Adult Mental Health Crisis and Acute Care: NHS England’s national programme

Bobby Pratap, Senior Programme Manager, Crisis and Acute Mental Health Care, NHS England
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1. Background and policy context:

Why is NHS England investing in mental health crisis & acute care?
Crisp Commission – what did it say? Some of the top recommendations

- **End the practice of sending acutely ill patients long distances** for treatment by October 2017.

- **Strengthening CR/HTs**, with a particular focus on ensuring that home treatment teams are adequately resourced to provide a safe and effective alternative to acute inpatient care where this is appropriate.

- A single set of **measurable quality standards** needs to be created spanning the acute care pathway, including a **maximum four-hour wait** for admission to an acute psychiatric ward for adults or acceptance for home-based treatment following assessment.
Mental Health Task Force – acute mental health

Recommendation 17:
• By 2020/21 24/7 community crisis response across all areas that are adequately resourced to offer intensive home treatment, backed by investment in CRHTTs.

Recommendation 22:
• Introduce standards for acute mental health care, with the expectation that care is provided in the least restrictive way and as close to home as possible.
• Eliminate the practice of sending people out of area for acute inpatient care as a result of local acute bed pressures by no later than 2020/21.
“By 2020, there should be 24-hour access to mental health crisis care, 7 days a week, 365 days a year – a ‘7 Day NHS for people’s mental health’.”

- **over £400m for crisis resolution and home treatment teams** (CRHTTs) to deliver 24/7 treatment in communities and homes as a safe and effective alternative to hospitals (over 4 years from 2017/18);

- **£247m for liaison mental health services** in every hospital emergency department (over 4 years from 2017/18);

- **£15m capital funding for Health Based Places of Safety** in 2016-18 (non-recurrent)
National programme – crisis & acute mental health

Phase 1: 2016/17:

• National policy development
• Embed crisis & acute care into as many national levers and incentives, infrastructure to drive local delivery from 2017/18:

Phase 2: 2017/18

Investment begins:
• £43m uplift to CCG baselines for CRHTTs in 2017/18
• £15m transformation funding for liaison in 2017/18

• Shift from national policy to driving regional implementation preparedness and supporting local delivery
Development of national policy

During 2016/17 multi-agency expert reference groups – service managers, clinicians, experts by experience, commissioners, social care, policy managers, police, academics have followed a NICE-guideline type process to develop national policy guidelines for crisis & acute care:

- Referral to treatment pathway, quality benchmarks / standards, including response times, interventions, NICE recommended care
- Implementation guidance & helpful resource pack – e.g. service examples
- CCQI England-wide quality assessment and improvement scheme
- Specify England-wide baseline audits & gap analysis
- Articulate key national metrics to measure pathways
Crisis & acute now hard-wired and prioritised in many of the national levers - this has not been the case until now

- Year long **CCQI implementation support scheme** following publication of **new suite of national quality benchmarks and resources**

- **CCG Improvement and Assessment Framework** – including transformation indicators for U&E MH in 2016/17, crisis & acute indicators prioritised in 2017/18;

- **NHS Planning guidance** – U&E MH explicit in 2 of the 9 NHS ‘must dos’ (UEC, MH)

- **NHSI Oversight Framework** and **CQC ratings** to be based on new U&E MH pathways;

- Aides memoires and assurances of **STPs** include U&E MH;

- **MH Dashboard, CCG Financial tracker** – specific returns and transparency on UEC Liaison and CRHTT spend and provision of services;

- Changes to **national datasets** – MHSDS and ECDS; establishment of new national statistics

- **CQUINs** (Frequent attenders to A&E), **CCG Quality Premium** (out of area placements);

- **New payment models** for UEC and MH;

- **NHS England assurance and performance** functions
2. Crisis Resolution & Home Treatment Teams

FYFV Deliverable: By 2020/21, NHS England should expand Crisis Resolution and Home Treatment Teams (CRHTTs) across England to ensure that:

- a 24/7 community-based mental health crisis response is available in all areas

- these teams are adequately resourced to offer intensive home treatment as an alternative to an acute inpatient admission.
CRHTTs – what are their key functions?

Community crisis assessment:

- Accessible **24/7**
- **Rapid assessment** to the community and people’s homes for urgent and emergency referrals
- **Gate-keeping** function (managing access to local acute inpatient beds)
- **Initial treatment package** (medical and brief psychological intervention)
- Management of **immediate risk**

The UCL Core study has a **39 point fidelity scale** for teams to assess themselves against

Intensive home treatment:

- **Short term intensive care spell**: aims to transfer patients according to an ongoing plan of care
- As many visits as necessary, **24/7**, likely to need visits of up to three times per day initially, with **frequency reducing** as patient recovers
- Visit **duration that meets the person’s needs** and allows for therapeutic care
- **Multi-professional team approach** with effective handover (at a minimum, daily), which allows case-load sharing and the offer of a **range of interventions**
- Partnership working with other community services to **facilitate ongoing care**
- **Facilitate early discharge** from inpatient settings.
- Subject to similar ‘**bed management’ approaches** as inpatient care
Benefits of CRHTTs when implemented in line with evidence base

- **24/7 access** to mental health crisis services
- **Timely assessment** in an appropriate place
- **Avoids unnecessary admission** when home treatment may be more suitable
- **Therapeutic care to support recovery**: in people’s home environment, social triggers to crisis, and barriers to independent living can be more visible, and therefore **assessed and acted upon in situ**, providing potential for **more sustainable coping skills** - including for instance family relationships, shopping, banking etc. As such, teams should be multi-disciplinary, not just doctors, nurses but psychology, pharmacist, social work, OT input in the skill mix
- Usually people report a **more positive experience** of care than for inpatient care
- **Facilitate early discharge** / supports people to go home on leave from the ward
- **Avoid A&E attendances**, free up acute hospital liaison service for ward in-reach
- When part of tight bed management process and acute care pathway, can help **reduce out of area placement**
- Where teams implemented with high fidelity, that incorporates gatekeeping and has 24-hour community-facing provision have been associated with **reduced admission rates with an associated reduction in costs**

Published evidence of impact (1); Evidence (2); Evidence (3); Evidence (4)
What do we know about CRHTTs – selected stats from UCL survey, 2016 (1/2)

Response time targets

- 45.4% have target to commence an assessment in under 4 hours
- 20.0% have target to complete an assessment in under 4 hours

CRHTT 24/7 offers

<table>
<thead>
<tr>
<th>Service Type</th>
<th>PR</th>
<th>PSCSU</th>
<th>ANRNHS</th>
<th>ANRH</th>
<th>VCSAH</th>
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<tbody>
<tr>
<td>Adults</td>
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<td>91.1</td>
<td>84.7</td>
<td>67.4</td>
<td>69.5</td>
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</table>

<table>
<thead>
<tr>
<th>Service Type</th>
<th>PR</th>
<th>PSCSU</th>
<th>ANRNHS</th>
<th>ANRH</th>
<th>VCSAH</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Phone referral</td>
<td>Phone Support to current CRHTT Service Users</td>
<td>Assessment of New Referrals on NHS premises</td>
<td>Assessment of new referrals at home</td>
<td>Visit current CRHTT Service users At Home</td>
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What do we know about CRHTTs – selected stats from UCL survey, 2016 (2/2)

<table>
<thead>
<tr>
<th>Eligible Referrer</th>
<th>Adult CRHTTs n/N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psych Liaison</td>
<td>180/184 (97.8)</td>
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<tr>
<td>GPs</td>
<td>148/184 (80.4)</td>
</tr>
<tr>
<td>NHS 111</td>
<td>108/184 (58.7)</td>
</tr>
<tr>
<td>Police</td>
<td>132/184 (71.7)</td>
</tr>
<tr>
<td>Self referral (known patient)</td>
<td>127/184 (67.4)</td>
</tr>
<tr>
<td>Self-referral (new patient)</td>
<td>79/184 (42.9)</td>
</tr>
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</table>

| Separate Assessment/SPOA team      | 59/184 (32%)         |
| 24/7 Crisis Line                   | 106/184 (58%)        |
| Crisis beds                        | 85/185 (46%)         |
| Acute Day Unit                     | 40/185 (22%)         |
| Crisis Cafe                        | 28/185 (15%)         |

Staffing and caseloads

- **35.4** – mean caseload of CRHTTS
- Around **55-65%** of teams have staffing: caseload ratio in line with 2000 policy implementation guidance
Early thinking from the ERGs on quality benchmarks: response times and interventions for emergency referrals

- Within a **maximum of 1 hour of contact**, the urgent and emergency mental health service should provide the person who contacted the service with an update/feedback on care and support to be provided;

- Within **4 hours** of a request for help, the person in crisis should have been provided with an assessment and have an urgent and emergency mental health care plan in place (the assessment should be biopsychosocial, but if this is not possible, an initial face-face crisis assessment should be undertaken as a minimum), and

  - been accepted and scheduled for follow-up care by an appropriate service (this could include support provided at home), or
  - been discharged because the crisis has resolved; or
  - started an assessment under the Mental Health Act.
Early thinking from the ERGs on quality benchmarks: response times and interventions for emergency referrals

• As well as the initial emergency response to a crisis within 4 hours, services should ensure **continuity of ongoing care outside of the 4-hour response** (this could include further assessment if necessary, for example to complete a biopsychosocial assessment if this was not possible within 4 hours)

• Advice should be sought from an appropriately trained and competent mental health professional immediately in the event of a mental health crisis. Each professional should ensure that they:
  
  • provide a **kind, compassionate and empathetic** response
  • plan for the **short-term safety** of the person, if necessary
  • undertake an **initial risk assessment**
  • plan **appropriate observations** for both mental and physical health
  • **access any existing mental health Plan**, where available
  • notify the local authority if the person is an ‘at risk’ adult or older adult.
### Example staffing from IRS & CRHT with high fidelity

- **Funding uplift in CCG baselines secured over 4 years to support similar resourcing everywhere!** Spend / resourcing now being tracked nationally

- **Savings** generated (e.g. reduced OAPs, ward closures) have been **reinvested in CRHTTs and community MH services** where transformation has worked well

<table>
<thead>
<tr>
<th>Profession</th>
<th>Grade</th>
<th>WTE</th>
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</thead>
<tbody>
<tr>
<td>Consultant Psychiatrist</td>
<td>Medic</td>
<td>2</td>
</tr>
<tr>
<td>Team Manager (CRHT &amp; IRS)</td>
<td>Band 7</td>
<td>1</td>
</tr>
<tr>
<td>Clinical Lead</td>
<td>Band 7</td>
<td>1</td>
</tr>
<tr>
<td>Crisis Clinicians</td>
<td>Band 6</td>
<td>20</td>
</tr>
<tr>
<td>Home Based Treatment Nurses</td>
<td>Band 5</td>
<td>3</td>
</tr>
<tr>
<td>Support Workers</td>
<td>Band 3</td>
<td>3</td>
</tr>
<tr>
<td>IRS Clinicians (Urgent telephone &amp; face to face triage)</td>
<td>Band 6</td>
<td>9</td>
</tr>
<tr>
<td>AHPs (pharmacists, social work, OT)</td>
<td>Band 6</td>
<td>3</td>
</tr>
<tr>
<td>Call Handlers</td>
<td>Band 3</td>
<td>11</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>53</strong></td>
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</table>

£2.2m for initial response service, crisis response, HTT for c300,000 population
Case study: example staffing cover over 24/7 spell from a high performing home treatment team. (below does not include crisis assessment function)

<table>
<thead>
<tr>
<th>Time of day</th>
<th>Staffing</th>
</tr>
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| 8.00 a.m. to 9.00 p.m. (this requires two shifts to ensure complete staffing coverage) | 3x Agenda for Change band 5 and 6 staff. This should be a mixture of nurses, social workers and occupational therapists  
  1x band 6 shift co-ordinator  
  At least one consultant psychiatrist on shift at all times throughout these hours |
| 9.00 p.m to 8.00 a.m                              | 3x band 6 staff providing both triage assessment and home treatment  
  Junior medical cover onsite and consultant on call |
| Overall team leadership and support              | Leadership provided by 1x team manager, 1x clinical lead and 0.25x nurse consultant  
  Pharmacist and pharmacy technician input for half a day every day  
  Clinical psychologist providing supervision, reflective practice and supporting formulation  
  Local Authority duty mental health social worker co-located with the team on weekdays. This is for joint working and referral pathway support for home treatment, rather than for mental health assessment work. |

*Note. This covers a population of 300,000*
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<th>Trust</th>
<th>HTT Team/Catchment area</th>
<th>Can the CRHTT visit current CRHTT service users at home 24/7?</th>
<th>Is there a 24/7 crisis line in this CRHTT area?</th>
<th>Does the team accept self-referrals from known patients?</th>
<th>Does the team accept self-referrals from new patients?</th>
<th>Does CRHTT have a 4 hour target for all new assessments?*</th>
<th>CRHTT Caseload upper limit</th>
<th>CRHTT staffing (FTE)</th>
<th>FTE staff to upper caseload ratio</th>
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<tr>
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<td>Dartford Gravesend &amp; Swanley (DGS) Mental Health Recovery Team</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>40</td>
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<td>CRHTT Caseload upper limit</td>
<td>CRHTT staffing (FTE)</td>
<td>FTE staff to upper caseload ratio</td>
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<td>CRHTT staffing (FTE)</td>
<td>FTE staff to upper caseload ratio</td>
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<td>CRHTT staffing (FTE)</td>
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<td>42</td>
<td>26.90</td>
<td>0.64</td>
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</tbody>
</table>
Case studies: community urgent & emergency response and HTTs

- Bradford **First Response service, Haven** – whole system approach including acute, community, social care and police services

- **Cambridge & Peterborough** has replicated Bradford crisis model, including **Sanctuary** - mental health attendances at all three EDs in the area have reduced by 20%

- Sunderland **Initial response service** with big focus on reducing clinician admin including digital dictation service that clinicians credit as key enabler of successful service

- Central and North West London NHS Foundation Trust: **Westminster Older Adults Integrated Community Mental Health and Home Treatment Team**

- Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH): **CRHTTs**

- 2gether NHS Foundation Trust: **Hereford Crisis Assessment and Home Treatment Team**
Data: new national reports coming in 2017 for CRHTTs, including response times - transparency at last!!

- **Reporting requests** submitted to NHSD, likely to include:
  
  - No / rates of referrals to CRHTTs
  - Response times from referral to contact by CRHTTs
  - NICE-recommended interventions
  - Total number / rates of ‘admissions’ (i.e. accepted referrals) for home treatment
  - For patients admitted to HTT number of care contacts broken down by week in care episode (eg how many contacts in week, 1,2,3,4 etc)
  - Median duration of care contact by HTT

- **Regular** (annual tbc) **national survey of CRHTTs**
3. Acute mental health care, inc. out of area placements

FYFV Deliverables:

- the practice of sending people out of area for acute inpatient care due to local acute bed pressures eliminated entirely by no later than 2020/21

- standards for acute care introduced

- full response to the Independent Commission on Acute Adult Psychiatric Care, established and supported by the Royal College of Psychiatrists
Early considerations from acute care ERG – quality benchmarks: time from referral to admission

People should start to access evidence-based, NICE-recommended care within:

- **4 hours of the decision for referral to inpatient** acute mental health services, including allocation of named professional and orientation onto inpatient ward

- **24 hours of the decision for referral to Community**-based acute mental health services

- All people who are referred onto the **community**-based acute mental health pathway must be **accepted for care by a service within 4 hours** of the referral decision.
Early considerations from acute care ERG what is NICE-recommended acute mental health care? (inpatient and community)

1. A comprehensive physical health assessment made within 24 hours of the start of treatment;

2. A care plan to be initiated within 72 hours of the start of treatment

3. A Care Act-compliant assessment to be completed within 72 hours of the start of treatment to identify any social care issues

4. The discharge destination to be considered within the first 72 hours of care for those who have housing needs

5. Access to daily meaningful and recovery-focused activities while receiving care

6. One-to-one face-to-face time with a care professional that the person knows, every day

7. Feedback on service experience to be sought to improve the delivery of care

8. Follow-up after discharge from an acute mental health inpatient setting to be made within 48 hours.

Case study: Navigo – award winning acute mental health service
Eliminating acute mental health out of area placements (OAPs)

• In their reports published last year, both the Commission on Acute Adult Psychiatric Care and the Mental Health Task Force called for an end to the practice of sending acutely ill people long distances for treatment, which leads to poor patient experience, outcomes and unnecessary costs to the NHS.
• We have committed to eliminating the practice completely by 2021 for those requiring non-specialist acute care.

Broader impact:

OAPs are a sentinel indicator of a mental health system under pressure, not simply the result of too few acute mental health beds nationally. System-wide solutions are therefore required with a focus on alternatives to admission, community mental health services and interfaces with key partners such as housing and social care.
## Headline Data reported for March 2017

<table>
<thead>
<tr>
<th>Region</th>
<th>Inappropriate OAPs started in period</th>
<th>Total no. of OAP days over the period</th>
<th>Total recorded costs over the period (1)</th>
<th>No. of OAPs that ended in the period with a length of 31 or more nights (2)</th>
<th>No. of OAPs active during the period with a distance of 100km or greater</th>
<th>Average recorded daily cost over the period (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>597</td>
<td>20,616</td>
<td>£7,161,350</td>
<td>115</td>
<td>297</td>
<td>£530</td>
</tr>
<tr>
<td>North</td>
<td>165</td>
<td>5,143</td>
<td>£789,295</td>
<td>25</td>
<td>35</td>
<td>£514</td>
</tr>
<tr>
<td>Mids &amp; East</td>
<td>140</td>
<td>6,005</td>
<td>£2,465,400</td>
<td>35</td>
<td>135</td>
<td>£525</td>
</tr>
<tr>
<td>London</td>
<td>115</td>
<td>3,460</td>
<td>£1,764,710</td>
<td>20</td>
<td>15</td>
<td>£525</td>
</tr>
<tr>
<td>South</td>
<td>170</td>
<td>5,197</td>
<td>£1,921,230</td>
<td>35</td>
<td>95</td>
<td>£580</td>
</tr>
<tr>
<td>Unknown</td>
<td>10</td>
<td>808</td>
<td>£220,706</td>
<td>*</td>
<td>5</td>
<td>£540</td>
</tr>
</tbody>
</table>

- The regional data in this table for ‘Inappropriate OAPs started in period’ is subject to NHS Digital’s suppression rules - counts have been rounded to the nearest five and those less than 5 are replaced by *.

- (1) Recorded Cost – since January cost has only been recorded where a provider has been charged by a different organisation for making the placement. (There are some scenarios where an OAP may take place within a provider organisation where the provider covers a very large geographical patch). As such the costs reported for 2017 should not be compared with those in 2016.

- (2) Only includes OAPs that ended during March and that started on or after the 17th October 2016. This means that the current maximum duration for an OAP included in the March report is 166 nights. It is not yet known what percentage of OAPs last longer than this, but it will become clearer collection runs for more time.
### South: total OAP bed days by provider (Mar 2017)

<table>
<thead>
<tr>
<th>Sending Provider</th>
<th>Jan 2017</th>
<th>Feb 2017</th>
<th>Mar 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>2Gether NHS Foundation Trust</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avon And Wiltshire Mental Health Partnership NHS Trust</td>
<td>1,168</td>
<td>1,080</td>
<td>1,350</td>
</tr>
<tr>
<td>Berkshire Healthcare NHS Foundation Trust</td>
<td>141</td>
<td>127</td>
<td>222</td>
</tr>
<tr>
<td>Cornwall Partnership NHS Foundation Trust</td>
<td>344</td>
<td>292</td>
<td>369</td>
</tr>
<tr>
<td>Devon Partnership NHS Trust</td>
<td>670</td>
<td>762</td>
<td>950</td>
</tr>
<tr>
<td>Dorset Healthcare University NHS Foundation Trust</td>
<td>237</td>
<td>175</td>
<td>159</td>
</tr>
<tr>
<td>Isle Of Wight NHS Trust</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kent And Medway NHS And Social Care Partnership Trust</td>
<td>*</td>
<td>*</td>
<td>38</td>
</tr>
<tr>
<td>Oxford Health NHS Foundation Trust</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Solent NHS Trust</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Somerset Partnership NHS Foundation Trust</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Southern Health NHS Foundation Trust</td>
<td>699</td>
<td>1,166</td>
<td>929</td>
</tr>
<tr>
<td>Surrey And Borders Partnership NHS Foundation Trust</td>
<td>293</td>
<td>268</td>
<td>315</td>
</tr>
<tr>
<td>Sussex Partnership NHS Foundation Trust</td>
<td>739</td>
<td>772</td>
<td>895</td>
</tr>
</tbody>
</table>

Some of the data in this table is subject to NHS Digital’s suppression rules. Where counts of placements are less than 5 the number has been replaced by *.
Case study: Sheffield (1/2) – headlines

- In 2011 **bed occupancy 120%, 142 beds, almost 3000 bed days out of area**
- **Wards now reduced in size**, (69 beds) staffing has stayed the same, so patient-to-staff ratios have improved, **zero out of area**.
- Because of the reduction of wards, SHSC has been able to significantly **reduce the use of agency staff**,
- **£2 million was invested in community services** to ensure its sustainability. This included investment in IHTTs and new services for people with highly complex problems often associated with a diagnosis of personality disorder. **In addition to this reinvestment, cost savings of over £1.5 million** were made
- No increase in incidents, close monitoring of quality markers – which have improved.

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**Table 3: Adult acute bed occupation in SHSC between 2011 and 2016**

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total beds (adults of all ages, including out-of-area)</td>
<td>141.8</td>
<td>127.8</td>
<td>116.1</td>
<td>104.7</td>
<td>84</td>
<td>68.7</td>
</tr>
<tr>
<td>Number of out-of-area bed nights due to lack of capacity</td>
<td>2939</td>
<td>1190</td>
<td>557</td>
<td>444</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Case study: Sheffield (2/2) – how did they do this?

- **Risk-sharing agreement** between SHSC and the Sheffield CCG. SHSC took responsibility for the budget for out-of-area placements.

- **Efficiency programmes** reduction in average length of stay from 56 to 31 days. Work focused on improving time spent with patients on the wards, discharge facilitators on every ward, planning for discharge on admission, particularly in relation to social factors and daily bed management meetings with consultants.

- **Quality initiatives**: included: psychology posts on wards; reflective practice supervision for staff; reduction in seclusion and restraint; service user-led, all-staff training programme to improve the management of violence and aggression.

- **Bed management** weekly bed-management meetings chaired by the clinical director, and including all consultants, ward managers, discharge coordinators, partner services (crisis house, respite provision, community teams). Meetings use live data and focus on patient flow.

- **Investment in intensive home treatment** bed-management processes were applied to manage the flow of people. Fewer people accessing home treatment, smaller team caseloads but more intensive treatment for those in HTT.

- **Whole system approach - vital**. Rethink crisis house and helpline, Wainwright Crescent respite and step-down beds; joined-up management/governance between inpatient and community services, live data showing flow across the whole system; and engagement with service users, carers and staff throughout.
Common themes from other areas that have / are attempting to reduce out of area placements

**Intensive focus on OAPs as a priority** – agreement of system priority at all levels

- Agreement at all levels that OAPs are a priority
- Principle that bed / HTT must always be available where that is the right choice
- Board-level responsibility
- Clinical and/or Service Director who is personally responsible
- Strengthened community services, savings reinvested back into MH
- Financial risk/benefit sharing agreement between providers and commissioners
- Whole system coming together in partnership to redesign pathways and agree processes – inpatient staff, CRHTTs, social care, AMHPs, CMHTs, vol sector, patients, IAPT, primary care
- Intensive focus on flow, bed management
- Community and inpatient teams attend regular MDT discharge meetings
- Use of real time data, including info on bed availability, capacity of HTTs, community alternatives (e.g. crisis houses)
- Info on patients who have passed discharge dates, reviews / new discharge dates
Further OAPs case studies and resources

- **Sheffield** – blog from clinical lead, Dr Mike Hunter – now associate national clinical director at NHS Improvement. Further detail can be found [here](#).

- **North East London Foundation Trust** – highlighted in [RCPsych Commission on adult acute psychiatric care](#) (p27) – NELFT has eliminated out of area placements for many years, with one of the lowest bed bases in the country - through investment in community services and intensive focus on acute pathway management.

- **Leeds and York Partnership NHS FT**: Efforts underway in [‘Leeds mental health flow’](#) project with write up of the how the whole system is coming together to reduce out of area placements to save £1.5m for the local health economy.

- **Bradford**: adopted an approach with similar principles to Sheffield. Highlights include:
  - Vital [partnership working with social care](#) and local authority services to reduce delayed transfers of care, mental health act detentions, admissions and recovery in the community
  - [Whole system approach](#) to eliminating out of area placements in Bradford.
  - [Focus on acute inpatient ward flow](#), DTOCs, including a 10 point discharge tracker (below):
Further positive practice case studies: acute care

- East London NHS Foundation Trust [Tower Hamlets acute mental health service](#)
- Camden and Islington NHS FT, [Drayton Park Women’s Crisis House](#)
- Mersey Care NHS FT has introduced [No Force First](#), an award-winning restraint reduction initiative.
- South London and Maudsley NHS FT [Gresham Unit Carers’ initiative](#)

Addressing inequalities in acute mental health

Resources from Joint Commissioning Panel on mental health for people from:

- **BAME backgrounds**,  
- **older people**  
- **learning disabilities**  
- **physical health needs**

Case study: [African Caribbean Community Initiative](#), Wolverhampton
Mental health rehabilitation service examples

- Cheshire and Wirral Partnership NHS Foundation Trust, Complex Recovery Assessment and Consultation service that has contributed to the elimination of out of area placements
- Cornwall Partnership NHS FT, Fettle House rehabilitation service
- Northumberland Tyne & Wear NHS FT Rehabilitation and Recovery Services

Mental health supported housing examples

- St Martin of Tours Housing Association, Islington
- Living Well, South Yorkshire Housing Association
Out of area placements: new national definition

An OAP occurs when an adult assessed as requiring acute mental health inpatient care, is admitted to a unit that does not form part of their usual local network of mental health services. This includes inpatient units that:

• are not run by the person’s usual provider;
• are not intended to admit people living in the catchment of the person’s local community mental health service;
• are located in a place where the person cannot be visited regularly by their care coordinator to ensure continuity of care and effective discharge planning; or
• are located in a place where the person cannot be visited regularly by their family, friends or support networks.

This definition was developed following considerable engagement with commissioners, providers and users of mental health services.

Given the varying sizes and geographical footprints of mental health providers, the definition necessarily places the onus on local sending providers to determine whether the placement is out of area, based on the key principles above.
Out of area placements: new national definition

It is important that the decision to place someone out of area is documented at the time of admission by the admissions team (e.g. CRHTTs who ‘gatekeep’ admissions). Their responsibility for assessing the person’s needs and their involvement in the placement process means they are best able to decide whether the placement is out of area in accordance with the definition. The information team within your organisation should not be relied upon to identify which placements are out of area based on retrospective analysis of notes or records.

Key Considerations when applying the definition locally:

- Are you paying another provider to place your patient?
- Is the person being placed outside the catchment area of their usual CMHT, or the CMHT that serves their home area if they are not previously known to services?
- Is the person’s care coordinator able to ensure continuity of care and effective discharge planning and visit as often as stated in the Trust’s policy?
- Can their friends/family/carers/support networks visit regularly - or is this made difficult because the person is admitted too far away? We know that in more rural areas some distances are unavoidable, but it’s important to apply local knowledge and check that the person has been admitted to their most local unit.
Data: new national reports coming in 2017-2019 for inpatient acute care

Inpatient activity – split by bed type for the first time:

For inpatient and HTT
- Referrals / referral rates
- Gatekeeping
- Admission / admission rates
- Readmission
- NICE-recommended interventions
- Average length of stay
- Follow up post-discharge
- Time from decision to admit to admission

Delayed Transfers of Care - by bed type
- With new categories for mental health

Out of area placements – MHSDS to replace special interim collection
- Numbers, bed days, reasons, distance, duration

Mental Health Act
- Including waiting times
.... thank you and questions

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