Close to Home:

review and recommendations for reducing **out of area placements** for adults with mental health conditions

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Foreword

By Andy Bell (Deputy Chief Executive, Centre for Mental Health)

Being admitted to hospital for a mental health problem can be a frightening and sometimes traumatic experience. Where the Mental Health Act is involved, it also means being subjected to compulsion. And in many cases it is prompted by a crisis for the person being admitted and those around them.

If that admission is far from home, these troubling experiences are compounded further. They mean people spend longer being transported, sometimes in a police vehicle, far from home. They make it harder for family and friends to visit. And in the worst cases they dislocate people from their social networks and the local services that are supposed to be enabling their return home.

It has already been recognised by the NHS that 'out of area placements' should be avoided. With a few exceptions, where very specialised care and treatment may only be available in specific places, out of area admissions are now widely known to pose significant problems for people, families and local services. As such, there is now a clear policy commitment from the NHS to end their 'inappropriate' use.

Bringing out of area admissions to an end is extremely challenging and touches on all parts of the health and care system. It requires organisations to come together and find shared solutions. It cannot be solved by the NHS on its own, and local councils have a pivotal role in both social care and housing support.

This useful guide from NDTi can help services to prevent out of area placements and get people who are currently far from home back to their local area. It draws on evidence collected over recent years, including by us at Centre for Mental Health, and NDTi's own work in supporting local systems to provide a compelling and practical picture of what needs to change and how.

People sent far from home cannot be ignored. And ending out of area placements can no longer be seen as optional. It is essential to creating an effective, efficient, compassionate and respectful health service.

Introduction

Too often, people with mental health problems who are considered to require admission, are admitted to wards or units that are situated outside their local service, often a long distance from home. These admissions are known as out of area placements (OAPs), formerly known as out of area treatments (OATs). They often cause problems such as discontinuity of care, isolation, lack of quality monitoring and increased costs.

People with learning disabilities and autistic people may also be detained under the Mental Health Act and admitted out of area, causing similar problems for them, and often worsened by very long lengths of stay.

An out of area placement may be a planned intervention, arranged in partnership with the person – for example, when a specific provider can offer a particular, specialist treatment. However, too many out of area placements are arranged at short notice, offering negative experience and outcomes to people with mental health issues, at great cost and often representing poor value for money.

The inappropriate use of out of area placements challenges individuals' rights and the chances of positive recovery. They also represent a substantial pressure on service operations and budgets locally. Government policy requires that inappropriate out of area placements are reduced to zero by 20/21. However, recent evidence suggests that the problem is sizeable and increasing.

The National Development Team for Inclusion (NDTi) is driven by a passionate interest in the rights and wellbeing of people using services. We support services to develop innovative strategies and approaches, based on the principle that people are best supported in their own homes and communities, and that coproduction must be at the heart of service practice and development. Our work to date on placements a long way from home has focused primarily on people with learning disabilities, with or without additional mental health problems or autism. There are many parallels and shared concerns in terms of the

issues faced by individuals, the monitoring of quality, continuity of care, and the costs involved.

Drawing on our own work and a rapid review of recent literature, this short paper aims to enable providers and commissioners to reduce out of area placements for adults with mental health problems and, where they are in place, to ensure they are used to best effect. We will draw on our expertise in supporting not only health services but, critically, Local Authorities, Public Health and other agencies to work in partnership to address out of area placements. We first explore the issues and concerns associated with OAPs and then offer a framework for local solutions.

Policy Context and the Bigger Picture

NHS England has set an ambition to reduce and finally eliminate "inappropriate" out of area placements in acute mental health services by 2020/21.[1] The policy states that people should be treated "in a location that helps them to retain the contact they want to maintain with family, carers and friends, and to feel as familiar as possible with the local environment".

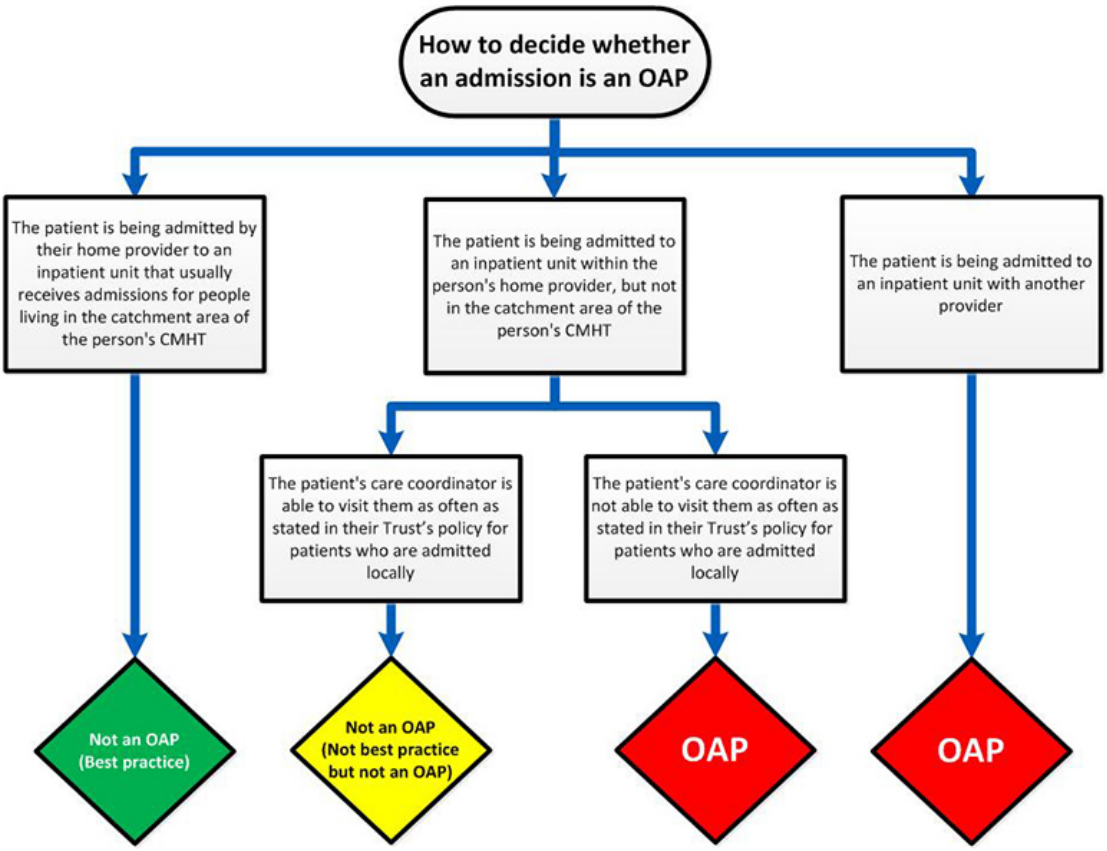
This ambition represents a demanding requirement for local commissioners and providers, and there are some important dimensions to the policy. Firstly, the guidance is concerned only with what it describes as "inappropriate" out of area admissions. 'Inappropriate' has been defined as when a person is admitted somewhere with a different catchment area from the person's home service. However, there are important caveats. According to the guidance[2], some acute out of area placements might be regarded as "appropriate", for example, if there is a safeguarding risk associated with a local admission (such as risk of violence to the person), the person is a member of staff, or if a person has explicitly requested not to be admitted locally.

A second critical element of the policy is that it is concerned only with what is known as 'acute overspill'; when there is not an acute bed available. The definition of appropriate/inappropriate starts with the phrase "A person with assessed acute mental health needs who requires adult mental health acute inpatient care." Acute placements for adults, including older adults, are within the scope of the strategy, whereas specialised placements are not. But psychiatric intensive care settings – PICUs – are within scope, and serve to further illustrate the complexity of the policy and its implementation.

[1] https://www.gov.uk/government/publications/oaps-in-mental-health-services-for-adults-in-acute-inpatient-care/out-of-area-placements-in-mental-health-services-for-adults-in-acute-inpatient-care#fn:1

[2] Department of Health & Social Care (2016) Guidance: Out of area placements in mental health services for adults in acute inpatient care. (Published 30th September 2016)

A further critical element in the policy definition of the out of area placement is whether the placement allows for the person's care coordinator to visit as often as required under NICE guidance, as shown in this diagram from the policy guidance[3]:



The dimensions that define out of area placements for government policy have the effect of focusing attention on one group of people, one type of out of area placement and represent a service-based approach. 'Acute overspill' is likely to be the major focus for Trusts and commissioners, rather than a consideration of what the person might need and how those needs might be met. Furthermore, the policy emphasis diverts attention from other situations and placement types that are part of the bigger picture of out of area placements. This picture needs to be understood if the person and their needs, preferences, health outcomes and quality of experience are truly at the heart of mental health service development.

[3] From https://www.gov.uk/government/publications/oaps-in-mental-health-services-for-adults-in-acute-inpatient-care/out-of-area-placements-in-mental-health-services-for-adults-in-acute-inpatient-care#fn:1

This NHSE strategy refers to acute adult inpatient beds. However, it is important to note that there is also a separate NHSE workstream to examine the out of area implications for people in locked rehabilitation services, which is also subject to the 'Getting It Right First Time' project. In addition, work is being undertaken to understand the out of area implications for children and young people and autistic people detained under the Mental Health Act.

In practice, there are many types of out of area placements, occurring in a diverse range of situations, under various conditions. Demand and availability of services, and the type of accommodation and care, are important dimensions of this wider picture. We now go on to explore this wider picture in detail.

Demand and Availability of Services

As we have seen, in policy terms, an out of area placement is defined as a placement that is provided for someone in need of an acute inpatient bed but cannot access one because the local service is full. It is not about service availability as such, but about the 'demand' on that service outstripping availability or local systems not operating that service effectively.

However, for some out of area placements, it is very much a question of availability. Some services may not be available because there are relatively few people locally who need that service (eg eating disorder services). The out of area placement offered then is known as a 'specialised' one and may be commissioned nationally rather than locally. Although this would constitute an out of area placement, it is not counted as such in terms of policy directives to reduce them. This somewhat distorts the true picture and does not reflect the experience of the person.

Accomodation and Care Type

Out of area placements may be in hospitals, residential units or other forms of accommodation, provided by an NHS or an independent (private) provider. For policy purposes, it is the acute sector that is of concern as we have seen. Yet many people are placed out of area in long-term, secure or rehabilitative settings. In particular, so-called 'rehabilitation' units and accommodation are an important category of out of area placement.

As the Centre for Mental Health has pointed out in its review of rehabilitation services, it is often people with severe mental ill health such as schizophrenia or schizoaffective disorder, and those coexisting conditions including learning disabilities (LD), who are placed in this type of service. These placements in particular can be very long term and are often locked, meaning that people are de facto detained.[4] The Royal College of Psychiatrists has recently expressed its serious concern about the use of locked doors in rehabilitation units[5], as have the Care Quality Commission.[6]

A key issue is the use of private providers. There are many excellent private providers, many of whom specialise in the type of provision that is in limited supply in the NHS or on a small, bespoke scale that cannot be provided by large organisations. However, commentators including the CQC and the BMA, note that many of private providers deliver unsatisfactory care – some of it even dangerous, often in out-of-the-way areas and at high cost. They describe the process as 'warehousing', a term which evokes a sense of storage of goods not of looking after people. Commenting on recent figures, the BMA lead for mental health, psychiatrist, Dr Andrew Molodynski said:

[4] Wright, E (2017) Long-stay rehabilitation services. Centre for Mental Health, London.

[5] BMJ 2018;363:k5294 doi: 10.1136/bmj.k5294 (Published 14 December 2018)

[6] Care Quality Commission (2018) The state of care in mental health services 2014-2017

"As seen in the cases of Whorlton Hall and Winterbourne, the 'cut-off' nature of these institutions can be a breeding ground for the development of harsh and abusive cultures. This has no place in modern mental healthcare." [7]

Another issue with private providers is the issue of ongoing care and support and assessment for discharge. Under the Mental Health Act (1983), the responsible clinician role passes to the consultant psychiatrist in the private hospital. It is hard for staff from the placing authority to be able to insist on discharge in this scenario.

[7] https://www.bma.org.uk/news/media-centre/press-releases/2019/april/bma-warns-that-out-of-area-placements-are-putting-mental-health-patients-at-risk

Trends and Costs

Policy notwithstanding, the numbers of out of area placements seem to be increasing. A survey by the British Medical Association (BMA) found that 5,876 adults were sent out of area for mental health care and treatment in 2016/17, a rise of almost 40 per cent from 4,213 in 2014/15.[8] Data published by NHS Digital in January 2018 found that numbers of admissions out of area had reached their highest numbers – 700 -- since the recording system started; a year later, in January 2019, 785 people started an out of area placement in England, with 675 placements still 'active' by the end of the month. The latest figures show that the number of out of area placements started in September 2019 were 730, with 805 still active by the end of the month. The problem is not easing off.

But the issue is not just about the number of people, it is also about the distance from home, and about length of stay. Numbers of people admitted more than 100km from home, and for more than a month, have also increased exponentially since recording started.[9]

Figures fluctuate but in May 2019, 560 placements were more than 100km from home, up 180 since January. Again, in May 2019, 240 placements were for longer than 30 days, up from 185 at the beginning of the year. However, the latest figures (September 2019) saw a reduction - down to 180 placements with lengths of stay of more than 30 days.

It is important to note that these figures are likely to be underestimates of both the rates and length of stays and further, they do not include:

- people in specialised service placements
- figures from organisations who have not submitted data (5% of English organisations do not submit, monthly. It is not compulsory).
- people already in out of area placements before counting began. Indeed, the CQC found that many placements lasted over three years[10], which means they would not be included in NHS Digital's figures.

[8] BMA News (2017) Far from home, far from hope.

[9] NHS Digital https://digital.nhs.uk/data-and-information/clinical-audits-and-registries/out-of-area-placements-oaps

[10] Care Quality Commission (2018) Mental Health Rehabilitation inpatient services: briefing https://www.cqc.org.uk/sites/default/files/20180301_mh_rehabilitation_briefing.pdf

- Figures for length of stay do not include stays that have not yet finished, only those that have ended during the reporting period.
- Because length of stay is only recorded in the current setting, it underestimates the actual length of stay out of area for people who move between placements. In other words, each placement will have been recorded separately and therefore will not reflect the person's actual experience of length of stay away from home.

The numbers do fluctuate, therefore, but overall, the numbers remain high. The reasons for this are difficult to ascertain but many analysts have pointed to the wider context of care, especially high acute bed occupancy. The Kings Fund reported a fall of 72.1% in mental health beds between 1987/8 and 2016/7.[11] Whilst this has largely been informed by policy and guidance backing community-oriented care and treatment, there have been concerns that radically fewer beds along with higher demand has resulted in very high bed occupancy in mental health units. For example, when Humber Foundation Trust reported three of its six units having more than 100% bed occupancy last year, the Royal College of Psychiatrists warned this was more than the problem of one trust. Rather, the College pointed out it was indicative of a national crisis, and expressed grave concerns about the concomitant need for people to be sent out of area.[12]

[11] The Kings' Fund (2017) NHS hospital bed numbers: past, present, future.

[12] Coggan A (2017) Royal College warns bed shortage. Health Service Journal, 11 July 2017

Costs Implications

Assessment of the costs of out of area placements varies. There also needs to be caution in stating costs as though they were absolute, because they must be set against the costs of alternative care and treatment. However, there is no doubt that out of area placements are expensive. The BMA survey found that the cost of out of area beds was £159m in 2016/7, a rise of 47% on the previous year. And as the Royal College of Psychiatrists has pointed out, many placements are contracted on a spot purchase basis, impeding financial planning for commissioners and providers and resulting in higher than necessary costs.[13] NHS Digital reports that the cost of recorded out of area placements in England for the month of September 2019 alone (the latest available figures) was more than £11.3 million, with an average daily cost of £560. Delayed discharges also increase costs, as do placements in private facilities.[14]

In addition to the costs to NHS, there are also costs to the local social care system. Under s117 aftercare and the Care Act, the Local Authority (LA) meets ongoing social care costs for people with high level support needs following their discharge from hospital. There are also workforce issues for the local AMHP service and the staff required to travel across the country to visit and support the people in OAPs.

LAs also have a substantial role in reducing costs for the NHS, if the costs and savings are seen as a local issue for the health and care economy. A specialist locked rehab bed can cost up to £3500 a week whilst high level supported housing commissioned by the LA will cost between £500 - £1200 a week.

[13] Royal College of Psychiatrists (2012) In sight and in mind.

[14] NHS Digital https://digital.nhs.uk/data-and-information/clinical-audits-and-registries/out-of-area-placements-oaps

Table 1 summarises the policy, practice and cost issues.

	Source
Numbers of OAPs are significant, and increasing: Approx. 6000 adults were placed in OAPs in 16/17, equating to a 40% increase on the previous year.	BMA
NHS data show fluctuations but the issue is not diminishing: • **JANUARY 2018 - 700 new out of area placements, 685 still active by the end of the month** • **JANUARY 2019 - 785 new out of area placements, 675 still active by the end of the month** • **MAY 2019 – 670 new out of area placements, 795 still active by the end of the month (due to people still in placements from previous months)** • **SEPT 2019 -730 new out of area placements, 690 still active by the end of the month**	NHS Digital
Numbers are likely to be under-estimates as definitions and inclusions/exclusions are complex	See Policy & Practice Context
Costs are also significant, and also increasing: • **Out of area beds cost approx. £160m in 2016/17, equating to a 47% increase on the previous year (1)** • **OAPS recorded in most recent month of September 2019 cost more than £11.3 million (2)** • **The average cost per day for an out of area placement is £560 (2)**	(1) BMA (2) NHS Digital
There are now regular warnings about the crisis in mental health services due to the closures of mental health beds (Over 70% were closed in the period between 1987/8 and 2016/17). **These warnings are accompanied with grave concerns about the concomitant impacts of sending more people Out Of Area for mental health interventions.**	Royal College of Psychiatrists

The Key Issues: Our Concerns

The evidence suggests, that whatever the circumstances, out of area placements can create problems in terms of:

1. the person's experience and outcomes
2. service issues including quality and continuity of care and
3. value for money

1.Experience for the person

We note that the different terms used to describe out of area placements are service--oriented terms rather than person-oriented. Regardless of whether they are acute, specialised, defined as "appropriate" or not, these placements are often problematic for the people who experience them.

As with CQC's report, the BMA report,[15] shows that people placed out of area can become isolated and lonely, separated from family, friends, colleagues and potential visitors. There is a risk of loss of contact with their home services and local opportunities. All of this disrupts recovery, and therefore significantly disadvantages individuals with mental health issues, and their friends and family who are actively invested in their recovery.

> *A family talk of their experience of their son David being placed out of area. David later took his own life while on leave from the placement:*
>
> 'He felt safe with me or he felt safe in (the local) hospital, but when he was there (an out of area placement, 3 1/2 hours drive away from home), it was just a load of strangers.'
>
> 'Coming from his home, where he stayed with his mum and dad and his family popping in, he had none of that (in the out of area placement). David asked us to stay a bit longer. He desperately wanted us to and we did. But it was such a long journey back. He was so far away, he just felt he was on his own.'
>
> **From British Medical Association- *Far from home, far from hope*, 2017**

In a survey of Trusts and CCGs, the BMA also analysed over 1000 journeys to people placed in out of area settings. They found that journeys to visit people averaged up to 7 and half hours, while a trip by public transport could be as great as 13 hours.[16] Our experience with people with learning disabilities and autistic people has shown that sometimes these journeys may not even result in an actual visit, as the placement ward can sometimes not

[15] BMA News (2017) Far from home, far from hope.

[16] https://www.bma.org.uk/news/media-centre/press-releases/2017/june/bma-figures-show-starling-rise-in-mental-health-out-of-area-placements

allow family and carers in for apparent operational or clinical reasons. The journey is not only long, it is wasted.[17]

The evidence shows that between 25% and 50% of adults with mental health problems in OAPs stay there long after they are ready to leave; even more worryingly, they are at increased risk of suicide post discharge.[18] In fact, the National Centre for Mental Health and Safety has stated that eliminating out of area placements is one of its key recommendations for reducing suicide in mental health.[19]

Further, our own work with health and social care organisations points to risks in the quality of care for people with learning disabilities, autistic people and mental health problems who are in out of area placements for long periods. They may experience fewer and fewer therapeutic interventions as time goes on and the longer they are in hospital, the less likely they are to be supported to prepare for discharge.[20] Indeed issues like this for people with learning disabilities and autistic people in out of area placements have been highlighted in high profile media cases, such as the case of "Bethany".[21]

The Care Quality Commission (CQC) singled out 'locked rehabilitation' units as particularly worrying in terms of isolation, poor experience and impaired outcomes:

"We are particularly concerned about the high number of people in 'locked rehabilitation wards'. These wards are often situated a long way from the patient's home, meaning people are isolated from their friends and families…. [People using these services could end up] feeling hopeless and powerless, and failing to fulfil their potential to regain control of how they live their lives."[22]

The experience of people admitted out of area, then, is a poor one, with the likelihood of isolation, loneliness, reduced therapeutic care, impaired recovery and higher risk of suicide.

[17] NDTi unpublished reports

[18] National Confidential Enquiry into Suicide and Homicide (NCISH) Annual Report (2017)

[19] NCISH (2017) Safer services: A toolkit for specialist mental health services and primary care – 10 key elements to improve safety.

[20] NDTi unpublished reports

[21] https://www.bbc.co.uk/news/uk-england-birmingham-45849075

[22] Care Quality Commission (2018) The state of care in mental health services 2014-2017

2.Service issues

The BMA reported that the rise in OAPs is a symptom of wholesale pressure across the mental health system, and needs to be managed as such. Their survey of Trusts found that 88% were said to be due to local bed shortages. But it is the whole system, not just acute hospital care that needs to be understood in terms of both problems and solutions. For example, one study found that out of area placements were more likely when people in 'home' services were inappropriately admitted or kept in hospital beds.[23]

Whole system thinking about where things are going wrong and how to improve them also needs to include non-NHS mental health services as evidenced by CQC. They found, for example, that timely discharge from out of area placements could be delayed due to shortage of onward placements, social housing and a range of funding challenges.[24] Such funding challenges are exacerbated by different systems growing and being affected by separate national legislation and guidance, rather than a national, integrated approach to planning.

The Nuffield Trust has argued that OAPs are an indicator of a whole system under pressure.[25] Signs of wider system issues usually include:

- A lack of focus on prevention throughout mental health services
- Pressures in community teams
- A lack of high quality crisis services
- A lack of joint working across health and social care

Questions may also be raised about whether or not specialised care and treatment out of area is always in fact necessary, and whether not having appropriate services available

[23] Ryan, T. (2005) Using a whole system approach to service development in rehabilitation and continuing care services. *Mental Health Review*. 10:4, 16–20.

[24] Care Quality Commission (2018) The state of care in mental health services 2014-2017

[25] https://www.nuffieldtrust.org.uk/resource/out-of-area-placements

closer to home is justified. This issue too relates to preventative approaches. For example, with eating disorder services, a stepped approach has been recommended.

The complications of funding

Funding issues are often caused by different pressures and systems. For example, the local CCG operates and funds NHS and private hospitals, Continuing Health Care and the health aspect of Section 117 funding for aftercare and long term care. Local Authorities fund residential and nursing care, supported housing and the social care aspects of Section 117 aftercare and the Care Act 2014.

Many people have complex needs that require both health and care funding at the same time and are subject to separate health and care assessments and eligibility criteria. Successful local systems have policies and agreements in place to make decisions and share costs easily. Even in these areas, the system is complicated and time consuming. In areas where there is reduced partnership working and disagreements over the responsibility for health or care funding, delays can easily occur.

The Mental Health Act review recommended the introduction of statutory care planning and a legal responsibility for health and care agencies to work together and pool budgets for people being discharged from hospital.

At the level of service delivery there are also problems that significantly affect quality of care. Despite NICE guidance stipulating the need for frequent review by home services, there is evidence that there is a lack of timely or regular review when people are placed out of area. As the CQC pointed out, the distance from home services means that care coordinators are less able to visit regularly and there is a real likelihood of discontinuity of care.[26] It can be more difficult for local care coordinators and commissioners to assure the quality and robustness of placements, monitor progress and prepare for timely discharge. It simply takes more time to visit to assess, check and to plan the move back home. The Chief Social Worker's office has proposed that each person who is detained out of area or in private sector provision has a named social worker from their local area to provide consistent care and discharge planning in line with Care Act and Section 117 (Mental Health Act) provision, but meanwhile the risk of lack of continuity and consistency remains.

[26] Care Quality Commission (2018) The state of care in mental health services 2014-2017

3.Value for money

Out of area placements are expensive, costing at least £120 million a year. The question is, whether this is the best use of scare resources, providing value for money?

NICE states that an intervention is "'cost effective' if it leads to better health than would otherwise be achieved by using the resources in other ways."[27] NICE also discusses 'cost consequence analysis' which allows for a review of different types of costs – including indirect costs - against quality of life. For example, in this context, in addition to the cost of the placement itself, there are costs associated with travel (eg for staff, families) and administration. There are also indirect costs, such as potentially the loss of the person's accommodation while they are living in an out of area placement. Finally, there are opportunity costs, for example in staff time taken to review a person's care far from home, or for the person themselves to recover in a timely way and take part in society.

This range of different types of costs is rarely if ever included in the figures. Costs will be borne not just within the mental health system but for social care, housing, for families and for the person in the placement. Approaches to considering value for money must see the costs not just as NHS or Local Authorities monies but part of the local health and care economy as a whole.

Achieving better experiences and outcomes for individuals and the service population as a whole depends on better use of resources. While resources are tied up in ineffective, long term placements out of area, they cannot be spent on improving services locally. And as we have seen, quality of life is likely to be poor for people in out of area placements. The test of value for money could hardly fail more starkly.

[27] NICE (2013) How NICE measures value for money in relation to public health interventions (LGB10)

Summary of Concerns

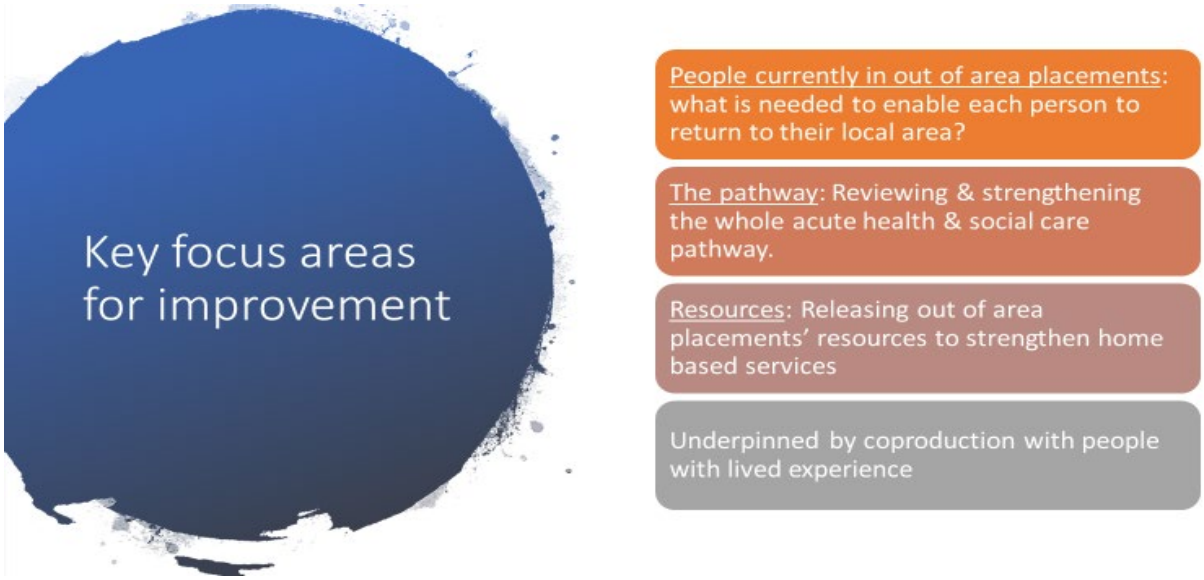
In summary then, out of area placements are expensive, make continuity of care and commissioning more difficult, cause problems of isolation and institutionalisation for individuals and may constitute a suicide risk. They reflect problems not just in acute care, but across the whole care pathway and across partner organisations within and outside of mental health services.

Reducing Out of Area Placements: What Can Be Done?

The business case for reducing out of area placements is crystal clear, nationally and locally. People's experience and outcomes are better closer to home; their care and treatment are better and the quality of services are likely to be better and certainly easier to monitor. People are likely to be discharged in a more timely way and their risk of suicide on discharge is reduced. Moreover, local care costs less. Despite the availability of good guidance and toolkits, we have seen there is a still a worrying lack of progress towards these reductions. So how can the rate of out of area placements be reduced?

One of the challenges is that out of area placements reflect pressures throughout the whole health and social care mental health system. By extension therefore, solutions must encompass a range of partner organisations both within and outside of mental health services. This means that there is a need not just to focus on those who have been placed away from home, although that is of course essential. Rather, it also requires a comprehensive consideration of availability, activity, quality and outcomes across the system to prevent the problem continuing and recurring.

NDTi has considerable experience of working systemically with people with learning disabilities and autistic people placed away from home. Our fieldwork suggests a focus on three specific areas of work, underpinned by coproduction activity.



Focus Area 1: People currently in out of area placements

The first step to reducing out of area placements is to work in a highly personalised way with people who are currently placed out of area to bring them back to their home locality. The aims here are to:

1. Release resources from clinically unnecessary placements.
2. Enable the individual to return to their home area, safely and with the right local support in place, and to facilitate that process so that it happens within a reasonable timescale.
3. Extrapolate from work with many individuals about what in general is needed locally to support more people appropriately and safely, and about what, if anything, needs to continue to be provided out of area and to turn this into a local integrated commissioning strategy.
4. Inspire further change by generating clear case studies that demonstrate what's possible.
5. Use the power of legislation to implement the rights of vulnerable people. The Mental Capacity Act is designed to enhance people's rights to make decisions for themselves. The Care Act is designed to support people to live independently and take control of their own support.

This is not revelatory work, but our case study from Certitude in Lambeth (below) demonstrates how successful it can be. Importantly, the case study also demonstrates how other changes, including change at practice level, must underpin the clinical work with individuals in order to be successful.

Case study – Lambeth Living Well Network Alliance (LWNA)

Elaine (53) has a diagnosis of schizophrenia alongside a number of serious physical health conditions. These, alongside issues with use of alcohol, resulted in Elaine being made the subject of a Court of Protection Order in relation to her property and affairs and subsequently losing her home. As a result, Elaine was placed in an out of area residential setting, which she shared with four others. The residential setting was restrictive: "There were workers there 24 hours and I would have liked more privacy and wanted to live on my own," Elaine says. "We were only allowed to go out for four hours a day."

The LWNA supports people who experience mental illness or distress, bringing together voluntary and statutory organisations to deliver personalised packages to support recovery. Through one of the alliance partners, Certitude, Elaine was supported to move back to Lambeth after four years living out of area. Elaine's support included a personal budget and work opportunities, as well as housing.

Elaine's social worker, Mohammed spent time getting to know Elaine and to recognise and understand her strengths as well as her vulnerabilities. One of the biggest challenges initially, was overcoming concerns from clinical colleagues. Mohammed says: "[They were] warning us about the risks Elaine posed in the past with regards to her alcohol consumption and the negative impact this would have on her mental health and wellbeing."

Mohammed says that LWNA focus on prevention, avoiding crises and unnecessary admissions to hospital delivered through a personalised approach ensuring people are able to be more autonomous has made a difference. "The way I have worked with Elaine differs in many ways to how I used to work in the community mental health team setting." He explains: "In this role, my main objective is to facilitate my clients to come out of the stigma of residential care, to more independent living with a personalised and holistic approach. The rewards are that Elaine has more independence in her life […] and I as her social worker feel proud for her achievements."

Elaine is also happier: "I am outgoing and like to enjoy myself. I like going to the South Bank and would like to be able to go to the theatre and to the gym. It felt strange at first to go out again… it still feels strange because I was isolated. I go to visit my mum every fortnight and enjoy my visits. I say hello and have a quick chat to the people who live here. I like to cook, and I look forward to seeing my friend who visits every week. My future looks bright and fulfilling."

The support Elaine has received has been expanded further over the last year to enable more people to avoid admission or come out of inpatient / residential settings including those that are out of area.

Focus Area 2: The local pathway

The second step is to review the local acute and rehabilitation care pathways in order to understand:

- What is available, where are the gaps and overlaps
- What is working well and not so well
- And especially, how the entry and exit into the acute care pathway is managed so that both are easy, timely, safe and responsive.
- This can be undertaken in parallel with the first step, resources permitting.

When setting out to understand the availability, activity and function of mental health services, acute inpatient beds are often seen as being at the core of the acute care pathway. However, it is frequently the structures and services around the beds that need strengthening, for example different services' criteria for entry and exit, and the efficiency of processes to achieve stepping up and down as clients' needs and preferences change. The good news is we know what makes for an effective whole system of mental health care; the evidence base is rich with models of services, and pathways. The challenge then is to apply this knowledge locally; in addition to acute beds, does your mental health acute pathway include:

- Effective community services to prevent admissions of people who can be supported in their own communities and to facilitate discharge?
- Effective, multiagency provision to support people to leave hospital in a timely and safe way – including social care, housing and employment?
- Rapid access to other inpatient resources if the person's needs are greater than can be met on an acute ward?
- Have partnership arrangements in place that can effectively plan joint budgets and commissioning when required?

We also know that good community assertive outreach and crisis resolution/home treatment teams that adhere to evidence based models can safely prevent admission,

enable early discharge and are much appreciated by service users.[28] Yet only 67% of crisis services were rated as good by CQC in their last review of mental health services, and some areas did not have fully functioning crisis teams at all. A very recent study found that only one out of 180 teams surveyed was meeting all of the staffing and access requirements set out in national guidance, and there was extremely wide variation in how crisis/home treatment teams were staffed and operating across the country.[29] The gatekeeping function (when the team screens people who need admission) was only working in half of the teams, yet research has shown that this function is critical in reducing unnecessary admissions. Crisis, Home Treatment and Liaison services are also enhanced by having social work integrated within them as so many crisis situations are caused by social issues and need to be resolved through social care legislation and support.

We also know that social care and housing support are key, particularly to reducing length of stay, and with good partnership working, can have a positive effect on reducing out of area placements.[30] How well are these partnerships working locally? Are housing support, enablement services, and other social supports available and working as well as they could? Where are the strengths in the system and how can we build on them?

In terms of how the pathway actually works, and especially how the critical points of entry and exit are working, we have found sample pathway audits to be highly effective and informative. Empirical data can be collected about individual pathways using a relatively simple audit of a small number of people, supplemented and enhanced with information and experiences of the people themselves. Using a pathways audit in this way can shine a light on blockages and reasons for problems at different stages of the pathway, identifying where improvements can be made locally. This is an extremely valuable exercise. Examining the right data about a small number of clients yields powerful learning about where and how your local service system needs to change.

[28] See for example, Audini et al (1994) who found that an active early discharge function for Crisis Resolution/Home Treatment can reduce acute length of stay by 25%.

[29] Lloyd-Evans B et al (2018) Mental Health Crisis Teams and Crisis Care systems in England: A National Survey. British Journal of Psychiatry Bulletin, 1-6.

[30] Trewin M (2017) Social care and the mental health forward view: Ending out of area placements. Centre for Mental Health.

Focus area 3: Resources

The aim of the third step is to work out how to better use current resources by strengthening local services and by avoiding out of area placements. This can often be transformational. A key question for local commissioners and providers is: what is the picture of current spend on out of area placements, compared with our local services, and how does that picture align with our top strategic aims? This means bringing together financial specialists with clinical and operational leaders to understand data relating to:

- Clients' needs and local service activity
- Clients' needs and OAP activity
- Spend across the different funding streams

How money is spent can be complex and difficult to unpick. Moreover, spend does not always bear much relationship to clinical priorities. By challenging the data, and facilitating the discussion across disciplines, solutions will emerge, often in the form of new working practices and/or new partnerships. Creative clinicians and bold commissioners will quickly spot how to better use finances locally to stimulate new ways of working locally, and so prevent the need for clients being treated out of area. NDTi has a track record in supporting these local discussions relating to people with learning disabilities, and in using benchmarking and data analysis tools to support the process.

Focus area 4: Underpin by coproducing your analysis and solutions

All our work at NDTi is underpinned and strengthened when we coproduce with people with a variety of needs, issues and experiences, recognising their skills, assets and contributions.

"Coproduction" blurs the distinction between professionals and those who use services, and engages people as peers in evaluating, transforming and delivering care. Specifically concerning OAPs, the coproduction targets are clear *('What did you need to stay at home? What did they do that we weren't doing? What would have made you feel safe? Who did you want with you? What difference would it have made for you?')* and the value of involving people themselves in generating solutions that work locally is self-evident, as well as exemplary practice.

Models of care which have people who use services at the heart of service design and development have been shown to improve outcomes and reduce the need for services, as well as result in mental health teams and services that are powerfully engaging to participants and their experts-by -experience peers.

Coproduction is a core area of expertise within NDTi and, with Skills for Care, we have codeveloped a guide for implementing coproduction in mental health, based on learning from those who are living and breathing it.[31] The guide offers practical advice including:

- expected benefits of coproduction
- overcoming barriers to coproduction
- leadership for coproduction
- top tips for implementation

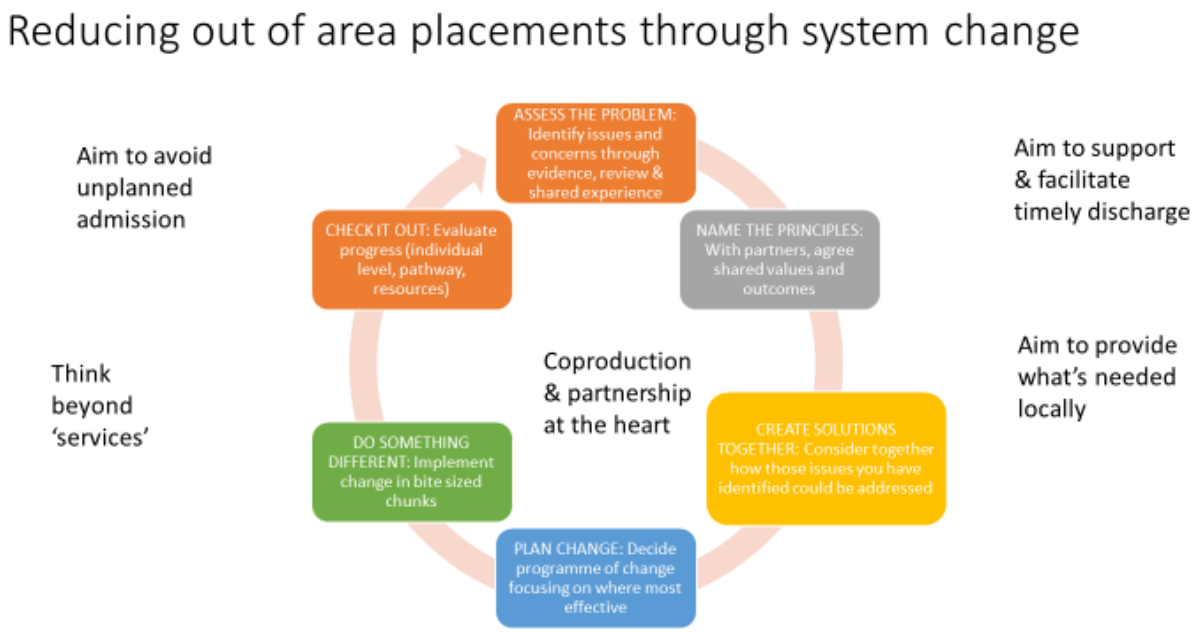
[31] Skills for Care with NDTi (2018) In press: Not another coproduction Guide

Next Steps – Working Together

Having supported people to leave out of area placements and focused on what is working well and where problems lie in the local mental health pathway, the next step is to look to the future - improving the system so that problems don't recur. Often individuals – whether commissioners, providers or practitioners – find that a combination of workload and the culture in which they are working, mean that their focus is on the problem in front of them. Seeing the whole picture, therefore, can be revelatory for all those involved.

Our work with people with learning disabilities and autistic people has shown that a whole system approach to improvement can help establish the conditions to significantly improve pathways and reduce out of area placements. The aim is to develop flexible, effective and high-quality services in the local area so that out of area placements become less and less needed.

This approach to improvement involves bringing together empirical data and findings from the reviews, with the knowledge and experience of various stakeholders: providers, commissioners, non-statutory sector, people with lived experience and other partners. Our approach is summarised in Figure 2.



Whole system working can be daunting, but our experience suggests that there are a number of critical issues, and solutions, to target:

- Are there common themes in the factors that led to crises and subsequent admission? If so, how can we work with people at risk of admission more proactively, before a crisis occurs?
- Are there services available to support admission avoidance and are they working effectively? If not, why not? If some are working well, how can we spread the good?
- What packages are needed to bring people home from out of area placements? What can we learn from good local examples and case studies?
- How can we support effective multi-agency working to ensure services work together to enable someone to be discharged home safely and to thrive?
- Where are the service gaps that lead to some out of area placements? Must we always go out of area or can we address these needs locally?
- How can we work together with community partners to build community-based support? Who are our partners?
- Does everyone share the same values around the aim of reducing OAPs? Culture change is probably needed to support a different way of working; how would that best be achieved?
- What should we focus on first to get some positive results quickly?
- What are the decision making and partnership arrangements locally?
- Is there joint commissioning of core services, or could that be achieved?
- Could budgets be pooled?
- What mechanisms are or could be in place to enable joint decision making for people with high level needs?
- Do agencies come together to review the community, crisis, police, A & E and inpatient services, along with experts by experience, ensuring that those present have the authority to make changes to service provision where needed?
- Where is the leadership?

Solutions are often more readily at hand than providers and commissioners anticipate, and they are revealed and built through the interrogatory and creative processes outlined here. In one locality, for example, we were asked to examine and reduce spiralling costs associated with OAPs for adults in their early twenties who lived with learning disabilities and mental health problems. Through the steps outlined here, we discovered that the out of area admission is often not due to a significant change in the mental health of the person themselves. More frequently it was the result of family breakdown; the most significant carers for the person “not coping”. It was also discovered that this was fairly predictable: there were some regular signs of what ‘not coping’ meant for the individual and the carers. Rather than a default to OAP, an alternative solution emerged: earlier, structured support to families and carers at critical times -- which are often predictable - to help avoid admission.

Coproduction continues to underlie this approach. People with lived experience, their families and carers, are at the core of the process, and there needs to be feedback from them about whether the changes are having the positive impact intended.

The Lambeth case study and that from Bradford (below) show how working together in partnership, with flexible personalised approaches and the will to ensure someone is living in the least restrictive environment, is better for the person and can release resources. Interestingly they also show that staff must work – and perhaps think - differently to make change happen. Further links to positive practice and case studies are found in the appendix.

Case study – Bradford alternatives to 'Locked Rehab'

Bradford have created a range of services to reduce out of area Locked Rehab placements. Key elements include:

- Using supported tenancies and supported living
- Using a "First response" approach with a crisis line
- Community provision working alongside inpatient services
- Providing an open rehab service
- Working together with voluntary sector services to offer imaginative options
- Working with people who use services to become Experts by Experience/ Peer Supporters
- Screening all placement requests
- Referrers for out of area Locked Rehab must demonstrate all local options have been exhausted
- Whole system approach including working with Police & other partners

Successes include:

- Cutting the number of people in out of area Locked Rehab by more than half from 30 in 2014 to 12 in 2019.
- Reducing out of area Locked Rehab costs from £3.8 million in 2014 by more than half to £1.8 million
- Providing Section 117 community services to significantly more people for less money per person. From £700,000 for 7 people in 2014 (£100,000 per person) to £3.5million for 90 people in 2019 (around £39,000 per person).

Critical success factors:

- Relationships - Excellent professional relationships that transcend organisations, trust and a recognition that each partner brings something unique to the table
- Values - All involved are driven by a desire to help people live locally

How Bradford works with people:

Most community services declined to work with Javid (not his real name) due to difficult behaviours and he had frequent admissions. An out of area placement was considered. However, Bradford worked closely with a local provider to provide intensive support to Javid with increased funding and with staff who could speak Javid's first language. Javid has had a year remaining in the community without admission and with reduced critical incidents. The cost of Javid's package of care is £2200 per week, with costs split between the CCG and the Local Authority. Cost of potential out of area placement would have been £3000 per week, to be met by the CCG.

Summary and Conclusions

NDTi's experience with people with learning disabilities and autistic people has demonstrated that the complex issues raised by the increasing use of out of area placements can be addressed. Our model identifies and addresses the system-wide problems likely to be driving OAPs locally. We propose focused activities in four main areas. ***Working to bring individuals home safely*** is the first priority. This may be obvious, but we are also clear that, on its own, it will not solve the issues that are likely to have contributed to placing people out of area, as OAPs are almost certainly the result of failures across whole service systems locally. Therefore, the second focus we suggest is ***a review of the local mental health pathway*** – especially the factors that lead to admission and prevent timely discharge. Examining the right data about a small numbers of clients' experiences reveals the top local failures in practice and process.

An important third area of focus is understanding ***how resources are currently used*** and working out how they could be released to make pathway improvements. Again, this is relatively simple, but requires systematic analysis and creativity to generate ideas about new ways of working locally, and/or new partnerships that will better use resources to meet peoples' needs and preferences locally. The fourth focus is ***coproduction***: approaching the work of understanding the problems, and generating locally effective solutions, in partnership with people with lived experience. The NDTi guide to coproduction outlines how to achieve these partnerships and build them into your development programmes.

We are confident that out of area placements can be brought close to home; the solutions are local and within your grasp.

Appendices

Lambeth| The Lambeth Living Well Alliance provides support to people experiencing mental illness or distress. You can find out more about the Alliance at: https://lambethtogether.net/living-well-network-alliance/get-help/

Certitude | London's leading adult social care provider for people living with learning disabilities, autism, mental health support needs and their families and carers. Find out more about Certitude at: www.certitude.london

Bradford | http://www.communitycare.co.uk/2016/05/20/one-areas-mental-health-teams-tackling-scandal-area-care/

Sheffield | https://www.england.nhs.uk/mental-health/case-studies/mh-sheffield/

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