

IN SIGHT AND IN MIND

A toolkit to reduce the use of out of area mental health services

March 2011

[to contents](#) 



CONTENTS

CONTRIBUTORS >>
EXECUTIVE SUMMARY >>
SEVEN STEPS >>
SCOPE >>
BACKGROUND >>
DEFINITIONS >>

SUMMARY OF KEY ISSUES
AND CURRENT KNOWLEDGE >>
RESEARCH EVIDENCE AND DATA >>

OVERVIEW OF MANAGING
WHOLE SYSTEMS AND REDUCING
OUT OF AREA SERVICES >>
ILLUSTRATION 1 >>
ILLUSTRATION 2 >>
ILLUSTRATION 3 >>

SYSTEMATIC APPROACH
TO REDUCING USE OF
OUT OF AREA SERVICES >>

STEP 1 >>
STOCKTAKE

STEP 2 >>
NEEDS ASSESSMENT

STEP 3 >>
ESTABLISH A PLANNING STRUCTURE

STEP 4 >>
AGREE AND COMMUNICATE
A WHOLE SYSTEM STRATEGY

STEP 5 >>
IMPLEMENTATION

STEP 6 >>
SET UP AND MONITOR
KEY PROCESSES

STEP 7 >>
REVIEW AND REFINE

GOOD PRACTICE
CASE STUDIES >>

TOOLS TO SUPPORT
COMMISSIONERS >>

REFERENCES >>



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EXECUTIVE SUMMARY

NAVIGATE THIS TOOLKIT
CONTRIBUTORS >>
EXECUTIVE SUMMARY >>
SEVEN STEPS >>
SCOPE >>
BACKGROUND >>
DEFINITIONS >>
SUMMARY OF KEY ISSUES AND CURRENT KNOWLEDGE >>
RESEARCH EVIDENCE AND DATA >>
OVERVIEW OF MANAGING WHOLE SYSTEMS AND REDUCING OUT OF AREA SERVICES >>
SYSTEMATIC APPROACH TO REDUCING USE OF OUT OF AREA SERVICES >>
GOOD PRACTICE CASE STUDIES >>
TOOLS TO SUPPORT COMMISSIONERS >>
REFERENCES >>

This toolkit has been designed to support health, social care and housing commissioners. It seeks to assist in developing and commissioning services that are as close to home as possible for people using mental health services and their families.

Out of area services make up a considerable proportion of mental health and social care provision and expenditure. This toolkit provides a framework for understanding the use of services out of area; what might contribute to their usage; and how taking a whole system approach could reduce the use of such services.

The toolkit is intended to contribute to local actions to improve quality and individual/system outcomes by:

- Limiting the number of people placed inappropriately
- Reducing the number of people placed at distance from families and social networks
- Minimising the length of time that people spend in out of area services
- Maximising and improving care coordination and monitoring of placements
- Specifying services to actively promote independence
- Encouraging services to be commissioned on a needs basis, at appropriate costs and within commissioning resources.

A summary of research and knowledge in this field is provided to give best evidence of the current picture and some of the issues associated with use of placements out of area.

A systematic seven-step framework to reduce the need for out of area services is described. This should support commissioners to consider the processes and actions that others have found helpful in improving their local performance and outcomes. Embedded within the toolkit is a range of tools that have been developed and used successfully across the country.

A series of case studies are also described where people have successfully reduced the need for unplanned use of out of area services. These contain contact details of key personnel who are prepared to provide further information about their work, if required.

KEY INFORMATION

Around £690 million was spent on mental health out of area placements in 2009/10.¹

Nearly half of out of area placements in the independent and voluntary sector are made by local authorities (48.6%), one quarter by NHS commissioners (24.3%) and roughly one quarter jointly funded (25.7%) (Ryan et al, 2007). Nearly two thirds of the funding for these placements (62.6%) comes from NHS commissioners (Ryan et al, 2007).

Lack of local capacity can be a key factor in needing to use out of area services, with 'in area' services known to have people unsuitably placed within them – 23% in one study (Ryan, 2005).

Effective planning and targeted rehabilitation can lead to many people returning to their area of origin and to lower levels of support – 63% in one study (Killaspy et al, 2009).

¹ QIPP workstream analysis based on Department of Health Mental Health Finance mapping 2009/10 (PCT and LA)

SEVEN STEPS

NAVIGATE THIS TOOLKIT
CONTRIBUTORS >>
EXECUTIVE SUMMARY >>
SEVEN STEPS >>
SCOPE >>
BACKGROUND >>
DEFINITIONS >>
SUMMARY OF KEY ISSUES AND CURRENT KNOWLEDGE >>
RESEARCH EVIDENCE AND DATA >>
OVERVIEW OF MANAGING WHOLE SYSTEMS AND REDUCING OUT OF AREA SERVICES >>
SYSTEMATIC APPROACH TO REDUCING USE OF OUT OF AREA SERVICES >>
GOOD PRACTICE CASE STUDIES >>
TOOLS TO SUPPORT COMMISSIONERS >>
REFERENCES >>

The seven steps to systematically reduce the need for out of area services are:

- 1 STOCKTAKE** – map provider services (where they are, the cost levels, how effective people find them, outcomes), analyse options to expand the range and choice of local services etc.
- 2 NEEDS ASSESSMENT** – what are the needs of people in the commissioner’s area, how do current services meet / not meet need?
- 3 ESTABLISH A PLANNING STRUCTURE** – to address the issues and outcomes to be achieved in a systematic, managed way, involving local leaders (clinical and political), frontline clinicians / practitioners, managers, people using the services, their families and carers.
- 4 AGREE AND COMMUNICATE A WHOLE SYSTEM STRATEGY** – agree goals, timescales etc. in a coherent development plan.
- 5 IMPLEMENTATION** – beginning with identifying options to develop:
 - Clinical and commissioning systems (e.g. assessment, review, etc.), leadership and care pathways
 - Data and information systems
 - Service choice for people using the services and their clinicians / practitioners (i.e. through market development including procurement frameworks)
 - Integrated service specifications and outcome measures across care pathways to build resilience and a ‘whole system’ focused on providing best outcomes for people (i.e. recovery and maximum independence from services).
- 6 SET UP AND MONITOR KEY PROCESSES** – e.g. quality assurance, case management and feedback, contracting systems, involvement of people who use the services and their carers.
- 7 REVIEW AND REFINE** – establish annual reviews of strategy, processes and services.



SCOPE

NAVIGATE THIS TOOLKIT
CONTRIBUTORS >>
EXECUTIVE SUMMARY >>
SEVEN STEPS >>
SCOPE >>
BACKGROUND >>
DEFINITIONS >>
SUMMARY OF KEY ISSUES AND CURRENT KNOWLEDGE >>
RESEARCH EVIDENCE AND DATA >>
OVERVIEW OF MANAGING WHOLE SYSTEMS AND REDUCING OUT OF AREA SERVICES >>
SYSTEMATIC APPROACH TO REDUCING USE OF OUT OF AREA SERVICES >>
GOOD PRACTICE CASE STUDIES >>
TOOLS TO SUPPORT COMMISSIONERS >>
REFERENCES >>

This toolkit has been developed as one of the products of a national partnership (see page 3) to gather and synthesise local best practice, evidence and successes from across the country. These have been identified at local and regional levels across local authorities, NHS commissioners (PCTs and GPs) and providers. They have all sought to ensure that people only need to use mental health services outside their local area when this is a positive individual clinical/professional option or personal choice. This work has also focussed on trying to identify best outcomes secured (quality, public value and procurement) from services commissioned, either when required out of area, or to support greater flexibility and resilience in local commissioned services.

The toolkit is intended to add value to the work going on in a local health and social care economy, or at sub-regional and regional level, and to ensure people have a positive experience of their care and support – a central tenet of the new English mental health outcomes strategy *No Health without Mental Health* (Department of Health, 2011). It also aims to support local commissioning actions to improve service quality and ensure a better use of resources. This is likely to be achieved through reducing out of area service use, shortening lengths of stay and developing local care pathways, thereby freeing capacity to reduce the need for other people to be placed or treated out of area.

The toolkit will be relevant whether or not the aim is to reduce high numbers of people needing to use services out of area, and can be used where areas already have good local performance but are grappling with the challenges of balancing need with service availability. Challenges can include:

- Building resilience into local systems and diversion processes to prevent people needing to leave their area to access services
- Using clinical expertise to generate commissioning dialogue across primary and secondary care
- Improving care pathways, and people's experience of service and outcomes through effective collaboration with people who use services, their families and carers, clinicians and practitioners
- Influencing professional microsystems to spread effective approaches with a focus on outcomes and quality in commissioning and decision-making
- Pathway and infrastructure re-engineering (e.g. models, buildings, services and skills) to widen options for people to remain living locally or, where appropriate, return from out of area
- Effective collaborative commissioning and procurement, again with a focus on quality and value for money, influenced and shaped to address local need and priorities

- Primary prevention for high-risk groups and pathways, for example in the criminal justice system or for people with eating disorders.

One of the main emerging findings is the central importance of multi-agency working, where housing strategy, primary care involvement and the availability of a wide range of local public services appear essential. Multi-agency working can provide 'whole system' resilience and also help meet people's needs in a personalised and flexible way across tiers of services. This can be done either through intensifying input as need increases, or supporting recovery through access to universal services, employment and community resources.



BACKGROUND

NAVIGATE THIS TOOLKIT
CONTRIBUTORS >>
EXECUTIVE SUMMARY >>
SEVEN STEPS >>
SCOPE >>
BACKGROUND >>
DEFINITIONS >>
SUMMARY OF KEY ISSUES AND CURRENT KNOWLEDGE >>
RESEARCH EVIDENCE AND DATA >>
OVERVIEW OF MANAGING WHOLE SYSTEMS AND REDUCING OUT OF AREA SERVICES >>
SYSTEMATIC APPROACH TO REDUCING USE OF OUT OF AREA SERVICES >>
GOOD PRACTICE CASE STUDIES >>
TOOLS TO SUPPORT COMMISSIONERS >>
REFERENCES >>

As part of their experience of mental health and social care support and treatment, considerable numbers of people are placed in facilities in the public, independent and third sectors for support, for example, in independent hospitals, care homes (with or without nursing) and housing schemes with care.

In many cases services are local to families, friends and services that may have supported people in the past. However, for some people these services may be outside the local area and at a considerable distance from their support networks.

Management of placements by care coordinators, practitioners and commissioners at a distance can create many difficulties. All out of area service use can impact on people's contact with family and friends and limit opportunities for social inclusion, employment, education and independence (Rethink & Care Services Improvement Partnership, 2007). This is the case whether or not the reason for an out of area placement is lack of local capacity, suitable skills or practical issues such as legal restrictions. This social dislocation can be especially problematic for people from minority ethnic groups.

From a commissioning and financial perspective, use of out of area services also means that monies and specialist skills are being lost from the local system that could be used to improve local capacity and capability. The use of out of area services represents a hidden cost that links to a lack of development of local services (Department of Health, 2007). This in turn can reduce choice for people, control over services and efficiency, and lead to public criticism.

Government reforms to health and social care (which are undergoing parliamentary scrutiny at time of going to press) will lead to the formal creation of the NHS Commissioning Board; *The NHS Outcomes Framework* (Department of Health, 2010a) will form part of the mandate that the Secretary of State of Health will set this Board. Commissioning consortia will be held to account for progress against a number of overarching indicators outlined in the framework, including 'enhancing quality of life for people with long-term conditions'.

Given that one aspect of improvement in this area will be a measure of the 'proportion of people feeling supported to manage their condition', the importance and relevance of a whole systems approach to the use of out of area services should be clear, as it is only through such an approach that people will be appropriately placed and effectively supported.

As the examples cited in this toolkit demonstrate, it is possible to improve both capacity and capability while at the same time reducing the need for some people to be placed out of area, by developing a managed whole system approach. This can result in more financial resources being invested in the local mental health and social care economy, and can potentially achieve savings as well.

This toolkit will be useful for local authority and NHS commissioners both now and in the new landscape for health, social care and public health. Collaboration between clinical commissioners (GP consortia) and commissioners of specialist services, and between local and collaborative commissioning is essential to deliver sustainable quality improvements as well as cash-releasing efficiencies.



DEFINITIONS

NAVIGATE THIS TOOLKIT
CONTRIBUTORS >>
EXECUTIVE SUMMARY >>
SEVEN STEPS >>
SCOPE >>
BACKGROUND >>
DEFINITIONS >>
SUMMARY OF KEY ISSUES AND CURRENT KNOWLEDGE >>
RESEARCH EVIDENCE AND DATA >>
OVERVIEW OF MANAGING WHOLE SYSTEMS AND REDUCING OUT OF AREA SERVICES >>
SYSTEMATIC APPROACH TO REDUCING USE OF OUT OF AREA SERVICES >>
GOOD PRACTICE CASE STUDIES >>
TOOLS TO SUPPORT COMMISSIONERS >>
REFERENCES >>

While it would be usual for a full range of services to be available locally, there are circumstances where it is entirely appropriate for people to access services outside their local area. The considerations that might apply include:

- Where the clinical expertise required cannot be offered in every local area and instead is offered at sub-regional, regional or national levels
- Where engagement with local user groups/professionals indicates that a service is better placed out of area
- Where it is likely to improve the clinical/quality of life outcomes, for example, if it means the person is closer to established support networks/family members
- Where there are particular reasons why it is more appropriate for the person to be placed out of area – for example, where legal restrictions apply or there are wider safeguarding concerns.

Over recent years a number of terms have been used to describe people who have been placed away from their home area. For the purposes of this toolkit the term 'out of area services' is applied to describe the different types of provision used.

OUT OF AREA SERVICES – covering people with assessed mental health/social care needs using medium-term treatment/rehabilitation or long-term care services away from their home area, where local services would have been a practical alternative, if available at the time of placement, or since.

A range of different terms is used within the umbrella term 'out of area'.

OUT OF AREA TREATMENTS (OATS) – a term used mainly in relation to NHS-commissioned and funded placements out of the area of the commissioner and / or its main NHS provider and in the non-statutory sector. These should not be confused with *extra contractual referrals* (ECRs) between NHS providers of in-patient hospital services. Out of area treatments are often undertaken on a spot-contracted basis, although not exclusively. They tend to be into independent hospitals, where people may be detained under mental health legislation, and into specialist services e.g. secure care, acute psychiatry, eating disorders etc. There are also examples of use of block-contracted independent sector services out of area (for example, for psychiatric intensive care units [PICUs]). These have often been developed as part of wider strategic commissioning plans.

OUT OF SECTOR (OOS) – usually refers to placements made outside the statutory sectors but they can be within the geographical area of the commissioner and / or its main NHS provider.

OUT OF CITY/COUNTY PLACEMENTS (OOC) – usually applied to local authority placements made outside the geographical boundaries of the local authority. Out of city / county placements are often in care homes, with or without nursing; they are either joint-funded between health and local authority or exclusively by the local authority. These tend to be commissioned for people with less complicated individual needs than people placed in independent hospitals.

WITHIN AREA OR WITHIN CITY / COUNTY PLACEMENTS – it is probably useful to clarify what *within area*, *within city* or *within county* mean in relation to local mental health and social care economy. Usually this refers to the boundary of the commissioning organisation(s) or geographical entity (e.g. city or county), but in some cases it may be other boundaries such as the service's main NHS provider trust for the area. It should be noted that sometimes formal boundaries are not coterminous with what people living in the vicinity define as their 'home' or 'local' area – for example, when this crosses a number of neighbouring boroughs in large conurbations.

SUMMARY OF KEY ISSUES AND CURRENT KNOWLEDGE

more 

NAVIGATE THIS TOOLKIT
CONTRIBUTORS >>
EXECUTIVE SUMMARY >>
SEVEN STEPS >>
SCOPE >>
BACKGROUND >>
DEFINITIONS >>
SUMMARY OF KEY ISSUES AND CURRENT KNOWLEDGE >>
RESEARCH EVIDENCE AND DATA >>
OVERVIEW OF MANAGING WHOLE SYSTEMS AND REDUCING OUT OF AREA SERVICES >>
SYSTEMATIC APPROACH TO REDUCING USE OF OUT OF AREA SERVICES >>
GOOD PRACTICE CASE STUDIES >>
TOOLS TO SUPPORT COMMISSIONERS >>
REFERENCES >>

In September 2010, a total of 23,280 NHS-provided mental health beds were available in England (of which 20,165 were occupied [86.6%]). In 2005, there were 31,286 NHS-provided beds available (of which 27,481 were occupied [87.8%]) (Department of Health, 2010b). This represents a reduction in availability of NHS beds of 25.6%. Between September 2005 and 2010 there was an increase in numbers of care and nursing home beds for mental disorder and / or dementia from 313,394 beds to 324,501, an increase of 3.4% (Care Quality Commission, 2010).

In 2009/10, just over £3 billion was spent by health and social care commissioners on specialist mental health services – specifically rehabilitation, treatment and long-term care where equivalent services could be provided in or out of area. Of this, approximately £692 million (around 23%) was spent on out of area services.¹ This largely comprises expenditure for placements in independent hospitals, care homes (with and without nursing) and various forms of housing with support.

Several key groups of people are supported in out of area services. Those in independent hospitals often have specialist needs related to their condition (e.g. eating disorders, Asperger's syndrome, acquired brain injury, etc.), that cannot be met by local services. People may also be placed out of area because they need specialist secure care and / or detention. People

may be placed in services of this type due to conditions of security and / or legal detention for the treatment they require. Often these services are so specialised that each geographical area does not have the volume of demand to support a service of its own. Therefore services are either collaboratively commissioned for a wider geographical area or otherwise contracted as needed. There will also be occasions where local services exist but do not have sufficient capacity at the time a placement is required. The location of some services is a legacy of the hospital closure programme in the second half of the twentieth century. Many of these services were originally set up to take people being resettled into the community. A number of these former 'resettlement' services now provide community-based rehabilitation and recovery schemes for people who may require detention under the Mental Health Act.

The monitoring of such placements varies widely across the country, from both care delivery and contracting perspectives. Experience shows that sometimes these specialist placements are no longer necessary, but this is not identified swiftly. People may be left in inappropriate and expensive out of area placements that are of no benefit to them. This may be detrimental to people's continued progress towards recovery. Also, given potential annual costs of between £50,000 and £150,000 per person, it does not make financial sense.

Having systems in place to monitor the placement for ongoing suitability and the associated contracting arrangements is essential to maximise cost- efficiency. Such systems are also essential to inform the development of recovery-focused support through the use of personal budgets. These can be used to provide alternative support arrangements, especially where the services available are not able to meet the needs of the person.

¹ QIPP workstream analysis based on Department of Health Mental Health Finance mapping 2009/10 (PCT and LA)



 [Back to contents](#)

SUMMARY OF KEY ISSUES AND CURRENT KNOWLEDGE CONTINUED

more 

NAVIGATE THIS TOOLKIT

CONTRIBUTORS >>

EXECUTIVE SUMMARY >>

SEVEN STEPS >>

SCOPE >>

BACKGROUND >>

DEFINITIONS >>

SUMMARY OF KEY ISSUES
AND CURRENT KNOWLEDGE >>

RESEARCH EVIDENCE AND DATA >>

OVERVIEW OF MANAGING
WHOLE SYSTEMS AND REDUCING
OUT OF AREA SERVICES >>

SYSTEMATIC APPROACH TO REDUCING
USE OF OUT OF AREA SERVICES >>

GOOD PRACTICE CASE STUDIES >>

TOOLS TO SUPPORT COMMISSIONERS >>

REFERENCES >>

Similar issues exist in relation to a range of other services, in particular for those people with learning disabilities, and there seems to be a strong case for transferable learning. For example, *The Mansell Report* (Department of Health, 2007) suggested commissioning priority should be given to developing services locally that work with people whose learning disability and behaviour or mental health needs challenge services the most. Key factors in their development should be how well they promote people's rights, inclusion, independence and choice. The service system should demonstrate its effectiveness through value for money, low numbers of placement breakdowns and use of out of area placements. Clearly the same effectiveness issues would apply to mental health service and commissioning systems.

Other challenges include the identification and management of the responsible commissioner and establishing where someone is 'ordinarily resident' (see page 31 for links to guidance). Again, without systems in place to address these issues people may remain in placements that are not required while responsibilities for commissioning and funding are being established, even though the rules for both local authorities and NHS are explicit that this should not occur.

Many out of area services are contracted on a 'spot' basis. From a provider perspective, this can create difficulties for business planning and, if their whole service is funded in such a way, providers invariably have to make financial provision for shortfalls in occupancy.

If commissioners are able to collaborate with each other across agency or geographical boundaries to procure services together, they are likely to get a 'better deal' than when contracting for individual placements. Examples of collaborative commissioning include the ten regional specialised commissioning teams in the NHS, and a wide range of consortia or joint commissioning arrangements between local authorities and/or NHS commissioning organisations. Nevertheless, there is considerable scope to broaden and systematise these arrangements to other areas by building on the experience of such collaborations to date.

While the issues associated with out of area services are complex from commissioning and case management perspectives, some parts of the country have developed effective approaches to reduce the need to place people away from their local mental health services and have built resilience into their local service system.



SUMMARY OF KEY ISSUES AND CURRENT KNOWLEDGE CONTINUED

NAVIGATE THIS TOOLKIT
CONTRIBUTORS >>
EXECUTIVE SUMMARY >>
SEVEN STEPS >>
SCOPE >>
BACKGROUND >>
DEFINITIONS >>
SUMMARY OF KEY ISSUES AND CURRENT KNOWLEDGE >>
RESEARCH EVIDENCE AND DATA >>
OVERVIEW OF MANAGING WHOLE SYSTEMS AND REDUCING OUT OF AREA SERVICES >>
SYSTEMATIC APPROACH TO REDUCING USE OF OUT OF AREA SERVICES >>
GOOD PRACTICE CASE STUDIES >>
TOOLS TO SUPPORT COMMISSIONERS >>
REFERENCES >>

Building effective relationships with commissioners and providers

Later in this toolkit we have included some case studies that highlight how whole system approaches across health and social care economies have been developed to good effect. They also describe ways that stakeholders have worked together to build better service and support systems for people back in their local areas. We have been able to glean some key features of good practice from this that seem central to commissioners and providers working together. These include:

- The need for open and transparent working relationships
- The development of effective working relationships through spending time together and working on system issues, not just individual service issues
- Clarity and honesty about the issues being addressed
- Recognition of the need for a place where providers and commissioners can share their views and ideas about how the services can develop as a system
- The need for providers to feel confident in being appropriately involved in all stages of the system development process, even where services are being decommissioned, redesigned or subject to procurement processes.

For the purposes of this toolkit it is important to recognise that the market for these services is already competitive and covered by competition law and policy.² There also remains a responsibility with commissioners, now and in the post-PCT landscape of GP consortia, NHS Commissioning Board and local authority commissioning, to plan and develop the range of services based on the outcomes of Joint Strategic Needs Assessments and locally defined priorities and choices. Good practice in doing this is likely to involve clearly communicating strategic priorities for market development, and the practical and commissioning actions arising from these priorities, across all current and potential providers. It would also cover engaging in dialogue with providers, people who use services, partners and the wider public about how services are shaped and improved.



² Department of Health (2010) *Principles and Rules for Cooperation and Competition*. London: Department of Health. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_118221

RESEARCH EVIDENCE AND DATA

NAVIGATE THIS TOOLKIT
CONTRIBUTORS >>
EXECUTIVE SUMMARY >>
SEVEN STEPS >>
SCOPE >>
BACKGROUND >>
DEFINITIONS >>
SUMMARY OF KEY ISSUES AND CURRENT KNOWLEDGE >>
RESEARCH EVIDENCE AND DATA >>
OVERVIEW OF MANAGING WHOLE SYSTEMS AND REDUCING OUT OF AREA SERVICES >>
SYSTEMATIC APPROACH TO REDUCING USE OF OUT OF AREA SERVICES >>
GOOD PRACTICE CASE STUDIES >>
TOOLS TO SUPPORT COMMISSIONERS >>
REFERENCES >>

The decline in NHS hospital beds over the past four decades as a result of the closure programme for the Victorian asylums and the policy of 'care in the community' has seen a corresponding, if sometimes unplanned, growth in alternative and smaller bed-based services (Holloway, 2005), particularly in the independent sector.

More recently, a lack of emphasis on the delivery of rehabilitation services (Mountain *et al*, 2009) may go some way to explaining why around one fifth of residential and nursing care placements in England are out of area, even though a very small proportion of individuals require specialist care (Killaspy & Meier, 2010).

Furthermore, research has indicated that quality of care is variable (Ryan *et al*, 2004). Published reports on individual services by various regulators, including the Care Quality Commission, Commission for Social Care Inspection and Healthcare Commission, highlight this variability.

Current understanding of out of area services indicates that the younger a person is, the further away from their home area they are likely to be placed, whereas older adults are more likely to be placed closer to their local area (Ryan *et al*, 2007). This probably reflects the availability of services for the two groups. Also, once placed out of area, people lose contact with the services in the area

they came from (and in many cases hope to return to). Sometimes they may not have an identified Care Programme Approach (CPA) care coordinator, and are likely to have care plans that largely reflect the management of behaviours rather than promote rehabilitation and recovery. As a result, some people may be over-supported in out of area services (Ryan *et al*, 2004).

Research has also indicated that some areas use more out of area services than others, with rates per 100,000 population ranging from 6.4 to 23.9 across health and social care commissioners within seven Strategic Health Authorities (Hatfield *et al*, 2007). A more recent study, based on a Freedom of Information Request to all primary care trusts and local authorities, found that 21% of placements were out of area (Killaspy & Meier, 2010). Use of placements ranges from those that are small in number but high in cost to those that are low in cost yet include large numbers of people (Hatfield *et al*, 2007; Ryan *et al*, 2007). In one study, covering 26.6% of the population of England, it was identified that 86.8% of adult placements and 94.5% of older adult placements were taken up by people requiring 'rehabilitation' or 'continuing care', (i.e. ongoing care, not necessarily continuing healthcare) (Hatfield *et al*, 2007). The remaining types of placement covered specialist services such as eating disorders, secure services, acute and psychiatric intensive care, psychotherapy and women only services.

At least 5% of placements were known to commissioners to be inappropriate, requiring alternative care planning arrangements to be initiated, although commissioners did not know whether or not placements were appropriate in a further 36.2% of cases (Ryan *et al*, 2007).

Almost half of such placements were made by local authorities (48.6%), one quarter were made by NHS commissioners (24.3%) and roughly one quarter were jointly funded (25.7%), meaning that local authorities were involved in about 74.3% (Ryan *et al*, 2007). However, 62.6% of the funding for all these placements came from NHS commissioners.

Having a lack of local capacity can be a key factor in needing to use out of area services. This in turn may be caused by 'in area' services having high rates of people unsuitably placed in them. One study identified this to be so in 23.3% of cases (Ryan, 2005).

Perhaps one of the most encouraging pieces of research in this area is that by Killaspy and colleagues, who looked at people placed out of area (Killaspy *et al*, 2009). They found that, with effective planning and targeted rehabilitation, 63% of people could return to their home area, all of them to more independent local facilities.

OVERVIEW OF MANAGING WHOLE SYSTEMS AND REDUCING OUT OF AREA SERVICES

[View Illustration 1](#) 

NAVIGATE THIS TOOLKIT
CONTRIBUTORS >>
EXECUTIVE SUMMARY >>
SEVEN STEPS >>
SCOPE >>
BACKGROUND >>
DEFINITIONS >>
SUMMARY OF KEY ISSUES AND CURRENT KNOWLEDGE >>
RESEARCH EVIDENCE AND DATA >>
OVERVIEW OF MANAGING WHOLE SYSTEMS AND REDUCING OUT OF AREA SERVICES >>
SYSTEMATIC APPROACH TO REDUCING USE OF OUT OF AREA SERVICES >>
GOOD PRACTICE CASE STUDIES >>
TOOLS TO SUPPORT COMMISSIONERS >>
REFERENCES >>

What is meant by a local whole system?

A 'whole system' refers to a number of services for a given service area across the third, private and public sectors that collectively work as part of a managed service system rather than a dispersed collection of loosely aligned service provision.

'Local' can also mean a range of things. In relation to commissioning services it usually means the area covered by the commissioning organisation, although it can be broader than this for some client groups. While the emphasis here is on 'local', not all elements of a whole system have to be within the geographical boundaries of the commissioning locality. For example, some specialist services may be provided across a wider geographical area than that of the commissioner and they may therefore fall outside their patch.

Benefits of whole system working

An effective whole system approach incorporates consistent service specifications and clarity about the role, function and responsibility of each service component. When functioning well there are a number of individual and clinical benefits, as well as associated efficiencies, to commissioning / managing a service system as opposed to having an unmanaged loose network of providers. These can include:

- Improved effectiveness and efficiency of services
- Improved communication across the service system
- Clear care pathways with improved outcomes and shorter 'lengths of stay'
- Options for a single point of entry and single referral systems
- Shared knowledge of capacity and availability (e.g. vacancies and waiting lists)
- Better use of existing resources
- Fewer inappropriate placements within the local system and those used out of the area
- Improved use of resources (human and financial) within local services rather than services outside the local system
- Reduced duplication amongst providers
- Clearer approaches to service development based on local need
- Local capacity and capability building in managing those with complex mental health needs
- Effective and robust care coordination, assessment and review of people's needs through the Care Programme Approach.

ILLUSTRATION 1

UNCOORDINATED NETWORKS OF PROVIDERS AND THE COMMISSIONING BOUNDARY

[View Illustration 2](#)

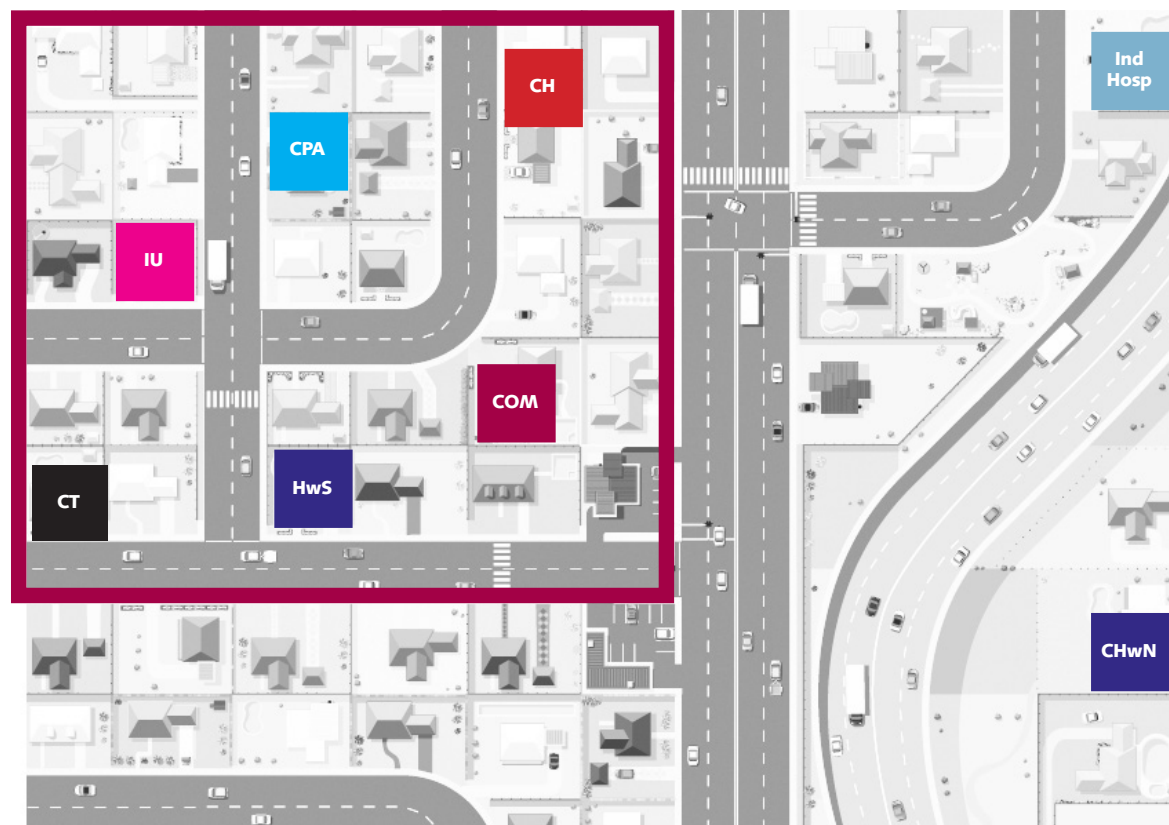
NAVIGATE THIS TOOLKIT

[CONTRIBUTORS >>](#)
[EXECUTIVE SUMMARY >>](#)
[SEVEN STEPS >>](#)
[SCOPE >>](#)
[BACKGROUND >>](#)
[DEFINITIONS >>](#)
[SUMMARY OF KEY ISSUES AND CURRENT KNOWLEDGE >>](#)
[RESEARCH EVIDENCE AND DATA >>](#)
[OVERVIEW OF MANAGING WHOLE SYSTEMS AND REDUCING OUT OF AREA SERVICES >>](#)
[SYSTEMATIC APPROACH TO REDUCING USE OF OUT OF AREA SERVICES >>](#)
[GOOD PRACTICE CASE STUDIES >>](#)
[TOOLS TO SUPPORT COMMISSIONERS >>](#)
[REFERENCES >>](#)

The following illustrations are intended to simplify what can be a very complex area. The graphics represent individual services and key stakeholders. The geographical boundary of the commissioner is depicted by the solid red line. The strength and direction of relationships are highlighted using arrows. Providers come in all shapes and sizes, and are rarely identical.

Some are within the geographical boundaries of the commissioner; some are outside the area. Some providers in the area will have been actively commissioned by local commissioners whilst others may not. This will also be the case for services outside the area. Ideally, all of the services within the geographical boundaries of the commissioner are ones that would

be required to meet the needs of the local population. Those used outside the area would be ones where the numbers of people needing the service are so small that it may not be practical to provide a local service or where the service model is so specialised that local services do not have the necessary skills to provide them.



Commissioning boundary

CH

Care Home

CHwN

Care Home with Nursing

COM

Commissioner

CPA

CPA Care Coordinator

CT

CT Community Team

HwS

Housing with Support

IU

In-patient Unit

Ind Hosp

Independent Hospital

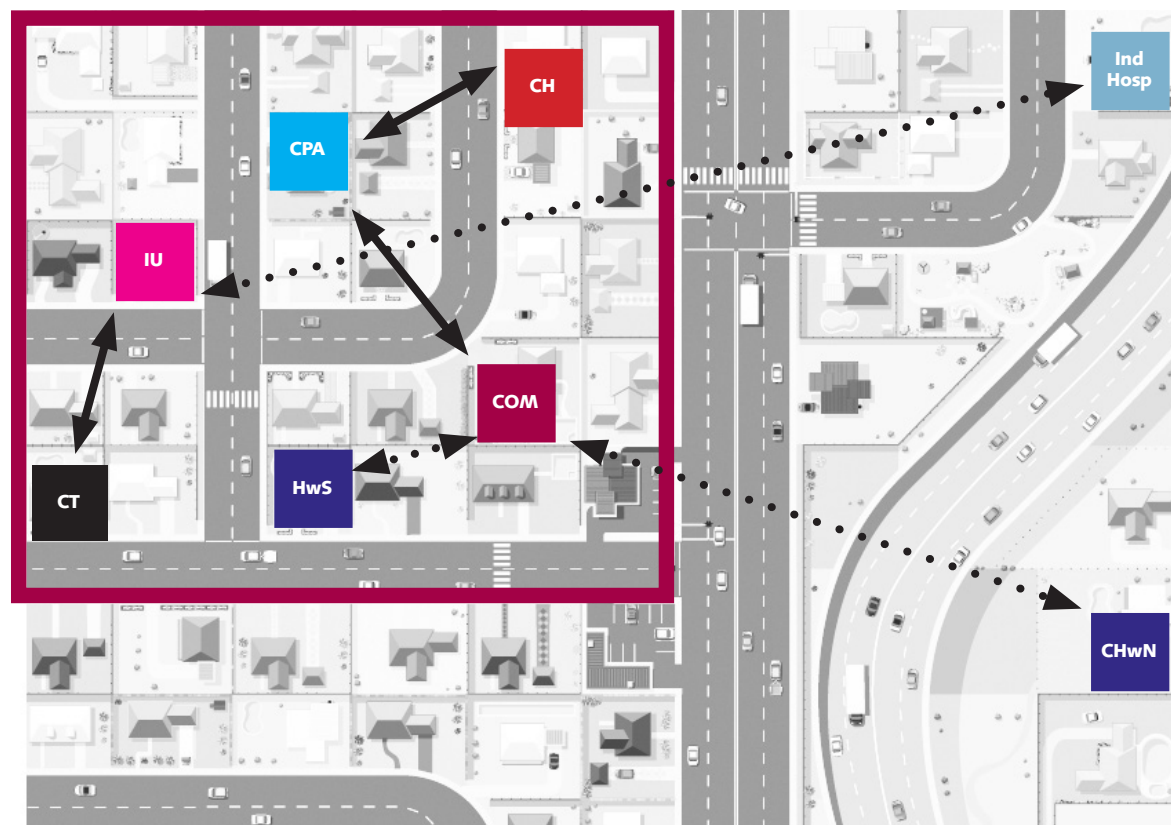
ILLUSTRATION 2 UNCOORDINATED NETWORKS OF PROVIDERS


[View Illustration 3](#) 

- NAVIGATE THIS TOOLKIT**
- CONTRIBUTORS >>
- EXECUTIVE SUMMARY >>
- SEVEN STEPS >>
- SCOPE >>
- BACKGROUND >>
- DEFINITIONS >>
- SUMMARY OF KEY ISSUES AND CURRENT KNOWLEDGE >>**
- RESEARCH EVIDENCE AND DATA >>**
- OVERVIEW OF MANAGING WHOLE SYSTEMS AND REDUCING OUT OF AREA SERVICES >>**
- SYSTEMATIC APPROACH TO REDUCING USE OF OUT OF AREA SERVICES >>
- GOOD PRACTICE CASE STUDIES >>**
- TOOLS TO SUPPORT COMMISSIONERS >>**
- REFERENCES >>

Some providers will have good links with each other, some are more tenuous and some do not have any contact. This can result in some people being placed in services that are not best equipped to meet their needs, multiple points

of access and referral, duplication of effort and some care groups' needs not being met. This can lead to an inefficient set of services and increase the risk of requiring out of area services.



-  Commissioning boundary
- CH**
Care Home
- CHwN**
Care Home with Nursing
- COM**
Commissioner
- CPA**
CPA Care Coordinator
- CT**
CT Community Team
- HwS**
Housing with Support
- IU**
In-patient Unit
- Ind Hosp**
Independent Hospital

 [Back to contents](#)

ILLUSTRATION 3 MANAGED WHOLE SYSTEM

NAVIGATE THIS TOOLKIT	
CONTRIBUTORS >>	
EXECUTIVE SUMMARY >>	
SEVEN STEPS >>	
SCOPE >>	
BACKGROUND >>	
DEFINITIONS >>	
SUMMARY OF KEY ISSUES AND CURRENT KNOWLEDGE >>	
RESEARCH EVIDENCE AND DATA >>	
OVERVIEW OF MANAGING WHOLE SYSTEMS AND REDUCING OUT OF AREA SERVICES >>	
SYSTEMATIC APPROACH TO REDUCING USE OF OUT OF AREA SERVICES >>	
GOOD PRACTICE CASE STUDIES >>	
TOOLS TO SUPPORT COMMISSIONERS >>	
REFERENCES >>	

Where a whole system works effectively, each component will have a clear role, know how it relates to other elements of the system and work effectively to meet the needs of the population. New developments in the area will only be

commissioned to meet assessed need. This should occur by harnessing provider innovation in a structured way through dialogue with a wide range of providers and other stakeholders. This can reduce the possibility of people being

'imported' into the area to fill vacant beds, and a breakdown of commissioner / provider relations.

↔ Good relationship between services



Managed whole system
 Commissioning boundary

- CH** Care Home
- CHwN** Care Home with Nursing
- COM** Commissioner
- CPA** CPA Care Coordinator
- CT** CT Community Team
- HwS** Housing with Support
- IU** In-patient Unit
- Ind Hosp** Independent Hospital

SYSTEMATIC APPROACH TO REDUCING USE OF OUT OF AREA SERVICES

NAVIGATE THIS TOOLKIT
CONTRIBUTORS >>
EXECUTIVE SUMMARY >>
SEVEN STEPS >>
SCOPE >>
BACKGROUND >>
DEFINITIONS >>
SUMMARY OF KEY ISSUES AND CURRENT KNOWLEDGE >>
RESEARCH EVIDENCE AND DATA >>
OVERVIEW OF MANAGING WHOLE SYSTEMS AND REDUCING OUT OF AREA SERVICES >>
SYSTEMATIC APPROACH TO REDUCING USE OF OUT OF AREA SERVICES >>
GOOD PRACTICE CASE STUDIES >>
TOOLS TO SUPPORT COMMISSIONERS >>
REFERENCES >>

The following pages describe a seven-step approach to systematically reducing the use of out of area placements and developing services locally to meet need.

[Go to step 1](#) 

A SYSTEMATIC SEVEN-STEP APPROACH TO REDUCING THE USE OF OUT OF AREA SERVICES

- 1 STOCKTAKE** – map who is providing services (where they are, how much they cost, how effective people find them, what outcomes they provide), analyse the options to expand the range and choice of local services etc.
- 2 NEEDS ASSESSMENT** – what are the specific needs of the people in the commissioner's area, how do current services meet / not meet those needs?
- 3 ESTABLISH A PLANNING STRUCTURE** – to address the issues and outcomes to be achieved in a managed and systematic way and involve local leaders (clinical and political, frontline clinicians, practitioners, service managers, people who use the service and their families and carers).
- 4 AGREE AND COMMUNICATE A WHOLE SYSTEM STRATEGY** – agree goals, timescales, etc. in a coherent plan for whole system development, including reconfiguration of existing services and reinvestment opportunities associated with finances released through repatriation (people moving back to local services).
- 5 IMPLEMENTATION** – commence implementation, beginning with identifying options to develop:
 - Clinical and commissioning systems (e.g. assessment and review), leadership and care pathways
 - Data and information systems
 - Service choice for people using the services and their clinicians / practitioners (i.e. market development including procurement frameworks)
 - Integrated service specifications and outcome measures across care pathways to build resilience and a 'whole system' focused on providing best outcomes for people (i.e. recovery and maximum independence from services).
- 6 SET UP AND MONITOR KEY PROCESSES** – e.g. quality assurance, case management and feedback, contracting systems, involvement of people who use the services and their carers.
- 7 REVIEW AND REFINE** – establish annual reviews of strategy, processes and services.

SYSTEMATIC APPROACH TO REDUCING USE OF OUT OF AREA SERVICES STEP 1

The seven steps are based on experience in areas where successes have been achieved in reducing the inappropriate use of out of area placements and improving the efficiency and effectiveness of services for those who use them (see case studies). In the [Tools to Support Commissioners](#) section are various tools that have been used to support similar processes across the country. While these may have proved very effective in the area where they were developed they may require adjustment for use elsewhere and in some cases may not be transferable.

STEP 1: STOCKTAKE

RATIONALE

To gain a clear understanding of local and out of area services in order to inform future commissioning and service planning

KEY TASKS

1 Identify:

- Which services in and out of area are being used
- Which services in area are not being used
- Who is providing the services
- Where the services are
- How much they cost
- Contracting arrangements
- How effective people find them
- What outcomes they provide
- How users and carers are involved in service delivery and service planning.

2 Analyse the options to expand the range and choice of local services.

OUTCOMES

- 1 A clear understanding of the services, their usage, quality, outcomes and cost.
- 2 Identification of key issues to be resolved (e.g. contracting arrangements, quality concerns, variation in cost and outcomes, level of participation by people using the services etc.)

[Go to step 2](#) 

SYSTEMATIC APPROACH TO REDUCING USE OF OUT OF AREA SERVICES

STEP 2

NAVIGATE THIS TOOLKIT
CONTRIBUTORS >>
EXECUTIVE SUMMARY >>
SEVEN STEPS >>
SCOPE >>
BACKGROUND >>
DEFINITIONS >>
SUMMARY OF KEY ISSUES AND CURRENT KNOWLEDGE >>
RESEARCH EVIDENCE AND DATA >>
OVERVIEW OF MANAGING WHOLE SYSTEMS AND REDUCING OUT OF AREA SERVICES >>
SYSTEMATIC APPROACH TO REDUCING USE OF OUT OF AREA SERVICES >>
GOOD PRACTICE CASE STUDIES >>
TOOLS TO SUPPORT COMMISSIONERS >>
REFERENCES >>

STEP 2: NEEDS ASSESSMENT

RATIONALE

To gain a clear understanding of the needs of people who are using local and out of area services, and those who may need to do so in the future, in order to inform future commissioning and service planning.

KEY TASKS

1 Identify:

- What the needs are of the people in the commissioner's area
- How the current services meet / do not meet these needs
- What indicators of unmet need exist (e.g. delayed discharge from acute in-patient wards and from out of area placements)
- Who is being over-supported
- Who is being under-supported.

2 Sources of information include:

- Provider activity data
- Delayed discharge information (including out of area services)
- CPA care coordinators' views on placements
- Placement providers' views on placements
- Independent assessment of placements
- Bespoke needs assessment exercises
- Regulator and advocate feedback.

OUTCOMES

- 1 A clear understanding of the needs of people in local and out of area services.
- 2 Identification of key issues to be resolved (e.g. number of people potentially over-supported, care coordinator contact and feedback, number of people inappropriately placed etc).

Go to step 3 

SYSTEMATIC APPROACH TO REDUCING USE OF OUT OF AREA SERVICES STEP 3

NAVIGATE THIS TOOLKIT

CONTRIBUTORS >>

EXECUTIVE SUMMARY >>

SEVEN STEPS >>

SCOPE >>

BACKGROUND >>

DEFINITIONS >>

SUMMARY OF KEY ISSUES
AND CURRENT KNOWLEDGE >>

RESEARCH EVIDENCE AND DATA >>

OVERVIEW OF MANAGING
WHOLE SYSTEMS AND REDUCING
OUT OF AREA SERVICES >>

SYSTEMATIC APPROACH TO REDUCING
USE OF OUT OF AREA SERVICES >>

GOOD PRACTICE CASE STUDIES >>

TOOLS TO SUPPORT COMMISSIONERS >>

REFERENCES >>

STEP 3: ESTABLISH A PLANNING STRUCTURE

RATIONALE

To address the issues identified in Steps 1 and 2 and how system development is to be achieved collectively across the commissioning and service system.

KEY TASKS

- 1 Agree terms of reference for the planning structure.
- 2 Agree who / which organisations the planning structure reports to.
- 3 Agree the outcomes to be achieved in a managed and systematic way.
- 4 Agree how to involve local leaders (clinical and political, frontline clinicians, practitioners, service managers, people who have used and currently use the services, carers, champions etc).
- 5 Gain sign-up for the planning structure from participating organisations at the highest levels possible.

OUTCOMES

- 1 A working forum that is commissioner-led and proactively plans and implements the commissioning and market development strategy and service / system redesign by involving key people.
- 2 Ownership and governance at senior level from participating organisations.

Go to step 4 

SYSTEMATIC APPROACH TO REDUCING USE OF OUT OF AREA SERVICES

STEP 4

NAVIGATE THIS TOOLKIT

CONTRIBUTORS >>

EXECUTIVE SUMMARY >>

SEVEN STEPS >>

SCOPE >>

BACKGROUND >>

DEFINITIONS >>

SUMMARY OF KEY ISSUES
AND CURRENT KNOWLEDGE >>

RESEARCH EVIDENCE AND DATA >>

OVERVIEW OF MANAGING
WHOLE SYSTEMS AND REDUCING
OUT OF AREA SERVICES >>

SYSTEMATIC APPROACH TO REDUCING
USE OF OUT OF AREA SERVICES >>

GOOD PRACTICE CASE STUDIES >>

TOOLS TO SUPPORT COMMISSIONERS >>

REFERENCES >>

STEP 4: AGREE AND COMMUNICATE A WHOLE SYSTEM STRATEGY

RATIONALE

To have a clear direction for future commissioning and provision that covers the whole service system, including any need for use of out of area services.

KEY TASKS

- 1 Plan for whole system development using information obtained in Steps 1 and 2 along with information that planning group members can add.
- 2 Agree goals, including:
 - When it is appropriate to use out of area placements
 - The role and function of CPA care coordinators
 - Finance management
 - Procurement and contracting arrangements
 - Responses to over-support
 - Responses to under-support
 - Development of new services and models of provision
 - Quality assurance arrangements
 - Outcomes
 - Involvement and engagement mechanisms.
- 3 Agree timescales.
- 4 Agree any reconfiguration of existing services.
- 5 Agree any investment opportunities associated with finances released through 'repatriation'.
- 6 Agree how structures (e.g. decision-making panels) and processes (e.g. Care Programme Approach) will operate to best effect.
- 7 Agree dissemination strategy.

OUTCOME

- 1 A whole system commissioning and providing strategy is agreed that seeks to minimise the use of out of area services and ensures the level of support available is appropriate to meet the needs of people and is cost-effective.

Go to step 5 

SYSTEMATIC APPROACH TO REDUCING USE OF OUT OF AREA SERVICES STEP 5

NAVIGATE THIS TOOLKIT
CONTRIBUTORS >>
EXECUTIVE SUMMARY >>
SEVEN STEPS >>
SCOPE >>
BACKGROUND >>
DEFINITIONS >>
SUMMARY OF KEY ISSUES AND CURRENT KNOWLEDGE >>
RESEARCH EVIDENCE AND DATA >>
OVERVIEW OF MANAGING WHOLE SYSTEMS AND REDUCING OUT OF AREA SERVICES >>
SYSTEMATIC APPROACH TO REDUCING USE OF OUT OF AREA SERVICES >>
GOOD PRACTICE CASE STUDIES >>
TOOLS TO SUPPORT COMMISSIONERS >>
REFERENCES >>

STEP 5: IMPLEMENTATION

RATIONALE

To improve outcomes for people who use the services and to commission with financial effectiveness.

KEY TASKS

- 1 Implement appropriate clinical systems (e.g. assessment, review, etc), leadership and care pathways.
- 2 Establish and maintain data and information systems.
- 3 Provide service choices for users and clinicians through market development, including the use of procurement frameworks.
- 4 Apply service specifications across all elements of care pathways to build a resilient and connected 'whole system'.
- 5 Commission for outcomes.
- 6 Monitor for outcomes, quality and cost-effectiveness.
- 7 Identify changing needs of users that are unmet.
- 8 Identify changes to service delivery that may be required.
- 9 Revise whole system strategy on the basis of experience and new information.

OUTCOME

- 1 A managed whole system approach to service commissioning and delivery.

Go to step 6 

SYSTEMATIC APPROACH TO REDUCING USE OF OUT OF AREA SERVICES STEP 6

NAVIGATE THIS TOOLKIT

[CONTRIBUTORS >>](#)

[EXECUTIVE SUMMARY >>](#)

[SEVEN STEPS >>](#)

[SCOPE >>](#)

[BACKGROUND >>](#)

[DEFINITIONS >>](#)

[SUMMARY OF KEY ISSUES
AND CURRENT KNOWLEDGE >>](#)

[RESEARCH EVIDENCE AND DATA >>](#)

[OVERVIEW OF MANAGING
WHOLE SYSTEMS AND REDUCING
OUT OF AREA SERVICES >>](#)

[SYSTEMATIC APPROACH TO REDUCING
USE OF OUT OF AREA SERVICES >>](#)

[GOOD PRACTICE CASE STUDIES >>](#)

[TOOLS TO SUPPORT COMMISSIONERS >>](#)

[REFERENCES >>](#)

STEP 6: SET UP AND MONITOR KEY PROCESSES

RATIONALE

To ensure the whole system functions collectively to deliver the most effective and efficient services to people they support.

KEY TASKS

Establish and agree reporting arrangements for:

- Quality assurance
- Case management and feedback
- Outcome monitoring
- Contracting
- Involvement of people who use the services, their families and carers
- Financial management
- Other local priority areas.

OUTCOME

Robust scrutiny of key processes that can determine success or otherwise and can help identify future planning needs.

[Go to step 7](#) 

SYSTEMATIC APPROACH TO REDUCING USE OF OUT OF AREA SERVICES STEP 7

NAVIGATE THIS TOOLKIT

[CONTRIBUTORS >>](#)

[EXECUTIVE SUMMARY >>](#)

[SEVEN STEPS >>](#)

[SCOPE >>](#)

[BACKGROUND >>](#)

[DEFINITIONS >>](#)

[SUMMARY OF KEY ISSUES
AND CURRENT KNOWLEDGE >>](#)

[RESEARCH EVIDENCE AND DATA >>](#)

[OVERVIEW OF MANAGING
WHOLE SYSTEMS AND REDUCING
OUT OF AREA SERVICES >>](#)

[SYSTEMATIC APPROACH TO REDUCING
USE OF OUT OF AREA SERVICES >>](#)

[GOOD PRACTICE CASE STUDIES >>](#)

[TOOLS TO SUPPORT COMMISSIONERS >>](#)

[REFERENCES >>](#)

STEP 7: REVIEW AND REFINE

RATIONALE

To take stock of success and progress against set aims, and to inform future planning across the whole system.

KEY TASKS

- 1 Analyse information obtained through Step 6.
- 2 Use external feedback mechanisms, e.g. CQC ratings, independent advocacy, service reviews etc.
- 3 Make recommendations to planning group on future developments.

OUTCOME

- 1 An understanding of the progress made to date with a clear plan for future commissioning and service provision as a result.

GOOD PRACTICE CASE STUDIES ABSTRACTS

NAVIGATE THIS TOOLKIT
CONTRIBUTORS >>
EXECUTIVE SUMMARY >>
SEVEN STEPS >>
SCOPE >>
BACKGROUND >>
DEFINITIONS >>
SUMMARY OF KEY ISSUES AND CURRENT KNOWLEDGE >>
RESEARCH EVIDENCE AND DATA >>
OVERVIEW OF MANAGING WHOLE SYSTEMS AND REDUCING OUT OF AREA SERVICES >>
SYSTEMATIC APPROACH TO REDUCING USE OF OUT OF AREA SERVICES >>
GOOD PRACTICE CASE STUDIES >>
TOOLS TO SUPPORT COMMISSIONERS >>
REFERENCES >>

A COMMISSIONER–CONSORTIA APPROACH TO MANAGING QUALITY, COST AND COMMUNICATION WITH OUT OF AREA INDEPENDENT HOSPITALS (NHS NORTH LANCASHIRE)

In 2008, the five PCTs across Lancashire identified difficulties with commissioning out of area specialist placements relating to contracting processes, service quality, variable pricing, value for money, lack of outcomes evidence and possible clinical risk. A consortium approach was established through a group of commissioners across Lancashire to develop and implement quality and outcomes measures through an Accreditation Scheme and a Quality Framework. This provided the basis for ensuring both that people were appropriately placed and costs could be negotiated on the basis of volume and quality. As a result, many service users have been able to move to lower levels of support rather than being over-provided for, costs have been renegotiated on the basis of volume and quality and a consortium approach (collaboration between commissioners) has led to reduced duplication of effort amongst commissioners while enabling a consistent approach between the consortium members to working with out of area independent hospitals.

[Read the North Lancashire case study \(A\)](#)

A PROJECT MANAGEMENT APPROACH TO REPATRIATING PEOPLE TO LOCAL SERVICES THAT MORE EFFECTIVELY MEET THEIR NEEDS (NHS NORTH LANCASHIRE)

NHS North Lancashire identified a group of people placed in rehabilitation services who were unresponsive to interventions being delivered, required an alternative form of care and were being over-provided for within the services where they were placed. A project was initiated to develop an alternative form of service through a procurement process designed to better meet the needs of the 11 people inappropriately placed. As a result, all 11 people moved back to their area of origin (from out of area placements), a new model of service now exists that enhances the range of local provision and a saving of £300,000 for year 2010/11 has resulted, with twice this amount anticipated in 2011/12. An additional gain from the initiative has been an improvement in relationships with individual service users and their carers (who were actively involved in the process), the local independent sector service providers and CPA care coordinators.

[Read the North Lancashire case study \(B\)](#)

GOOD PRACTICE CASE STUDIES ABSTRACTS

NAVIGATE THIS TOOLKIT
CONTRIBUTORS >>
EXECUTIVE SUMMARY >>
SEVEN STEPS >>
SCOPE >>
BACKGROUND >>
DEFINITIONS >>
SUMMARY OF KEY ISSUES AND CURRENT KNOWLEDGE >>
RESEARCH EVIDENCE AND DATA >>
OVERVIEW OF MANAGING WHOLE SYSTEMS AND REDUCING OUT OF AREA SERVICES >>
SYSTEMATIC APPROACH TO REDUCING USE OF OUT OF AREA SERVICES >>
GOOD PRACTICE CASE STUDIES >>
TOOLS TO SUPPORT COMMISSIONERS >>
REFERENCES >>

A PROJECT MANAGEMENT APPROACH TO DEVELOPING SERVICE PROVISION, IMPROVING PLACEMENT APPROPRIATENESS AND CONTRACTING ARRANGEMENTS (MANCHESTER)

Commissioners in NHS Manchester, Manchester Health and Social Care Trust and the North West Specialised Commissioning Team were faced with increasing year-on-year demand (and associated costs) for secure services for Manchester residents. A bespoke, time-limited project was undertaken between the partner organisations that was designed to move, where appropriate, people placed in spot-commissioned services into newly-commissioned block-contracted NHS provision; step down some people who were inappropriately placed in services that provided greater security than they needed; and develop a robust system of tracking and monitoring progress through the care pathways. The project saved £1.8 million over the two years of its existence and 43 people moved from independent sector services to NHS secure and non-secure beds. The case study describes how this was achieved, how barriers were overcome, and gives suggestions for anyone wishing to undertake a similar piece of work.

[Read the Manchester case study](#) 

A WHOLE SYSTEM APPROACH TO REPATRIATION THAT IMPROVED QUALITY AND CASE MANAGEMENT AND DELIVERED SIGNIFICANT LONG-TERM FINANCIAL SAVINGS (WIGAN)

In 2003, Ashton, Wigan and Leigh PCT and Wigan MBC identified they did not have a satisfactory understanding of the situation with regard to people with mental health problems who were placed out of the area. Nor did they have a coordinated approach to working with providers in the borough to deliver its rehabilitation and ongoing care services to the same client group. An independent whole system review of out of area placements and local service provision identified a range of systemic, quality, practice and financial issues for the commissioners and provided a direction for significant change in how placements are commissioned and how local service delivery meets the needs of Wigan residents. A total of 70 people were identified as being placed out of area in 12 services, with a further seven in-area services with 92 beds identified. A total of £4,359,012 was spent in 2003 on these services. Through implementing a series of initiatives over the following six years, 29 people were returned to the borough, of whom 23 stepped down to lower levels of support, while a further three people stepped down to lower levels of support in the area where they had been placed. The savings to the PCT and MBC over this period were £1.5 million, with a further £250,000 saved in 2009/10. Systems are now in place to ensure placements are appropriate and regularly monitored, and users who wish to live in the borough do so, while reducing the risk of people being placed out of area in the future.

[Read the Wigan case study](#) 

GOOD PRACTICE CASE STUDIES ABSTRACTS

NAVIGATE THIS TOOLKIT
CONTRIBUTORS >>
EXECUTIVE SUMMARY >>
SEVEN STEPS >>
SCOPE >>
BACKGROUND >>
DEFINITIONS >>
SUMMARY OF KEY ISSUES AND CURRENT KNOWLEDGE >>
RESEARCH EVIDENCE AND DATA >>
OVERVIEW OF MANAGING WHOLE SYSTEMS AND REDUCING OUT OF AREA SERVICES >>
SYSTEMATIC APPROACH TO REDUCING USE OF OUT OF AREA SERVICES >>
GOOD PRACTICE CASE STUDIES >>
TOOLS TO SUPPORT COMMISSIONERS >>
REFERENCES >>

AN INITIATIVE THAT SUPPORTED PEOPLE TO RETURN TO LOCAL SERVICES AND INCREASED THEIR INDEPENDENCE (OPTIONS FOR SUPPORTED LIVING, LIVERPOOL)

Health and social care commissioners in Liverpool sought to support all people using learning disability services within the city boundaries, irrespective of their levels of need. The commissioners supported the development of *Options for Supported Living*, a small bespoke provider (along with three other providers), to undertake the work of bringing people back into the area and meeting their needs through a person-centred approach. From 1993 onwards, a total of 20 people were identified as living out of the area (some in placements that were no longer meeting their assessed needs, including Ashworth and Rampton Special Hospitals) and supported them to move back to Liverpool. Many of these people have reduced support needs as a result and are now able to live more independently. The reduced need for support from other community teams has also resulted in resources being freed up for commissioners.

Read the Liverpool case study



A SERIES OF PROJECTS TO RETURN PEOPLE TO AREA, STEP DOWN FROM OVER-PROVIDED SERVICES AND DEVELOP LOCAL SERVICES WHILST REDUCING EXPENDITURE (PENNINE CARE)

Across the Pennine Care Trust footprint, 180 people had been placed in out of area services in 2004. A series of projects have been undertaken to return people to their area of origin where appropriate, and have resulted in 79 step-down beds and 20 low secure unit beds being developed within the local mental health economy. The projects have also seen the development of a Clinical Pathway Team that has led the repatriation process over the past six years. In total, 83 people have moved back to their local area, with 53 of these stepping down to a lower level of service provision.

Read the Pennine Care case study



GOOD PRACTICE CASE STUDIES ABSTRACTS

NAVIGATE THIS TOOLKIT

[CONTRIBUTORS >>](#)

[EXECUTIVE SUMMARY >>](#)

[SEVEN STEPS >>](#)

[SCOPE >>](#)

[BACKGROUND >>](#)

[DEFINITIONS >>](#)

[SUMMARY OF KEY ISSUES
AND CURRENT KNOWLEDGE >>](#)

[RESEARCH EVIDENCE AND DATA >>](#)

[OVERVIEW OF MANAGING
WHOLE SYSTEMS AND REDUCING
OUT OF AREA SERVICES >>](#)

[SYSTEMATIC APPROACH TO REDUCING
USE OF OUT OF AREA SERVICES >>](#)

[GOOD PRACTICE CASE STUDIES >>](#)

[TOOLS TO SUPPORT COMMISSIONERS >>](#)

[REFERENCES >>](#)

GROWING HOUSING PROVISION IN OXFORDSHIRE

As a result of a high number of out of area placements at relatively high cost that were not being reviewed as regularly as would be ideal, a project to redesign and recommission all local mental health housing and support services was established. These new services: would be able to take a much wider range of clients into supported living, as opposed to registered care environments; would enable more people to live at home; and would prevent acute admissions and reduce future need for out of area placements. This project was directed and supported by the establishment of a framework, pathway and strategy, agreed by health, social care, housing and the voluntary sector. The results of the project have been increased opportunities for local providers and so greater local provider stability, which also retained resources within the local area. It has also achieved better liaison with providers generally, and service overview, as opposed to individual care coordinators only 'seeing' their individual client. Providers have 'geared up' for the new tenders, and are moving towards a more recovery-based approach.

[Read the Oxfordshire
Housing case study](#) 

USING A SPECIALIST PLACEMENT SERVICE TO REPATRIATE PEOPLE TO THEIR HOME AREA (NORTH LONDON FORENSIC SERVICE)

The original service was established in 1996, following comprehensive needs assessment of approximately 70 people placed out of area. Over the past 14 years the North London Forensic Service has undertaken a wide range of service developments driven by the needs of people using out of area services. In addition, vital commissioning information has been passed to local services to help drive local service developments in each of the boroughs. The original aim was to use the clinical information provided by the Specialist Placement Service team to improve the experience of people using out of area placements and to drive local NHS services and pathway development using a methodology underpinned by a thorough clinical needs assessment. In the life of the team's existence, key developments have included redesign of service pathways and development of local services to better meet the needs of the group. An example of this was the development of a 15-bedded low secure unit, allowing repatriation of people back to a local resource from out of area placements and more readily re-establishing links into local services .

[Read the North London
Forensic Service
case study](#) 

GOOD PRACTICE CASE STUDIES ABSTRACTS

NAVIGATE THIS TOOLKIT

[CONTRIBUTORS >>](#)

[EXECUTIVE SUMMARY >>](#)

[SEVEN STEPS >>](#)

[SCOPE >>](#)

[BACKGROUND >>](#)

[DEFINITIONS >>](#)

[SUMMARY OF KEY ISSUES
AND CURRENT KNOWLEDGE >>](#)

[RESEARCH EVIDENCE AND DATA >>](#)

[OVERVIEW OF MANAGING
WHOLE SYSTEMS AND REDUCING
OUT OF AREA SERVICES >>](#)

[SYSTEMATIC APPROACH TO REDUCING
USE OF OUT OF AREA SERVICES >>](#)

[GOOD PRACTICE CASE STUDIES >>](#)

[TOOLS TO SUPPORT COMMISSIONERS >>](#)

[REFERENCES >>](#)

LOOK AHEAD HOUSING AND CARE – REHABILITATION IN TOWER HAMLETS

NHS Tower Hamlets wanted to increase local service options for people with mental health conditions and reduce the costs of out of area residential care placements. The majority of these placements were for forensic, older people and personality disorder groups. They worked with a local provider, Look Ahead Housing and Care, to explore how increasing local provision could be achieved. The Tower Hamlets rehabilitation service is a new innovative partnership between Look Ahead Housing and Care and the East London NHS Foundation Trust. It works with 11 people, focused on the principles of recovery, helping them to take control and develop or rediscover the skills, goals and aspirations of the future. Look Ahead holds the contract with the PCT and commissions the clinical input from the foundation trust. The two organisations have worked closely together to develop the service, undertake assessments, and deliver a coordinated care management approach. The new rehabilitation model works to move people on to more independent living options within 12 months, whereas prior to this people were in residential care for between six and seven years at a significant cost to both the NHS and the individual.

[Read the Tower Hamlets case study](#) 

LONDON CYRENIANS HOUSING – DEVELOPING LOCAL PROVISION IN HOUNSLOW

In 2005, the local Joint Commissioner for Mental Health identified that there were too many people in out of area placements. This was also resulting in significant cost in terms of time and travel for the PCT, local authority and local care management staff. London Cyrenians Housing was commissioned to develop a new service in borough for nine people. A multi-agency steering panel was established to support the project and a programme was established to review existing out of area placements and prepare a business case for the new scheme. Cyrenians undertook assessments of 22 people and identified 13 who could move back into the borough. By working with a larger housing association, they were able to lever in additional resources from the Housing Corporation (now the Homes and Communities Agency) for refurbishment. Moving people back into the borough and into a scheme designed to work towards recovery and independent living has realised savings of around £100,000 per year.

[Read the Hounslow Housing case study](#) 

GOOD PRACTICE CASE STUDIES ABSTRACTS

NAVIGATE THIS TOOLKIT

[CONTRIBUTORS >>](#)

[EXECUTIVE SUMMARY >>](#)

[SEVEN STEPS >>](#)

[SCOPE >>](#)

[BACKGROUND >>](#)

[DEFINITIONS >>](#)

[SUMMARY OF KEY ISSUES
AND CURRENT KNOWLEDGE >>](#)

[RESEARCH EVIDENCE AND DATA >>](#)

[OVERVIEW OF MANAGING
WHOLE SYSTEMS AND REDUCING
OUT OF AREA SERVICES >>](#)

[SYSTEMATIC APPROACH TO REDUCING
USE OF OUT OF AREA SERVICES >>](#)

[GOOD PRACTICE CASE STUDIES >>](#)

[TOOLS TO SUPPORT COMMISSIONERS >>](#)

[REFERENCES >>](#)

LONDON CYRENIANS HOUSING – KENSINGTON & CHELSEA SUPPORTED HOUSING PROJECT

Following a strategic review of mental health services in the Royal Borough of Kensington & Chelsea, the five-year Supporting People Strategy (2008 – 2012) was agreed. A key element of this strategy was the procurement of local high level supported housing services for people with complex mental health needs and a reduced reliance on expensive out of area placements. London Cyrenians Housing was commissioned to re-provide an existing scheme, bringing people back into the borough and improving the quality and experience of their housing and support. There was close collaboration between the Royal Borough, the PCT, the housing provider (Notting Hill Housing Group), Central and North West London Foundation Trust, the Cyrenians and other local mental health support providers. Cyrenians undertook assessments of people placed out of borough and identified those for whom the scheme would be most suitable. They also worked with local residents who were concerned about people with complex needs, including forensic histories, moving into the neighbourhood. The scheme for 10 people opened in spring 2010 and will over time realise savings of at least £10,000 per person per year.

[Read the Kensington
and Chelsea Housing
case study](#)

TOOLS TO SUPPORT COMMISSIONERS

NAVIGATE THIS TOOLKIT
CONTRIBUTORS >>
EXECUTIVE SUMMARY >>
SEVEN STEPS >>
SCOPE >>
BACKGROUND >>
DEFINITIONS >>
SUMMARY OF KEY ISSUES AND CURRENT KNOWLEDGE >>
RESEARCH EVIDENCE AND DATA >>
OVERVIEW OF MANAGING WHOLE SYSTEMS AND REDUCING OUT OF AREA SERVICES >>
SYSTEMATIC APPROACH TO REDUCING USE OF OUT OF AREA SERVICES >>
GOOD PRACTICE CASE STUDIES >>
TOOLS TO SUPPORT COMMISSIONERS >>
REFERENCES >>

A wide range of tools and other aids to support whole system working have been gathered from across the country and are available here.

In one way or another, they have been used to reduce the use of out of area services. However, it should be noted that something that has proved useful in one area may not be so helpful in another and may need to be adapted or further developed to suit the circumstances.

1 GOOD PRACTICE GUIDANCE AND OUTCOME MEASURES AND TOOLS

In this section we have included a range of good practice guidance and outcome measures that can be referred to when undertaking or reviewing the use of out of area placements, and developing the local systems to support placements in and out of area.

- *Good practice guide for commissioners, CPA care coordinator and independent sector providers of out of area treatments* (Care Services Improvement Partnership)
http://icn.csip.org.uk/_library/Good_practice_guide_for_CPA_care_comms.pdf
- *Involving carers in out of area treatments: A good practice guide* (Rethink)
<http://www.rethink.org/>
- *Commissioning for mental health outcomes in the North West* (NHS North West & National Mental Health Development Unit)
<http://www.rcpsych.ac.uk/campaigns/fairdeal.aspx>
- *Outcomes framework for mental health services*
http://www.socialinclusion.org.uk/publications/Broadened_Social_Inclusion_Outcomes_Framework.pdf
- *Mental health outcomes compendium*
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_093677.pdf
- [*Mental health outcome measures \(North Lancashire\)* >>](#)
- *Enabling recovery for people with complex mental health needs: a template for rehabilitation services* (Royal College of Psychiatrists)
http://www.rcpsych.ac.uk/pdf/fr_rs_1_forwebsite.pdf
- *Ordinary residence: guidance on the identification of the ordinary residence of people in need of community care services, England*
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_114338.pdf
- *Who pays? Establishing the responsible commissioner*
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_079724.pdf

All websites in this document were accessed in March 2011.

TOOLS TO SUPPORT COMMISSIONERS CONTINUED

NAVIGATE THIS TOOLKIT
CONTRIBUTORS >>
EXECUTIVE SUMMARY >>
SEVEN STEPS >>
SCOPE >>
BACKGROUND >>
DEFINITIONS >>
SUMMARY OF KEY ISSUES AND CURRENT KNOWLEDGE >>
RESEARCH EVIDENCE AND DATA >>
OVERVIEW OF MANAGING WHOLE SYSTEMS AND REDUCING OUT OF AREA SERVICES >>
SYSTEMATIC APPROACH TO REDUCING USE OF OUT OF AREA SERVICES >>
GOOD PRACTICE CASE STUDIES >>
TOOLS TO SUPPORT COMMISSIONERS >>
REFERENCES >>

2 DATA TOOLS

In this section of the toolkit you will find a selection of tools for recording placement information, reporting, and the calculation of placement costs.

- **South West Improvement and Efficiency Partnership care funding calculator:**
<http://www.southwestiep.gov.uk/workstreams/Adult%20Services/fairpricingtool.htm>
- **South East Improvement and Efficiency Partnership placement calculator:**
<http://www.southeastiep.gov.uk/categories/adult-social-care-and-services-for-children/projects/care-funding-calculator>
- **Placement cost and modelling calculators:**
[Excel based tool for placement cost calculation >>](#)
[Excel based tool for modelling change >>](#)
- **Fair cost calculator:**
[Explanation and contact details for placement service >>](#)
- **Mental health monthly data return:**
[Excel based spreadsheet for the recording of KPI and performance measures by providers >>](#)
- **Quarterly placement report template:**
[Sample proforma for reporting on placement usage >>](#)
- **Out of area data pack:**
[Suggested out of area dataset and key performance indicators >>](#)

3 ASSESSMENT TOOLS

In this section of the toolkit are listed a range of assessment pro forma. Since providers will have their own assessment format and increasingly all clinical and risk assessment information is available on electronic case notes, these are intended simply as examples.

In assessing a referral, comprehensive clinical information needs to be provided to enable decision-making to be effective and accurate. Broadly speaking, you would expect to see information in the following areas:

- Circumstances leading to current episode/admission/placement
- Family history
- Personal history
- Past and current medical history
- Forensic history
- Past psychiatric history including dates of previous admissions, use of Mental Health Act
- Is there a forthcoming managers hearing or Mental Health Review Tribunal planned?
- History of substance use/misuse
- Medication history and current medication
- Does the out of area assessment need to feed into this process?
- Personal choices and preferences of the person

- Types of previous care settings/placements – local, out of area, secure, non-secure, rehabilitation etc.
- Social history – accommodation history, i.e. what is the highest level of independent living this person has achieved?
- What is their current living situation?
- Which housing authority has responsibility for the person?
- Social supports, ongoing family/carer involvement, finances – are appropriate benefits being claimed? Is an appointeeship/guardianship in place and, if so, why?
- Cultural and other specific individual needs.

Similarly, risk assessment pro forma should be available in standard format locally. Again, within this you would expect to see information in the following areas:

- A risk history that covered past and current risks and how assessments were made
- Risks to others
- Risks to self
- Details of risk episodes, including outcomes
- Risk management information
- Involvement of the person using services and carer involvement in risk assessment and management.

TOOLS TO SUPPORT COMMISSIONERS CONTINUED

NAVIGATE THIS TOOLKIT
CONTRIBUTORS >>
EXECUTIVE SUMMARY >>
SEVEN STEPS >>
SCOPE >>
BACKGROUND >>
DEFINITIONS >>
SUMMARY OF KEY ISSUES AND CURRENT KNOWLEDGE >>
RESEARCH EVIDENCE AND DATA >>
OVERVIEW OF MANAGING WHOLE SYSTEMS AND REDUCING OUT OF AREA SERVICES >>
SYSTEMATIC APPROACH TO REDUCING USE OF OUT OF AREA SERVICES >>
GOOD PRACTICE CASE STUDIES >>
TOOLS TO SUPPORT COMMISSIONERS >>
REFERENCES >>

The following give links to standardised assessment tools, i.e. these tools can be used for clinical information and / or to review group data.

- **The Community Placement Questionnaire (CPQ)**

The CPQ is a detailed schedule that helps decision-making about community placements for people who have spent considerable periods of time in hospital facilities. It is easy to use and works to inform day-to-day practice and service planning.

[Access the questionnaire >>](#)

[Access the completed example >>](#)

(NB. Contains fictitious information)

- **The Camberwell Assessment of Need Short Appraisal Schedule (CANSAS)**

CANSAS provides information about unmet needs and needs met in respect of people with serious mental ill health. It is a short version for clinical use of the lengthier research tool the Camberwell Assessment of Need (CAN) >>

<http://www.iop.kcl.ac.uk/virtual/?path=/hsr/prism/can/>

- **Social Functioning Questionnaire**

The Social Functioning Questionnaire is designed to enable a detailed assessment of an individual's social functioning for both rehabilitation and research purposes. It is divided into 5 sections, each containing 8 items to be completed for each person: Self-care Skills, Domestic Skills, Community Skills, Social Skills and Responsibility.

[The SFQ is recommended by the Royal College of Psychiatrists Faculty of Rehabilitation and Social Psychiatry >>](#)

- **The Global Assessment of Functioning (GAF)**

This scale considers psychological, social and occupational functioning on a hypothetical continuum of mental health to illness (rated from 90 to 01). It has been used worldwide for both research and clinical practice. It is quick and easy to use. It is best used to describe populations and changes in the mental health of populations over time.

[Access the GAF Scale >>](#)

- **The Health of the Nation Outcome Scales (HoNOS)**

HoNOS is the most widely used outcome measure within mental health services in England. HoNOS measures behaviour, impairment, symptoms and social functioning >>

Explanations of the use of the tools can be found within the attached links.

Links to further examples of non-standardised assessment/information pro forma are listed below:

- [Initial Assessment Form Pennine Care >>](#)
- [Sample Assessment Pro Forma >>](#)
- [North Lancashire Assessment Report Blank >>](#)
- [North Lancashire QAF tool >>](#)
- [Liverpool MOST >>](#)
- [Liverpool Quality Assurance Audit >>](#)
- [JRAMP >>](#)

4 PATHWAYS AND PANEL POLICIES

In this section of the toolkit, we have provided a selection of sample pathways and protocols for decision-making in the referral process. These are intended to act as a guide and can be adapted to reflect the nature of local services. Also contained is a sample Project Initiation Document (PID), which may be used as a guide for undertaking a project to address out of area services. The tools are:

- [Sample Project Initiation Document Time Line >>](#)
- [Sample Out of Hours Emergency Process >>](#)
- [Sample Clinical Pathway Team Protocol – Out of Area Placements >>](#)
- [Sample Out of Area Referral Process >>](#)
- [Sample reporting arrangements to the service commissioner and the CPA care coordinator for out of area placements >>](#)
- [Brent Adult Mental Health Continuing Healthcare and Placement Panel >>](#)

TOOLS TO SUPPORT COMMISSIONERS CONTINUED

NAVIGATE THIS TOOLKIT
CONTRIBUTORS >>
EXECUTIVE SUMMARY >>
SEVEN STEPS >>
SCOPE >>
BACKGROUND >>
DEFINITIONS >>
SUMMARY OF KEY ISSUES AND CURRENT KNOWLEDGE >>
RESEARCH EVIDENCE AND DATA >>
OVERVIEW OF MANAGING WHOLE SYSTEMS AND REDUCING OUT OF AREA SERVICES >>
SYSTEMATIC APPROACH TO REDUCING USE OF OUT OF AREA SERVICES >>
GOOD PRACTICE CASE STUDIES >>
TOOLS TO SUPPORT COMMISSIONERS >>
REFERENCES >>

5 JOB DESCRIPTIONS

The value of clinical review posts has long been recognised as an effective part of managing services out of area. We have included a number of job descriptions at various levels that are available to be used or adapted. Also included in this section is a short paper from the Royal College of Psychiatrists on the efficacy of placement reviewing services.

- [Out of area treatment 'reviewers': how common are they, how much money do they save, and how do they go about their work? Richard Meier, Policy Analyst, Royal College of Psychiatrists >>](#)
- [Job Description Nurse Specialist >>](#)
- [Person Specification Nurse Specialist >>](#)
- [Job Description Clinical Pathway Nurse >>](#)
- [Person Specification Clinical Pathway Nurse >>](#)
- [Mental Health Continuing Care Assessor Job Description >>](#)
- [Placement Review Officer Job Description >>](#)
- [Placement Review Officer Person Specification >>](#)
- [Move On Team Manager Job Description >>](#)
- [Move On Service Job Description >>](#)

6 OTHER RESOURCES

Information about services regulated by the Care Quality Commission, including reports from inspections, that could assist in establishing the quality of local or out of area services are available at:

<http://caredirectory.cqc.org.uk/caredirectory/searchthecaredirectory.cfm>

The Royal College of Psychiatrists' Fair Deal campaign is at:

<http://www.rcpsych.ac.uk/campaigns/fairdeal.aspx>

King's Fund, Royal College of Psychiatrists, NHS Confederation Mental Health Network and the Centre for Mental Health report and video *Mental health and the productivity challenge* is available at:

http://www.kingsfund.org.uk/current_projects/mental_health_in_a_cold_climate/

FUTURE MATERIALS AND TOOLS

If you have developed any tools that could be useful to other service systems, please feel free to forward them to Richard Meier at RMeier@rcpsych.ac.uk

We would like periodically to add any new tools we can, although changes in support to maintain these pages may prevent this over time.

REFERENCES

NAVIGATE THIS TOOLKIT
CONTRIBUTORS >>
EXECUTIVE SUMMARY >>
SEVEN STEPS >>
SCOPE >>
BACKGROUND >>
DEFINITIONS >>
SUMMARY OF KEY ISSUES AND CURRENT KNOWLEDGE >>
RESEARCH EVIDENCE AND DATA >>
OVERVIEW OF MANAGING WHOLE SYSTEMS AND REDUCING OUT OF AREA SERVICES >>
SYSTEMATIC APPROACH TO REDUCING USE OF OUT OF AREA SERVICES >>
GOOD PRACTICE CASE STUDIES >>
TOOLS TO SUPPORT COMMISSIONERS >>
REFERENCES >>

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