

Policy Briefing

Eliminating Inappropriate Out of Area Placements in Mental Health

June 2022

Background

The long-term commitment to improve the accessibility and quality of mental health services across the country has been very welcome. Progress has been variable, however, and the government's deadline to eliminate inappropriate out of area placements for adult acute patients by the end of March 2021 has now been missed by a full year. Patients admitted to out of area units have been left paying the price. Sometimes hundreds of miles away from home, they are unable to access their usual support networks while at their most vulnerable, often finding their care seriously disrupted with long term implications for their recovery.

Inappropriate out of area placements refer to a situation where a patient is admitted to inpatient unit outside of their local area because no appropriate bed is available locally. The 2016 Crisp Commission highlighted the hugely detrimental impact out of area placements can have on patients and how public funds are wasted on these expensive placements, prompting the government commitment to eliminate them within 5 years. Despite some variation, patients have spent an average of 60,000 bed days in inappropriate out of area placements each rolling quarter since August 2017, with some regions sending far more patients out of area than others. In the year since the original deadline to eliminate inappropriate out of area placements, 205,990 inappropriate out of area placement days have been reported by NHS Digital.¹

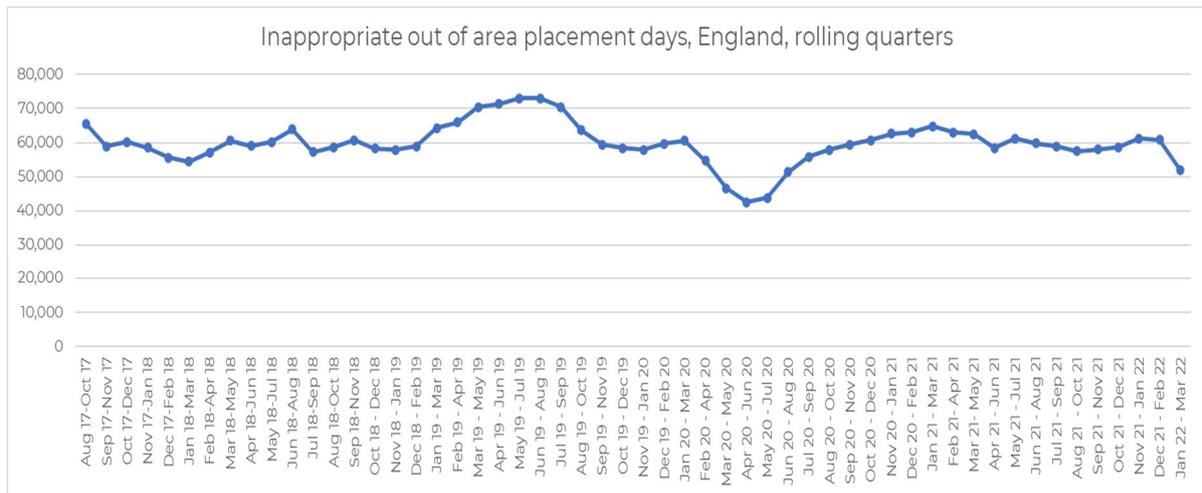
Ongoing efforts to improve mental health services, especially community provision, will ensure fewer patients need to be admitted to a mental health hospital. But those facing an acute mental health crisis today cannot wait for these efforts to bear fruit, and urgent action is required to put an end to the harmful practice once and for all. With increased pressure on mental health services as a result of the pandemic, the need for concrete action has never been more urgent.

Complex policy problems require complex policy solutions, which are explored in greater detail in this briefing. NHS leaders have been working up and down the country to try to drive down inappropriate out of area placements, but it is clear

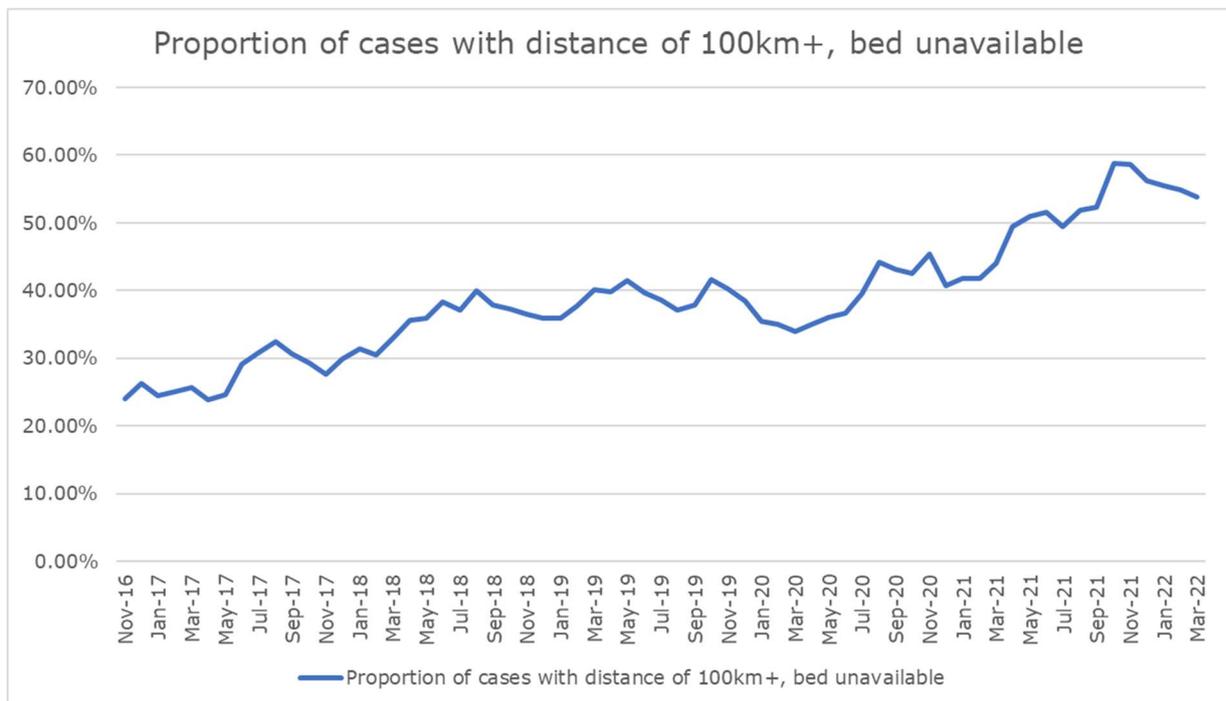
that the whole system must come together to deliver a concrete plan that makes progress at the scale and pace now needed.

What the data shows

The most recent data released by NHS Digital paints the following picture about inappropriate out of area placements and efforts to eliminate them.

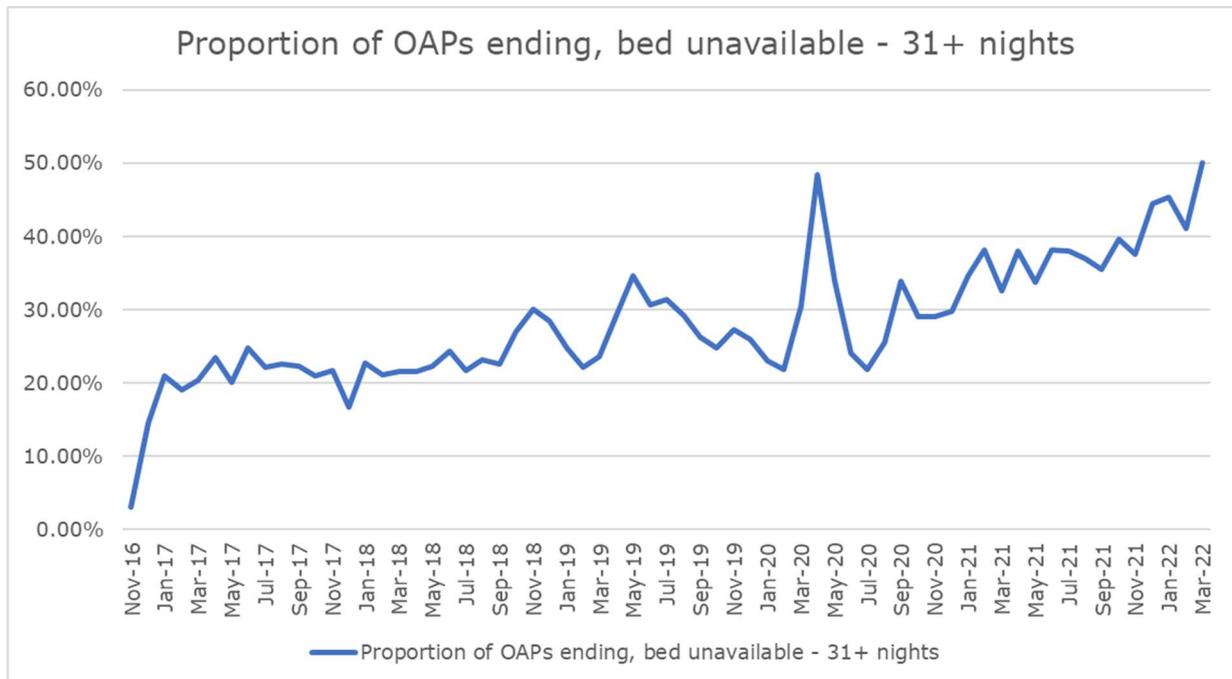


Source: [NHS Digital](#)



Source: [NHS Digital](#)

UNDER EMBARGO 00:01 MONDAY 13 June



Source: [NHS Digital](#)

In the year following the original deadline to eliminate inappropriate out of area placements, this equates to:

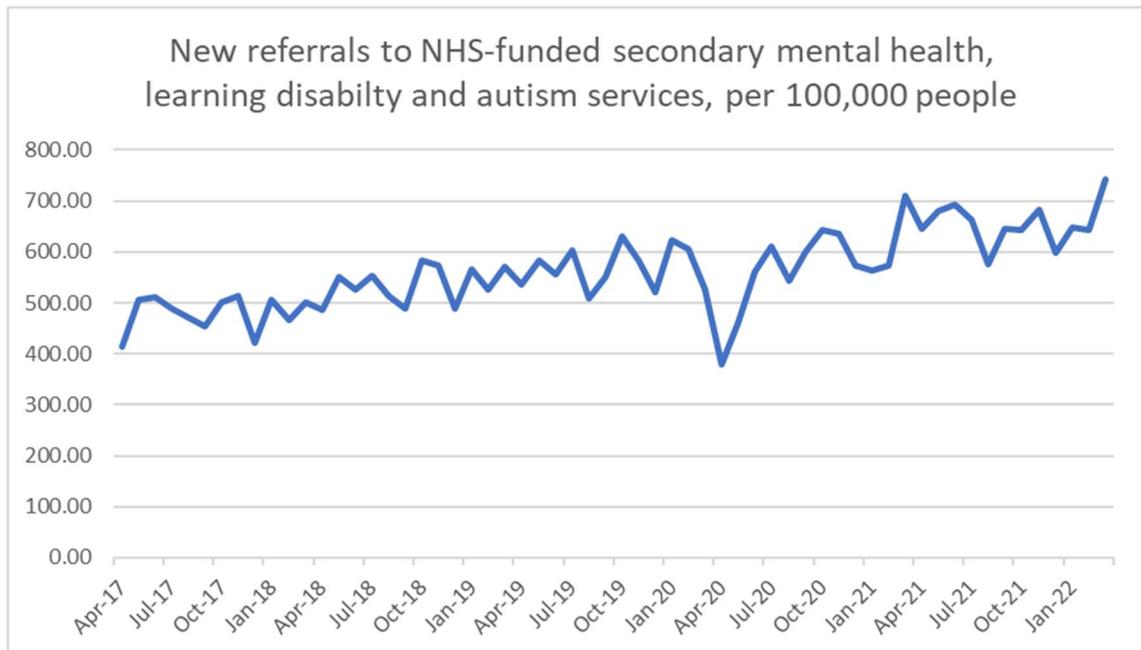
16 trips around earth

In total, inappropriate out of area placements cost the NHS £102.30m in the 12 months up to and including March 2022.

While some local areas have made substantial progress in recent years, a minority of local areas have struggled, continuing to send a disproportionately high number of patients out of area. Combined, the following 9 local areas were responsible for a majority of all inappropriate bed days in 2021/22, showing a significant and consistent mismatch between local inpatient capacity and demand.

- West Yorkshire and Harrogate (Health and Care Partnership)
- Lancashire and South Cumbria
- Hertfordshire and West Essex
- Birmingham and Solihull
- Humber, Coast and Vale
- Cheshire and Merseyside
- Devon
- Coventry and Warwickshire
- Greater Manchester

Given the significant and continued increase in demand on mental health services, particularly since the start of the pandemic, the challenge of inappropriate out of area placements will persist unless concrete and additional action is taken now.



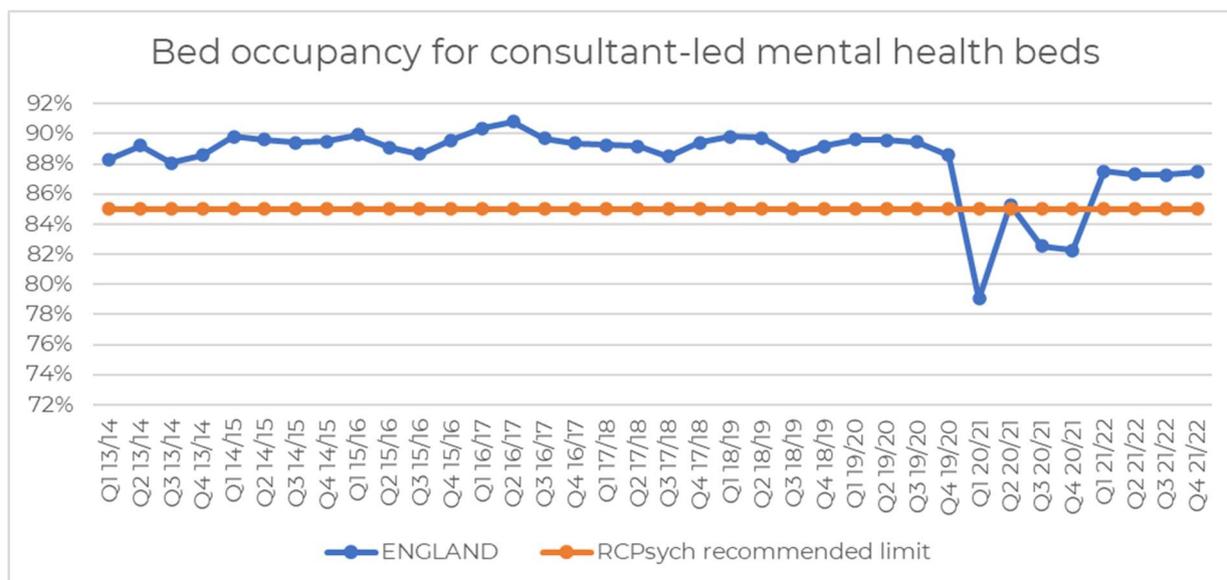
Source: [NHS Digital](#)

A harmful back-up plan

The lack of capacity within the mental health system is well established, with services all over the country struggling to meet demand.ⁱⁱ The effect of this on the accessibility and quality of services is considerable, both in inpatient and community settings.

In inpatient settings, occupancy rates for consultant-led mental health beds have consistently been higher than the 85% 'safe limit' recommended by the Royal College of Psychiatrists.^{iii,1} This safe limit was defined to ensure staff are able to offer the safest possible care and to give services the flexibility to respond to shifts in demand while still avoiding harmful inappropriate out of area placements.

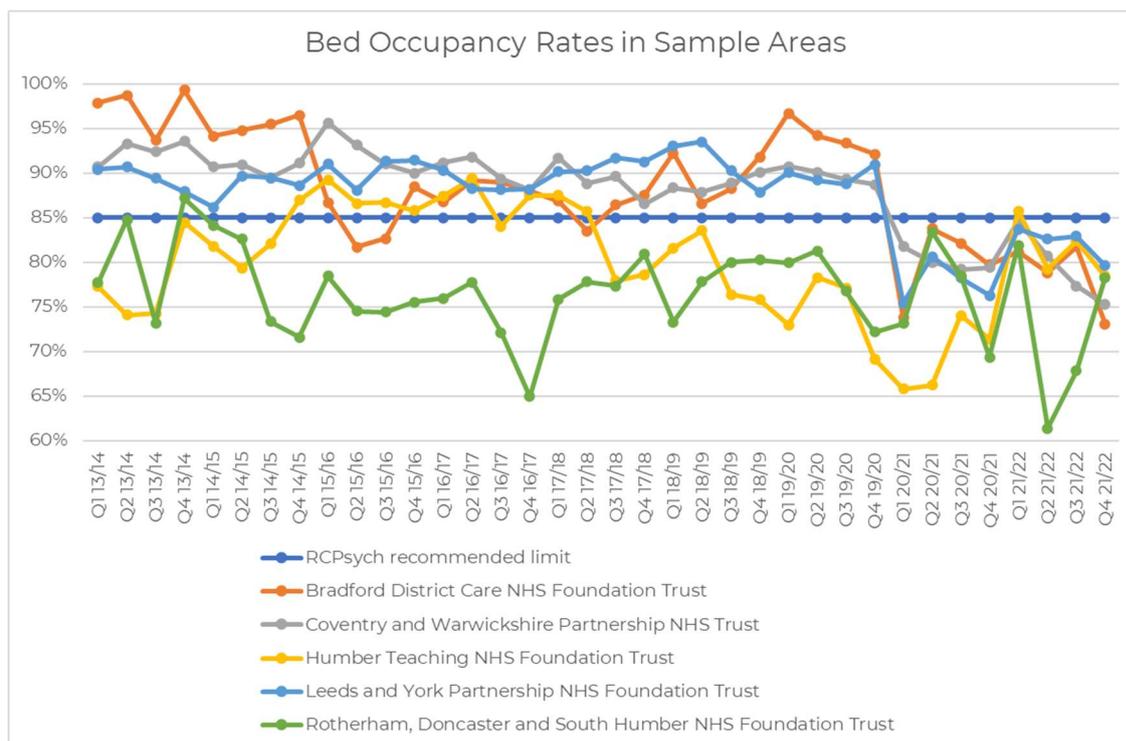
¹ When interpreting data from March 2020 onwards, NHSE notes that: "Hospital capacity has had to be organised in new ways as a result of the pandemic to treat Covid and non-Covid patients separately and safely in meeting the enhanced Infection Prevention Control measures. This results in beds and staff being deployed differently from in previous years in both emergency and elective settings within the hospital. As a result, caution should be exercised in comparing overall occupancy rates between this year and previous years". See more information, [here](#).



Source: [NHS England](#)

There are a range of potential factors driving high bed occupancy rates, including the number of available beds, admission thresholds, the length of inpatient stays, the robustness and capacity of community mental health services and discharge delays due to housing or social care challenges. When occupancy rates are above this level, clinicians have less time to spend with individual patients, more violent incidents can occur, and staff are placed under immense pressure.^{iv}

Some ICS areas have been able to keep occupancy rates closer to the recommended threshold, but still struggle with high numbers of inappropriate out of area placements. Aside from high occupancy rates in inpatient services, capacity constraints in community and crisis services can also result in inappropriate out of area placements. Patients who might otherwise not need an inpatient admission but for whom no specialist intensive provision exists locally can also be sent out of area. One example of this is people with learning disabilities and autism. Areas might also struggle with other challenges, such as in securing appropriate discharge support, including local community and inpatient mental health rehabilitation provision that forces services to admit patients to inpatient acute units. Other areas might have a mismatch between the type of specialist inpatient beds available and the specific needs of people requiring admission.



Source: [NHS England](#)

Inappropriate out of area placements are hugely detrimental to patients. Friends and family are not able to visit, leaving patients feeling isolated. This is particularly the case for those families for whom travelling long distances, taking time off work and paying for local accommodation is simply unaffordable. They are removed from local services that they engaged with previously and will rely on after discharge, making it much harder for staff to plan for and coordinate care. The effect of this is that patients often spend longer in hospital and have a harder time after being discharged, with long term implications on their recovery.^v This is unacceptable.

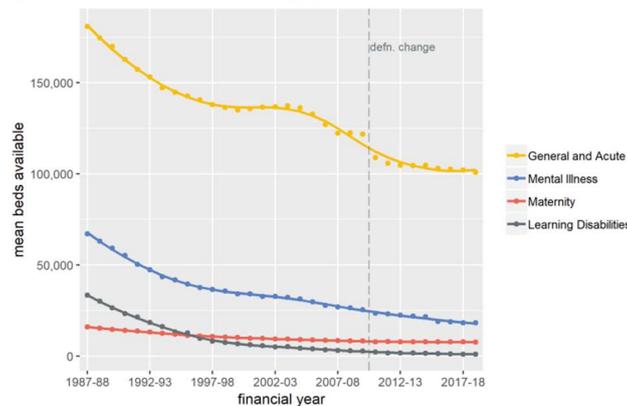
The practice is also hugely costly to the health service. Sending a patient to a unit in another service is far more expensive than admitting a patient to a locally commissioned bed. In addition to the fact that patients in out of area placements often spend longer in hospitals, this means that the NHS has spent more than £102 million on inappropriate out of area placements in the year to March 2022.

For these reasons, inappropriate out of area placements were always intended to be the absolute last resort. However, NHS data shows that inappropriate out of area placements are still heavily relied on to manage pressure on the system. Hundreds of patients are affected each month, with 605 inappropriate out of area placements active at the end of March 2022. In fact, things have gotten worse in some regard. In March 2022, over half of all inappropriate out of area placements saw patients travel more than 100km from home because a local bed was unavailable for the eighth month running.

Building better mental health services in the long term

The NHS Long Term Plan sets out an ambitious programme to improve mental health services, backed by at least £2.3 billion annual additional investment in real terms by 2023/24. As part of this programme of work, a new, community-based offer is being developed to ensure adults with severe mental illnesses can access care from multidisciplinary teams in their local area, usually while living at home. The expansion of crisis support, including community-based alternatives to inpatient admission, are being expanded. There are also efforts to reduce the admission of children, young people, and adults with learning disabilities, autism or both to inpatient facilities. These efforts are part of a long history of moving mental health care out of inpatient settings and into the community, working closely with voluntary and community sector organisations to make treatment more accessible and acceptable to patients while bringing about a dramatic reduction in inpatient beds since the 1980s.

Figure 2i: Long term trends in bed numbers by type, England 1987/88 – 2017/18



Source: KH03 returns

The recently introduced Health and Care Act will result in further reforms. It is hoped that the creation of Integrated Care Systems (ICSs) will enable more responsive, local planning and closer collaboration between health and social care. The expansion of so-called provider collaboratives will bring different parts of the health system closer together to help them plan services collaboratively and ensure a smoother experience for patients moving from one service to another.

The Royal College of Psychiatrists has welcomed the ambitions set out in the Long Term Plan. We know that patients prefer to be treated in the community and often have better long-term outcomes when supported to access care while living at home. When asked which interventions would have the greatest impact on reducing pressure on inpatient services, psychiatrists have long emphasised the importance of investing in community services. Today, the College is campaigning for the investment in workforce and facilities necessary to make these plans a reality.

While the increased investment in mental health promised alongside the Long Term Plan will help address decades of neglect, the direct and indirect impact of

the COVID-19 pandemic have had an enormous impact on this work. Perhaps unsurprisingly, a number of key delivery timelines have been delayed. For example, the go-live date for ICSs was pushed from early April 2022 to early July 2022. The expansion of provider collaboratives has also been delayed, as have aspects of community transformation.

Simultaneously, the demand on mental health services has skyrocketed. It's expected that 1.8 million additional referrals will be made to mental health services between 2020/21 and 2022/23 as a result of the pandemic, an overall increase of 33%.^{vi} Waiting lists have ballooned, with over 1.4 million people thought to be waiting for care with mental illnesses such as eating disorders, addictions, severe anxiety or depression.^{vii} Children and young people seem to be particularly affected, with record numbers referred to mental health services.^{viii}

For a system that was already struggling to meet demand before the pandemic, responding to this surge while also adapting and expanding services in line with Long Term Plan ambitions is proving to be a real challenge. With the current cost of living crisis putting a further strain on the nations' mental health while also stretching NHS budgets further, the elimination of inappropriate out of area placements will require significant and sustained effort by the whole system.

Meeting patient needs today

The commitment to eliminate inappropriate out of area placements was first made in 2016 as part of the Five Year Forward View for Mental Health, long before the introduction of the Long Term Plan.^{ix} While the final year of the programme was no doubt affected by the pandemic, NHS data shows a lack of progress even prior to the first national lockdown in March 2020.

Reducing inappropriate out of area placements and broader pressure on inpatient beds is recognised as a particularly complex challenge. The full delivery of the NHS Long Term Plan will almost certainly address many of these challenges. However, the sheer volume of inappropriate out of area placements still occurring a year after the delivery deadline demonstrate the fact that efforts to date have not driven down pressure on inpatient beds at anywhere near sufficient scale or speed.

Six years after the commitment to eliminate inappropriate out of area placements, hundreds of patients are still being subjected to this inhumane practice. This situation is unacceptable, and patients experiencing an acute mental health crisis can't afford to wait any longer. Systems must be put in place that bridge the gap between the current status quo and the full delivery of the Long Term Plan, to ensure that all patients require intense treatment and support receive the best possible standard of care.

A relatively small number of local areas are responsible for the vast majority of inappropriate out of area placements, with variation remaining even after population size and need are adjusted for. In these areas, targeted and concerted action could have a marked impact on reducing the number of patients being forced to travel long distances to access inpatient care.

The exact interventions required to tackle inappropriate out of area placements will vary from local area to local area, depending on the needs of their local population and the strengths and challenges of existing services. Some local areas have been able to dramatically reduce inappropriate out of area placements, and key learnings can be drawn from their experience. But the situation can change quickly and local areas must keep a constant eye on capacity and demand across their services and respond quickly to avoid inappropriate out of area placements ballooning again. Urgent action is required across the health service, but particularly in those areas who have consistently failed to drive down inappropriate out of area placements, making use of the following proven interventions as appropriate:

Additional beds

Inpatient units provide clinicians with a means of rapidly reducing risk and a place to safely initiate and calibrate complex treatment regimens. While the policy focus has rightly been on reducing the number of patients being admitted for inpatient care, they cannot be eliminated altogether. Much in the same way that you might reduce the number of people having heart attacks through prevention and community care, some people experiencing an acute mental health crisis will still need hospital care in the same way that someone having a heart attack would.

In areas consistently sending a disproportionate number of patients out of area, or where occupancy rates are so high that this presents a risk to quality of care, there is an evident and sustained mismatch between the demand for inpatient beds and local capacity. In many areas, this goes far beyond what could reasonably be addressed in the short to medium term through the gradual expansion of community provision.

We know that sustained high occupancy rates present a catch-22 for these local areas. The Mental Health Act review found that high occupancy rates lead to later admission and more detentions under mental health legislation, earlier discharge and greater re-admission rates, leading to high pressure on inpatient beds being sustained. Simultaneously, the higher cost of out of area placements versus locally commissioned beds mean precious resources are being spent sending patients out of area. Beds are expensive but a lack of beds is even more expensive, leaving even less money available for expanding much needed local provision.

As recommended by the College in 2019, these areas should be supported to get out of their 'beds trap' by commissioning additional and appropriately staffed inpatient beds within local services in the short to medium term. While these inpatient beds would likely be filled quickly, the quality of care for these patients would be dramatically improved and, since locally commissioned beds are much cheaper than out of area provision, these additional beds would likely still represent a net saving. Simultaneously, commissioners would be given the breathing space to invest in the delivery of the Long Term Plan ambitions which,

in the longer run, should enable them to reduce inpatient capacity again as pressure on these services is reduced.

Increasing therapeutic value of admission

Just as the reduced therapeutic value of an inappropriate out of area placement leads to longer and repeat admissions, increasing the therapeutic value of all inpatient admissions can significantly reduce pressure on services and free up capacity.

Therapeutic value can be increased through closer coordination between in- and outpatient services, setting clear objectives for admission, and planning for discharge from the outset with active patient involvement and shared decision making, where appropriate. Care contracts between services and stepped care models could be key ways of achieving this, by removing the artificial dichotomy between in- and outpatient provision and integrating both into a seamless care offer that meets patients' needs over time.

The NHS Long Term Plan included a commitment to improve the therapeutic value of inpatient admission, ensuring "purposeful, patient-oriented and recovery-focused care is the goal from the outset". Notably, it goes on to recognise that "units operating beyond capacity may struggle to offer such care", highlighting how overstretched services and inappropriate out of area placements are incongruous with this ambition.

Capital investment in the built environment of inpatient services is also critical in this regard. The mental health trust estate is some of the oldest and least sustainable in the NHS, with 18% constructed before the NHS was formed. The clinical space of multiple mental health sites has been classified as "not functionally suitable" and there has been a consistent rise in the 'high risk' maintenance backlog that, if not repaired urgently, could lead to "catastrophic failure, major disruption to clinical services or deficiencies in safety liable to cause serious injury and/or prosecution." While last autumn's spending review failed to respond to this challenge, the College is calling for mental health facilities to be prioritised in the final funding window of the government's flagship New Hospital's Programme.

Managing patient flow

While closer coordination between in- and outpatient services and investment in facilities will increase the therapeutic value of admissions and ensure patients spend less time in hospital, further interventions can be pursued to unnecessary discharge delays and ensure patients are supported enough to prevent re-admission.

Specifically trained 'discharge coordinators' can manage the interface between in- and outpatient services, including social care, to prepare for and manage a patient's discharge. These roles are particularly helpful where workforce shortages mean clinical staff have limited capacity. Their work can be better supported through live bed management platforms that give commissioners a

clear insight into service capacity and space to respond, and arrangements with private providers that mean local beds are prioritised for local patients. Intermediate care offers that ensure speedier follow up from community services can also be critical in supporting patients to transition out of inpatient care successfully.

Finally, local service capacity assessments can highlight specific local pressures driving inpatient admission, including crisis support, drug and alcohol services, public health, housing and social care. The expansion and strengthening of these services will likely already be a part of longer term objectives set out in local planning, but may be brought forward or targeted towards specific risk groups where they are found to be driving unsustainable and counterproductive inappropriate out of area placements.

Workforce

Workforce shortages continue to pose a major challenge for mental health services up and down the country, with a tangible effect on service expansion efforts. The most recent workforce census conducted by the Royal College of Psychiatrists found that 10% of consultant psychiatrist posts are vacant, with much higher vacancy rates in some regions and specialties.^x

It is critical that the commissioning of additional beds and other services to tackle inappropriate out of area placements is backed by sufficient staffing to deliver quality care. In the longer term, the delivery of the Long Term Plan will rely on a sustainable solution to the mental health workforce crisis. The workforce strategy currently being developed by government requires appropriate funding, including for interventions like an expansion of medical school places and core psychiatry training posts. In the short term, services will need to explore evolving their staffing mix to make the most of the multidisciplinary team and ensure posts across both inpatient and community services are able to attract and retain staff.

A zero tolerance approach

We welcome the ongoing efforts of NHS teams to tackle this challenge but tackling this challenge quickly will rely on everyone working together with a laser focus. Inappropriate out of area placements are unacceptable. They should not be seen as an interim solution pending the delivery of Long Term Plan commitments, but a central indicator for new Integrated Care Systems to assess their overall performance. With insufficient signs of progress and the deadline for their elimination having been missed by a full year, we need a dramatic step change and a concrete, national plan to eliminate inappropriate out of area placements once and for all.

Creative, responsive commissioning will be critical in this regard. Commissioners must understand that investing locally, even if difficult, is always preferable to sending patients hundreds of miles away. Strategic needs assessments should be conducted as a priority, with investment channelled towards those interventions that will enable more patients to access treatment close to home. NHS leaders

must hold commissioners to account and offer additional support to those areas struggling with pressures that are insurmountable without central support, working with government to ensure they have the resources they need to get out of their 'beds trap'.

Recommendations

- Conduct service capacity assessments and target investment towards services driving inappropriate out of area placements locally
- Make inappropriate out of area placements a key performance indicator for new Integrated Care Boards to monitor progress and respond rapidly to changes in demand and supply.
- Invest in additional, properly staffed inpatient capacity in local areas with consistent and disproportionate inappropriate out of area placements
- Improve the therapeutic value of inpatient admission, by supporting proactive collaboration between in- and outpatient care
- Improve patient flow by actively managing inpatient capacity and enabling proactive discharge planning
- Invest in the mental health estate, to ensure patients receive treatment in an environment conducive to their recovery
- Address the workforce crisis, by ensuring optimal staff mix and investing in training
- Ensure all providers consistently report monthly OAP data to NHS Digital to enable data-driven and targeted support for local areas struggling and the identification of best practice

References

ⁱ NHS Digital (2022), Out of Area Placements in Mental Health Services. Available online: [Out of Area Placements in Mental Health Services](#) [Last date of access: 09/06/2022].

ⁱⁱ The Commission to review the provision of acute inpatient psychiatric care for adults (2016) Old problems, new solutions: improving acute psychiatric care for adults in England. Royal College of Psychiatrists. Available online: [policy-old-problems-new-solutions-caapc-report-england.pdf \(rcpsych.ac.uk\)](#) [Last date of access: 13/01/2021]

ⁱⁱⁱ NHS England (2021) Statistics – Bed Availability and Occupancy. Available online: [Statistics » Bed Availability and Occupancy \(england.nhs.uk\)](#) [last date of access: 13/01/2021]

^{iv} Strategy Unit (2019) Exploring mental health inpatient capacity across Sustainability and Transformation Partnerships in England. Royal College of Psychiatrists. Available online: [Exploring Mental Health Inpatient Capacity | The Strategy Unit \(strategyunitwm.nhs.uk\)](#)

^v SU Report

^{vi} Strategy Unit (2020) The Mental Health Surge Model – Estimating the impacts of COVID-19 on mental health services in England. Available online: [Mental Health Surge Model | The Strategy Unit \(strategyunitwm.nhs.uk\)](#) [Last date of access: 13/01/2022]

^{vii} Royal College of Psychiatrists (2021) Pandemic impact on mental health backlog catastrophic, says Royal College of Psychiatrists. Available online: [Pandemic impact on mental health backlog catastrophic, says Royal College of Psychiatrists \(rcpsych.ac.uk\)](#) [Last date of access: 13/10/2022]

^{viii} NHS Digital (2022) Mental Health Services Monthly Statistics. Available online: [Mental Health Services Monthly Statistics - NHS Digital](#) [Last date of access: 13/01/2022]

^{ix} NHS England (2016) The Five Year Forward View for Mental Health. Available online: [The Five Year Forward View for Mental Health \(england.nhs.uk\)](#) [Last date of access: 13/01/2021]

^x Royal College of Psychiatrists (2021) 2021 Workforce Census – Available online: [Our workforce census \(rcpsych.ac.uk\)](#)