Out of area treatments for working age adults with complex and severe psychiatric disorders: review of current situation and recommendations for good practice.

Working Group Report – September 2005

Faculty of Rehabilitation and Social Psychiatry, the Royal College of Psychiatrists.

Out of Area treatments are a key issue for the Faculty. A working group has prepared a Faculty statement, which has been endorsed by the executive. It has already been used in discussions with Trust managers about the future of rehabilitation services. Feedback on this statement would be gratefully received by the executive.

Faculty Reports are recommended by the Executive of a College Faculty to its members. They have not received approval by the College’s Central Policy Coordination Committee and do not necessarily reflect the policy of the Royal College of Psychiatrists.
FACULTY OF REHABILITATION AND SOCIAL PSYCHIATRY,
THE ROYAL COLLEGE OF PSYCHIATRISTS,
WORKING GROUP REPORT - SEPTEMBER 2005

OUT OF AREA TREATMENTS FOR WORKING AGE ADULTS WITH COMPLEX AND SEVERE PSYCHIATRIC DISORDERS:
REVIEW OF CURRENT SITUATION AND RECOMMENDATIONS FOR GOOD PRACTICE

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Executive summary

As recent changes in the organisation of psychiatric services have taken shape, with the development of community resources and the reduction of inpatient beds, this Faculty has become increasingly concerned about the provision for the group of service users who require high levels of long-term support in residential or inpatient settings. This group is not specifically identified in the NSF and many are cared for with Out of Area Treatments (OATs) in statutory, voluntary and independent sector placements.

In this paper we review the current position and make recommendations for good practice in the delivery of OATs. Full implementation of NSF standards 4 (CPA), 5 (inpatient care) and 6 (support for carers) would address many of the difficulties identified.

The principal concerns are in relation to:

- Lack of a coherent overview of service need and provision at
  - local;
  - national;
  - specialist tertiary level.
- Social exclusion of service users that is maintained or worsened by:
  - geographical dislocation;
  - poverty (long-term low-level benefits);
- Poor quality monitoring of placements, resulting in
  - inadequate or inappropriate care;
  - lack of reinvestment in local services and staff.
- Current commissioning arrangements that appear to block improvement in these areas.

Recommendations

Case Management

1. All patients in long-term placements purchased by PCTs and LASSDs, including OATs placements, must be subject to enhanced CPA (NSF Standard 4).
2. It is the responsibility of mental health services from the area of origin, appropriately resourced from the funding district, to ensure that the CPA process is implemented.
3. Provider units must engage with the CPA process, work to implement its recommendations and access appropriate resources as necessary.
4. Carers should be supported and resourced to maintain contact with their relatives and friends in OATs placements (NSF Standard 6).
5. Independent advocacy services should be available to all patients in OATs placements and their carers.
6. Commissioners must ensure local services are adequately resourced to maintain contact with individuals in OATs placements and provide resources for additional needs outwith the placement to be met as clinically appropriate.

**Monitoring and management of OATs process**

1. Local clinicians must be involved in the initial placement and ongoing monitoring of OATs placements.
2. OATs placements should comply with the appropriate NSF standards, in particular **Standard 5 being as close to home as possible, in the least restrictive environment commensurate with managing risk** and fully implementing CPA.
3. Provision must be made for access to additional resources to those provided by placements as clinically appropriate.
4. Care should comply with appropriate national standards such as NICE guidelines.
5. There must be agreed standards of documentation, care planning, record keeping etc. We hope national standards will be agreed in this area.
6. Commissioning bodies must apprise themselves of relevant inspectorate reports for facilities they fund and ensure that they are able to meet cultural needs.
7. Services should be appropriate and responsive to individual needs including those relating to gender, ethnicity, race and culture.
8. The ultimate aim for the majority of patients should be to return to local services and community accommodation with appropriate levels of support. Commissioners need to work actively with local services to support this process.

**Commissioning for populations**

1. There must be an explicit strategy for collaborative commissioning for larger populations (e.g. Strategic Health Authorities, individually or in small groups) for those with severe enduring mental illness.
2. There should be a local forum, involving all stakeholders, PCTs, Social Services, Mental Health Trusts, clinicians, to provide an overview of OATs placements, including financial implications, clinical appropriateness, service development and geographical location.
3. Commissioning and performance managers should draw up service level agreements with providers, which are fully compliant with the provisions of the **Race Relations (Amendment) Act (2000)**.
4. There is an urgent need to review the funding streams for OATs to facilitate the process of step-down and after-care without a change of commissioning team (**the care pathway needs to be the driver, not the money**).
5. A nationally agreed minimum dataset should be kept by health and social care commissioners, on all OATs in order to inform service and system development and to monitor progress over time.
6. Methods of user and carer involvement in the OATs agenda should be developed and include users and carers with the unique experience of OATs placements.
1. Why do we need this statement?

The executive committee of the Rehabilitation and Social Psychiatry Faculty has, in recent years, become increasingly aware about the lack of local service provision for people with severe and complex long-term needs who require high levels of support in residential or inpatient settings and the variability in quality of the alternatives available. Individuals are often moved to residential or inpatient settings within the statutory, voluntary and independent sector, outside their geographical area of origin (so called “Out of Area Treatments” or “OATs”).

We are a group of specialist rehabilitation psychiatrists representing different parts of the UK, including Scotland, Wales and Northern Ireland and the Republic of Ireland, with experience in a range of different geographical and service settings – urban, rural, forensic, academic and independent sectors. There is regular active user and carer involvement in the work of the Faculty. As such we are key players in this priority area and feel it is important to express our views at a time when widespread concerns over the current situation are also being voiced by other agencies [within England] such as the Department of Health, NIMHE, Healthcare Commission, Mental Health Act Commission and HASCAS.

The main focus of this document is the provision of services in England but we hope that the recommendations will be of value in a wider context. It describes the range of care funded as OATs by health and social services from residential homes to highly specialist in-patient services. While OATs can provide high-quality placements and value for money, this is often not the case. There are strong arguments, both clinical and financial, for a more rational approach to the provision of appropriate long-term support locally, which would include more effective review of people placed out-of-area and better integration within local services. The Faculty position on the need for Specialist Local Rehabilitation and Recovery Services and their potential role in better management of OATs is outlined in The Forgotten Need for Rehabilitation in Contemporary Mental Health Services: A position statement from the Executive Committee of the Faculty of Rehabilitation and Social Psychiatry, Royal College of Psychiatrists (Holloway (2005)).

The National Service Framework for Mental Health – Five Years On (NSF five years on) (DoH, 2004) reiterates a number of standards which, if properly applied, would do much to improve the current situation. These include: Standard 4, that all mental health service users on CPA should receive care which optimises engagement, anticipates or prevents a crisis and reduces risk and have a copy of their care plan which is regularly reviewed; Standard 5, that each service user who is assessed as requiring a period of care away from home should have timely access to a hospital bed or an alternative place, which is in the least restrictive environment consistent with the need to protect them and the public and as close to home as possible; Standard 6, support for carers, enabling them to remain involved in their friends’ and relatives’ care, is also relevant.

2. What are the gaps in the current provision?
There are a number of gaps in the provision of services for adults of working age, without learning disabilities and who have continuing complex needs, high levels of disability and may represent risks to themselves or others. These gaps occur in a number of different areas, including:

- the range of clinical conditions provided for;
- geographical location of services;
- appropriate and responsive services;
- commissioning arrangements;
- organisation of services;
- information;
- monitoring and follow-up;
- strategic planning.

2.1 Clinical conditions
The development of mainstream services based on functional community teams with clear inclusion criteria (assertive outreach (AO), early intervention (EI), crisis resolution teams (CRT)), while welcome, has in many cases contributed to a loss of focus for those with long-term complex needs. The NSF five years on (DoH, 2004, p22) acknowledges that the development of these new teams has, at times, been via ‘dismantling existing services’.

The largest group are those with treatment-resistant psychotic illnesses who require high degrees of support, and often supported accommodation or inpatient care, but who do not fit the remit for acute inpatient services or the developing functional teams. For these patients, co-morbidity (with addictions, personality disorder, low IQ) is more often the norm than the exception.

Supported accommodation for those with severe enduring mental illness is often unavailable from local NHS and social services, leading to provision by private and voluntary sectors and often patchy provision of the range of accommodation needed (e.g. group homes, supported housing schemes, hostels, mental health nursing homes, longer-term rehabilitation and inpatient care) (Macpherson, 2004). Specialist in-patient care for other groups such as those - requiring secure facilities; those with learning disabilities; developmental disorders (autism, Aspergers syndrome); brain injury; early onset dementias; eating disorders - is frequently commissioned in the independent sector.

2.2 Geographical location of services
Many patients requiring residential or longer-term inpatient care are placed outside local service systems. While this can at times lead to the provision of very high-quality specialist care, it is often at some distance from their homes, families and communities. Care can also be of poor standard (see the current position below).

While highly specialist regional or national services justify being placed at considerable distances from one’s district of origin, this is much harder to justify for less complex care needs. Geographical isolation is likely to compound problems of social isolation and exclusion and to make return to one’s community of origin more difficult. It may also
lead to problems in accessing services not provided directly by the placement e.g. psychological therapies.

2.3 Appropriate and responsive services sensitive to issues of gender and the needs of Black and Minority Ethnic Groups

People from ethnic minority populations may experience the negative effects of the location of services more than others. If they are placed with a provider in a geographical area with low levels of ethnic minorities they may feel isolated. This is compounded if the OATs unit has little ability or experience in assessing and meeting their cultural needs and may therefore specifically misunderstand their idioms of distress.

Research evidence indicates that levels of psychosis, common mental disorders, suicide and deliberate self-harm are higher in ethnic minorities when they are living in areas where the proportion of ethnic minorities is low. It is unclear how being sent to an area with a low proportion of ethnic minorities impacts on care and outcome of rehabilitation (McKenzie, personal communication).

Department of Health (2005) Delivering race equality in mental health care: An action plan for reform inside and outside services and the governments response to the independent inquiry into the death of David Bennett, outlines recommendations for reform in mental health services and needs to be implemented in independent as well as statutory sectors ‘all of which must be fully compliant with all the provisions of the Race Relations (Amendment) Act 2000’.

Gender issues are also of great importance especially for women placed in predominantly male services. Women’s Mental Health: into the mainstream (Department of Health, 2002) again sets out national policy on gender issues. Independent sector providers have been amongst the leaders in provided dedicated women’s forensic services.

2.4 Commissioning

The financial impact of out-of-area placements on commissioners and local services can be profound. Small numbers of costly placements can distort local service priorities, while large numbers of lower-cost residential and nursing home placements may present an opportunity to develop a more local solution, possibly with independent sector providers.

The nature of commissioning does not always lend itself to a flexible response to these needs. ‘Pots of money’, like clearly defined services, do not always meet the needs of individuals, nor do they always follow the patient through their whole recovery journey. Often they are pooled from a number of sources, including health, social services, the Benefits Agency and Supporting People, which can cause difficulties in drawing the ‘pot’ together and making it sustainable. In relation to progression through the system, intensive care, for example, may be funded from a different source from low secure rehabilitation, which may delay the patient’s move from one clinical area to another. Commissioners not uncommonly lose control of negotiation and renegotiation of contract
pricing as well as quality of provision. A better managed system for assessment, placement, monitoring and re-configuration of services may lead to clinical and financial benefits (Killaspy, personal communication).

2.4 Organisation of services
The organisation of services is fragmented. There are poor links between statutory and independent (private) services, so from the patient’s point of view it is far from ‘seamless care’. The links are better between statutory and voluntary sectors, as the latter are less able to develop services using commercial finance than the private sector. Voluntary sector organisations have an established history of working closely with local commissioners and services and of providing services more related to local need.

The arrangements for assessment of needs and risk and the sharing of documentation and patient histories can be poor, and devoid of cultural needs, particularly when services are geographically very dispersed (see section 3). Further fragmentation occurs when placements are at a distance from family and locality of origin. It is difficult to arrange visits home, for family to keep in contact and for local service workers to attend reviews. Although the CPA is the one system that in theory should hold the network together, in reality it often fails, in some cases because the placement predated the CPA. Repeated reorganisation of services over recent years has led to a loss of ‘ownership’ of placements and on occasion to patients being lost and forgotten in faraway places without any CPA review process. (Ryan et al., 2004)

2.5 Information
Information about services can be hard to find. There is no easily accessible database about services, no equivalent to the ‘Good Hotel Guide’ for Rehabilitation Units in the Independent Sector. The information provided by the Healthcare Commission, Commission for Social Care Inspection and Mental Health Act Commission is all pertinent to service commissioners and CPA co-ordinators. However, it can be difficult to obtain, even through their respective websites, and there is evidence that it is not used by either of these two important groups (Ryan et al, 2005). Information made available in an easy-to-access and digest format would support both commissioners and CPA care co-ordinators in their roles.

Clinicians who have predominantly trained in the statutory sector may have little knowledge of working in the independent sector. Jaydeokar and Piachaud (2004) have highlighted the importance of placements with independent providers during training and inter-professional training in order to develop a ‘whole-system understanding’ for learning disability services. There are a number of assumptions that are currently held by private, voluntary and public services about each other, which do not help collaboration. There are good and bad services in all sectors; working together and celebrating good practice will promote improvement in both sectors.

2.6 Monitoring and follow-up
There is also a significant gap in relation to the monitoring of the quality of services and placements. The Healthcare Commission visits and inspects all providers of independent hospitals. The Commission for Social Care Inspection regulates care homes and care homes with nursing. The Mental Health Act Commission inspects those hospitals caring for detained patients. However, the inspection procedures and reports are not linked to commissioning, either at the level of individual placements or strategically.

2.7 Strategic planning
Overall there is a lack of joined-up thinking, particularly at national level, and a lack of any systemic understanding for planning and co-ordination of services across the public and independent sectors. The need for ‘proper systems to develop, manage and monitor cooperation between public and private sectors’ has been identified (Poole et al., 2002) but not acted upon. There is a need for leadership across organisations with an interest to develop such systems; we hope the recommendations of this working group will contribute to this process.

3. Consequences of gaps in provision
There are potentially negative consequences for all stakeholders, but especially for users and carers, in the current situation:

Users can often be placed at great distance from their homes, further damaging social networks and increasing isolation. This can be particularly so for people from BME groups. While some may be receiving high-quality specialist care, many are receiving inadequate care, often in locked facilities (although not subject to the Mental Health Act), without independent advocacy and not benefiting from CPA procedures (Ryan et al., 2004). Often they will also have less access to services in the new locality than they would in their home area. They will have reduced contact with their home services, making a return to their community of origin (if appropriate) more difficult; in extreme cases they may lose contact completely.

Carers will be at greater distances from their relatives, often with journeys that are very difficult by public transport, making it difficult to maintain contact and to be involved in the care process. NSF Standard 6, support for carers, should be implemented for carers of those in OATs placements to enable them to maintain contact and continue to be involved in any plans to return to the district of origin. Often they feel ignored and do not know how to make their concerns known without jeopardising the care and treatment of their relative. This can again be exacerbated for people from BME groups.

Unplanned and costly OATs can starve local services of resources. Reinvestment of these resources in local NHS or independent sector facilities can enhance local services, improve standards of care, promote earlier returns to community living and result in financial savings. This is particularly the case where a facility cannot cope with a person who is then transferred as an emergency back into local NHS provision but away from their area of origin.
Services in areas with large numbers of independent sector providers, particularly in rural areas with low property prices, may come under pressure to provide for complex patients placed in the area by other authorities without consultation. Provision of services will often be at the expense of services to the local population.

Commissioning agencies will often have to deal with multiple and geographically dispersed providers about whom they have little knowledge or experience. Costs can be extremely difficult to plan for and to control - a small number of high-cost placements can distort local priorities. Unplanned development of independent sector provision can also distort the local health economy and workforce planning by recruiting scarce healthcare staff, often by paying premium rates.

The potential for scandals in the independent sector are great. There is a real risk of a repeat of the scandals in ‘private madhouses’ that led to the establishment of the local authority (later NHS) asylums which the independent sector is currently replacing.

4. How have the gaps arisen and what are the compounding factors?
The issue of OATs is acknowledged in NSF 5 years on (DoH, 2004, p 27) but focused on use for acute admissions rather than on longer-term care.

The gaps in longer-term care have arisen largely through the redevelopment and reorganisation of services - a reduction of long-stay NHS provision; development of specialist services; NSF targets that exclude certain patient groups; uneven development of services by PCTs and financial constraints - all contribute to the gaps in provision and compound each other. All of this has occurred while commissioning structures have been destabilised by repeated reorganisation.

In addition, we live in a media-driven, risk-averse world where people with complex needs, often without a voice, are too often subjected to excessive caution rather than having therapeutic risks taken as part of their rehabilitation. The expansion of secure services and private sector provision has been described as a process of reinstitutionalisation (Priebe & Turner, 2003), and seems to be taking place in several European countries, possibly driven by concerns about risk rather than by clinical need (Priebe et al, 2005).

As with learning disability services, there is great national variation in service provision and some areas are net exporters of care while others are importers (Jaydeokar and Piachaud, 2004). This has an effect on the ability of those areas to develop appropriate services for their needs. It may seem easier and cheaper to fund an out-of-area residential treatment than to develop a possibly more expensive complex community or residential care package locally.

The lack of development of local capacity also leads in turn to a reduced local capability, which means that OATs become a self-fulfilling prophecy. Additionally, ‘while a PCT can be hauled over the coals for keeping somebody in an NHS facility, it can with impunity leave somebody to languish in a private hospital’ (Brindle 2004). When money
is limited, this situation will not change quickly unless the patient has a good solicitor who can use MHRT recommendations to ensure appropriate placements.

5. The current position

Department of Health figures for England and Wales from 1994/5 to 2000/1 (www.performance.doh.gov.uk/HPSSS/TBL_B23.HTM) showed a 46% decrease in long-stay NHS beds from 7,830 to 4,200 (-3630) (similar changes have taken place in Scotland www.scotland.gov.uk/stats/bulletins).

Over the same period, those in NHS residential facilities increased from 1,160 to 1,280 (+120). Secure unit places increased over the same period from 1,080 to 1,950 (+870) and short-stay (acute admission) beds decreased from 15,210 to 14,380 (-820).

There was a rise in private and independent sector provision over the same period. Beds in private nursing homes and independent hospitals etc increased from 4,860, peaking in 1997/8 at 9,150 (+4290) then declining by 2000/1 to 7,280 (overall + 2420). Staffed residential home places rose from 12,960 to around 14,900 (+1940). Small registered home places also rose from 1,610 to 2,320 (+710). Overall there was a decline in NHS long-term and residential facilities of 3,490 (39%) over the 7-year period and an increase in private and independent sector provision of 5,060 (26%).

Similar changes have been reported in several European countries, along with rising prison populations; Priebe speculates that these changes maybe due to changes in the societies’ attitude to risk rather than to changing morbidity and methods of healthcare delivery (Priebe et al., 2005).

Ryan et al (2004) surveyed the out-of-area placements from one PCT and social services area in 2003. They identified 70 individuals placed out-of-area (63% had a diagnosis of schizophrenia). Significant numbers of service users were not in receipt of CPA (64%) or of multi-disciplinary review (63%). Most were in locked facilities, although they were informal patients (79%). Clinical and treatment histories were absent for around half the sample. A quarter were felt to need supported accommodation rather than residential care. Placement costs for 2003/4 were over £2m, with a mean of over £30k per placement. They estimated expenditure of around £650m for the whole of England based on these figures.

Further work quantified the cost to the former North West Region for all mental health independent sector facilities (excluding local authority-only funded dementia placement) at £101 million per annum (Ryan et al, 2005a). Places were commissioned from 539 organisations for 2900 people. Thirty organisations accounted for 44% of placements and 8.8% were with 256 organisations providing only one placement. This has not proved to be an issue isolated to the North West, as similar patterns have been found in the West Midlands and in the County Durham and Tees Valley Strategic Health Authority area (Ryan et al, 2005b & 2005c).
Sharp (2004) describes visiting a northern Italian town 25 years after Italy’s elimination of mental hospitals with Law 180. He found the most disabled patients still in a medieval building that had been the local asylum, and old-fashioned community services for those with enduring mental health problems. The de-institutionalisation had catered for a younger, more acute patient group, but had largely forgotten those with severe enduring mental illness. There is a risk of a similar process occurring in the UK, where the focus of mental health services is increasingly on functional teams concentrating on younger, more acute patients while those with longer-term needs are in danger of becoming a lost generation.

The last decade, which began with the completion of the asylum closure programme, has seen a continued loss of NHS long-stay provision. This has been mirrored by an increase in provision in the independent sector. This has largely happened in a piecemeal fashion without strategic planning. Ryan’s paper suggests that standards in many of these places are inadequate. There is a need for an improvement in individual care packages, for much greater clinical involvement in managing the long-term care system and for more co-ordinated and systematic planning of private, voluntary and NHS provision.

6. Current commissioning

NHS services are predominantly commissioned by Primary Care Trusts (PCTs). There are currently 303 PCTs in England, varying in the population they serve, with an average population of 180,000.

Although only established in 2002, PCTs are already being reformed, as they are seen as ‘too weak to stand up to providers of acute care’ and ‘too small to fulfil their public health responsibilities’ (Walshe, 2004). The current reforms will result in larger PCTs but also a move towards practice based commissioning. Some Mental Health Services based within PCTs also being reorganised. This latest series of reforms will again run the risk of exacerbating the problems around strategic commissioning and monitoring OATs placements as key personnel change roles and employers. Many PCTs will in future have pooled arrangements whereby one PCT will take the lead for a particular service or group of services, such as mental health. Groupings often relate to former Health Authorities or existing Mental Health Trusts.

Strategic Health Authorities (SHA) cover larger areas, often amalgamations of previous Health Authorities, but smaller than the former NHS regions. These have an overview and performance management function but do not generally commission services. A small number of services are commissioned nationally, by the National Specialist Commissioning Advisory Group (NSCAG) - for example, Mental Health Services for Deaf Children and Adolescents (inpatient), Secure Adolescent Mental Health Services. (http://www.advisorybodies.doh.gov.uk/nscag/) The High Security Hospitals are also commissioned nationally but through lead PCTs overseen by a National Oversight Group.

The main development in mental services commissioned by PCTs relates to the National Service Framework (NSF) targets such as Assertive Outreach (AO), Early Intervention
(EI) and Crisis Resolution Teams (CRT). Development of these services is very important for provider Trusts and PCTs as part of their performance targets for their star rating status. Services and patient groups not on these target lists are less of a priority both for Trusts and PCTs. There is some anecdotal evidence that the development of AO teams has been partially at the expense of existing community rehabilitation teams.

The increasing complexity and sub-specialisation of psychiatric services make commissioning more difficult. The multiple reorganisation of NHS commissioning and provision over the last decade has made it difficult to develop and retain commissioning expertise, particularly at the level of PCTs that are responsible for purchasing an entire range of NHS services for small populations.

The need to meet NSF targets and the small numbers of complex long-term patients in any individual PCT level have led to a situation where the development of specialist services for such groups has become almost impossible if not highlighted by national strategies.

In Forensic Services, traditionally provided at a regional level, there are often more advanced arrangements in place. Even here there have been problems, with only some regions developing services for longer-term patients and women’s services. Complexities of capital planning - including private finance initiative (PFI), difficulties in obtaining planning permission, changing political and service priorities - have led to problems even when there are specific targets for reducing the size of the High Security hospitals by alternative provision. This is an area of the market that has been particularly well targeted by the private sector in recent years, resulting in over one third of secure beds in England being in this sector in October 2000 (Department of Health, 2000/2001).

There are, however, sophisticated arrangements in place for managing independent sector placements and for developing service strategies for larger populations. These arrangements are primarily for medium secure services, but at times they also include longer-term secure services (http://www.hants.gov.uk/wessexconsortium/SSN-01.pdf). The funding for the developments of forensic services is predicted to come from savings in the cost of the High Security hospitals as they reduce in size and from the repatriation of patients from private sector placements.

A further complication is the funding of social care placements through local social services departments (LASSD). These fund placements predominantly for accommodation and social needs, often hostel placements or supported accommodation schemes, rather than primarily for medical and nursing care. The distinction between health and social care, particularly in mental health, is not easily defined. We hope the development of combined health and social care Trusts and pooled health and social services budgets will help this situation over time.

There are, however, examples of good practice at individual PCT and Trust levels. Camden and Islington Mental Health and Social Care Trust (CIMHSCT) and Islington Primary Care Trust (PCT) established a system to review out-of-borough placements.
This resulted in a number of individuals being enabled to return to the borough, and the resulting financial savings for social services and the PCT allowed reinvestment in high quality local supported accommodation (Killaspy, personal communication). Other areas are following suit, although this requires commissioners with a long-term vision working closely with clinical champions.

7. Recent commissioning developments

Difficulties in the current commissioning process are acknowledged in NSF - 5 years on (DoH, 2004, p22, para 1) with work under way to provide guidance to commissioners of specialised mental health services including those for treatment resistant psychosis.

The Department of Health has recently (October 2004) issued ‘Commissioning service close to home: Note of clarification for commissioners and regulation and inspection authorities’ in relation to learning disabilities services’ (Appendix 2). It reiterates the message that local needs should be responded to by local expertise and should adhere to 7 principles: community rather than institutional services where possible; near to home and families; development of local services; no greater security than justified by risk; maximisation of rehabilitation; highly individualised service planning and delivery for challenging behaviour; local specialist services that support good mainstream services.

The Rehabilitation and Social Psychiatry Faculty wishes to endorse both these initiatives and the development of similar ‘clarification’ for services for working age adults in need of residential services and community rehabilitation and recovery services.

8. A mixed economy of provision

There is a long history of independent (private and voluntary) sector provision in mental health, with charitable institutions such as St Andrew’s Hospital and The Retreat having been in existence long before the NHS (from 1796 in the case of The Retreat). The private sector is very variable, ranging from large commercial groups with hundreds of beds, through a number of smaller, not-for-profit charities, to small units on little more than a domestic scale, with only a few beds. The voluntary sector also includes providers such as MIND and RETHINK and a number of housing associations. Provision ranges from providing long-term supported accommodation with varying levels of support (see Macpherson, 2004) to complex in-patient treatment packages for specific disorders such as brain injury, personality disorder or rehabilitation of mentally ill offenders.

Independent providers can often respond more quickly than statutory ones and they can make a real difference to the quality and choice of care available, but they rely on market research or on entrepreneurial spirit rather than on strategic regional planning, which does not always lead to the right service in the right place for the patient. In an environment where the clinical need cannot be met by local NHS services, it is possible for independent sector providers to develop services (either by developing a niche market or by collaborative partnerships which play to the strengths of both sectors). Any provision that is considered must fully meet all the provisions of the Race Relations (Amendment) Act 2000. This has led to the development of long-stay residential services.
following hospital closure programmes, but also to development of other services such as long-term medium-secure services which at one stage were almost exclusively provided by the independent sector.

In 2000/2001 around a third of all secure beds in England and Wales were provided in the private sector (Department of Health, 2000/01). Other, less prevalent, conditions such as acquired brain injury and adolescent learning disabilities are being provided for by the independent sector in a situation where the population that would be served by such services is too large to co-ordinate NHS provision in the current situation. It is only on a national level that NSCAG is able to commission services (see Appendix 1 below).

Despite the range of providers, there is often little choice for the individual about which service they receive care from. If the local NHS provider cannot meet their needs they may have to accept whichever independent provider the PCT will fund (or knows of), or, if they are unhappy with the quality of the local care, they may end up having to fight for a referral to another provider. In neither case do the needs and wishes of the individual come first. Placement decisions are often based on what is available rather than on a service that fits the patient’s needs. Carers, in particular parents and partners, often have strong views about placements and the quality of care. Their distress and sometimes anger need to be understood and worked through and not, as they often are, to be seen as ‘pathology’.

9. Rational Commissioning in a mixed economy

There is currently a mixed economy of provision for residential and in-patient services for individuals with longer-term mental health problems; given this, there is a real need to manage this economy better and to have a rational system for commissioning services. This should encompass strategic planning, monitoring and standard setting.

At present, commissioners can buy a single placement for complex care without the need to develop a permanent service, but if they end up buying many such placements the development of a local service might become cost-effective. It should be acknowledged, however, that the quality of some independent services may indeed be better than the statutory provision.

Planning should be based on needs assessment. This should be at a regional level for low prevalence conditions where it is not viable for individual PCTs to commission. Specialist clinicians from both NHS and independent sectors should advise the planning process. Services should, where possible, no longer be allowed to develop piecemeal and according to the exploitation of niche markets by the private sector.

In order to ensure minimum standards of care there should be Service Level Agreements between commissioners and providers as standard, with built-in removal clauses for poor quality and performance.

In a number of areas and for specific conditions, the status of ‘Preferred Provider’ allows a good working relationship to develop between the commissioner and the provider. This
encourages more local placements and collaboration for further developments. It should be acknowledged that the ‘Preferred Provider’ status can lead to complacency if not effectively managed by commissioners.

Regulatory bodies such as the Healthcare Commission, Commission for Social Care Inspection and the Mental Health Act Commission could perhaps have a wider and better co-ordinated role than standard setting and inspection. For example, the Mental Health Act Commission could have a greater role in inspecting facilities where non-detained patients are in the same facility as those who are detained, as this can lead to de facto detentions (Ryan et al 2004). The most recent judgement by the European Court on Human Rights on the Bournewood case may have profound implications for the long-term care sector, particularly in the light of Ryan’s finding that 79% were in locked facilities while informal patients (not detained under the Mental Health Act). Improved links with the commissioning and providing parts of the system could greatly enhance the quality of care.

10. Recommendations

We make recommendations at three levels: 1) case management for individual patients; 2) management and monitoring of the OATs process; 3) commissioning for populations. At all three levels there is a need for a whole system approach and an understanding of the importance of collaboration. The NSF 5 years on (DoH, 2004) details a number of standards and ongoing work that would greatly improve the situation, if properly implemented. There is a need for leadership at national level across all organisations with an interest in the commissioning and provision of services.

**Case Management**

1. All patients in long-term placements purchased by PCTs and LASSDs, including OATs placements, must be subject to enhanced CPA which includes an assessment of individual needs, including those relating to gender and culture, and the development of a care plan which meets these needs. The NSF 5 years on (DoH, 2004) states in Standard 4, that all mental health service users on CPA should receive care which optimises engagement, anticipates or prevents a crisis and reduces risk, and have a copy of their care plan which is regularly reviewed, this standard should be complied with.

2. It is the responsibility of the mental health services in the area of origin, appropriately resourced from the funding district, to ensure the implementation of the CPA process. While elements of this may be delegated to the clinicians in the provider unit, clinicians from the area of origin should be in attendance at CPA reviews to maintain a link with their local services. The aim should be to maximise rehabilitation and social inclusion and eventual return to local services where appropriate (for some individuals, there may be good reasons to not return, for example where the area of origin is also where an index offence took place).
3. Provider units must engage with the CPA process, must work to implement its recommendations and must access appropriate resources as necessary.

4. Carers should be supported and resourced to maintain contact with their relatives and friends in OATs placements. Standard 6, **individuals who provide regular and substantial care for a person on CPA should have an assessment of their physical and mental health needs repeated at least annually and have their own written care plan implemented in discussion with them** should be interpreted flexibly to enable them to provide regular care and to assist them in doing so. This may include subsidising transport or providing voluntary drivers to enable them to visit. Carers should be involved in and invited to CPA meetings where appropriate.

5. Independent advocacy services should be available to all patients in OATs placements and to their carers. Opportunities for whistleblowing should be explained and supported.

6. Commissioners must ensure local services are adequately resourced to maintain contact with individuals in OATs placements, and must provide resources for additional needs outwith the placement to be met as clinically appropriate.

**Monitoring and management of OATs process**

1. Clinicians from the area of origin must be involved in the initial placement and ongoing monitoring of OATs placements. This requires a multi-disciplinary team with experience of (and preferably specialised in) severe enduring mental illness and long-term care. This should include as a minimum psychiatric, psychology, social work, nursing and occupational therapy input. Psychiatrists should have **Rehabilitation and Recovery** experience and should ideally be a Rehabilitation specialist. (Similar arrangements should also be in place for other populations, for example, those with learning disabilities, adolescents etc.)

2. OATs placements should comply with the appropriate NSF standards in particular standard 5, **being as close to home as possible, in the least restrictive environment commensurate with managing risk** and fully implementing CPA.

3. Provision must be made for access to additional resources to those provided by placements as clinically appropriate. These may include health resources such as psychological therapies or access to other services, such as education. This provision remains the financial responsibility of the placing authority unless alternative arrangements are agreed with other agencies.

4. Care should comply with appropriate national standards such as NICE guidelines.

5. There must be agreed standards of documentation, care planning, record-keeping etc. We hope national standards will be agreed in this area.
6. Commissioning bodies must apprise themselves of relevant inspectorate reports for facilities they fund, e.g. Healthcare Commission, Commission for Social Care Inspection and Mental Health Act Commission. Ideally, commissioners should liaise with these agencies about their experiences of placements, good and bad.

7. Services should be appropriate and responsive to individual needs including those relating to gender, race, culture and ethnicity and comply with national policy in these areas. Commissioners should make sure that their choice of services used for OATs do not represent discriminatory care by ignoring the cultural needs of ethnic minorities or the impact of being moved to a low density ethnic minority population area.

8. The ultimate aim for the majority of patients should be to return to local services and community accommodation with appropriate levels of support. Commissioners need to work actively with local services to support this process.

Commissioning for populations

1. There must be an explicit strategy for collaborative commissioning for larger populations (e.g. Strategic Health Authorities, individually or in small groups) for those with severe enduring mental illness, including the provision of a range of accommodation from supported individual housing through to secure forensic rehabilitation services. These should include assistance to return to work, meaningful activity and rehabilitative resources, across services for high-cost, low-volume conditions (e.g. long-term low-secure, brain injury, Aspergers, autism) that are not viable to provide at the level of single PCT or Trust, but below the level of national services commissioned by NSCAG. We would endorse the recently released ‘Note of clarification’ (Appendix 2) and the intention in the NSF 5 years on (DoH, 2004, p22, para 1) to provide guidance to commissioners of specialised mental health services, including those for treatment-resistant psychosis.

2. There should be a local forum, involving all stakeholders, PCTs, Social Services, Mental Health Trusts and clinicians, to provide an overview of OATs, including financial implications, clinical appropriateness, service development and geographical location.

3. Commissioning and performance managers should draw up service level agreements with providers [based on an agreed template] linked to Healthcare Commission and Commission for Social Care Inspection Standards and guidance from other official bodies such as NICE. This should be for a ‘package of care’, not just the placement, including, for example:
   - monitoring by the service of origin;
   - additional specialist treatment if necessary;
• additional community services at placement site where appropriate;
• travel time and costs for carers and provider teams;
• specialist after-care and follow-up.
Information on services should be readily available and shared between commissioners.

4. There is an urgent need to review the funding streams for OATs to facilitate the process of step-down and after-care without a change of commissioning team (the care pathway needs to be the driver, not the money).

5. A nationally agreed minimum dataset should be kept by health and social care commissioners, on all OATs, in order to inform service and system development and to monitor progress over time.

6. Methods of user and carer involvement in the OATs agenda should be developed and should include users and carers with the unique experience of OATs placements.
References


Ryan T, Hatfield B, Sharma I et al (2005b) A census day audit of mental health out of sector placements in the West Midlands. HASCAS & University of Manchester.

Ryan T, Hatfield B & Sharma I (2005c) A census day audit of Social Services and NHS non-statutory sector placements and ‘Spot purchase NHS placements’ for the County Durham & Tees Valley Strategic Health Authority area. HASCAS & University of Manchester.


Appendix 1: The National Specialist Commissioning Advisory Group terms of reference.

To advise the Secretary of State for Health, through the NHS Executive Board, on:

a. the identification and funding of services under the Supra Regional Services arrangements
b. the identification and funding of specialised services not qualifying for Supra Regional Service designation, but where there is an economic and/or clinical justification for contracting centrally for their delivery;
c. the commissioning of commissioner guidelines for specialised services where commissioning is best arranged through local commissioners by means of lead commissioners or commissioner consortium arrangements; and,
d. funding the service costs of new developments, in those services for which it is likely to become the commissioner, to enable full evaluation to take place.

Supra Regional Services

Supra regional services (SRS) are those very specialised services which need to be provided in a small number of centres and planned and funded on a national basis.

The most significant criteria for SRS definition are:

a. the service must be an already established clinical service;
b. relate to a clearly defined group of patients and be capable of being provided in a small number of centres which between them can meet the needs of the national caseload;
c. be able to justify its costs when set against alternative uses of NHS funds;
d. relate to a condition whose rarity is such that the national caseload would not normally exceed 1,000 and would normally be about 400;
e. have sufficient financial impact, when cases arise, that HAs are unable to respond in-year from contingency funds.

The total national caseload should normally be capable of being treated in fewer than six centres.
Appendix 2: Commissioning service close to home: Note of clarification for commissioners & regulation and inspection authorities (DoH, October 2004).

**Issue**
Over recent months, a number of stakeholders have expressed increasing concern about the growing number and size of independent sector hospitals for people with learning disabilities. Many of the people who are in-patients in such settings are many miles from their families and originating authority.

This paper intends to:

1. clarify and reiterate the Government position on appropriate commissioning of services for people with learning disabilities. This includes those who require health placements as well as other ‘out of area’ placements such as specialist residential or nursing home provision.
2. clarify the information available to regulatory and inspection bodies to enable them to challenge service developments that are not in line with government policy and good practice guidance.
3. continue to encourage local commissioners from both health and social care to generate local solutions to meet the needs of individuals in their area and to work with neighbouring areas to consider regional resources.
4. build the capacity and confidence of local communities to support individuals with higher or more complex needs. Taking account of the concept of care in the ‘least restrictive setting’.

**Background**
Whilst progress has been made to close the remaining long stay NHS hospitals for people with learning disabilities it is clear that the number of people in the independent sector hospitals is increasing with the number of registered independent hospital beds approximately 1,000 (actual patients 850-900) according to a Healthcare Commission Survey (Healthcare Commission, July 2004).

People with learning disabilities who are currently in independent hospitals are usually formally detained under a section of the Mental Health Act (1983) and are often described as having ‘forensic’ or ‘severely challenging’/mental health needs. Many of the hospitals offer services that are described as ‘low secure’.

More than 5 years ago, research undertaken for *Facing the Facts* (DH 1999) found that only a third of authorities reported adequate forensic and mental health services and a significant increase in NHS secure accommodation was anticipated.

From a commissioning perspective, placing someone in an out of area independent hospital presents several challenges. Visiting that person creates logistical difficulties in relation to monitoring the quality and cost effectiveness of the service the person is receiving. The individual’s relationship with their family and friends is vulnerable if they
are many miles away. This is also true of their relationship with their care manager, which may be tenuous.

Costs of such placements can be high and may represent a significant percentage of the local area’s budget for learning disability services. This can place local commissioners in the position where they recognise the need to develop appropriate local services but are unable to do so because of lack of available resources.

**Policy context**


Continued government commitment to the development of local services for local people and the reduction in the use of out of area placements is evidenced by a priority use of Learning Disability Development Fund:

- *Enabling local providers to develop specialist services for people with severe challenging behaviour: e.g. small step down facilities to enable people to move on from more secure accommodation, additional homes to reduce reliance on out of county placements, respite care homes.* (DH – HSC 2001/016 LAC(2001)23)

These documents form a framework for commissioners and reiterate the message that local needs should be responded to by local expertise and resources and adhere to the following key principles –

1. **Individuals should have services provided as far as possible in community rather than institutional settings**
2. **People should be supported as near as possible to their homes and families**
3. **Development and expansion of the capacity of local services to understand and respond to challenging behaviour**
4. ** Individuals should be in conditions of no greater security than is justified by the danger they present to themselves and others**
5. **Services should maximise rehabilitation and the individuals’ chances of sustaining an independent living**
6. **The differing needs of people with challenging behaviour should be responded to by highly individualised service planning and delivery**
7. **Local specialist services should be provided which support good mainstream practice as well as directly serving people with the most challenging needs**
Appendix 3: Anonymized Case Studies to illustrate some OATs scenarios

One
Ruth, 64, has been an in-patient for over 20 years. When the mental hospital where she lived was closed she was moved to a ‘hostel ward’ in another NHS hospital 30 miles away near to a relative but not in an area where she herself had lived. Now, due to development of assertive outreach and crisis teams, the ‘hostel ward’ is to close in order to release funds and the only place that can meet her needs is an independent hospital near the original hospital. She does not want to move and has become mentally unstable. Her needs appear now to be secondary to the needs of the local service development. She has an advocate who tries to ensure that her needs are addressed.

Two
James, 27, has been in several acute admission wards and has been detained under the Mental Health Act. His placement in supported accommodation has broken down due to his drug use and he has now been in a high dependency unit for 2 years. No suitable rehabilitation facility is available within 80 miles. He is transferred to a specialist rehabilitation unit in the independent sector 2 hours’ drive from home, where after 2 years, he is ready for home leave and plans for a move back to supported accommodation in his local area. Attendance by the local team at CPA reviews has been poor. It takes a further year for a local care co-ordinator to be appointed and to secure suitable accommodation. When he is discharged there is no local worker trained in psychosocial interventions (PSI) to continue the specialist work that he has benefited from in the rehabilitation unit. Telephone support is arranged until a suitably trained worker is in post.

Three
Darren, 18, is from an Afro-Caribbean background and grew up in the city. He has a severe illness and needs a period of time in a low-secure rehabilitation unit. A place is found in an independent sector hospital in another county where he is the only patient from a BME group. He is detained under the Mental Health Act and his mother wishes to attend CPA reviews and MHRTs. As she is employed she cannot get any financial assistance with time and travel to come to these meetings and fears losing her job.

Four
Lynne, 30, has been in a medium secure unit in the independent sector for 18 months. Local clinicians have not been able to engage well with her in the past and have not kept in contact during her admission. A MHRT discharges her Section, she leaves hospital and she defaults from follow-up. A year later she again requires intensive care and is managed in the local service until she needs rehabilitation. This cannot be provided locally and she is referred to a different independent provider. By now both she and her family have lost faith in mental health service providers and it takes skilled work to rebuild this trust and help her recover.
Five
Janet, 55, has epilepsy, learning disability and psychosis and was placed in a nursing home more than 10 years ago when the asylum in which she had lived for 15 years closed. It was wrongly assumed at the time that she had no relatives nearby. The nursing home was not registered for the care of people with learning disability and subsequently has registered as an independent hospital but without provision for learning disability. Her referral predated the CPA and in the meantime the responsible funding authority had changed and effectively she had been ‘forgotten’ by them. It has taken the independent hospital clinical team nearly 2 years to get a reassessment of her needs by the funding authority and for an appropriate community placement to be found. Her family have been involved in her relocation.

Six
Simon, 32, has a severe psychosis and needs long periods of care in secure provision in the independent sector, which is funded by forensic services. When he is ready to move to a less secure setting within the same hospital his care will be funded by continuing care funding. This is held in a separate budget and involves a different commissioning team. This brings with it a delay which is detrimental to his care.

Seven
John, 65, has lived in a small home with 6 other residents for 25 years. He is an informal patient but his behaviour is impulsive at times and due to shortage of staff it is necessary to keep the unit locked. He is therefore de facto detained in his home.

Eight
Sally, 18, has anorexia nervosa with impulsive behaviour and has been in a specialist private eating disorders unit for young people for 2 years. This is a long way from home. She is deemed to need a low-secure facility but there is no such unit that can meet her needs in her region. Her family are very concerned about the effect of being so far from home is having on her, but have so far failed to bring about any change in the situation.