People with learning disabilities in ‘out-of-area’ residential placements: I. Policy context

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Abstract

Background A growing shortage of residential care for people with learning disabilities leads to placement funded by one authority in another authority’s area. Such out-of-area placements are governed by guidance from different government departments in respect of different funding streams.

Method This paper presents an analysis of this guidance and shows that it is inconsistent and incomplete.

Results and Conclusion The guidance creates a framework of incentives for health and social services authorities that could lead to people being placed out-of-area against their own best interests, with negative consequences for them and for the ‘receiving’ authorities. A companion paper uses interview data to examine the reasons for and effects of out-of-area placement.

Keywords learning disabilities, market, out-of-area placement, residential care

Introduction

Approximately 44,000 people with learning disabilities live in residential care in England, mostly in relatively small residential homes of, on average, 5–6 people (Department of Health 2004; National Care Standards Commission 2004). The need for accommodation with support is increasing, because of demographic changes (more people, better survival, longer life expectancy), and there is a growing shortage of places (Emerson & Hatton 2004). In addition, the distribution of places varies widely between different parts of the UK, so that places are particularly scarce in some areas (Emerson & Hatton 1998).

If suitable services are not available locally, people with learning disabilities may end up in residential homes outside their own local area, sometimes a long way away. Moving away from their own community is likely to make it more difficult for people to keep in touch with their family and friends. This was an important criticism of the long-stay hospitals before they were largely replaced by residential homes (Morris 1969). Generally, contact with family and friends has increased for people moved out of institutions (Emerson & Hatton 1994). If some people are now not able to find the accommodation and support they need in their local area, this runs counter to the Government policy objective of greater social inclusion for people with learning disabilities (Department of Health 2001).

Out-of-area placement may not just reflect a general local shortage of residential care but a shortage of particular kinds of accommodation and support. Among the people for whom this is most likely to be an issue are those who present challenging behaviour or mental health needs. The shortage of good local services to support people in spite of their challenging
behaviour or mental health needs has been recognized for some time, and concern has been expressed about the quality of alternatives (Department of Health 1993a).

In general, where residents have moved to a home from another part of the country, they remain the responsibility of the ‘placing’ social services for funding and care management. They get health services they need from those in their new home’s area. The possibility therefore exists for difficulties in communication and coordination. A graphic example of this was the Longcare scandal, where failure of care managers to keep in touch with people placed in a residential home contributed to extensive abuse and neglect (Buckinghamshire County Council 1998; Pring 2003).

Out-of-area placement is therefore potentially an important policy issue in a context where residential care is a quasi-market in which there are shortages of the help and accommodation that disabled people need. However, there are no national statistics on the number of people with learning disabilities placed in residential care out of their local area. Evaluative data, in the form of inspection reports produced by the Commission for Social Care Inspection, do not differentiate between the quality of placements of people within their local area or out-of-area. This study was conceived of in order to provide some information on the issue of out-of-area placements. This paper presents an analysis of the policy framework for health and social services concerning out-of-area placements, the service context in which these placements occur, and the implications for service users, service providers and commissioners. The companion paper (Beadle-Brown et al. 2006) reports the results of an in-depth investigation of the reasons for and effects of out-of-area placement on the individuals, their families, the homes and the professionals serving them.

In order to be clear, throughout the paper, the authority arranging the placement of an individual in a residential home in another area is called the ‘placing’ authority; the authority to which the person moves is called the ‘receiving’ authority.

Policy framework

The national policy context relating to this issue is a complex area which is based on inconsistent, even contradictory, assumptions. The two key pieces of Government guidance that impact on inter-authority placement practice are, first, the Department of Health (1993b) local authority circular on ‘ordinary residence’ and second, the health guidance for primary care trusts on ‘establishing the responsible commissioner’ (Department of Health 2003).

The local authority circular refers back to the National Assistance Act 1948 (Great Britain 1948), where, under sections 21 and 29:

... each local authority has a power, and as far as directed by the Secretary of State a duty, to provide residential accommodation and certain other welfare services for people who are ‘ordinarily resident’ in the authority’s area.

There is no definition of ‘ordinarily resident’ in the Act, so ‘the term should be given its ordinary and natural meaning subject to any interpretation by the courts’ (Department of Health 1993a, paragraph 2). Under section 24 of the Act,

... where a person is provided with residential accommodation he shall be deemed to be ordinarily resident in the area in which he was ordinarily resident before the residential accommodation was provided to him.

What this means, as the guidance explains, is that

... where, following an assessment, a local authority arranges a placement in a private or voluntary home in another authority’s area or in a home provided by another local authority, the placing authority will normally retain for that person the same responsibility that it has for someone living in its own area.

So adults with learning disabilities placed in one local authority area from other areas do not become ‘ordinarily resident’ for social care purposes. Instead, they remain the financial and social care responsibility of the ‘placing’ care management services. This is different from the situation of people who arrange their own residential care in another area without the involvement of the local authority social services, where responsibility for social care transfers to the ‘receiving’ authority immediately (paragraph 10):

... when an individual arranges to go into permanent residential or nursing home care in a new
area, without any local authority having taken responsibility for the arrangements, they usually become ordinarily resident in the new area. If subsequently social services help is sought the person will look to the authority where the residential accommodation is situated.

The guidance also includes some clear instructions, setting out how placements should be arranged and managed, when they are being made out-of-area. Section 8 states that:

A local authority should not place a person for whom they are financially responsible in accommodation provided by a private proprietor or voluntary organisation in the area of another authority without informing the other authority. They should also ensure that satisfactory arrangements are made before placement for any necessary support services, such as day care, and for periodic reviews, and that there are clear agreements about the financing for all aspects of the individual’s care.

There is one key exception to the rule whereby the placing authority retains responsibility for the needs of people placed out-of-area. That is when an adult protection alert is raised. As in child protection, the host authority is responsible for the initial investigation of all adult protection alerts, and for coordinating liaison with other agencies, such as local police and health services, as well as with the placing authority.

The other major piece of guidance that directs agency and financial responsibilities as regards people placed in residential care from out-of-area, is guidance for primary care trusts (PCTs) on ‘establishing the responsible commissioner’, published in October 2003 (Department of Health 2003). The key feature of this guidance, from the point of view of out-of-area placements, is that the responsible PCT for commissioning health services for any individual is the one associated with the general practitioner (GP) with whom the patient is registered. This is the case even when people are placed in a residential home in another authority area by their ‘placing’ social services department. Paragraph 69 states:

Where a person is permanently resident in a care home and the placement is not fully funded by a PCT, the PCT responsible for providing health care, including nursing care, is determined in the usual way based on the GP or the GP partnership with whom the patient is registered. If the patient is not registered with a GP, the responsible PCT is determined by the person’s usual residence.

This is the case as soon as the person moves; there is no delay in the transfer of responsibility.

The guidance is different for people requiring continuing health care. It states (paragraph 67),

The Department of Health intends to introduce new legislation concerning the transfer by PCTs of patients who require continuing NHS healthcare to care homes in the area of another PCT. When in force, these changes will mean that in future the ‘placing’ PCT will remain responsible for providing the care home placement and most secondary care services for such persons, even if the person changes their GP (and associated PCT).

A draft of the new regulations has been issued (Department of Health 2005).

Where people move to health-funded out-of-area placements, their access to social services in the ‘receiving’ authority is unclear. Guidance in the ‘ordinary residence’ circular (paragraph 11) was that specific agreements should be reached so that social services were clear about their responsibilities:

Health authorities might negotiate with local authorities to provide finance in respect of people moving from long-stay hospitals . . . Funding may be provided to a particular local authority for a number of individuals regardless of their original ‘ordinary residence’. In entering into such agreements local authorities must be clear about the responsibilities they entail. Such agreements should always be recorded in writing to avoid disputes . . .

These two pieces of government guidance are the most important in relation to placement in residential homes out-of-area. Another source of guidance that interacts in important ways with the principle of ‘ordinary residence’ and of responsible statutory agencies, is that relating to housing legislation and policy. Under the Housing Act 1996 (Great Britain 1996), section 193, a local housing authority must provide accommodation for 2 years to those with a local connection, who are in ‘priority need’,

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and who are not homeless intentionally. Importantly, once a person has signed a social housing tenancy in another local authority area from where they originated, they sever their claim to a ‘local connection’ in their ‘home’ area or anywhere else, and so have no rights to social housing there any longer – even if all their family and social networks remain in the area that they came from.

The effect of this is compounded by paragraph 7 of the ordinary residence circular, that if people, once placed in a residential home in another local authority area, then decide to move on from that home of their own accord, either into another residential home or into more independent living, they would be likely to be deemed to have decided to locate themselves as a permanent resident in that geographical area and would thus become ‘ordinarily resident’ there, should they ever require social services support in the future.

These two statements of law and policy have implications for people moving from residential care into their own accommodation with support, under the ‘Supporting People’ scheme (Department of the EnvironmentTransport and the Regions 1998). Since the introduction of the scheme, a large number of formerly registered care homes (2700 by October 2003) have been converted to accommodation with support funded by ‘Supporting People’ grants (National Care Standards Commission 2004). The significance of this is that Supporting People services cannot be provided under section 21 of the National Assistance Act 1948, because taking up a Supporting People service involves signing a tenancy. In accordance with housing law and ordinary residence protocols, in doing so, service users who were originally placed in the homes from out-of-area placements when they were still registered care facilities, thus sever their connections and rights in their ‘home’ authority area. Should they require section 21 assistance again, they would be deemed to be ‘ordinarily resident’ in the area in which they have signed the tenancy.

These three sources of official guidance – the ordinary residence circular, the responsible commissioner guidance and the 1996 Housing Act – all have to be taken into account in defining responsibility for the health and social care of people who move out of their area. The different possibilities are summarized in Table 1.

The changes proposed to guidance on the responsible commissioner (Department of Health 2005) would modify this picture slightly. For out-of-area placements made by PCTs or jointly by PCTs and social services, the placing authority should confirm with the receiving PCT whether the people have any healthcare needs as part of their care package. If they have, the placing authority will continue to pay. If not, the receiving PCT will meet the cost of any health care arising after placement.
Service context

Official guidance on the responsibilities of health and social care agencies for people moving to residential care in another area was prompted by two major developments in the organization and delivery of services since 1980. The first of these was the process of replacing long-stay institutions for people with learning disabilities with services providing staff support in housing in the community (Mansell & Ericsson 1996). The second was the creation of a ‘mixed economy of welfare’, by which many social care services came to be provided by private and not-for-profit organizations rather than by the Government (Department of Health 1989; Wistow et al. 1994).

As the long-stay ‘mental handicap’ hospitals began to close from the late 1980s, a large number of people with learning disabilities were relocated in smaller institutions or residential homes. The number of people with learning disabilities in National Health Service (NHS) long-stay hospitals in England has declined from about 46,000 in 1980 (Department of Health and Social Security 1987) to about 750 in 2003 (Ladyman 2003). Having, in many cases, lost their links with wherever they came from or were born – many had spent all their adult lives in the hospitals – relocation largely took place on the basis of where accommodation was available. People setting up new residential facilities often used less expensive property in the rural and coastal areas of the country, rather than in urban areas. Health and social services, faced with the need to get the maximum amount of service from their budgets, have sometimes been able to purchase more places if they move people out of their area. The effect of this has been that many people in residential care are placed in areas a long way away from their original home, and often a long way away from the institution in which they lived.

In the context of out-of-area placements, this is a significant group, because this influx of vulnerable people, many with complex health needs, concentrated into the areas often already deprived in the UK, is thought to have had a large impact on the time and resources of local health and social care services (Forsyth & Winterbottom 2002).

It is not only ‘dowry-funded’ residents of the long-stay hospitals who move out of their area. There are marked variations between geographical areas in the availability of accommodation and care. Emerson & Hatton (1998) analysed 1991 Census data for England and found that the number of residential care places for people with learning disabilities in each of the 14 health regions varied between 77% and 145% of the national average. The types of provision also varied dramatically: non-government care homes accounted for 16% of provision in the northern and north-western regions but 60% in the south-east Thames region. More recently, the National Care Standards Commission (2004) reported that in 2003, the number of places in registered care homes for younger adults (i.e. all service user groups) in each of nine regions varied between 77% and 131% of the national average. This variation means that it is likely that many people with learning disabilities entering adult residential care for the first time continue to be placed in homes in other local authority areas.

Implications for service users, service providers and commissioners

Given the rules set out in official guidance and the context in which services for people with learning disabilities have been developing, it is possible to identify a series of implications for everyone involved in out-of-area placements.

Incentives

First, there are some obvious financial incentives embedded in these arrangements. For social services, if a person they support can be argued successfully to need secondary health care, then the cost of that will be born by the health service rather than the local authority. Thus, for example, if people’s challenging behaviour or mental health deteriorates and they need a much more carefully structured environment in which psychological, psychiatric or other health inputs play a guiding role, social services may be able to argue that the person needs to be in a healthcare placement. This applies whether or not the people is placed out of their area. The impact on out-of-area placement is that because such placements are scarce, there is much more likelihood of them being outside the local authority area. A shift to health-funded placements is likely to mean a shift to out-of-area placements.
The second cost incentive for local authorities is that if people are placed out-of-area, either in accommodation with support funded by the Supporting People arrangements or in a residential home, but then subsequently in such accommodation, the ‘placing’ local authority ceases to fund them, and their social care becomes the responsibility of the ‘receiving’ authority. Similarly, if a PCT funds this kind of development, the cost of health care will fall on the ‘receiving’ authority.

Then, there is also a financial incentive to place people out-of-area if the price of care is lower, because more people can be served with the same resources. The price of care for out-of-area placement will not necessarily be lower than for comparable local placements and may in fact be much higher – for example, placements for people with learning disabilities and challenging behaviour are often more expensive than other placements (Mansell et al. 2001) – but insofar as price reflects housing cost, then urban authorities can probably save money by placing people in rural or coastal areas.

In addition to these financial incentives, there are some practical incentives to place people out-of-area. The most important of these is likely to be the shortage of time when decisions are being made to place people. As the programme of closing long-stay hospitals got under way, the time allocated for the closure programme tended to be reduced in order to minimize the transitional (‘double-running’) cost. Thus, for example, one of the earliest hospitals to close (Darenth Park) took nearly 10 years (Korman & Glennerster 1990); one of the last (Royal Earlswood) took 3 years (P. Kinsey, personal communication). Faced with demands to resettle a large number of residents quickly, a shortage of services, and given the lack of effective local ties for many people who have lived in institutions, it is not surprising that people have been placed in homes away from where they or their family lived.

Similarly, under conditions of shortage of places, when people living in their own home or in a residential home in their home area have a crisis, the probability of them being placed out of their area will be increased. Probably the most common example of this is out-of-area placement due to the breakdown of existing arrangements because of challenging behaviour or mental health needs. Mansell et al. (1994), for example, describe a case study of an organization facing repeated placement breakdowns due to challenging behaviour, leading to out-of-area placement, because local services were not sufficiently well-organized to meet the needs of people with long-term problems.

In addition to these incentives, commissioners may also seek to place people out of their area because they perceive this to be in their best interests. For example, this might be because of the shortage of placements locally that can provide the kind of support the person needs; because people need or want to move to be near their family members; or because it is decided that they need or want to move away from abusive or exploitative relationships.

Effects

The potential effects of out-of-area placement on the people served could be mixed. On the one hand, they may get the benefit of a service they have chosen, that better meets their needs and wishes. If they have moved from another setting, they may be able to stay with people they have known for many years. On the other hand, the possible disadvantages may include the difficulty of maintaining contact with their family and friends, due to the expense and time involved in visiting. It may also be difficult for people placed out of their area to access other social services. For example, people placed in residential care may not have access to local day care or supported employment facilities. Thus, their opportunities for meeting other people with learning disabilities in the area where they now live may be reduced. They may not have a voice on the local Learning Disability Partnership Board.

Although they should have access to local health services they need, in practice this may be lessened if concentrations of out-of-area placements in particular areas overwhelm the capacity of local health services to cope (Mitra & Alexander 2003).

There might also be problems for the providers and commissioners of services. For the placing authority, it will be more expensive and more difficult to provide effective care management. For example, it will be more difficult to attend reviews or person-centred planning meetings and more difficult to contribute to improving the person’s quality of life because of a lack of knowledge of local opportunities.

For the receiving authority, it may be more difficult to plan and fund services, especially where the num-
number of incoming placements imposes more than marginal requirements. Even if the expectation in existing guidance of proper notification and coordination between placing and receiving authorities is met, the essential unpredictability of this kind of migration is likely to pose problems. This is especially important for the health service, where resource allocation does not yet take account of these migratory flows (Russell & Stanley 1996; Forsyth & Winterbottom 2002).

Conclusion

It is clear from the discussion above that out-of-area placements are potentially a problematic area. The official guidance is incomplete and inconsistent. It sets up a series of incentives that could have adverse effects on service users, on their families and on the providers and commissioners of services. However, despite this, there is relatively little information available about out-of-area placements. There are no national statistics on the number of people placed out-of-area. Individual service user information is not collated by the Commission for Social Care Inspection in relation to healthcare placements. The financial and case management information that must exist lies within the records of local authority social services and PCTs.

There is also no information about the effects of out-of-area placements. The possible advantages and disadvantages outlined above remain hypothetical in the absence of fieldwork to explore the lives of people placed out of their area. These issues are explored in the companion paper (Beadle-Brown et al. 2006).

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