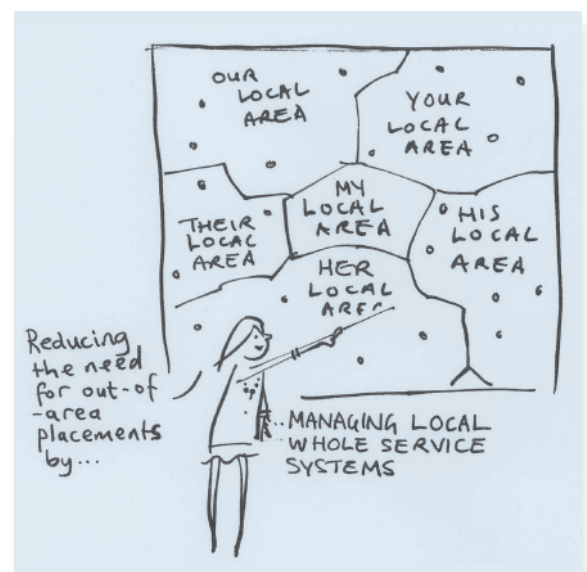


Chapter Six Developing and managing the market

Reducing the need for out of area placements through managing local whole service systems

by Tony Ryan



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[View Biography](#)

Abstract

Out of area placements are causing significant budget overspends for many commissioners and great concern for finance departments in both PCTs and Local Authority social service departments. Capacity and capability within commissioners' local service systems are often the reasons behind the need for out of area placements. This paper discusses how managing local whole systems can improve effectiveness and efficiency in services and at the same time impact on the number of people requiring out of area placements. The paper utilises mental health as a case study area and provides a significant number of practical tools (referenced as "links" throughout the paper) that can be adapted and utilised by commissioners. It also describes processes that have been successfully employed in several areas to address these issues. A full list of downloadable links is given in the Appendix.

Key words: out of area placements; mental health; repatriation; managing whole systems.

Introduction

Considerable numbers of people are placed in facilities in the independent sector ("for profit" and "not for profit" sectors) for support. In many cases placements are local to families, friends and statutory services that have supported the user in the past. Others may be placed a considerable distance away from these links. Management of placements by care co-ordinators, responsible medical officers (RMO) and commissioners at a distance can create many difficulties. Such placements can be very unfair to the service user, their family and friends if the reason for such a distant placement is due to lack of local capacity or capability rather than for reasons such as personal choice or Home Office restriction. From a commissioning and financial perspective it also means that monies are being lost from the local system that could be used to develop local services and their capacity and capability.

This paper is intended to support commissioners and services to develop a managed local whole system. Through such an approach it is possible to improve both capacity and capability whilst at the same time reduce the need for some clients to be placed at distance from their closest social networks.

What is meant by a "local whole system"?

A local whole system means a number of services for a given client group from statutory and / or independent sectors that collectively work as a managed service system rather than a dispersed collection of loosely aligned service providers.

"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 specialised

services may be provided across a wider geographical area than that of the commissioner and they may therefore fall outside their patch.

Why manage services as systems?

Over the past 30 years or more there has been considerable change in the profile of mental health services, particularly those provided in the independent sector. Also, the growth in registered facilities such as independent hospitals, care homes with nursing, or care homes shows no sign of slowing. Between 1994/5 and 2004/5 the number of NHS beds fell by 23.5% from 41,380 to 31,645¹ while between 1994/5 and 2000/1 the number of private sector beds rose by 49.2% from 47,980 to 97,600². Therefore, the private and voluntary sectors constitute a significant proportion of total mental health bed capacity in England. Plurality of provision has led to innovation in many cases but also some fragmentation. When services are co-ordinated or managed as a system it results in more effective and appropriate care and treatment for service users than when they operate separately.

What are the benefits of having a whole system approach to providing services locally?

Services working outside a managed whole system often have many positive aspects in relation to their service provision and when part of a managed system they can be enhanced and utilised to best effect. Nevertheless, there are a number of benefits to managing a service system as opposed to an unmanaged loose network of providers. These can include:

- Improved effectiveness and efficiency of services.
- Improved communication across the service system.
- Care pathways can improve and become clearer.
- Options for a single point of entry and single referral systems.
- Shared knowledge of vacancies and waiting lists.
- Better use of existing resources.
- Less inappropriate placements within the local system or out of the area.
- Improved use of monies on local services rather than services outside the local system.
- Reduced duplication amongst providers.
- Clearer approaches to service development based on local need.
- Effective and robust Care Programme Approach (CPA) particularly when care co-ordinators operate in a clear system.

What processes can be used to develop a whole system approach?

Developing and managing a whole system can be achieved in numerous ways; the one outlined here should not be regarded as the only way to do this. This is simply intended to serve as an example and one which can be adapted and developed to meet local needs.

From studies of the use of the independent sector it has been established that the overwhelming majority of services that are commissioned are described as rehabilitation and continuing care

¹ Department of Health (2005). Average daily number of available and occupied beds by sector. Strategic Health Authorities in England, 2004-05. London: Department of Health. www.performance.doh.gov.uk

² Department of Health (2005). Hospital beds and places in residential and nursing care homes for people with mental illness in England (personal communication).

services^{3,4,5}. Consequently this area will form the basis of the “case study” that is used here. This paper will take you through the process step by step.

Step 1 – Mapping the components of the system

There are a number of ways on which commissioners can map out the services within their geographical patch. Triangulating a series of approaches ensures that all services are identified. Methods can include:

- Consulting the local mental health services directory.
- Identifying services currently being contracted (e.g. through the finance department).
- Liaising with local CPA care co-ordinators
- Searching for services in the locality through the regulators’ websites:
 - Commission for Social Care Inspection
www.csci.org.uk
 - Healthcare Commission
www.healthcarecommission.org.uk

This approach ensures that the commissioner knows:

- What services are currently being used.
- What other services exist in the locality.
- The quality of the services (for example, through accessing inspection reports on the Healthcare Commission and CSCI websites).
- The view of local practitioners.

Step 2 – Identifying missing components

There are several methods that can be adopted to identify any missing components to the local system. These include:

- Undertaking assessments with local clinicians and providers to identify client needs that are not currently being appropriately met. For example, see [link 10](#) CANSAS, [link 11](#) SPRS, [link 12](#) Life Skills Profile, [link 13](#) HONOS, and [link 14](#) Global Assessment of Functioning (GAF).
- Identifying historical needs data available locally through commissioners and providers that identifies trends over time, e.g. in relation to service usage, throughput, unmet needs, etc.
- Reviewing all placements outside the locality that are paid for by the commissioner for appropriateness of provision both in terms of meeting need and providing user satisfaction. Such a review can assess the reason for continuing the placement, e.g. lack of local capacity of capability, user preference, etc.

³ Ryan, T., Hatfield, B., Simpson, V. & Sharma, I. (2005). A census day audit of mental health out of sector placements in the North West. HASCAS & Manchester University.

⁴ Ryan, T., Hatfield, B., Sharma, I. & Simpson, V. (2005). A census day audit of mental health out of sector placements in the West Midlands. HASCAS & Manchester University.

⁵ Ryan, T., Hatfield, B. & Sharma, I. (2005). 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 & Manchester University.

- Identifying points of the wider system where there are blocks, e.g. delayed transfers of care from acute wards or secure services.
- Gathering epidemiological data. For a review of how to conduct a mental health needs assessment see [link 9](#) Needs Assessment in Mental Health.

Step 3 – Identifying key personnel in the system

There are a number of key personnel who should be identified and involved in the development of a whole systems approach. They will probably include:

- Psychiatrists working in the specialism concerned.
- Care co-ordinators for people placed in the local whole system.
- Care co-ordinators for people placed outside the local system – often referred to as OATs (Out of Area Treatment) placements.
- Other commissioners of services within the locality.
- Managers of local provider services.
- Local user and carer representatives associated with the services in the system.

Step 4 – Bringing the system together

Once the local services have been mapped, the next task is to determine which services are required within the local system. In some cases services will have been specifically commissioned (for example following a hospital closure programme) others will have developed through encouragement from local commissioners and other providers. In some cases services may have been established without any reference to the local commissioners and other providers.

Inevitably there will be a role for commissioners in managing the local “market” into a system that meets the need of the local population and its users – rather than the needs of the providers. There are examples in many places where services have been established without reference or regard to the local commissioners or providers and they have “imported” clients into the local area because the need for the service locally was not there and this can lead to an increased burden upon statutory provider services as a result⁶.

Commissioners will need to make decisions on which services they wish to be part of the local whole system. It is likely that they will have a reasonable idea of which these services are but they may wish to take the views of other key personnel identified in Step 3.

Once the key service components of the whole system have been identified, commissioners will need to begin the process of managing these services as a system.

Many of the providers will be aware of each other but it is doubtful if they will all have an up to date and fully informed view of each of the other services within the system. Therefore an event that brings together all the parties can usefully dispel myths and start the process of providers becoming and feeling an integral part of a managed whole service system.

⁶Forsyth, B. & Winterbottom, P. (2002). Beds, budgets and burdens: learning disability expenditure v. workload across English health authorities. *British Journal of Psychiatry*. 181: 200-207

A number of meetings, seminars, forums, training sessions and other types of event will be needed over time to:

- Agree the role and function of the system and its components.
- Agree its aims and goals.
- Set priorities for system development (as opposed to individual services).
- Identify actions necessary for system development (e.g. having single processes for assessment or access into the system).
- Define areas of common working (e.g. staff training needs).
- Demonstrate benefits to service users and others.
- Share training needs.
- Review the needs of the clients in the current services.
- Review the needs of people placed out of the locality and develop opportunities for their return to the area (as appropriate).
- Plan the ongoing management and co-ordination of the whole system.

Sample session agendas have been developed ([link 1](#)) and are also provided as PowerPoint presentations for initial meetings of the whole system and are provided as suggested ways of beginning the process (links for sessions 1-5, detailed below). They are not definitive but are intended to give some structure and suggestions on how to commence the process of setting up a whole system. They can be amended to fit local circumstances as required. The sessions included are:

Session 1 – Setting up the whole system ([link 2](#))

Session 2 – Identifying needs of clients within the system ([link 3](#), [link 4](#) and [link 5](#))

Session 3 – Working with other systems and identifying client need ([link 6](#))

Session 4 – Strategic development beyond the initial whole system ([link 7](#))

Session 5 – Maintaining a healthy and functioning whole system ([link 8](#))

Step 5 – Care co-ordination, people placed out of area and in the local whole system

Policy guidance states that the Care Programme Approach applies “to all adults of working age in contact with the secondary mental health system (health and social care)... the principles of the CPA are relevant to the care and treatment of younger and older people with mental health problems”⁷.

In many cases CPA care co-ordinators will have one or two of the people who are on their caseload in out of area placements. Often due to workload, emergency cases and distance care co-ordinators can find it difficult to regularly review the needs of people in such placements. As a result some areas are now developing specialist roles where a worker or team of workers specialise in reviewing such placements ([link 15](#) and [link 16](#)).

There are a number of strengths and weaknesses with taking this approach. The main strength is that the CPA care co-ordinator has a dedicated role in reviewing such placements and therefore

⁷ NHS Executive & Social Services Inspectorate (1999). Effective Care Co-ordination in Mental Health Services. Modernising the Care Programme Approach. A Policy Booklet. London: NHSE and SSI.

cannot overlook cases due to pressures or crises associated with their local caseload and increases the likelihood that all cases are reviewed regularly. It also encourages the individual worker to build up a level of expertise in dealing with placements at distance in the independent sector. They can also gain a better understanding of an individual facility if there are a number of clients placed in it by comparison to the situation, for example, where four care co-ordinators are each responsible for a single case. It also gives the care co-ordinator and the provider the opportunity to develop a more effective working relationship.

The main drawback with this approach is associated with transfer of clients to and from the original care co-ordinator to the specialist worker who becomes responsible for such out of area placements. The client may have developed a good working relationship with their care co-ordinator and this may mean the transfer has to be handled sensitively or after a period of joint working. Naturally, for short term placements there is less need for such transfers to specialist care co-ordinators.

In some areas a team approach has been used to monitor OATs placements and placements within the local service system. This has a number of additional benefits including development of a body of expertise within a small number of workers, and the process of liaison and information provision being made easier for commissioners due to less people being involved in the process. The CPA care co-ordinators undertaking this specialist role can have a wider understanding of the issues as they relate to both the OATs placements and the local whole system which can be particularly useful to commissioners managing local whole systems.

Step 6 – Establishing quality within the system

Quality within the whole service system can be established and required through a wide range of methods. These include:

Accreditation – service commissioners may utilise a system of accrediting providers who meet a required set of quality standards. In North Tyneside such a system has been developed and is available here for adaptation:

- [Link 17](#) Accreditation application and business questionnaire.
- [Link 18](#) Approved provider scheme information pack.
- [Link 19](#) Accreditation information.
- [Link 20](#) Accreditation methodology.
- [Link 21](#) Accreditation record of achievement.

External scrutiny – regulators such as the Health Care Commission⁸ and the Commission for Social Care Inspection⁹ provide inspection reports of services.

In addition, quality can be reviewed through commissioned independent reviews, peer service audits, benchmarking against other services and user and carer monitoring systems.

Other methods of establishing quality within the service system include active user and carer involvement within each service, with representation at the strategic level of managing the system, use of independent advocacy, and opportunities for staff working across the service system to share experiences and expertise.

⁸ www.healthcarecommission.org.uk

⁹ www.csci.org.uk

How can users and carers be involved and provide feedback?

As part of the CPA process users and carers should be involved in the care process. However, this should not be the only option for providing feedback to providers that service commissioners should look for when agreeing to develop a service or fund a placement.

Many providers have developed systems where independent advocacy services are available to their service users. The key word here is “independent”. Any advocacy service that is run by the provider has a conflict of interest and cannot claim to provide genuine advocacy. Many independent advocacy services are run by voluntary sector organisations, often operated by service users or former service users.

Patients Advice and Liaison Services (PALS), run by NHS Trusts, also provide some services to people who are in NHS funded placements in services provided by the independent sector.

Although the primary method of ensuring individual client satisfaction is through the CPA, some commissioners also actively seek feedback from users and their families directly through face to face contact, telephone or letter. This is particularly so when the placement is at great distance, where the placement is known to be inappropriate, or when the costs are high.

Contracting with independent sector providers

Service providers often issue commissioners a contract at the time of placement. This is sometimes felt to be appropriate and therefore adapted through discussion between the two parties. The practice gives both parties a framework for working together. This framework has been developed by the provider, and sole reliance on this practice may therefore favour them to some degree. Using a contract developed by the commissioner that reflects the needs of the person placed, and the interests of the commissioner, is obviously an improvement on the provider dictating terms of what will be delivered. Examples of a service level agreement (SLA) with suggested reporting arrangements, and a set of terms and conditions, are provided here for local adaptation ([link 22](#) and [link 23](#)).

Placement Panels

Many areas have developed “Placement Panels” to manage placements in services that are outside existing contractual arrangements (often into the independent sector). Placement Panels can operate in relation to both internal placements within a local system and also in respect of people whose needs cannot be met within the system.

There are a range of methods of operating Placement Panels. Some have a fixed membership of social services and health commissioners, local senior clinicians and service providers. Others operate with commissioners as permanent members and care co-ordinators participating on a case by case basis. There are also variations based on these two approaches. The approach where commissioners, providers and local clinicians are all active participants is the most conducive to supporting whole systems thinking.

Commissioners seeking to manage whole service systems will need to consider how they link with any local panels of this type.

Knowledge management and service development

Studies have shown that people placed outside the area of the commissioner can be lost to the local system if CPA and system management measures are not effective. One aid to co-ordinating such information is a robust database that can be used at an operational level to track and

manage cases whilst at the same time providing useful strategic information, particularly if its contents are saved on a regular basis, as this will offer information on local trends. Such a database has been developed and utilised effectively for some time in Trafford and is available here for adaptation as fits local needs ([link 24](#) Placements database and [link 25](#) Placements database notes).

Knowing when the system is effective

The task of managing whole systems is an ongoing one, as aspects of each service and the collective system will be continually developing. However, a useful checklist for self assessment has been developed by CSIP NIMHE North West and can be adapted locally if necessary for this purpose ([link 26](#)).

Conclusions

This paper has described a process designed to manage local service systems and the need for out of area placements caused by a lack of local capacity or capability. Putting such systems in place requires hard work and ongoing effort to maintain. There is no easy quick fix, particularly if the number of out of area placements is high and local provision is limited. However, it is possible to manage costs and reduce the risk of future overspend through the steps described here. The tools provided are intended to assist commissioners in improving their control of the local provider market and can be developed and adapted to suit local circumstances and conditions.

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Appendix: Resources linked to paper

Link	Resource
1	Whole systems development – session plans
2	Whole systems development – session 1
3	Whole systems development – session 2
4	Sample snapshot census proforma
5	Excel needs assessment proforma
6	Whole systems development – session 3
7	Whole systems development – session 4
8	Whole systems development – session 5
9	Needs Assessment in Mental Health
10	CANSAS
11	SPRS
12	Life Skills Profile

13	HONOS
14	Global assessment of functioning (GAF)
15	Placement Review Officer.JD
16	Placement Review Officer.PS
17	Accreditation application and business questionnaire
18	Approved provider scheme information pack
19	Accreditation information
20	Accreditation methodology
21	Accreditation record of achievement
22	Sample service level agreement (SLA)
23	PASA Sample Terms and Conditions
24	Placements database
25	Placements database brief notes
26	Indicators of a healthy mental health commissioning system

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Useful contacts

Service Provider Accreditation Tool

The Service Provider Accreditation Tool is being further developed and an updated version should be available in the near future. If you would like a copy of the updated version or would like to provide feedback in order to assist its refinement please email Alec Fraher at bluefish62@hotmail.com

Placements database

The placements database was developed by Phil Carroll and Stephanie Joubert at Trafford PCTs and has been adopted by all Greater Manchester PCTs. They would be pleased to receive comments and feedback at Philip.Carroll@trafford.nhs.uk

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Biography

Tony Ryan has worked in service and organisational development since 2000. He has undertaken work in a wide range of areas including service development, whole systems approaches, service evaluation, research and audit. Tony has worked in England and Wales in the fields of mental health, alcohol misuse, substance misuse and learning disabilities. He has undertaken work for a variety of organisations including Primary Care Trusts, Strategic Health Authorities, National Institute for Mental Health in England, the National Patients Safety Agency, specialist mental health providers, Local Authority Social Services Departments and a number of voluntary and user organisations. Tony also has 10 years clinical experience working in the NHS as a mental health nurse and eight years experience of working in the voluntary sector. He was awarded his PhD from Lancaster University in 2000 and has published considerably on mental health policy, research methods and service and practice development. Tony edited *Managing Crisis and Risk for Mental Health Nursing* (1999) and co-edited *Good Practice in Adult Mental Health* (2004) and *New Approaches to Suicide Prevention* (2004).

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