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We need to talk about social care

Social care and the mental health forward view: ending out of area placements

1. Introduction

One of the major objectives within the implementation plan of the Five Year Forward View for mental health is the need to support people locally and reduce the number of out of area placements, or 'OAPs'. There is also a related target to reduce the number of detentions under the Mental Health Act.

All CCGs and mental health trusts will be looking to redesign their services to try and reduce bed occupancy in order to achieve this aim and reduce costs. In my area of Bradford and District, the local mental health trust has been able to successfully treat people locally, reducing OAPs and the use of local private sector hospitals for acute care down to zero for two years. This was achieved by a complete redesign of the Acute Care pathway by the trust that was focused on robust planning, prevention, discharge and recovery planning. This was undertaken in a partnership with the local authority, police and voluntary (or third sector) colleagues delivered through the Crisis Care Concordat. Our Crisis Care Concordat developed a 'whole systems' model of partnership working over 2014-16 that led

to all of the agencies in the partnership winning the Positive Practice Collaborative in Mental Health Crisis Services Award in December 2016.

You can read about the specific action that Bradford District Care NHS Foundation Trust took to achieve this in the case studies on the NHS England mental health website and ['one year on' reviews](#).

A key part of this achievement has been partnership working with the NHS, local authority, police and voluntary sector in Bradford. The purpose of this briefing is to explore the role of the social care and local authority involvement in relation to reduced out of area placements and lengths of stay. This will include better support and prevention for people in mental health crisis and discuss how mental health trusts can develop effective partnerships with social care agencies to use bed space more effectively, reduce OAPs and improve strength and rights-based services for people in mental health crisis.



2. Out of area placements and their impact

OAPs cause a great deal of hardship to service users, their families and the professionals working with them. A person may be admitted to hospital informally, but increasingly they are detained under the Mental Health Act (MHA) following a decision made by a local authority authorised Approved Mental Health Professional (AMHP), supported by two doctors. Once the decision is made, the responsibility to find an appropriate bed belongs with the local mental health NHS trust, who should be commissioned by their CCG to provide appropriate inpatient accommodation. Section 140 of the MHA puts a specific responsibility on CCGs to identify placements for people who urgently need admission. An appropriate agreement between the CCG and their local authority or AMHP service under s140 should be the immediate priority for any area struggling with bed management issues.

The process of identifying beds for detained people is considered to be in crisis in many areas of the country. A lack of beds, combined with a lack of alternatives to hospital, reduced community prevention support and an increase in mental health issues due to austerity and other social issues, has meant that beds in a local acute or specialised mental health unit are often not available and so placements are sought many miles away in private or NHS provision.

The impact of this for the detained person can be confusing and traumatic. A long ambulance ride leads to admission to a place far from home and family. Having a loved one detained under the Act is hard, but not being able to visit them is harder still. For professionals, the act of finding a bed can make the vital roles of AMHP and of 'bed manager' very challenging. Bed managers are searching the country and redesigning their own resources to free up bed space. AMHPs are increasingly concerned about attending assessments without a bed available. This is practice that goes against the spirit of the code of practice, as an assessment should not assume that detention is the outcome. AMHPs have another problem in that they

cannot detain until they can name the admitting hospital on the legal form and so often find themselves waiting for hours with a distressed person while the placement is sorted out. AMHPs are not supposed to have a formal role in finding a bed but they often end up taking on this role in order to sort out the problem for themselves and the detained person. AMHPs, doctors, nurses and police are under increasing stress and pressure operating this system. Resolving this issue is not just in the interest of mental health trusts.

Transport (or 'conveyance') is another problem, with AMHPs and trusts having to negotiate with ambulance services to use one of their vehicles, sometimes for hours of motorway travel.

The impact on the police can also be substantial. They are increasingly frustrated with the time they spend supporting people and professionals detained under the MHA. The recent Police and Crime Act aims to reduce some of this pressure but will be hard to implement in some areas of the country without more resources.

Once the placement is finally made, local authorities need to ensure that they follow up a person under their care and detained in an out of area hospital. Local authorities have an ongoing responsibility to oversee the person's care and often need to undertake another MHA assessment within a month. If the client is 200 miles away, that is a major logistical problem and so the local council services, who had nothing to do with the decision or the patient, are asked to divert their services to assess and detain a person they know little about, which is also outside the spirit of the code of practice for the MHA.

The final implication of OAPs is cost and conflict. In some NHS trusts and CCGs the annual cost of funding full wards and a large number of OAPs is very high, and this reduces the ability to fund other projects. The inevitable result of this can be daily conflict between hard working public servants struggling to work in a faltering system and a poor experience for vulnerable people, especially those who are detained.

3. What should be done to reduce out of area placements?

The obvious answer to this is to ensure that each area has enough specialist mental health units to support its population and urgent need for admission under s140. There will always be some people who need the protection of the Mental Health Act with good quality inpatient support, but an increase in bed capacity is not the best use of resources in every case. Prevention of deterioration and crisis, together with alternatives to hospital are also very important factors in reducing the need for inpatient beds.

A reduction in detentions and treating people locally and independently are key NHS England objectives. To achieve this and reduce OAPs, the main priority is to free up bed space so that the available beds are operating under capacity and have some flexibility in admissions. This has the added benefit of improving the experience, outcomes and engagement for inpatients.

To achieve this, mental health trusts tend to undergo scientific explorations of patient flow models. This is useful, but many of the reasons that reduce flow are outside the control of the Trust. In order to control bed occupancy, there has to be a reduction in detentions under the MHA, reduced lengths of stay, resolution of the reasons that force people to remain in hospital longer than necessary, and improved discharge planning.

It is my opinion that none of these objectives can be fully met without a partnership with the local authority.

Social workers and housing support workers in community mental health teams, Early Intervention services, Crisis Resolution and Home Treatment teams, police and A&E triage services will improve the quality and remit of prevention and recovery services.

AMHPs are on the front line making decisions about detention to hospital. The best way of reducing detentions is to work with AMHPs to explore the pressures on them, and to jointly commission services that support them to make the least restrictive decision. Discharge arrangements are often reliant upon the work of mental health social workers using the housing, care and home support options under the control of the local authority.

It is often the case that agencies within the voluntary (or third) sector can support people in the community more effectively than professional agencies, especially those in crisis, where peer support services building resilience and reducing distress are required. These agencies are often jointly commissioned by the local authority and CCG.

4. What causes delayed discharge?

To reduce length of stay and improve discharge, we have to understand why people stay in acute wards longer than is clinically necessary. This is different across the country but there are some key similarities in most areas:

- **Housing issues:** Many service users are homeless or lose housing on admission, or have been refused access to housing providers due to complexity of need, previous behaviour, family breakdown or debt. Housing is one of the main causes of delayed discharges in mental health services. This needs robust protocols and agreements that can support housing providers to take more people with ongoing housing and mental health problems. CCGs and LAs are best placed to jointly commission step down and supported accommodation for people with mental health issues.
- **Capacity to live independently:** Some people with a severe mental illness have limited capacity to make decisions and live independently, and need a range of support to be able to do so. This has led in the past to a tendency to place people in institutional care but a move towards a human rights and strengths based approach, together with reduced funding, means that most authorities consider support in a person's home to be the best option.
- **Access to NHS and local authority funded services:** Many people are assessed as needing services that require the decisions of both the LA and CCG or continuing health care team. These organisations often use funding panels to make decisions. A lack of access to these panels or differences of opinion between professionals, commissioners and budget holders can lead to major delays in discharge arrangements.
- **Recovery and enablement:** Many people soon reach a point where they do not need inpatient acute care, but are not yet well enough or recovered enough to live independently. The key to timely discharge, therefore, is having a range of step down options, supported housing and the ability to enable recovery and the development of independent living skills in the community.
- **Complex and joint presentations:** Whilst the main focus of efforts to reduce OAPs is with discharge from acute mental health wards, there are also a large number of people in secure and forensic hospitals across the country who need to be discharged with Section 117 aftercare and have very complex presentations. Patients in acute care increasingly have other needs in addition to their mental health issues due to drug or alcohol use or to being on the autism spectrum. These presentations make accessing community support and housing more complicated.

5. The role of local authorities and mental health social workers in reducing OAPs

In the past, local authorities have often felt forgotten about when the Government, NHS and media discuss mental health issues, but they have a vital and statutory role to play that is of equal importance, and often complementary to, that of the NHS. Local authorities not only provide services themselves, but also commission a large number of services from voluntary, private and not for profit

organisations. The majority of a person's life with mental illness will be spent in their community with their family, rather than receiving medical care, and so the social care aspect of recovery needs to be at the forefront.

The development of Sustainability and Transformation Plans (STPs) means that there is a responsibility on both health and social care commissioners to act jointly for the best

outcomes for their communities. Some STPs are clearly jointly produced with the relevant local authorities – others much less so and health and wellbeing boards in some areas are refusing to sign them off if mental health and social care provision are not good enough.

At the heart of local authority mental health services are the mental health social workers. These professionals are committed to prevention, recovery, supporting strengths and independence, and respecting the human rights of vulnerable people. They do this through comprehensive assessments of need and capacity, service user involvement and working towards the least restrictive intervention. The Care Act 2014, the Mental Capacity Act 2005 and the Human Rights Act guide the role of the mental health social worker - especially Article 3 (the right to avoid degrading treatment), Article 5 (the right to liberty and self-determination), and Article 8 (the right to family life).

Social workers also work to the concept of strength or asset based service provision. This approach searches for the strengths and recovery opportunities in every service user and balances this with positive risk taking and an appreciation that each individual has the right to make their own way in the world as much as possible. Using the provision of wellbeing and enablement in the Care Act, social workers can use individual budgets and advanced decisions to support people to take as much control as possible.

Here are some of the services that local authorities have to provide for people with mental health issues, many of which can be integrated with similar NHS functions or jointly commissioned so that they can be delivered alongside similar health services:

- A 24 hour AMHP service providing specialist assessment under the MHA 1983.
- 24 hour access to local authority services for people in crisis.
- Access to advice, prevention and wellbeing services for people under the Care Act.
- Access to assessment and personalised support such as direct payments for eligible people with mental health issues under the Care Act.
- A comprehensive aftercare and discharge support package under s117 Mental Health Act (MHA) for everyone subject to s3 or s37 MHA 1983 (usually integrated with the Care Act and Care Programme Approach), including people in acute care wards but also longer term NHS, forensic or private placements.
- A service that can reduce delayed transfers of care for people in acute mental health hospitals and support properly planned and timely discharge home.
- The commissioning of social housing, including services for homeless people.
- The commissioning of support for people in their own homes and specialist accommodation for people with mental health problems, especially under s117 aftercare.
- Support and advice with financial issues and advocacy.
- Support for people with mental health issues who have no recourse to public funds in the UK, especially those with rights under s117.
- Best Interest Assessors, who are experts in assessing the rights and capacity of people under the Mental Capacity Act 2005 and supporting them to make their own decisions and be as independent as possible.
- The commissioning and support of a range of community and voluntary sector services supporting mental health service users to engage in employment, activities, education etc.
- The commissioning and overview of residential and nursing homes and agencies providing support in the home and community.
- Public health services including support for schools and young people and suicide prevention policies.
- The appointing of a local politician as a mental health champion.

6. The Bradford Experience

To see how this can work in practice, in Bradford we have worked to ensure that social care is integrated across a range of acute and community mental health services. This was developed as part of the multi agency Crisis Care Concordat partnership. The aim is to prevent admission, support recovery or to discharge when appropriate. We work to support people at home where possible, using collaborative work between health, social care and voluntary services to achieve the least restrictive and most appropriate care through a single point of access across Bradford, Airedale, Wharfedale and Craven.

Mental health social workers are based in or involved with the following NHS and police services:

- **The 24/7 First Response crisis service:** The role of the social worker is to use their expertise to provide urgent social care assessments and support services following telephone triage. This can include a swift response to requests by the police or assessments in A&E. We find that a substantial proportion of people in mental health crisis have underlying social care, financial or housing issues and that resolving these issues alongside nursing colleagues reduces future crises.
- **The Haven:** This is a project that provides a non-clinical community alternative to A&E, and reduces the number of admissions and mental health crisis for people in contact with CMHTs. The Cellar Trust, a voluntary sector service working in collaboration with Bradford District Care NHS Foundation Trust and the local authority, delivers the service. The Sanctuary service at Bradford Mind offers crisis support out of hours, via the First Response Service. A duty social worker is based in the Haven every day.
- **The Intensive Home Treatment (IHT) team** sees people at home or in the community, working intensively to avoid admission or on discharge through nursing or social work intervention. IHT is a least restrictive alternative to admission.
- **The Police Hub** provides NHS and social care expertise in the police control room to advise police on the appropriate support for vulnerable people who come into contact with the police under s136 or for other reasons. This service has access to the NHS and Social Care database and links to both services including a version of street triage.
- **The Approved Mental Health Professional service** is operated and managed by Bradford Council but is located with the First Response Service and Intensive Home Treatment team to support integrated, least restrictive working and a timely response when a Mental Health Act assessment is required. This means that Intensive Home Treatment, First Response Service and the AMHPs can discuss requests for Mental Health Act assessments and divert to a less restrictive approach if appropriate. In addition, the bed manager is a core part of this team and so access to beds is discussed and managed in partnership, reducing stress and conflict on all sides and improving planning and allocation of resources including the s136 suite.
- **Specialist housing social worker:** Our housing specialist is funded by the council housing department and adult social care, with a remit to improve working arrangements between mental health services and housing and facilitate easy access to housing for vulnerable people on the wards and in the community. This post has made a major difference to our levels of Delayed Transfers of Care as the worker supports community and ward staff, service users and families, to begin resolving housing issues immediately after admission.
- **Community mental health teams, Early Intervention teams, Assertive Outreach teams and community support services** all have social workers, who are either AMHPs, Best Interest Assessors or care coordinators. They have a key role in supporting social care needs, assessing

people under the Care Act, and providing personalised packages of support and supported accommodation that improves prevention and reduces admission.

- **Residential and Nursing Care Framework:** Bradford Council commissions residential and nursing care through a framework. We have been able to use this to work with key providers to develop high quality services that support intensive rehabilitation in the community, in addition to long term support.
- **Shared Lives:** Bradford has been one of the local authorities to explore the use of the Shared Lives model for mental health service users, especially for respite.
- **Supported Accommodation Framework:** Like many areas, Bradford has worked to develop and commission a range of accommodation services to support discharge. This includes step down accommodation and housing for 'hard to place' people with high needs who tend to get stuck on the wards. Housing is the key to low levels of delayed discharges and is best commissioned jointly across health and social care.
- **Joint mental health commissioning:** Bradford, Airedale, Wharfedale and Craven have a joint commissioning arrangement that allows both health and social care to be commissioned in a strategic way, pooling resources and leading to more effective planning. This arrangement is still developing but will be vital in the future for the delivery of our mental wellbeing strategy.

- **Access to social care and health services in discharge planning:** Both the NHS and local authorities increasingly make funding decisions through panels. In Bradford the senior managers with responsibility for health and social care budgets meet with ward managers regularly to discuss issues in relation to accessibility and how people subject to Delayed Transfers of Care are supported. In addition, the local authority panel is often based near the inpatient units so that ward nurses and other interested parties can discuss cases and get advice about the most appropriate discharge plans under s117 Aftercare. CCG and local authority managers both attend these panels and make joint funding agreements where appropriate. This approach reduces costs and increases independence and choice for service users.

The Bradford experience demonstrates the importance of practical and creative partnerships between health and social care that can reduce bed occupancy and improve prevention and discharge. This, alongside a redesigned Acute Care Service that concentrates on service user recovery and effective planning for discharge, has led to us being able to treat all of our service users in acute care locally for two years.

My advice to any CCG, mental health trust or local authority that is struggling to contain the expenditure and logistics of a high volume of OAP or private sector bed usage would be to join together all NHS, local authority, VCS, police, housing and service user groups, and review how integrated working and joint commissioning together might change the way that people are cared for in your area.

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This briefing is part of a series on social care written by guest authors to stimulate debate and discussion.

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