Chapter 4
Case studies

This guidance was withdrawn in January 2021. For the latest information see the NHS England and NHS Improvement website.

Purpose of the case studies

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The purpose of the case studies is to test the framework and to provide practical examples of the evidence-based arguments that the framework and toolkit will help users construct when making decisions about designating services as CRS/LSS.

Methodology

Case study participants were sent a draft version of the guidance in advance and asked to think about how they might apply it, either to a service that they commission (Clinical Commissioning Group participants) or a service that they offer (provider participants). This was followed up with a visit to discuss feedback, and to develop each case study. Finalised case studies were then shared with each participant for final comment.

Why they are important

The case studies are important because they will help to build Monitor's understanding of the issues that framework users will face when identifying *Commissioner Requested Services/Location Specific Services.*

They seek to cover a range of scenarios, including urban and rural settings, and public and private providers. Though hypothetical, "real life" case study participants have been used to make them as realistic as possible.

Outputs from the case studies

In each case study we outline the:

- background to the service in question;
- hypothetical scenario; and
- case for designating the service as CRS/LSS using the framework and toolkit as a guide.

In each of the case studies, the framework questions have been used to build a narrative that will be similar to decisions made by framework users. Framework users will be able to use the excel-based toolkit to follow each question in the framework in more detail.

Summary of the case study experience

Case study participants reacted positively to the framework and suggested that it could be used in other ways, such as when thinking about how services are delivered. Key challenges they faced when applying the steps were:

- availability of detailed data;
- the need for clinical input, for example to understand interdependencies;
- the need for provider input, for example to understand capacity; and
- the importance of independent advice, for example on ability of other providers to deal with increases in demand.

Case study 1: Pathology provider in a deprived urban area

About pathology services

Pathology services (also known as laboratory medicine) cover the screening of blood, fluids, tissue and other samples for the purpose of providing knowledge and diagnostic information on patients. Test results directly inform clinical decisions and ultimately the quality and speed of patient care – it is estimated that approximately 70% of clinical decisions are made as a result of pathology test results*.

There are two main pathology specialities:

- blood sciences including clinical biochemistry, haematology, blood transfusion, immunopathology and cytogenetics; and
- cellular pathology & infection including histopathology, cytopathology, mortuary service, microbiology & virology.

In England, approximately 697million pathology tests are conducted every year. This is comprised of 500 million biochemistry, 130 million haematology, 50 million microbiology, 13 million histopathology and 4 million cytology tests. An estimated 35%-45% of these tests originate from primary care, and there are approximately 25,000 pathologists working in England.

For patients, the journey typically begins with a request for a blood sample by a GP. The patient then has the blood taken by a phlebotomist either in another part of the GP surgery, a health centre, or a hospital outpatient department. For some tests, the results can be communicated back to the GP within hours (e.g. haematological or biochemical analysis). Microbiological analyses will take longer (1-3 days) and histopathology results longer still (up to a week). The GP is then able to communicate the results back to the patient, at which point diagnosis and treatment can be discussed.

*Modernising pathology services in London NHS London – Pathology modernising programme (2011)

* 'Report of the Review of NHS Pathology Services in England – Review for the Department of Health' Chaired by Lord Carter of Coles (2006)

Applying the framework

For this case study we consider the potential closure of an acute provider in a deprived urban area.

Stage 1

About the service

The nature of pathology services suggests that the majority should be considered as routine in terms of their clinical urgency. However, some pathology sub-specialities require quicker turnaround times, such as testing blood for kidney function which requires results within the hour. These types of sub-specialities can be considered as 'urgent' for the purposes of the framework, and account for 20% of all pathology cases conducted at the provider in question. The remaining 80% of the nearly 8 million tests in the area were considered routine by the commissioners using the framework.

Who provides the service?

The provider in question is a multi-site acute NHS trust provider, with the site in question located in a deprived community. It specialises in blood transfusions and tests, clinical biochemistry, haematology and histology services.

In this particular urban area, pathology services are provided by nearly 30 NHS trust laboratories, each providing between 1–20 million tests per annum, primarily for their own trusts/hospitals.

Case study 1: Pathology provider in a deprived urban area

There are also a small number of commercial providers, one public and private sector joint venture, and a small number of service level agreements. It can therefore be assumed that there are a number of alternative pathology service providers, with many providing services on a broadly similar scale to the provider in question.

Users of the service

The Joint Strategic Needs Assessment for the area suggests there is a relatively low life expectancy and a health inequalities gap, with male life expectancy just over two years lower than the national average. There are high preventable mortality rates, primarily from cancer, cardiovascular disease and chronic respiratory disease. There is also a high burden of disease – diabetes, mental health, diabetes, obesity, HIV.

Independent research suggests that around 48% of the population is drawn from minority ethnic groups. The area is also characterised by high levels of unemployment (11%) and poorer households (18% living on less than £15k a year). In comparison with England as a whole there is a higher incidence of disease and reduced life expectancy caused in the main by cancer and coronary heart disease.

<u>Stage 2</u>

Who could provide pathology services to local residents?

The nature of pathology services means that the primary challenge comes from the transportation of samples between sites (e.g. from the GP surgery, where the sample is collected, to the hospital laboratories where it is tested). Except for specialised pathology services, transportation to a lab, rather than the lab itself, is the key issue.

Therefore the key determinants of the market for pathology services will be availability of local transport, speed of analysis and the speed of conveying results (e.g. IT availability). For the purposes of this case study however, commissioners conservatively assumed that for the routine service, potential alternative providers can be drawn from any of the other 26 active NHS trust laboratories in the area. In total these provide approximately 110 million tests a year between them.

For urgent services however, where tests must be completed within the hour, only the three closest trusts, who also provide these services, were considered in the market. Between them, they account for 55 million urgent tests a year.

These are reasonably conservative estimates because, given the factors that drive the market for pathology services, there are potentially other providers within the region and even further afield that could potentially offer alternative supply, in both the urgent and routine tests.

Can alternative providers take on the increased capacity?

Using the volume data, collected from the reference cost database, the provider in question accounts for around 6% of routine pathology services (out of the larger, 26 provider market), and around 3% of the urgent pathology services (in the much smaller, 3 provider market). On the face of it, this relatively small share of activity suggests there is potential for alternative providers to be able to cope with an increase in demand if the provider in question were to reduce or cease provision.

Further evidence, from discussions with other providers, suggests that there is excess capacity in the urban area. Providers are able to increase capacity by 10-30%, incurring minimal marginal costs in the process. We can therefore assume that the increased demand

Case study 1: Pathology provider in a deprived urban area

resulting from the provider in question withdrawing from the pathology market could be absorbed, if not immediately then within a year.

On this basis, the framework would suggest not designating the service provided at this location as CRS.

Stage 3

Are any disadvantaged groups affected?

There are also significant health inequalities within the area at present – while male life expectancy is just over two years lower than the national average, there is an eight-year gap between the men living in the least and most deprived parts of the area, and a four-year gap for women. It could be argued, therefore, that withdrawing the service from the local community could have a further, detrimental impact on health inequalities.

However, we can reasonably expect this to be offset by the high levels of alternative provision, combined with the typical patient journey (which starts with the GP, of which there are 36 practices in the area where samples could potentially be taken).

For these reasons, commissioners, using the framework, felt that pathology services provided at this particular provider should not be designated CRS.

Stage 4

What are the interdependent services prior to, during or post the provision of this service?

This is not applicable since the service has not been designated CRS.

Case study 2: Paediatric services in a deprived rural area

About paediatric services

Paediatrics covers a wide range of general and specialist services that deal with the health needs of infants, children and young adults (from birth to 16/17 years of age).

Services within the paediatrics department vary from immediate paediatric A&E, ambulatory and intensive care, to routine paediatric cardiology and dermatology.

Generally the paediatric service is split into out-patient appointments, 24-hour paediatric A&E, in-patient wards and paediatric intensive care.

As of 2009 there were 263 paediatric services in the UK, comprising of general, community and tertiary services. Of these, 218 ran an in-patient service. Of the in-patient providers, 30 were classed as very small (defined as <1,500 annual emergency paediatric admissions) and 75 small (1,501-2,500 annual admissions) representing 14% and 34% of the total respectively. Medium (2,501-5,000) and large (>5,001) providers accounted for 47% and 5% of provision respectively.

Applying the framework

For this case study we considered whether or not to designate paediatric services as CRS in a general hospital that serves a community in a deprived rural area. The general hospital is just one site of a large foundation trust that has other sites across the very rural county.

Stage 1

About the service

The total volume of paediatric services provided at the location is 492 consultations/month, spanning a range of clinical urgency levels:

- Day case/In-patient elective and Non-elective – approximately 227 attendances/month, representing 46% of total paediatric provision.
- Out-patient appointments, follow-ups and those undergoing procedures – approximately 265 attendances/month, representing 54% of paediatric provision.

Who provides the service?

The foundation trust has a number of sites that broadly service different population centres across the large rural county. These include a paediatric service at the site in question, plus two other sites.

Users of the service

According to the Joint Strategic Needs Assessment (JSNA) for the area, the main disadvantaged groups are children and younger people (particularly those from unemployed families), elderly people and other disadvantaged groups, such as ethnic minorities.

Case study 2: Paediatric services in a deprived rural area

The county has a higher than national average occurrence of circulatory disease and cancer. Smoking and alcohol-related admission are also above the national average.

The unemployment rate is as high as 10% in the town where the provider is situated, compared to 4.4% in the wider county and 4% nationally. Evidence also suggests that mental health issues are more prevalent among that group (50-60 suicides occur per annum, above the national average).

Obesity is also high in children, with one in five ten-year-olds classified as clinically obese. Within the ageing adult population, there is a 20-year gap in life expectancy and a high prevalence of long-term conditions (LTCs). The community in question is also one of the most deprived in the UK.

<u>Stage 2</u>

Who could provide paediatric services?

Besides immediate and life-threatening paediatric services, referral patterns suggest that patients are willing to travel up to just over two hours to receive services. However, the characteristics of the county present a number of challenges. There are approximately 500,000 people in the county, with 60-70,000 within the community in question.

The county population is spread over approximately 2,635 sq miles with population settlements spaced around the perimeter. In terms of alternative providers, there is a multi-site provider that offers paediatric services (approximately 1,300 consultations/month in total). Sites can be found:

- one approximately 46 miles from the community in question, with a travel time of 1hr 30 min by car; and
- another approximately 70 miles from the community in question, with a travel time of 2hrs by car.

There are also single-site potential alternatives, including one around 50 miles away - a travel time of 1-2 hours (approximately 510 consultations /month); a second around 70-80 miles away (approximately 500 consultations/month); and a third also around 70-80 miles away (approximately 791 consultations/ month).

There are also 83 GP practices across the county.

The total volume of these identified providers is approximately 3,100 patients/month, putting aside the significant travel times from the community in question.

However, not all of the alternatives offer the range of paediatric services that the provider in question does. This suggests that a further disaggregation of paediatric services may be needed.

Can alternative providers take on the increased capacity?

Using the above data, we estimate that the provider in question accounts for 16% of all paediatric service activity. This share of activity suggests that existing alternative providers could absorb the increased demand.

Case study 2: Paediatric services in a deprived rural area

The considerable distances between providers, however, suggests that transferring patients to other providers may only be suitable for some services (urgent, expedited and routine) and not for others (immediate and life-threatening services).

Commissioners are willing to use the existing provider in a triage capacity for paediatric patients, stabilising them and either admitting them (in the case of life-threatening conditions) or transporting them to the identified alternative providers for less serious conditions. A similar successful exercise has already been implemented over the past 12 months, albeit for a different service.

Could new providers enter the market?

Owing to the geographic spread of the population and the existing potential providers, there is currently little incentive for new providers to enter the market. A recent attempt by commissioners to invite a new provider into the area proved unsuccessful because of the low volume of patients, as expected in rural areas, and the lack of clinical adjacency.

On this basis, commissioners using the framework felt they should consider designating immediate and life threatening paediatric services as CRS. However, they also felt that they should consider not designating the non-immediate services as CRS at this stage.

Stage 3

Are any disadvantaged groups affected?

JSNA data suggests that the area has a disproportionately high level of child obesity and poverty, compared to the national average. Removing paediatric services, which are primarily used by this group, would have a direct impact on health inequalities.

This would be exacerbated by the large geographic distances to alternative providers.

Based on this, commissioners felt that they should be designating all paediatric services as CRS.

Stage 4

What are the interdependent services prior to, during or post the provision of this service?

The paediatric team links closely with neonatology and maternity as well as imaging (such as radiology), pathology and ophthalmology services. A&E services are also vitally important to paediatric services in this area.

There are approximately 600 paediatric-related A&E cases/month at the provider in question. On the basis that commissioners were unwilling to send immediate and life threatening cases to distant providers, using the framework they came to the conclusion that they would protect or opt-in A&E services for the purpose of paediatric services, since they are vital for treating the most serious cases.

Case study 3: Urgent care provider in a deprived urban area

About secure urgent care

Urgent care describes a situation where medical attention is needed by a patient, but the case is not immediately life-threatening. People who use urgent care services can reasonably expect 24/7 availability of consistent and rigorous assessment of the urgency of their care, and an appropriate response to the diagnosed need. This can be provided by a number of health care service providers, including:

- GPs;
- Out-of-hours GPs;
- Pharmacists;
- NHS dentists;
- Walk-in centres;
- Ambulances; and
- Local A&Es.

However, a significant number perceive urgent and emergency care as one and the same. The result is that patients often use A&E services for non life-threatening conditions. However, of the alternatives listed, A&E departments are the best equipped, in terms of diagnostic tools, like scanning and imaging equipment, to determine whether cases are emergency, urgent or more routine.

Applying the framework

This case study considers a scenario when a local A&E provider - which also houses the Urgent Care Centre on its ground floor - fails. The service is provided in the same areas as the pathology service in the previous case study.

<u>Stage 1</u>

About the service

The scenario is considering the urgent care centre in the A&E department, so this suggests that the clinical urgency level of the services provided is 'urgent'. Reference cost data suggests that there are approximately 6,685 consultations/month, needing 'urgent' or category 1 treatment, at the A&E provider, which have been used as proxies for urgent care cases as treated at the provider's urgent care centre.

Who provides the service?

There is a mix of providers that offer similar services in the same setting and similar services in different settings in the area. There are GP practices (36 in total); local out-of-hours GP services (provided by local GPs, and hosted in the A&E of the failing provider); two walk-in-centres; a Pharmacy First service; ambulance services; NHS Direct; as well as neighbouring A&E services (including those provided at four closely located hospitals).

Users of the service?

The urgent care service is provided in the same area as the pathology services in the first case study, where the Joint Strategic Needs Assessment showed relatively low life expectancy, pointing to a significant health inequalities gap. This lower life expectancy was driven by premature mortality from a number of preventable conditions.

Independent analysis suggests that A&E and walk-in centre services are used by young people (0-4 and 20-30) in particular.

Case study 3: Urgent care provider in a deprived urban area

Stage 2

Who could provide urgent care services?

Referral evidence suggests that commissioners are willing to send patients as far away as 4.5 miles to another hospital to receive urgent care services, which suggests a number of potential alternative providers:

- Walk-in-centres: since data on this particular walk-in centre is unavailable, estimates from a similar size centre close to the area suggest that the number of patients using this service is around 5,500 patients/month;
- A&E services at four other neighbouring hospitals. Reference cost A&E data for these locations suggest that they deal with a total of approximately 10,766 consultations /month requiring category 1 treatment;
- Pharmacy first services – dealing with approximately 3,500 patients/month;
- 36 GP centres – all offering more extended hours;
- Ambulance services - 60 in the area, responding to approximately 7,800 calls/ month; and
- NHS Direct.

This suggests that a total of at least 24,500 patients per month use urgent care services in this area, not including GP visits and NHS Direct.

Can alternative providers take on the increased demand?

On this basis, urgent care at the provider in question accounts for around 25% of activity in the market. As this is a reasonably significant proportion, commissioners should seek to get assurances from alternative providers that they would be able to cope with the increase in demand if the provider failed. If the identified alternatives were unable to provide excess capacity immediately, commissioners would need to consider whether alternative providers could build capacity, either through more intensive use of the assets they use in the provision of urgent care, or through reconfiguration.

Case management, used to help patients co-ordinate their care (aimed to help around 1,100 patients reduce their reliance on emergency services), would also support the ability of alternatives to deal with increased demand.

Could new providers enter the market?

Existing providers could further move into the market:

- GPs offering the extended services - a recent survey suggested GP practices in the borough were offering 48-hour access to a GP 68% of the time, as opposed to the London average of 81%. The barriers to setting up a walk-in centre are arguably sufficiently low as to allow a new entrant to enter the market.
- One GP out-of-hours service, which is hosted in the failing provider could move into new hosting premises.
- In terms of new entrants, further discussions with potential entrants would be needed.

Based on current and prospective alternative provision, commissioners felt that they would consider not designating urgent care services provided at the failing provider as LSS.

Case study 3: Urgent care provider in a deprived urban area

Stage 3

Are any disadvantaged groups affected?

The area's strategy for urgent care suggests that just over 30% of A&E services are used for non-immediate urgent care and primarily by disadvantaged people, for reasons including perceived inability to access GP services, especially out of hours, and feelings that A&E offers higher quality services than primary care.

The demographic mix of the area also suggests that urgent care services may be used by disadvantaged groups, so withdrawing the urgent service could have a significant adverse impact on health inequalities.

However, Stage 2 showed that there were a large number of easily accessible alternative providers of urgent care services. Based on this commissioners did not feel that there were grounds to designate urgent care services provided at this location as LSS.

Stage 4

What are the interdependent services prior to, during or post the provision of this service?

This is not applicable since the service has not been protected.

Case study 4: Rheumatology services across an urban/rural area

About musculoskeletal services

Musculoskeletal (MSK) services, of which rheumatology is a sub-speciality, are defined as the assessment, treatment and management of congenital and familial conditions affecting the joints, soft tissues and connective tissues. In addition to rheumatology, MSK services also include trauma and orthopaedics as well as the treatment of a number of auto-immune conditions.

Common in the UK, MSK related conditions are a major cause of disability, pain and illness - it is estimated that one third of the adult population and 12,000 children suffer with an MSK related illness.

MSK problems are also the main cause of repeat GP appointments, accounting for up to 30% of primary care consultations.

For rheumatology in particular, common conditions include arthritis, back pain and osteoporosis, which tend to increase with age and can, in some cases, result in long term disability. It is estimated, for example, that 40% of people over 70 have osteoarthritis of the knee.

MSK services are currently delivered in in-patient, outpatient, paediatric or community settings, though only a small proportion of patients require hospital admissions or treatment using equipment that can only be found in a hospital setting.

Applying the framework

In this case study, we considered whether to designate rheumatology services as CRS in a large general hospital that serves a community spread across three densely packed urban areas (market towns), surrounded by a rural area. This is in the context of a review of MSK provision by local commissioners, who, among other things, are considering the integration of existing MSK services, re-contracting with providers and the expansion of preventative community services.

Stage 1

About the service

The total volume of rheumatology services provided at the location is approximately 150 patients per month, including new appointments and follow ups. All rheumatology services provided at the location can also be classified as ‘routine’ in terms of their clinical urgency.

Who provides the service?

Across musculoskeletal services, the CCG commissions a number of different providers, with the majority of its expenditure in secondary care settings (>80%), though this does include both in-patient and out-patient provision.

Case study 4: Rheumatology services across an urban/rural area

Users of the service

There are approximately 430,000 people living in the urban and surrounding rural area, according to the Joint Strategic Needs Assessment (JSNA). The key demographic challenges include:

- An ageing population – there was a 6.1% increase in the general population from 2001-2008, with a 23% rise in those aged 85+. This trend is set to continue up to 2021, with the over 85s increasing in number at a rate 6 times faster than the total population.
- An increasingly diverse population – 19.2% of the population are from minority ethnic groups, compared to 13% nationally.
- Increasing number of births – largely among mothers born outside of the UK.

As well as a large elderly population, approximately 32% of the population is under 24 years old in the two main urban centres, compared to 28% in the surrounding rural areas. In addition, there is a high level of deprivation among children and the older population, although the area is not ranked among the most deprived areas in England. Although the area has a higher than national average life expectancy, there is a large gap in life expectancy within the population. The most affluent and deprived areas have an average of nine years' difference in life expectancy.

<u>Stage 2</u>

Who could provide rheumatology services to residents within this area?

Since the service under consideration is routine (i.e. elective), the market for provision has been defined by reference to those providers to which commissioners would be willing to send patients. For patients living in rural areas and in two of the market towns, commissioners are willing to send them to surrounding counties, since at present they are already travelling to receive rheumatology services. The same applies to patients in the market town where the provider is based, on account of the strong transport network. On that basis, commissioners considered the market to be the market town in which the provider is located and any of the immediately surrounding counties.

Given this, the alternative providers for rheumatology services to the site in question include:

- 58 GP surgeries (with over 80% which operate late opening hours and are open on weekends);
- 10 hospitals with A&E services (including one private provider);
- 4 community services providers; and
- 2 walk-in centres.

Available data from the 10 hospital providers only suggests that they account for around 643 patients per month in the identified market.

Case study 4: Rheumatology services across an urban/rural area

Can alternative providers take on the increased capacity?

Using the above data, we estimate that the provider in question accounts for approximately 18% of rheumatology service activity. However, this is likely to be an underestimate since it is only based on the activity of acute providers. Commissioners felt that demand could be met both in the acute sector and by the alternative providers listed.

Could new providers enter the market?

As part of the review of MSK services in the area, commissioners felt that there was scope for new providers to enter the market. Community service providers in particular were considered to be the most likely candidates for entry, since, in the CCG's view, the lack of hospital-based interdependencies, such as theatre services, meant that there is no need for elective rheumatology services to be provided in a hospital setting. Different models of delivery, for example in the Pennines, were also seen as potentially new ways of establishing extra capacity.

Stage 3

Are any disadvantaged groups affected?

The proportion of elderly people in the area is set to rise sixfold by 2021. Currently almost 20% of people living in the packed urban areas, and almost 25% in the surrounding rural area, are over 60. Given the high correlation between age and consumption of rheumatology services it is possible that elderly people in the area could be disproportionately impacted by the withdrawal of these services at the provider in question.

However, the strength of the local transport network for patients in the urban areas, and the fact that rural patients are travelling anyway, meant that even on health inequalities grounds, commissioners felt that they should not designate the rheumatology service as CRS.

Stage 4

What are the interdependent services prior to, during or post the provision of this service?

This is not applicable since the service has not been designated CRS.

Case study 5: A private mental health provider in an urban location

About the market for secure mental health services

Secure mental health comprises high, medium and low secure in-patient services. All patients in secure care have been detained under the Mental Health Act as being at risk of harming themselves and / or others. In many but not all cases, their detention will have been in response to a criminal offence.

High security

There are only 3 high secure facilities within the country – Ashworth, Broadmoor and Rampton hospitals – all of which are NHS providers. Patients in high secure hospitals present an immediate and serious danger to members of the public, and need treatment for significant periods of time.

Medium secure

Medium secure services are part of an integrated care pathway, specifically designed to meet the needs of adults with serious mental illness who require care in a secure setting. Patients will usually have a history of criminal offending, though some may be referred from general mental health services. Patients may also be transferred from high secure services. Medium secure care is provided by a range of NHS and independent providers.

Low secure

Low secure services are provided for patients with disorders that are too challenging to be treated in a community setting. Like medium secure services, low secure services are provided by a range of NHS and independent sector organisations.

Applying the framework

This case study looks at whether to designate medium and low secure services as CRS at a mental health provider in an urban area. The provider in question also offers rehabilitation services to male patients. Note that this case study has been developed with a provider, not a commissioner, to give their perspective on using the framework.

Stage 1

About the service

At the location, there are 61 beds, 17 of which are dedicated for rehabilitation. The way secure mental health services are commissioned (see Stage 2) suggests that clinical urgency level of these services is 'planned' or 'expedited'.

Who provides the service?

There are 31 independent sector providers of medium secure mental health nationally, and a further 38 independent providers of low secure services, accounting for around 2,500 and just over 1,000 beds respectively. However, there are a further 123 independent sector providers who can accept patients who have been detained under the Mental Health Act, which accounts for a further 3,288 beds[1]. There are also almost 70[2] NHS Mental Health Trusts, and figures for all mental provision show that the NHS accounts for over 70% of mental health provision[3].

Users of the service?

A large percentage of patients are referred from courts, which suggests a demographic profile typical of a prison population. Recent data shows that 46% of patients come from ethnic minority groups against 54% classified as White (British).

[1] 'Mental Health and Specialist Care Services – UK Market Report 2010/11', Laing and Buisson (2011)

[2] 'Mental Health Bulletin - Fourth report from Mental Health Minimum Dataset (MHMDS) annual returns' NHS Information Centre (2010)

[3] 'Mental Health and Specialist Care Services – UK Market Report 2010/11', Laing and Buisson (2011)

Case study 5: A private mental health provider in an urban location

Stage 2

How far can patients be sent to receive the service?

Currently, commissioning of medium and low secure services is done by Specialised Commissioning Groups (SCGs). As regional bodies, they aim to place patients in the local, also known as catchment, area if it is in the best interests of patients. However, as of 1 April 2013, all secure mental health services will be commissioned by the NHS Commissioning Board.

Assuming the current commissioning model, it is not unreasonable to assume that the market for low and secure mental health services is *regional*. However a complaint to the CCP by one medium secure mental health provider, Hanover Healthcare, in the North West suggested that the SCG, North West Specialised Commissioning Group (NWSCG), was placing patients outside of the North West Region, and as far away as Newbury (200 miles). Therefore although a regional market has been assumed, a provider could use this as evidence of a national rather than regional market for secure mental health services. However, as it is the subject of a complaint they would need to demonstrate that it was reasonable practice.

Who are the alternative providers

Regionally, there are at least 8 NHS and independent sector providers, representing capacity in excess of 1,255 beds. Based only on this regional view of the market, the provider in question accounts for less than 5% of the market.

Do they have capacity now or potentially?

The low share of activity and the high number of alternative providers suggests that there is alternative capacity to absorb demand. This is supported by further anecdotal evidence. In terms of short-term emergency cases, such evidence suggests that there is immediate alternative provision within the local area. In the case of a 2008 fire at a nearby provider, 68 patients had to be evacuated. Nearby NHS providers were able to house 19 patients, with independent sector units absorbing the remainder.

These cases suggest that, at least in the immediate term, there is enough capacity to allow alternative providers to absorb demand, if provision at the location in question were to cease. Further to this, Laing and Buisson estimates that there are over 1,000 beds in the urban area alone and over 2,000 regionally, suggesting long term capacity as well.

At a national level, Laing and Buisson estimates that occupancy rates in the independent sector are around 80-85%, including providers of mixed and female-only secure mental health services. If the market were defined nationally, this would also suggest that there is capacity to absorb demand if services at the location in question were to cease.

Could new providers enter the market?

In terms of other new entrants, the high capital costs associated with secure mental health services suggest that new entry within a year may not be possible. New providers may also need time to build reputations before they are commissioned, and would need to be registered with the Care Quality Commission (CQC).

Case study 5: A private mental health provider in an urban location

However, since current capacity would appear to be sufficient to absorb demand if services at the location in question ceased, the provider of that service would be able to make the case to their commissioners not to consider designating the service as CRS.

Further examples of failed providers continuing to meet the needs of patients while in administration also support this view.

Stage 3

Are there health inequality impacts?

The evidence does suggest that 46% of patients come from ethnic minority groups against 54% classified as White (British).

However the absolute volume of patients (39 in total), the nature of the service (with patients that have been deprived of their liberty), and the high number of alternative providers suggest that disadvantaged groups would not be adversely affected. The provider would be able to make this case to their commissioner not to consider designating the service as CRS on health inequality grounds.

Stage 4

What are the interdependent services prior to, during or post the provision of this service?

This is not applicable since the service has not been designated as CRS.

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