CTC's Residential Meeting where there was little hesitancy from trainees in identifying this subject as important, topical and worthy of a forum. There were three speakers who each talked for 20 minutes before the floor was opened to discussion. Below is an outline of these talks and the key issues which arose afterwards.

Dr McKim Thompson, who is a Deputy Secretary of the British Medical Association, was the first to speak. He stressed how important it is for doctors to take an active interest in management and for trainees to find the 'willpower' to acquire some training. He told us that in some Regions, consultant appointments are not made when the senior registrar has not acquired specific management training. After giving us a multi-faceted definition of management, he examined some specific issues which any doctor involved in management should address. These included an understanding of industrial relations (which is complex within an organisation which has 42 unions), terms of service, and disciplinary procedures. He stressed the importance of discovering as an aspirant consultant, how a service is being delivered at a local level. He stressed the need to talk to local consultants in your own and other specialties.

Dr McKim Thompson concluded with suggestions for personal management training. He advised trainees to be alert to advertisements on courses in journals and periodicals. He suggested that initially, attendance at a unidisciplinary course is advisable, that is one targeted at doctors or even psychiatrists only, rather than several different health care professionals. He recommended a number of interested organisations which offer courses in conjunction with the BMA, which include the International Business Management Services at Aston and the Health Services Management Centre at Birmingham. He expressed a BMA concern that consultants, particularly in psychiatry, were abdicating a leadership role and apropos this, he recommended that trainees should acquire training in interpersonal skills, communication and team leadership. Additionally, he stressed the importance of developing an understanding of planning and financial management, funding of the NHS, and Department of Health procedures. Like the next two speakers, he emphasised the need to develop skills in personal time management.

Our second speaker was Dr Master, who had held the post of Director of the Mental Illness Services at Guy's Hospital for the last 18 months. He started by pointing out how doctors and managers come from ideologically different backgrounds which may account for the lack of interest which most doctors have for involving themselves in management. Whereas doctors are concerned with short-term goals for their individual patients, regardless of cost,

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