

Making the case for a rehabilitation facility

Helping psychiatrists to work
together with commissioners
and senior service managers

Faculty report FR/RS/05
Royal College of Psychiatrists
Faculty of Rehabilitation and Social Psychiatry

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1 Introduction

Rehabilitation psychiatrists will be all too aware of how the closure of large mental health hospitals in recent decades, coupled with disinvestment in local rehabilitation services, has led to an exponential rise in the number of their patients – whose needs lead them to require longer-term and/or specialist in-patient care – being placed out of area (Holloway, 2005).

Many commissioners will also have concerns about this situation, but will have been hampered in their ability to stem the growth in out-of-area placements by a lack of policy guidance relating to rehabilitation services (leading to increased numbers of ‘revolving door’ patients) (Killaspy & Meier, 2010), and a dearth of suitable step-down accommodation for patients ready to move on from forensic settings. Once patients have been placed out of area, a lack of appropriate systems for their care coordination and review further exacerbates the problem.

Although the complex and specialist nature of some patients’ needs means that the use of some out-of-area treatments is clinically justified, a substantial proportion of patients placed out of area receive what is essentially standard care. Most out-of-area placements are provided by the independent sector. Some out-of-area treatments provide highly specialist services commissioned from a number of geographically spread regions. This is appropriate and represents an economy of scale not realisable locally due to the low volume of patients with very specialist requirements. However, inappropriate use of out-of-area treatments in hospital settings and other forms of placement (e.g. in residential and nursing care settings) has negative clinical, social and economic consequences. Service users become socially dislocated from family, friends and local communities, disaggregated care coordination and care management impair timely reviews, leading to over-support and institutionalisation, and the financial impact of this on continuing care and community care budgets is significant. It has been estimated that over £100 million could be released for investment in the local mental health economy by addressing the inappropriate use of out-of-area treatments (Killaspy & Meier, 2010).

The Royal College of Psychiatrists’ response to the current economic downturn emphasises the need to address out-of-area treatment expenditure and the need to support commissioners to do so (Royal College of Psychiatrists *et al*, 2009). In addition, the Department of Health’s *New Horizons* document (Department of Health, 2009) includes a clear steer to reduce out-of-area treatments and this has been incorporated into the latest National Health

Service (NHS) Quality, Innovation, Productivity and Prevention programmes (www.dh.gov.uk/en/Healthcare/Qualityandproductivity/index.htm). Further guidance on out-of-area treatments is due to be published by the National Mental Health Development Unit by the end of 2010.

These issues are therefore likely to be of major concern to clinicians, commissioners and service managers alike, and many independent sector providers are also keen to assist in the repatriation of those currently in inappropriate out-of-area placements.

Recent guidance from the Royal College of Psychiatrists' Faculty of Rehabilitation and Social Psychiatry has described the types of facilities needed to provide a comprehensive rehabilitation service (Wolfson *et al*, 2009). As well as a range of community services, these include community rehabilitation units, high dependency rehabilitation units, longer-term complex care, secure rehabilitation units and highly specialist in-patient services.¹ However, realising the ambitions of this document remains a task which clinicians, commissioners and senior service managers can only achieve collaboratively.

Indeed, now that the government has spelt out its desire that a new NHS Commissioning Board hold commissioners to account for the provision of a comprehensive healthcare service to meet the five domains of its outcomes framework² (Department of Health, 2010a), it could be argued that the opportunity and necessity for collaboration between clinicians, commissioners, service managers, independent and other third-sector providers has never been greater.

1. For a typology of in-patient rehabilitation units which comprise a comprehensive service (devised by Dr Steffan Davies), see Wolfson *et al*, 2009: pp. 30–32).

2. The proposed framework *Liberating the NHS: Transparency in Outcomes* will have five domains, including: preventing people from dying prematurely; enhancing quality of life for people with long-term conditions; helping people to recover from episodes of ill health or following injury; ensuring people have a positive experience of care; and treating and caring for people in a safe environment and protecting them from avoidable harm (Department of Health, 2010a).

2 Preparing the case: what psychiatrists need to know before making the case for a rehabilitation facility

WHO NEEDS TO BE PERSUADED?

It is likely that the first audience to persuade of the relevance of a rehabilitation service is the senior management within the provider organisation. In the past, rehabilitation services have been seen as an easy target for savings. Any proposal to invest in a rehabilitation facility will need to emphasise how this will potentially improve the wider care pathway (e.g. by providing for patients 'stuck' in acute wards) and enhance the current rehabilitation care pathway (where it exists). This will include some description of the pathway beyond the proposed facility (e.g. to supported accommodation).

STRENGTHS OF THE DIFFERENT SECTORS INVOLVED AND HOW SECTORS CAN COLLABORATE EFFECTIVELY

Increasingly, independent sector providers are developing rehabilitative care pathways, although these are often still located out of area. Greater collaboration between local NHS commissioners, providers and independent and third-sector providers can lead to mutually beneficial partnerships that capitalise on the strengths of each to provide appropriate care pathways locally. For example, the independent sector can develop services at greater speed and with greater flexibility to meet changing patient needs than the NHS through its access to capital. The voluntary sector has enormous experience in the provision of supported accommodation and facilitation of service users' engagement in meaningful occupation.

All providers should be held to account for achieving the outcomes they are commissioned to deliver, including the clinical outcomes for individual service users. An understanding therefore of any potential collaboration with

the third sector will be of great importance in the preparation of the case for the proposed rehabilitation facility. Although clinicians and service managers may not have the complete overview of where these exist and could be developed, raising this with commissioners as an area for potential development is likely to be well received.

LEVEL OF NEED FOR THE PROPOSED SERVICE (OR EXISTING SERVICE IF ITS CONTINUATION IS UNDER THREAT)

This must include data on the number of patients placed out of area, their clinical profile, length of stay and whether the number of suitable patients is large enough to justify the particular type and size of rehabilitation unit or service proposed. Some NHS trusts and primary care trusts employ dedicated staff to review all individuals in out-of-area treatments, which facilitates comprehensive clinical and social needs assessments as part of this process. This is in order to identify how many patients could be repatriated to existing/proposed rehabilitation services or supported accommodation in the local area. Where NHS trusts and primary care trusts do not employ out-of-area reviewing officers, this data should be available directly from primary care trust commissioners (in 2009, for example, over 70% of primary care trusts provided detailed data on the number of patients placed out of area and related expenditure in response to a Freedom of Information request from the Royal College of Psychiatrists on the subject of residential and nursing care placements for people with severe and enduring mental health problems; www.rcpsych.ac.uk/policy/policyandparliamentary/projects/live/outofareatreatments.aspx). Commissioners also have access to comparison data from local boroughs and regions with similar morbidity, which can be used to benchmark the use of out-of-area treatments locally. In addition, many rehabilitation psychiatrists – who play a key role in the decision-making process through sitting on ‘placement panels’ – will be aware of the number of individuals from their area placed out of area, their clinical needs and the associated costs.

RANGE OF CURRENT PROVISION AND HOW A PROPOSED SERVICE WOULD COMPLEMENT THIS

That is, what type of rehabilitation service is proposed³ and how this will reduce the need in the future for individuals with complex mental health needs to be transferred to out-of-area placements, allow appropriate flows of patients through the care pathway and reduce pressures elsewhere within the local service system. The template for rehabilitation services (Wolfson *et al*, 2009)

3. For a typology of in-patient rehabilitation units which comprise a comprehensive service (devised by Dr Steffan Davies), see Wolfson *et al*, 2009: pp. 30–32.

was sent to all mental health commissioners in January 2010; the majority of commissioners should therefore have (or be able to access) information about what each of the five types of rehabilitation facility advocated in the document (community rehabilitation unit, high dependency rehabilitation, longer-term complex care, secure rehabilitation, highly specialist services) offers in terms of service user characteristics, anticipated length of stay, specialist functions, risk management and area served (local or regional). Obviously the location of any proposed service (e.g. rural/urban) will have a bearing on the proposal and may present additional challenges in terms of the logistical and demographic characteristics of realising any proposal.

SIZE OF THE POTENTIAL FINANCIAL FLOWS FROM THE PROPOSAL

Some estimation of the potential financial flows that could result from the provision (or re-provision) of the proposed facility or service will be an important element of any proposal, as will an understanding of how these could be reinvested locally. This could perhaps be in partnership with independent and/or third-sector providers, to develop local rehabilitation and supported accommodation services (see, for example, a study on financial savings made by repatriating service users from out-of-area treatments to appropriate local settings in Islington (Killaspy *et al*, 2009)).

WHO IS THE 'COMPETITION'?

Although partnership working with the independent and voluntary sector is encouraged, NHS providers increasingly have to compete for investment from commissioners' finite budgets. The independent sector has been able to move into niche areas of specialist mental health service provision and is not constrained by serving a particular geographical area in the same way as NHS providers, and can make appropriate economies of scale for very specialist care where the local demand would clearly not justify local investment. The independent sector and voluntary sector also have a longer history than NHS providers in attracting investment through competition.

3 Working with commissioners

Proposals contained in the government's White Paper *Equity and Excellence: Liberating the NHS* (Department of Health, 2010b) – that primary care trusts and strategic health authorities be abolished by 2013, and responsibility for commissioning be given largely to general practitioners (GPs) – suggest that the world of healthcare commissioning is set for some upheaval. Clearly, it will be important for clinicians to establish how far changes to local commissioning arrangements have progressed (whether, for example, GP consortia have been set up locally, either in reality or in shadow form, and what is the proposed, or new, structure of mental health commissioning in their area). It may be that neighbouring GP consortia will commission mental health services together rather than separately (since consortia are likely to serve smaller populations than the current primary care trusts), while some may work more independently; the picture is as yet unclear.

Over and above the actual commissioning arrangements that exist in clinicians' local areas however (and acknowledging that the changes above do not apply everywhere in the UK), the point at which commissioners become involved in any proposal may well be critical to its chances of success. Rather than presenting primary care trust or GP consortia commissioners with an exhaustive business case, it is more advisable to involve them earlier in the process in order to give them the opportunity to develop an outline business case in collaboration with clinicians and service managers.

Although the data described above is a starting point for making an initial financial case to a commissioner, the clinical case also needs to be made. Clinicians are in the best position to do this, stressing issues of equity of, and access to, high-quality clinical care that addresses the needs of the local population. Areas that may be worth stressing in making the case for the proposal include the following.

- The advantage of geographical proximity for service users to keep in touch with their family, friends and local community.
- The continuity of clinical care provided by local services that allows effective monitoring of service users' progress.
- The importance of the care coordinator's and rehabilitation practitioner's knowledge of local appropriate and available 'move-on' facilities in making suitable discharge plans for the service user in a timely fashion.
- The lack of financial disincentives to service user move-on within a local rehabilitation system.
- The benefits to the service user of increased autonomy, which result from being able to access treatment more locally.

4 Elements of an outline business case

The outline business case needs to provide adequate detail concerning areas such as the strategic context and potential financial advantages of the project, while being sufficiently succinct to communicate the salient points for a full business case to be sanctioned subsequently. Core elements of any outline business case are likely to include the following.

INTRODUCTION

- What is the proposal about (e.g. a new facility such as an in-patient rehabilitation unit, re-provision of an existing facility or reconfiguration of rehabilitation services across an area)?
- Are there any potential collaborative partnerships across providers?
- Are there any competitors, and if so, what are their strengths and weaknesses in comparison to the local proposal?
- Brief statement regarding rehabilitation services and their importance (depending on the level of knowledge/expertise/interest which the commissioners you are seeking to influence have about rehabilitation services: for example, general definition of rehabilitation services,⁴ and/or a description of their purpose).⁵
- Indication whether this is an options paper or a outline business case for one particular proposal (containing explicit justification regarding choice of site for the proposed unit).

4. 'A whole systems approach to recovery from mental illness that maximizes an individual's quality of life and social inclusion by encouraging their skills, promoting independence and autonomy in order to give them hope for the future and leads to successful community living through appropriate support' (Wolfson *et al*, 2009: p. 10).

5. The purpose of specialist rehabilitation services is to deliver effective rehabilitation and recovery to people whose needs cannot be met by less intensive mainstream adult mental health services. The focus is on the treatment and care of people with severe and complex mental health problems who are disabled and often distressed, and who are or would otherwise be high users of in-patient and community services. The aim is to promote personal recovery, 'whilst accepting and accounting for continuing difficulty and disability' (Roberts *et al*, 2006). What makes rehabilitation services unique is the length of time they expect to work alongside individual service users. They will support people as they gain or regain confidence and skills in everyday activities, a process which can take months or even years. Maintaining expectations of recovery over long periods of time can be difficult for staff and service users alike. A major aspect of the purpose of rehabilitation services is the continuous promotion of therapeutic optimism (Wolfson *et al*, 2009: p. 12).

- Brief statement about the need for the proposed change (e.g. what benefits would the proposed change bring and for whom. It might be useful, for example, to describe a typical patient that a rehabilitation service might help (Box 1)).

THE STRATEGIC CASE

- The local (e.g. are there any Commissioning for Quality and Innovation (CQUIN)⁶ targets which your proposal might help local providers to meet?), regional (how, for example, does your proposal fit in with your primary care trust's or GP consortium's strategic plan?) and national⁷ policy contexts (e.g. you might want to quote from point 1 of *New Horizons* (Department of Health, 2009: p. 35) and the Royal College of Psychiatrists' report *Mental Health and the Economic Downturn* (Royal College of Psychiatrists *et al*, 2009: p. 20)).

THE CASE FOR CHANGE

- An outline of current service provision and implications of the status quo (i.e. an analysis of whether adaptations could be made to existing facilities to obviate the need to build, purchase or lease new sites).
- An explanation of how the proposed facility/service(s) might help the primary care trust/GP consortium provide a more comprehensive suite of care (this section could make reference to *Enabling Recovery for People with Complex Mental Health Needs* (in particularly 'Typology of in-patient rehabilitation units'; Wolfson *et al*, 2009: pp. 30–32).
- Service delivery benefits of the proposal (e.g. how might your proposal: enhance the whole system of local care pathways; make for more accessible, locally based services; enable care coordinators to be better able to monitor the progress of their patients; negate the future requirement for patients having to be transferred out of area and also help repatriate those already in such placements).
- Arguments relating to vulnerable groups (this section might make particular reference to any impact/benefits which might accrue from the proposal to

6. The CQUIN payment framework is a national framework for locally agreed quality improvement schemes. It makes a proportion of provider income conditional on the achievement of ambitious quality improvement goals and innovations agreed between commissioner and provider, with active clinical engagement. Commissioning for Quality and Innovation schemes are required to include goals in the three domains of quality: safety, effectiveness and patient experience; and to reflect innovation.

7. *New Horizons* (Department of Health, 2009) – in line with the major shift of emphasis towards person-centred and recovery-focused services that had been gathering strength over the previous decade – announced a pivotal shift in focusing on the individual as an active participant in their own care and recovery and made clear that services should optimise the opportunities for people to exercise choice, express preferences and have control over their own lives. The government is expected to publish its mental health strategy in Autumn 2010 and it is widely believed that these commitments to person-centred and recovery-focused services will be maintained. The government has recently consulted on its White Paper, *Liberating the NHS*. The *Transparency in Outcomes* consultation which forms a part of the White Paper as a whole contains proposals to measure the effectiveness, patient experience and safety of health services in regard to five domains, one of which is 'enhancing quality of life for people with long-term conditions'. It may be useful therefore for anyone preparing an outline business case to seek to link their proposals to the national policy context.

Box 1 DESCRIPTIONS OF TYPICAL PATIENTS WHOM REHABILITATION PSYCHIATRY AIMS TO HELP

A young man with a recurrent psychotic condition, probably diagnosed as schizophrenia. He would be unemployed, intermittently used street drugs and have great difficulty achieving stable accommodation, occupation or finances. He would be at risk of homelessness, of being a victim of crime and of additional physical illnesses resulting from poor diet, self-care and lifestyle. He would have strained or estranged relationships with his family and few or no friends. He would have few or no financial resources and is more likely to have debts or have got to a position where he is denied financial services. He may wish to have a home, a job and a partner – but has none of these and at the time of engagement – little prospect of gaining them. He is down and without skilled assistance has little prospect of going up. He may already have long experience of psychiatric services but people around him feel stuck with few ideas of how to help or how to find the time, hope and patience needed to find a productive way of working with him to find a route to recovery (G. Roberts, personal communication, 2009).⁸

A man in his early 40s. He has had a diagnosis of schizophrenia for 15 years. He has been hospitalised five times, being compulsorily detained three times. A prominent feature of his illness is his unshakeable conviction that he is under constant surveillance by a government organisation. He believes he is followed wherever he goes and frequently sees people whom he believes to be these agents on the street and in local shops. Partly through fearfulness and partly through apathy, he spends most of his time alone in his flat. He takes no interest in his appearance or hygiene and has serious problems managing the upkeep of his flat, on which he owes a considerable amount of unpaid rent. He has not worked for many years. The view of some clinicians is that his is a pretty hopeless case. In the course of the long illness, he has received all the usual (and some not so usual) pharmacological and available psychosocial interventions, to apparently little effect (Craig, 2006: p. 4).

groups which your local primary care trust/GP consortia have identified as disadvantaged/priority or which are especially socially excluded).

PROPOSED SERVICE MODEL(S)

- A description of the proposed model.
- Evidence of the model's efficacy in clinical terms (these references may be useful if helping formulate this section: Roberts *et al*, 2006; Corrigan *et al*, 2007; and Liberman, 2008).
- An analysis of risk for each of the options (including clinical risks, as well as the health and safety risks, of current provision versus the options outlined in the case; also, the reputation of all the organisations involved if a collaborative venture with neighbouring trusts/other providers is being proposed).

COMMUNITY INVOLVEMENT AND SUPPORT

- Acknowledgement of the potential sensitivities which various options may have, including any findings from, or plans for, consultations with service users and carers and with the wider public.

8. From Roberts, G. (2009) Who needs rehabilitation services and why? Unpublished paper available from the author on request (email: glennroberts@scriptorium42.wanadoo.co.uk).

RISKS

- Acknowledgment of the financial risks (e.g. if the proposal were to include financial flows from reconfiguration/sale of another facility that did not deliver the projected surplus).
- Planning risks (i.e. if the proposal requires planning permission that may be rejected for any reason).
- Market risk (e.g. if the estimated number of patients who could potentially relocate to the new facility is not achieved).
- Acknowledgement of any risks resulting from doing nothing.

THE COMMERCIAL CASE

- A financial model that shows phased start-up and cash-flow requirements.
- An estimate of the financial issues/benefits of the proposed facility (while acknowledging that the proposed service may generate increasing income over a period of time as the service reaches full capacity and steady state, rather than being at full operational capacity from the start). For example, this section might touch on the potential for such a facility/service to help your primary care trust/local GP consortia to reinvest funds into the local health economy rather than spending them outside the borough on out-of-area treatments.
- Capital costs (brief details, including approximate figures if available, regarding aspects of the proposal such as a range of possible sites, whether these are leased, already owned for another purpose or whether land and/or property would need to be purchased).
- Workforce implications and costs (i.e. what staff would be required for the proposed facility/service? Are there any costs associated with any proposed movement of existing staff?).

MANAGING CHANGE

- If the proposal concerns making amendments to an existing service, then this section might refer to the need to:
 - manage the incremental change in the culture of the unit
 - inform referring mental health services
 - work to help current staff adapt as any modified remit and referral criteria begin to take effect.
- If the proposal concerns the development of a new rehabilitation facility, then this section might reflect the need for clinicians to:
 - work with the providers to inform the building and service design to ensure best practice;
 - engage with, and inform, referring mental health services about the purpose and remit of the new facility to ensure that referrals to the new service are appropriate.

5 Conclusion

This document is not meant to be exhaustive but rather a guide to the preliminary approach to making a case for a rehabilitation facility. It is not expected that the rehabilitation psychiatrist would be the only person working on such a case, but hopefully the document provides enough clarity about the structure and content of an initial business case to be useful practically.

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