Southern Health
NHS Foundation Trust

07 2019
Communications and Engagement Team

Briefing note:

Providing acute inpatient mental health care within Hampshire

Overview

Out of area (OOA) bed placements, and the reality of sending patients miles away from their family and friends, is serious issue affecting almost every mental health provider across the country. However, Southern Health NHS Foundation Trust was recently highlighted as having more OOA bed placements than some other trusts and we are keen to address this.

This paper outlines the plans we are putting in place to tackle the OOA bed issue within our adult mental health services – which, most importantly, will benefit future patients who need an inpatient stay. It will ensure a more effective use of the Trust's resources, as the costs of OOA beds are currently a significant burden on the Trust's finances.

Background

What is an out of area placement?

An 'out of area placement' for acute mental health inpatient care happens when a person with assessed acute mental health needs who requires adult inpatient care, is admitted to a unit that does not form part of the usual local network of funded services. This maybe an inpatient unit that does not usually admit people living in the catchment of the person's local community mental health service and where the person cannot be visited regularly by their care co-ordinator to ensure continuity of care and effective discharge planning.

Southern Health has a contractual responsibility to provide inpatient care when patient need exceeds what can be supported in the community. Unfortunately, demand for inpatient care has exceeded Southern Health's bed capacity since May 2016 and the underlying root cause of the situation is complex, with no single solution to fix the problem.

What are the challenges to reducing OOA bed placements?

Reducing the number of OOA bed placements is not a simple task and it is complicated by a number of factors.

These challenges include:

- An increase in the number and acuity of the patients we see in Hampshire, with 57.3% of admissions being detained under the Mental Health Act, compared to 45.5% in 2016/17.
- Fewer acute beds in Hampshire than the national average (14 per 100,000 compared to 19 per 100,000) - national benchmarking would suggest we have 40 too few beds compared to similar populations.
- Longer average lengths of stay in Hampshire (44 days compared to the national average of 32) - with 39% of beds occupied by patients who have been in them more than 100 days.

- A perceived lack of investment in alternatives to inpatient care - such as community mental health services, home treatment and crisis response.

Although these issues are key to ensuring a stable bed position in the longer term, this paper focuses on the management of flow across our patient pathways as an immediate action to effect change fast.

What is the current process for bed management?

Southern Health's Adult Mental Health services are divided into four geographical areas/divisions – North and Mid Hampshire, South West Hampshire, East Hampshire and Southampton. Currently, mental health beds and patient flow are managed by the Trust's Acute Care Support Team (and not by individual divisions). This is a **centralised bed management model** which unfortunately has not proved successful enough in managing the resource. There have also been local operational concerns regarding the sustainability of the model in the longer term.

These concerns include difficulty in managing planned admissions locally; continuity of care; and differing thresholds for admission, discharge and potential risk across divisions. By using this centralised bed management system, we have found there are a number of factors that can cause an increase in a patient's length of stay (when compared to beds being managed more locally by areas/divisions):

- Admission/gatekeeping is less robust when making the decision to admit a patient to shared bed stock. Incentives to intensively treat a patient in their own home and effectively manage risks, compared to admitting to another division's bed are lacking (particularly out of hours).
- Once admitted, there is little incentive for the patient's home area/division to prioritise early discharge or repatriate the patient when they are 'safe' in a bed and staff are stretched. Travelling and lack of familiarity with other teams further impact on the ability of one division to in-reach to another.
- When a local Acute Mental Health Team (AMHT) is looking for a bed for their patient they can more easily identify a local patient on their ward to home treat, than a patient from another area/division. A 'one in, one out' model between an AMHT and a local ward works well, where locational relationships are strong.
- The inpatient team does not have the benefit of 'knowing' the patient as well as patients from their own area/division and may take some time to make themselves familiar with the case and start an effective treatment plan. Prior knowledge as well as community in-reach and information sharing make timely and effective treatment more likely.
- The responsible clinician will be less likely to consider leave for a patient who is from another division and this can impact on recovery. Reasons include: logistical transport issues, difficulty getting the patient back for early review, lack of relationship with the AMHT that will be reviewing the patient whilst on leave, difficulties getting prescriptions issued/delivered and also a concern that if a patient needs to be recalled the bed won't have been protected and will have been given to someone else.
- Discharge planning can be difficult and untimely, as a safe discharge will often involve direct communication with the AMHT/Community Mental Health Team who will be following the patient up. Organising this in a timely fashion when clinicians are far away is difficult, so significant delays are frequent. Added complications include social care packages that need to be coordinated by teams remotely, who have no relationship with the inpatient team.

In essence, all areas/divisions report that not having 'ownership' of their beds, in respect of planning admissions and discharges is the single biggest barrier to the maintenance of patient flow through the inpatient services. The Divisional Bed Model is proposed in order to address these issues (see below).

What have we been doing to improve the situation up until now?

Before outlining the planned new way of managing mental health beds, it is important to understand all the work already taking place to try and address the unacceptable rise in OOA bed placements.

The Trust has been investing significant efforts into reducing OOA bed placements and developed a seven point 'Right Care, Right Place' plan to run alongside the current centralised bed management model. The seven point plan is:

(1) To embed the principles of effective patient flow and supporting resource
(2) To improve the culture in which beds are managed
(3) To fully develop and implement the Emotionally Unstable Personality Disorder Clinical Pathway
(4) To develop and embed system-wide resilience and escalation
(5) To develop accommodation solutions to admission prevention and early discharge
(6) To improve access to longer-term placement, including the rehabilitation pathway
(7) To review the system-wide capacity and demand

We did this by taking part in a number of multi-agency meetings to help us understand the local system, work with our partners and find solutions. These include:

- Local meetings in all areas with Hampshire County Council; unblocking issues and delays to discharge
- Weekly Stranded Patient Meetings with HCC, Southampton City Council and local commissioners
- Strategy meetings between HCC and Southern Health senior managers
- Meetings with different housing providers to investigate housing options
- Weekly meetings with local authority colleagues to look at any delays in the transfer of care
- Monthly mental health directors meetings – where it was agreed that OOA placements were a system-wide, multi-organisational priority and an ECR programme board was established.

We have also been applying the Quality Improvement methodology to the flow of acute patients through Southampton, working with all local partners, with a view to potentially standardising the approach across the Trust. We are also working with Hampshire County Council to apply the QI methodology to our social care flow, ensuring that patients who are discharged and need Social Care input do not fall through the gaps and end up back in the system.

In addition, we have been working to provide more support to people before they get to the point of crisis/admission, e.g.

- Opening a community based Crisis Lounge in Southampton
- Placing mental health nurses in the NHS111 call centre to offer support and triage, freeing up teams to support more patients
- Working with commissioners to bid for transformation funds to support crisis services, alternatives to admission and improved psychiatric liaison in our acute hospitals
- Setting up a Psychiatric Intensive Care Unit working group.

As is clear, much work has been undertaken to address the issue of OOA bed placement but it has not been significantly impactful, which is why we are now proposing to make swift changes internally to how we manage the process.

Proposed Changes

We are proposing to align bed allocation to areas/divisions, moving away from the current centralised bed management model. This new way of working is called the Divisional Bed Model and has the support of our commissioners.

It is a system which has had success in the past, and which we can learn from. In 2014/15, a similar area model system saw the use of out of area beds drop rapidly for the Trust - and the position was sustained through the following financial year. Whilst the model worked well, some areas were subsidising others and a perverse

incentive developed, where the more successful an area was, the higher the volume of referrals, discharges and leave that had to be managed by staff, with a negative impact on them.

Through a period of significant organisational change, plus several changes in senior leadership and the temporary closure of Hamtun Ward (on the grounds of safety) and Kingsley Ward (for a significant refurbishment), the model eroded until we ended in our current position. However, with the Mental Health and Learning Disability Division now replaced by Integrated Locality Divisions, the Trust is in a position to once again adopt a local bed management model to allow divisions to have more control of clinical pathways and improve overall patient experience.

Scope

Currently the scope of the Divisional Bed Model includes Adult Acute and PICU wards across North and Mid Hampshire, South West Hampshire, Southampton and South East Hampshire. Older People's Dementia and Functional beds will potentially come into scope following this first phase.

The Detail

Beds available will be ring-fenced for each division for their sole use. Each division will not have assumed use of acute beds outside of their division (with the exception of when bed allocation exceeds resource available within a division).

By 'owning' the beds, each division will be better placed to identify individuals likely to require admission earlier and be confident that if admission is required a bed will remain available (without other divisions filling it). By having this control over the acute resource, each division will also be in a position manage the whole pathway (community and acute inpatient), rather than the current situation where care is fragmented.

The key principles include:

1. The management of the commissioned bed stock lies with each division.
2. The divisions are able to offer beds to the system to offset any overspill from other divisions, but they are also able to decline on the basis of demand, acuity and staffing levels.
3. Referrals for a bed from another division should go from one Acute Mental Health Team to another, as gate keepers. Therefore, the current centralised Acute Care Support Team will no longer be required – and resources will instead transfer into AMHTs to allow local services to extend the bed management role out of hours, reducing the pressure on on-call services.

In order to establish the number of acute beds to each Division, the total numbers of beds were allocated against the weighted population. For the duration of the trial period beds have been allocated as follows.

- Southampton has the sole use of Saxon and Trinity wards. The wards are based at Antelope House and each ward has 18 beds.
- South East will have use of Elmleigh and the three purchased beds in Solent. Elmleigh is an Acute hospital in Havant which has 34 beds. The Solent beds are in the Portsmouth area.
- North Hampshire will have use of Hawthorns 2. These 23 beds are based in Parklands Hospital, Basingstoke
- South West and Mid Hampshire will have access to Kingsley Ward and the ten contracted beds at Marchwood Priory. Kingsley ward is a 25 bedded unit in Winchester, and Marchwood provides 10 additional beds between Totton and Hythe.

Timing, oversight and evaluation

The proposal will initially run for six months, from 8 July 2019, with a three-month review at the end of September. All key stakeholders including commissioners will provide ongoing oversight during this period. In order to evaluate the outcome of the 6 month trial we will look at the number of patients being sent outside of the Southern Health footprint, the number of miles patients have had to travel to access inpatient care, length of stay and number of admissions.

Next Steps

In order for the new Divisional Bed Model to work as effectively as possible, we will be implementing some associated changes - working up plans and liaising closely in partnership with our staff and commissioners and in consultation with our local scrutiny committees. This will include agreeing some changes to the configuration of mental health beds across Southern Health.

For example, whilst we will retain the six contracted beds with Solent NHS Foundation Trust to mitigate any initial risks in the new model, Southern Health plans to cease the contract for 10 beds at Marchwood Priory when no longer required.

In order to give the new model the best chance of success from the outset, it is planned that patients currently in out of area beds will not be repatriated to Hampshire but instead will remain in their current unit until discharged back to our local community services. Whilst clearly not an ideal course of action and not a decision that was taken lightly, it was deemed absolutely essential for divisions to have the necessary time to firmly establish the new bed model within their teams.

We also recognise that during the trial period the situation may arise where a patient is placed out of area whilst a bed is available in Hampshire. However, on balance the benefits of working to the Divisional model during this period, to test if over the short to medium term it can dramatically reduce the number of people overall being placed out of area, is a calculated risk.

There will always be individual circumstances that are considered and made an exception to this rule and we have protocols in place should these situations arise. This short term impact on some of our inpatients should result in a longer term benefit for the majority of our patients going forward.

In summary

Whilst the current centralised bed management system initially makes sense when looking at economies of scale, in reality it generates perverse incentive, longer bed stays, is inefficient, and relies on the premise that there is consistency across all teams and pathways, which is not always the case.

Most importantly, we continue to use an excess numbers of out of area beds at significant financial risk, caring for people away from their local communities, and failing to provide continuity through the clinical pathway.

At present, if a division is struggling with bed management, it impacts on the system as a whole. However if divisions are able to retain management of their own bed stock, the Trust can focus its support, resource and interventions trying to find local solutions to local pressures, rather than engaging in system wide change (which has a negative impact on other divisions).

Ultimately we believe the new bed model will reduce the number of patients treated out of area, away from their local communities. It will also significantly improve the Trust's financial position.

Any questions?

If you have any questions, please contact the communications team on 02380874666 or email communications@southernhealth.nhs.uk

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