Herefordshire Council

Agenda

Health, Care and Wellbeing Scrutiny Committee

Date: **Monday 19 May 2025**

Time: **2.00 pm**

Place: **Conference Room 1 - Herefordshire Council, Plough Lane Offices, Hereford, HR4 0LE**

Notes: Please note the time, date and venue of the meeting.

For any further information please contact:

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Agenda for the Meeting of the Health, Care and Wellbeing Scrutiny Committee

Membership

Chairperson	**Councillor Pauline Crockett**
Vice-Chairperson	**Councillor Polly Andrews**
	Councillor Jenny Bartlett
	Councillor Simeon Cole
	Councillor Dave Davies
	Councillor Mark Dykes
	Councillor Richard Thomas

Agenda

Pages

1. APOLOGIES FOR ABSENCE

To receive apologies for absence.

2. NAMED SUBSTITUTES

To receive details of any councillor nominated to attend the meeting in place of a member of the committee.

3. DECLARATIONS OF INTEREST

To receive declarations of interest in respect of items on the agenda.

4. MINUTES 11 - 22

To receive the minutes of the meeting held on Monday 31 March 2025.

HOW TO SUBMIT QUESTIONS

The deadline for the submission of questions for this meeting is 5.00 pm on Tuesday 13 May 2025.

Questions must be submitted to councillorservices@herefordshire.gov.uk. Questions sent to any other address may not be accepted.

Accepted questions and the responses will be published as a supplement to the agenda papers prior to the meeting. Further information and guidance is available at www.herefordshire.gov.uk/getinvolved

5. QUESTIONS FROM MEMBERS OF THE PUBLIC

To receive any written questions from members of the public.

6. QUESTIONS FROM MEMBERS OF THE COUNCIL

To receive any written questions from members of the council.

7. ADULT MENTAL HEALTH INPATIENT AND REHABILITATION SERVICES REDESIGN 23 - 90

To provide an update on Herefordshire and Worcestershire Health and Care NHS Trust's Adult Mental Health Inpatient and Rehabilitation Services Redesign.

8. ALL-AGE CARERS' STRATEGY ACTION PLAN - RECOMMENDATIONS OF THE WORKING GROUP To Follow

To discuss and agree any proposed recommendations from the committee's working group on the All-age carers' strategy action plan.

9. WORK PROGRAMME 2024/5 91 - 108

To consider the work programme for Herefordshire Council's Health, Care and Wellbeing Scrutiny Committee for the municipal year 2024/25.

10. DATE OF THE NEXT MEETING

Date of the next scheduled meeting: Monday 28 July 2025, 2.00 pm

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You have a right to:

- Attend all council, cabinet, committee and sub-committee meetings unless the business to be transacted would disclose 'confidential' or 'exempt' information.
- Inspect agenda and public reports at least five clear days before the date of the meeting. Agenda and reports (relating to items to be considered in public) are available at www.herefordshire.gov.uk/meetings
- Inspect minutes of the council and all committees and sub-committees and written statements of decisions taken by the cabinet or individual cabinet members for up to six years following a meeting.
- Inspect background papers used in the preparation of public reports for a period of up to four years from the date of the meeting (a list of the background papers to a report is given at the end of each report). A background paper is a document on which the officer has relied in writing the report and which otherwise is not available to the public.
- Access to a public register stating the names, addresses and wards of all councillors with details of the membership of cabinet and of all committees and sub-committees. Information about councillors is available at www.herefordshire.gov.uk/councillors
- Have access to a list specifying those powers on which the council have delegated decision making to their officers identifying the officers concerned by title. The council's constitution is available at www.herefordshire.gov.uk/constitution
- Access to this summary of your rights as members of the public to attend meetings of the council, cabinet, committees and sub-committees and to inspect documents.

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Bus maps are available here: www.herefordshire.gov.uk/downloads/download/78/bus_maps

Herefordshire Council

The seven principles of public life

(Nolan Principles)

1. Selflessness

Holders of public office should act solely in terms of the public interest.

2. Integrity

Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.

3. Objectivity

Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.

4. Accountability

Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.

5. Openness

Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.

6. Honesty

Holders of public office should be truthful.

7. Leadership

Holders of public office should exhibit these principles in their own behaviour and treat others with respect. They should actively promote and robustly support the principles and challenge poor behaviour wherever it occurs.

Guide to Health, Care and Wellbeing Scrutiny Committee

Committee membership

Scrutiny is a statutory role fulfilled by councillors who are not members of the cabinet.

The role of the scrutiny committees is to help develop policy, to carry out reviews of council and other local services, and to hold decision makers to account for their actions and decisions.

Council has decided that there will be five scrutiny committees. The committees reflect the balance of political groups on the council.

The Health, Care and Wellbeing Scrutiny Committee consists of 7 councillors.

Councillor	Party
Polly Andrews (Vice-Chairperson)	Liberal Democrats
Jenny Bartlett	The Green Party
Pauline Crockett (Chairperson)	Independents for Herefordshire
Simeon Cole	Conservative Party
Dave Davies	Conservative Party
Mark Dykes	Liberal Democrats
Richard Thomas	Conservative Party

Scrutiny functions

The committees have the power:

(a) to review, influence policy or scrutinise decisions made, or other action taken, in connection with the discharge of any functions which are the responsibility of the executive,

(b) to make reports or recommendations to the authority or the executive with respect to the discharge of any functions which are the responsibility of the executive,

(c) to review or scrutinise decisions made, or other action taken, in connection with the discharge of any functions which are not the responsibility of the executive,

(d) to make reports or recommendations to council or the cabinet with respect to the discharge of any functions which are not the responsibility of the executive,

(e) to make reports or recommendations to council or the cabinet on matters which affect the authority's area or the inhabitants of that area,

(f) to review or scrutinise decisions made, or other action taken, in connection with the discharge by the responsible authorities of their crime and disorder functions and to make reports or recommendations to the council with respect to the discharge of those functions. In this regard crime and disorder functions means:

  (i) a strategy for the reduction of crime and disorder in the area (including anti-social and other behaviour adversely affecting the local environment); and

  (ii) a strategy for combatting the misuse of drugs, alcohol and other substances in the area; and

  (iii) a strategy for the reduction of re-offending in the area

(g) to review and scrutinise any matter relating to the planning, provision and operation of the health service in its area and make reports and recommendations to a responsible person on any matter it has reviewed or scrutinised or to be consulted by a relevant NHS body or health service provider in accordance with the Regulations (2013/218) as amended. In this regard *health service* includes services designed to secure improvement

(i) in the physical and mental health of the people of England, and

(ii) in the prevention, diagnosis and treatment of physical and mental illness, and

(iii) any services provided in pursuance of arrangements under section 75 in relation to the exercise of health-related functions of a local authority.

(h) to review and scrutinise the exercise by risk management authorities of flood risk management functions or coastal erosion risk management functions which may affect the local authority's area.

(i) To track actions and undertake an annual effectiveness review

The remit of Health, Care and Wellbeing Scrutiny Committee

- Adult social care (including adult safeguarding)
- Health and wellbeing board
- Housing
- Adults mental and physical health and wellbeing
- Safe Herefordshire campaign
- Outbreak control plan
- New models of care accommodation
- Talk Communities
- Homelessness
- All ages whole system commissioning strategy
- Independent living services and assistive technology plan
- Adults and communities budget and policy framework
- Statutory health scrutiny powers including the review and scrutiny of any matter relating to the planning provision and operation of health services affecting the area and to make reports and recommendations on these matters

Who attends scrutiny committee meetings?

- Members of the committee, including the chairperson and vice-chairperson.
- Cabinet members, they are not members of the committee but attend principally to answer any questions the committee may have and inform the debate.
- Officers of the council to present reports and give technical advice to the committee.
- People external to the council invited to provide information to the committee.
- Other councillors can attend but can only speak at the discretion of the chairperson.

Herefordshire Council

Minutes of the meeting of the Health, Care and Wellbeing Scrutiny Committee held in Conference Room 1 - Herefordshire Council, Plough Lane Offices, Hereford, HR4 0LE on Monday 31 March 2025 at 2.00 pm

Committee members present in person and voting:	**Councillors: Polly Andrews (Vice-Chairperson), Jenny Bartlett, Simeon Cole, Pauline Crockett (Chairperson), Dave Davies, Ben Proctor and Richard Thomas**

Others in attendance:

Z Clifford	Director of Public Health	Herefordshire Council
M Cook	Chief Officer, Echo (Chair of Herefordshire Activities Together)	Echo Herefordshire
M Essoussi	Public Health Programme Officer (Strategy and Partnerships)	Herefordshire Council
Councillor C Gandy	Cabinet Member Adults, Health and Wellbeing	Herefordshire Council
H Hall	Corporate Director Community Wellbeing	Herefordshire Council
G Jaques	Registered Manager Shared Lives	Herefordshire Council
M Jhawar-Gill	Head of Service, Living Well	Herefordshire Council
D Knight	Childrens Centre Services Manager	Herefordshire Council
L MacHardy	Public Health Principal	Herefordshire Council
H Merricks-Murgatroyd	Democratic Services Officer	Herefordshire Council
K Pritchard	Public Health Lead - Mental Health	Herefordshire Council
J Stephens	Public Health Lead – CYP and Sexual Health	Herefordshire Council
D Thornton	Democratic Services Support Officer	Herefordshire Council
N Turvey	Head of Service Early Help	Herefordshire Council
D Webb	Statutory Scrutiny Officer	Herefordshire Council

42. APOLOGIES FOR ABSENCE

Apologies were received from Cllr Mark Dykes.

43. NAMED SUBSTITUTES

Cllr Ben Proctor was present as the named substitute for Cllr Mark Dykes.

44. DECLARATIONS OF INTEREST

Cllr Jenny Bartlett noted that she is a volunteer of ECHO.

No other declarations of interest were made.

45. MINUTES

The minutes of the previous meeting were received.

Resolved: That the minutes of the meeting held on 17 February 2025 be confirmed as a correct record.

46. QUESTIONS FROM MEMBERS OF THE PUBLIC

No questions had been received from members of the public.

47. QUESTIONS FROM MEMBERS OF THE COUNCIL

No questions had been received from councillors.

48. HEALTH AND WELLBEING STRATEGY

The committee considered a report on the Health and Wellbeing Strategy.

The principal points of the discussion are summarised below:

1. The Public Health Principal noted that this was the first time that the Health and Wellbeing Strategy had been brought to scrutiny and provided a background on the strategy.

    a. In 2022, the council undertook an extensive consultation process with a range of groups, organisations and the public in an online survey. 960 responses were received to the online survey, including 17 from organisations. Representation was received from across the county and in terms of areas of deprivation.

    b. Together with the Joint Strategic Needs Assessment (JSNA) and the Children and Young People's quality of life survey, all of the information was put together to create the HWB Strategy.

    c. There were two key priorities that were voted for across all the consultation and engagement: 1. Best Start in Life and; 2. Good Mental Health.

    d. The objectives of the strategy are underpinned by four ambitions:

        i. Living in thriving communities
        ii. Living in environments that are healthy and sustainable
        iii. Opportunities for all to fulfil their potential
        iv. People will be empowered to take control of their health

    e. There is a focus on prevention, working with and understanding our communities, reducing health inequalities, working as a whole system, and using evidence and outcomes to review progress and shape new programmes of work.

    f. The HWB Strategy is not only a council strategy but rather is a partnership strategy and the emphasis is on taking a partnership approach.

    g. The strategy was informed by a range of inputs including the 2021 JSNA, and the e Public Health Outcomes Framework (PHOF) which all local authorities sign up to reporting and recording data on. The PHOF is important, particularly in terms of the long-term approach for this strategy

and provides robust data which is Herefordshire-specific. There is a time lag, however, and it can be difficult to demonstrate impact in real-time. These time lags make reporting impact more difficult to attribute to actions taken in the short-term.

h. Work has been ongoing with the groups to begin developing a dashboard including long-term outcome indicators and some proxy indicators, drawn from across partner organisations. For example, on smoking cessation, as of December 2024, local data indicates that the proportion of mothers who were smokers at the birth of their baby has fallen to 6.2% compared to around 8.8% on the PHOF.

i. As part of the strategy, the Herefordshire Together programme was developed across the two priority areas. Local communities and groups were awarded funding to take pieces of work forward. The full evaluation report will be due next month.

j. One of the most successful achievements with the strategy are the two implementation plans for each of the core priority areas. In each of the two implementation plans, it was wanted to make sure that children enjoy good mental health, are protected from harm in their community, achieve their early milestones, and parents are well-supported during pregnancy and post-birth and access appropriate information, resources, and services.

k. When looking at the implementation plans for both priorities, a lot of progress has been made and this helps provide an opportunity to review and rethink the implementation plans in relation to potential new areas of concern, areas of limited progress, for example.

l. The Health and Wellbeing Board and One Herefordshire Partnership (1HP) are being reported to twice a year for each of the implementation plans. Therefore, there is a robust governance in terms of how actions are set out and the direction going forward.

m. In relation to the partnership groups, there is a Best Start in Life Early Years partnership group which operates across children's, NHS, education, and other partners. Similarly, the Good Mental Health group mostly focuses on adults but also has a standing item on children and young people's emotional health and mental wellbeing.

n. In terms of the Good Mental Health priority, there are four overarching goals:

    i. People feel satisfied with life and have a positive sense of personal wellbeing.
    ii. Individuals and families are able access appropriate mental health information and services when they need it.
    iii. People feel safe from harm in their community.
    iv. People feel connected to their community.

o. The mental health priority is more difficult to measure and to develop programmes that are led by a single agency. A lot of the work is community based, what is going on in schools, and training.

p. Through the implementation plan, there are a number of areas where significant progress has been made including the Prevention Concordat for Better Mental Health, and the Suicide Audit Group, for example.

q. Looking ahead, it is intended to demonstrate more quickly the progress that it is being made so that this can be reported back to the Health and Wellbeing more quickly. It is intended that 1HP are worked with slightly differently so that a better dialogue can be ensured so that primary care colleagues are on board and that there are no issues coming through from general practice.

r. It is intended that the implementation plans be revised so that a record of achievements are kept succinctly without bloating the document further.

The slides presented by the Children's Centre Services Manager are outlined below (in italics), with the principal points noted below.

A The Children's Centre Services Manager presented:

Early Help Offer – overview including Best Start in Life Offer

a.1 It was clarified what services are provided to reach out to different people in relation to the council's Early Help offer.

Talk Community Offer

a.2 It was clarified what list of initiatives that Talk Community are doing with children and families in the community.

The Future – Strengthening Early Support for Families

a.3 Moving forward, Talk Community are having a bigger input into the children and families' agenda including the recruitment of Children and Families Community Development Officers.

Children's Centre Services Targeted Offer

a.4 Every time that work is done with a family one-to-one, who have level 3 needs and who need a multi-agency approach, within that piece of support there will always be a consideration of their health and wellbeing.

a.5 Therefore, as well as the targeted support that is offered, there are opportunities for children to learn and develop and help their parents to give them the best start.

Children's Centre Services – First Steps offer

a.6 First Steps is a flag-ship service that is offered to new parents under the age of 21 who have identified vulnerabilities. This service provides extra support to help them get onto the journey of parenting.

a.7 This is done in partnership with health visitors, midwifery colleagues, and a national learning provider.

a.8 It was noted that in some cases, new parents gain their confidence and do not complete the whole journey provided by the First Steps service.

Feedback from families

B The Head of Service Early Help presented:

Families First Partnership programme

b.1 As part of the new Families First Partnership programme are two parts, Family Help and Multi-Agency Child Protection Teams.

Family Help – providing supportive and welcoming services to families

b.2 Family Help will merge the strengths of targeted early help and section 17 (Children in Need) work. This has already begun with some early help family support workers (FSW) moving into social care teams to be doing that work with children and families in most need.

b.3 It was noted that as part of the restructuring, some of the teams are now located in Leominster, Ross, and in Plough Lane.

b.4 The name of the child protection/court teams has changed to safeguarding and support which is more restorative for families.

b.5 The programme also talks about the establishment of a Family Help Lead Practitioner role which has already been in place in Early Help where the family decides who is going to be the lead person when they have an assessment and who will be the lead person holding all the other agencies together in supporting them.

Family Help – Where are we in Herefordshire?

b.6 As part of the work with the whole family, there are 8 weekly review meetings with lead professionals as well as officers from the council.

b.7 The council also commissions a targeted service, delivered by Vennture, so that families have a choice if they do not want to be supported by the council at the early help stage.

Next Steps – Family Help

b.8 It was clarified what the council will be doing going forward in providing family support.

The principal points of the subsequent discussion included:

i. The Cabinet Member Adults Health and Wellbeing commented that the Health and Wellbeing Strategy is a significant piece of work with a lot of objectives as to the improvement of lives of children and adults. In general, a lot of this work falls on public health and few members of the public and councillors recognised the extent of the work that goes on in the background by public health. It was added that it is probably easier to deal with the Best Start in Life because there is some control over that in the local authority, in comparison to mental health.

ii. The Chair welcomed the new Director of Public Health, who noted that she previously worked regionally in public health and in public health at Gloucestershire County Council. The Director of Public Health added that priorities of the HWB Strategy will be key areas of focus for public health for the population of Herefordshire.

iii. In response to a question about how effectively the strategy translates into actions and measurable results, the Public Health Lead – CYP and Sexual Health noted that in relation to oral health, there is a problem with 0–5-year-olds with the number of cavities. There are over 45 schools in Herefordshire that have signed up to supervised toothbrushing, many of which are in deprived areas. A lot of work has been done around supervised toothbrushing which has seen positive results in prevention. It was added that the prediction for those children currently will be better learned when the results from the oral health survey are received by the end of the Summer/early Autumn. In relation to the recruitment of dentists into Herefordshire, the establishment of two new dental practices in the county is in place.

iv. The Cabinet Member Adults Health and Wellbeing noted that the work being done in the schools is positive. However, where there is a problem is in relation to access to dental services in which people in rural areas do not have adequate transport links to dental practices.

v. In relation to a question about the use of Fingertips as a data collection service, the Director of Public Health noted that Fingertips is a national tool that enables the council to compare with similar local authorities as well as the rest of the region and nationally. Therefore, it is a robust data set. However, it was added that there is a time lag with the data available through Fingertips so the availability of local data was emphasised.

vi. In response to a question about council provision of housing and financial help as part of Family Help, the Head of Service Early Help noted that the Children's Help and Advice Team (CHAT) have the telephone helpline and would sign post families to help that is available including Housing Solutions and Talk Community. If families have very specific needs, there could be the offer of an assessment of all their needs and targeted support with potentially a family support worker helping them on a family one-to-one basis.

vii. Responding to a question on Best Start in Life and Good Mental Health going to be the priorities for ten years and if they are going to change, how does that happen, the Public Health Principal commented that the strategy is set for ten years and the implementation plans are live documents. Therefore, the whole strategy is under constant review. The initial data was developed from consultation and engagement that was previously collected before developing a new commissioned service for the health visiting school nursing work. New information is always being collected and is being fed in to the strategy. It would be for the Health and Wellbeing Board to make a decision on the strategy's priorities and whether they should change.

viii. In response to a question about who is triangulating back the success/failure of the individual sets of four aims of the two priorities back to the overall objectives as set out at the beginning of the strategy, the Public Health Principal noted that there is existing data that can be used to rate the success/failure of the aims as set out in relation to the two core priorities and that there are other opportunities to bring in new data including, for example, Talk Community who now sit in public health which will make it easier to triangulate data to further help assess the progress of the strategy.

ix. The Public Health Principal also emphasized the significance of integrating qualitative data with quantitative data to evaluate the strategy's progress toward its primary goals. It was noted that established trajectories help guide the strategy's direction, allowing for adjustments if necessary.

x. The Corporate Director Community Wellbeing added that while the two core priorities in the strategy are set, as part of reviewing, that focus could be switched away toward other areas.

xi. The Public Health Programme Officer – Strategy & Partnership noted that new data on vaccination for children was recently received which is encouraging and underlines the work that partners are doing. For example, amongst children up to 24 months of age, the rate of vaccination was 94.7% for Quarter 3 of 2024/25.

xii. The Cabinet Member Adults Health and Wellbeing commented that in between public Health and Wellbeing Board meetings, workshops would be held to concentrate on specific issues such as obesity, for example.

xiii. In relation to a question about access to green space, the Cabinet Member Adults Health and Wellbeing clarified that the Community Open Space grant exists for building/improving buildings to allow health and wellbeing activity to participate that otherwise would not happen.

xiv. In response to a question about provision under the First Steps programme, the Children's Centre Services Manager commented that whilst targeted support cannot be provided universally, if a family had other vulnerabilities such as being out of work, for example, then they would qualify for that support.

xv. Responding to a question about the impact of social media on children, the Public Health Lead Mental Health noted that social media is referenced frequently through engagement with schools and school staff. It is a focus for the healthy schools programme to build resilience and to do the preventative work around safe usage and who to go to if issues arise.

xvi. In relation to mental health support for older people, the Public Health Lead Mental Health added that throughout the Mental Health Needs Assessment, it was noted that there is a lack of data around the mental health of older people. A lot of the work that Talk Community does helps to address isolation and loneliness in rural communities.

xvii. The Public Health Lead - CYP and Sexual Health highlighted that public health have commissioned a 0-19 public health nursing service. This involves school nurses operating drop-in sessions with every high school in the county once a week.

xviii. In response to a question about what mechanisms are in place to update the committee on progress against the implementation milestones, the Public Health Principal thanked the committee for the opportunity to inform scrutiny and receive questions and concerns from members. She noted that she would be happy to bring back the implementation plans for the two core priority areas and suggested in the following year when more information is available and the dashboards are developed further.

The draft recommendation was then read out by the Statutory Scrutiny Officer, and the following resolution was agreed by the committee.

Resolved:

That Herefordshire Council:

1. **Demonstrates in its delivery plans how the work public health undertakes relates to the strategic vision and four ambitions of the Health and Wellbeing Strategy.**

49. COMMUNITY ACTIVITY - DAY PROVISION

The committee considered a report on Community Activity – Day Provision.

The slides presented by the Head of Service Living Well are outlined below (in italics), with the principal points noted below.

A The Head of Service Living Well introduced the presentation on Community Activity – Day Provision.

B The Head of Service Living Well presented:

Overview

b.1 It was clarified that some of the services provided allow unpaid carers to receive respite and rest from their main caring duties.

How Do We Commission?

b.2 It was noted that there is a team of direct payments officers that monitor payments and procurement cards on a regular basis directly with the individuals that are cared for.

Community Activities

b.3 Community activities are an important element of the council's preventative services that help to promote the independence of participants and support individuals to gain a number of different skills.

b.4 For some, community activities can be an early introduction into mainstream services that are assessed. It supports the unpaid carer to get the rest that they need.

b.5 It was added that there is an upcoming review of the council's community activities. In the previous year, there was a review of community activities working in partnership with Herefordshire Activities Together. The second phase of that piece of work will focus on a wider review of the service provision to look at some of the council's building-based services and will consider the utilisation of technologies to help promote the independence of individuals.

Community Activity Review

b.6 The review is currently in its early stages of planning for that piece of work and is intended to be a co-production between the council and individuals who currently access the community activities provision.

C The Registered Manager Shared Lives presented:

Herefordshire Shared Lives

c.1 In addition to the provision of long-term arrangements, and short breaks, a model has just been launched around 'Shared Days' which offers an opportunity to find other ways to offer family carers a break during the day.

c.2 Once people have been assessed and approved, there is a nominated coordinator who monitors the work that they are doing and supports them to make sure that CQC requirements are met and that the individuals and carers are happy and the arrangements are working.

Living Well, Supporting Well

Shared Days Scenarios

D The Head of Service Living Well presented:

Respite

d.1 Respite encapsulates a range of different services including bed-based respite, as well as the ability for individuals to have shared lives or take a direct payment to receive respite.

d.2 Work is ongoing with the Carers' Partnership Board to collect data as part of the carers' action plan to help understand who else is out there who may need a service.

Respite Provisions

d.3 There are a number of respite services that are delivered in the county that are both bed-based and non-bed-based by different providers.

d.4 It was noted that a capital programme exists to support developments in some of the council's buildings and data will be utilised to help understand what provision is required.

What can we learn from other areas?

d.5 It was added that there are a number of areas where best practice can be learned from.

The Chief Officer Echo introduced himself to the committee.

The slides presented by the Chief Officer Echo are outlined below (in italics), with the principal points noted below.

E The Chief Officer Echo introduced the presentation on Community Activities in Herefordshire.

Who are Herefordshire Activities Together?

e.1 It was noted that Herefordshire Activities Together (HAT) is a network of 16 VCSE providers who work together to develop specialist support and accessible community activities for people of all abilities, for public benefit.

Community Activities

e.2 It was added that support does not often end with the activity that they are doing but it can encompass all aspects of someone's life.

e.3 Community engagement helps to promote the work that is ongoing to support individuals participating in community activities.

Community Activities benefits

e.4 The services provided help to produce a reduction in the need for acute services through prevention rather than through expensive crisis management.

Arts Activities

Outdoor Activities

Work Skills

e.5 Community Activities also help individuals into the workplace and sector specific skills are taught such as woodwork and carpentry, in addition to core work skills such as time-keeping and responsibility.

Specialist areas

Continuing Improvement

e.6 HAT is currently planning its co-production work with other stakeholders which aims to focus on the social care system and the pressure points within it.

The Chairperson thanked the Chief Officer Echo for his presentation. The principal points of the subsequent discussion included:

i. The Cabinet Member Adults Health and Wellbeing thanked the voluntary sector for the work that they do with people with learning disabilities and encouraged committee members to visit some of the providers to see the work that is ongoing in the sector.

ii. In response to a question about how much the geographic make-up and the lack of transport links across the county make service provision more complicated, the Chief Officer Echo noted that transport provision is challenging and it is difficult to ensure that everyone has access to the services that they need to access community activities.

iii. The Head of Service Living Well added that there is community activities review that HAT members and non-HAT members will be involved in. As part of the review, work will be done to hear from people who are not currently utilising services but are incoming and how services can be shaped in the future to meet that increase in need.

iv. The Chief Officer Echo added that support to unpaid carers enables savings to acute services in addition to keeping the cared for independent.

v. The Head of Service Living Well noted that there is an under-utilisation and that there are regular contractual meetings with providers who deliver council services to address this under-utilisation. One way to address this is a new process around all of the council's respite going through the brokerage team who will do the physical purchasing once need is identified.

The draft recommendation was then read out by the Statutory Scrutiny Officer, and the following resolution was agreed by the committee.

Resolved:

That Herefordshire Council:

1. That Herefordshire Council organises a briefing for councillors on the community activity services available in Herefordshire.

50. UPDATE ON RECOMMENDATIONS MADE BY THE HEALTH, CARE AND WELLBEING SCRUTINY COMMITTEE

The Statutory Scrutiny Officer recommended that the item be deferred to a future meeting. The committee unanimously agreed to the proposal.

51. WORK PROGRAMME 2024/5

The Statutory Scrutiny Officer noted the draft work programme for the Health, Care, and Wellbeing Scrutiny Committee for the municipal year 2024/25. The Statutory Scrutiny Officer also noted that the committee will also be carrying out a review of its work programme prior to its next committee meeting.

Resolved that:

The committee agree the work programme for Health, Care, and Wellbeing Scrutiny Committee contained in the work programme report attached as appendix 1.

52. DATE OF THE NEXT MEETING

The next scheduled meeting in public was confirmed as Monday 19 May 2025, 2.00 pm.

The meeting ended at 5.00 pm **Chairperson**

Herefordshire Council

Title of report: Adult Mental Health Inpatient and Rehabilitation Services Redesign

Meeting: **Health, Care and Wellbeing Scrutiny Committee**

Meeting date: **Monday 19 May 2025**

Report by: **Deputy Programme Director, Adult Mental Health Rehabilitation Redesign and Acute Inpatient improvement Programme, Herefordshire and Worcestershire Health and Care NHS Trust**

Classification

Open

Decision type

This is not an executive decision

Wards affected

All Wards

Purpose

To provide an update on Herefordshire and Worcestershire Health and Care NHS Trust's Adult Mental Health Inpatient and Rehabilitation Services Redesign.

Recommendation(s)

That the committee:

a) **note the report and**

b) **decide upon any further scrutiny that they wish to undertake regarding adult mental health provision in Herefordshire.**

Alternative options

1. As this report provides information only, it presents no alternative options for consideration.

Key considerations

2. The Herefordshire and Worcestershire Health and Care NHS Trust 's Community Mental Health Transformation programme was completed in 2024 and changed the way in which community mental health services were offered. It has developed new ways of working for adults with acute mental health needs, in partnership across several providers including the Voluntary, Community and Social Enterprise (VCSE) sector and Social Care.

3. It is a logical next step to consider the acute and rehabilitation care that people receive alongside the community mental health services, including purposeful admission, in addition to evidence-based interventions. Purposeful admission is ensuring that every person admitted to hospital has a plan about the aims of admission, length of time it is anticipated the plan will take and an agreement to discharge them as soon as care can safely be delivered out of hospital.

4. The overall purpose of the adult mental health rehabilitation redesign and acute inpatient improvement programme is to ensure that all who access services receive nationally standardised, evidence based, quality care without variation to the patient experience that is in line with the national commissioning guidance.

5. The adult mental health inpatient and rehabilitation services redesign programme is structured around two distinct areas: rehabilitation redesign and acute mental health inpatient improvement.

6. The programme is following the NHS England (NHSE) major change process. This process is followed when a service change broadly encompasses any change to the provision of NHS services which involves a shift in the way frontline health services are delivered. There is no formal definition of 'major' service change, but this usually involves a change to the range of services available and/or the geographical location from which services are delivered. The timelines have been adjusted and are now contingent upon the classification of this work as a 'major service change'

Context

7. The *'Commissioner Guidance for Adult Mental Health Rehabilitation inpatients services'* (NHS England 2024), attached as Appendix 2, specifies the types of Mental Health rehabilitation services that should be provided for local service users. The guidance is supported and underpinned by the Royal College of Psychiatrists *'Getting it Right First Time' (GIRFT)* programme for Rehabilitation Psychiatry.

8. GIRFT methodology is being used to drive change, and the Trust is fully engaged with the national and regional GIRFT systems. As a basis for this programme, the national GIRFT team undertook a review of the Trust's rehabilitation services in Worcestershire. This, combined with the commissioning guidance for rehabilitation, has given the programme indicated areas which will benefit from the GIRFT approach, which consists of:

    a) Improving the use of data to drive services, patient pathways, community rehabilitation and supported housing.

    b) Developing the NHS-led provider collaboratives and integrated rehabilitation systems.

    c) Data-driven continuous Quality Improvement (QI).

    d) Standardisation of local procurement processes and protocols.

e) Ensuring the right workforce with the right training to support improved patient care, treatment, and outcomes.

9. The overall objectives for the programme are:

a) Reduce unwarranted variation identified within inpatient and rehabilitation services.

b) Reduce patients being placed out of area, inappropriately, to 0%.

c) Achieve and maintain an average length of stay of below 35 days, excluding patients in Psychiatric Intensive Care Unit (PICU) with no patients staying longer than 60 days in an inpatient setting.

d) Ensure the Trust no longer use any high-cost agency staff on adult and rehabilitation services.

e) Reduce rolling 12-month staff turnover to below 12%.

f) Ensure person-centred care and co-production of care plans is standard practice.

g) Capture and analyse the impact of interventions to assess risks and benefits as part of evidence-based practice.

h) Develop and report robust ways for capturing interventions and outcomes for services that are heavily linked into partnership working.

i) Develop an induction and training package that enables and maintains a skilled and sustainable workforce with staff experience being measured through an improvement identified in the staff survey.

j) Review existing mental health estate to ensure it fits with the new clinical services model and can provide environments that will support improvement in health outcomes and afford protection against discrimination, reducing inequality of access, experience, and outcome.

k) Implement a “Best Use of Resources” philosophy, to deliver a sustainable and affordable service by management of current resource, ensuring efficiency and reducing unwarranted variation.

Current Provision

10. Mental Health Acute Wards provide treatment to people with severe mental disorders like schizophrenia, bi-polar disorder, severe depression or personality disorders (severe and persistent psychological problems often associated with childhood trauma). Admissions are for an average of around 30 days, with ongoing follow up treatment provided in the community. the trust’s current acute wards are at the Elgar Unit in Worcester and Stonebow Unit in Hereford – 50 beds in total. These units are supported by a 9 bed psychiatric intensive care unit (PICU), also at the Elgar Unit – serving both counties. The PICU is for acutely unwell patients who have very high support needs

11. A minority of people with severe mental disorders are so profoundly affected by them that they need a longer period of rehabilitation as an inpatient. Admission would typically be for up to a year (sometimes longer) and intensive support is given to help service users regain the life skills, confidence and mental health stability to live more independently again in the community. The Trust’s current Community Rehabilitation Units are at Oak House in Hereford, Keith Winter House in Bromsgrove and Cromwell House in Worcester (39 beds in total).

12. The programme is separated into two strands: adult acute improvement and rehabilitation redesign.

13. This aspect of the programme will have a quality improvement approach, it will strive to ensure patients who require a purposeful admission are treated locally with evidence-based treatment for the least amount of time possible for the patient and their loved ones. This work will follow the *'Commissioning to Achieve What 'Good' Looks Like'* guidance, as well as the *'Four Key Elements of an Inpatient Pathway'* guidance (both contained within NHSE's Commissioning Framework for Mental Health Inpatient Services guidance, attached as Appendix 3), ensuring patients are at the centre of their care, whilst enhancing the connectivity of all mental health services to promote patient flow.

14. A number of initiatives have been launched. However, in recent months, the focus has moved towards the elimination of inappropriate out-of-area mental health bed placements and reducing the length of stay, aligning with national planning guidance. A recovery plan has been developed, outlining clear timelines, key deliverables and designated accountable leaders to drive progress.

Adult Rehabilitation Redesign

15. The new national guidance states that two levels of Mental Health Rehabilitation should be available:

    a) Level 1 – Community Rehabilitation Units.

    b) Level 2 – Intensive Rehabilitation Support.

16. At present, all of the Trust's rehabilitation units fall somewhere between Level 1 and Level 2. This means that there are always groups of patients that require a bit more rehabilitation to successfully transfer to more independent living, but do not require treatment at one of the current units. The Trust also has other patients who need rehabilitation but have too high a level of need for one of the units to manage safely. The first group often spend an extended time in acute wards, or return to supported accommodation, but fail to thrive. The second group may be sent out of area for Level 2 Rehabilitation formerly known as 'Locked Rehabilitation' (a term we no longer use), or similarly return to their own accommodation, but are quickly readmitted to acute care. The second group can often have behavioural challenges or co-morbid substance misuse problems.

17. The aim of the programme is to design a solution that can meet Level 1 and Level 2 mental health rehabilitation needs for local people, within the existing resource envelope.

18. There will be a redesign of rehabilitation services, with an aim that patients who require a level of rehabilitation need are served within the local community, following a national standard, thus reducing out of area placements. The rehabilitation redesign will follow the NHSE's commissioning guidance, appended as Appendix 2.

19. Adult rehabilitation will have a defined purpose, ensuring appropriate purposeful admission with clear evidence-based treatment pathways that all staff across providers understand. The redesign will work alongside local authority and non-NHS providers. An enhanced community rehabilitation team will become an additional focussed pathway aligning inpatient services with community transformation.

20. The organisation will show success by evolving and transforming services and will demonstrate this by:

a) Best use of resources.

b) Ensuring purposeful admission, with treatment guided by evidence based NICE guidance.

c) Personalised care with a trauma informed approach.

d) Successful partnership working.

e) Significantly improving health outcomes and reduce inequalities.

f) Access to quality data metrics to understand the day-to-day operations of the services and foresee service problems based upon the demand and capacity and patient flow.

g) Use of digital technology.

21. The programme will follow the phases below:

Phase 1	Development of Programme Initiation Document (PID) and programme governance (Jan 2023 – May 2023)	Complete
Phase 2	Ideas formulation/hurdle process/patient & staff Engagement/ public engagement feedback formulation (May 2023 – Apr 2024)	Complete
Phase 2A	• Finalise case for change. Strategic sense check. Develop options appraisal. Finalise PCBC. Service Improvement & Rehab deep dive. (May 2024 – May 2026) • NHSE Stage 1 Meeting (May 2025) • Clinical Senate (January 2026 – May 2026) • NHSE Stage 2 Meeting (April/May 2026)	Commenced May 2024
Phase 3	Public Consultation and service improvement. (June 2026 – October 2026)	Not started
Phase 4	Implementation.	Not started

22. Progress to date has included:

a) Ideas for rehabilitation redesign were formulated with stakeholders.

b) Pre-consultations have taken place across Herefordshire and Worcestershire and were attended by a range of stakeholders.

c) A pre-consultation report has been completed, ensuring the Trust has the patient voice throughout the programme journey. In addition, the programme has two participation partners who sit within the programme, on steering group and programme board.

d) The ‘Hurdle’ Criteria Evaluation sessions have been completed (where ideas are reviewed to determine which ideas meet the broad objectives of the programme and can move to the

next ‘stage’). The results of the evaluation of the initial seven ideas showed that two ideas failed to meet the initial ‘Hurdle’ criteria. The Programme Board then approved the move to the next stage.

e) In April 2024, a stocktake of the programme and work completed to date was carried out following a change of Programme Director and new Deputy Programme Director. This stocktake led to a refreshed programme aim, timeline and plan for the next stage (Phase 2a).

f) In May 2024, Phase 2a commenced.

g) A small group of stakeholders met to develop ‘Desirable Criteria’ in June 2024. Desirable Criteria is defined as the preferred qualifications, or conditions that enhance the suitability of an idea or proposal beyond the minimum requirements.

h) The Desirable Criteria sessions were held with a wide range of stakeholders to enable the reduction of ideas; however, this was not initially successful as stakeholders felt they did not have enough information to effectively rank an idea. As part of this process, stakeholder feedback was incorporated, resulting in amendments to certain proposals however maintain the core elements.

i) A review of how a further ‘Desirable Criteria’ session should be undertaken was reconsidered by the programme team. The ideas were re-written and A patient journey was added to inform the stakeholders of the how a new pathway may look.

j) Following review of the Desirable Criteria sessions, it was agreed that a ‘Nominal Group Ranking’ technique would be deployed. This is a structured decision-making technique where participants individually rank or prioritise a set of ideas, and the collective rankings are then aggregated to determine the most preferred choices. These sessions were undertaken and were successful, with the five ideas being reduced to three.

k) The programme management team have reviewed timelines based upon NHS Major Change guidance and NHSE Planning and Producing a Pre-Consultation Business Case (PCBC) guidance.

l) Clinical Senate will be commissioned by the ICB. As a trust we are having regular contact with Clinical Senate, and we would anticipate their review in 2026.

m) There is regular engagement with NHS England (NHSE) and the programme is following Major Change process passing through NHSE stages.

23. Communicating the programme has involved the following:

a) An internal website, which is regularly updated.

b) Monthly drop-in sessions with the programme team for staff to discuss the piece of work where stakeholders have questions.

c) Attendance at Clinical Group Meetings for GPs for Herefordshire.

d) Deputy Programme Director maintaining continuous engagement with all the units involved in the programme in addition to engagement across all systems.

e) Attendance at service away days to give progress updates.

f) Posters for inpatient units.

24. **Here is a summary of the options** (a full breakdown is available at Appendix 1)

Option	Overview
Option 1	• Close Oak House Mental Health Rehabilitation Unit (Herefordshire) • Close Cromwell House Mental Health Rehabilitation Unit (Worcestershire) • Convert the vacant Hill Crest (former Acute Mental Health) into a Level 2 Rehabilitation Unit • Create a Herefordshire & Worcestershire Enhanced Community Rehabilitation Team • Seek external partnership to provide a Level 1 Mental Health Rehabilitation Unit in Herefordshire
Option 2	• Reduce bed numbers at Oak House Mental Health Rehabilitation Unit (Herefordshire) • Close Cromwell House Mental Health Rehabilitation Unit (Worcestershire) • Convert the vacant Hill Crest unit (former Acute Mental Health) into a Level 2 Rehabilitation Unit • Create a Herefordshire & Worcestershire Enhanced Community Rehabilitation Team
Option 3	• Close Oak House Mental Health Rehabilitation Unit (Herefordshire) • Close Cromwell House Mental Health Rehabilitation Unit (Worcestershire) • Convert the vacant Hill Crest unit (former Acute Mental Health) into a Level 2 Rehabilitation Unit. • Create 4 Level 2 step down beds at the vacant Holywell unit. • Create a Herefordshire & Worcestershire Enhanced Community Rehabilitation Team • Seek external partnership to provide a Level 1 MH Rehabilitation Unit in Herefordshire.

25. Level 1 rehabilitation will be delivered in two modes, an enhanced community rehabilitation team in addition to an inpatient level 1 rehabilitation unit.

26. People who require level 1 care will have ongoing complex needs; these services exist to meet the needs of people who have a mental health rehabilitation need that can only be treated within an inpatient environment. Level 1 services are part of a clear, agreed pathway that includes community mental health rehabilitation teams and wider general and specialist teams (Commissioner Guidance for Adult Mental Health Rehabilitation Inpatient Services, 2024).

27. The key difference between level 1 and level 2 mental health rehabilitation inpatient services is that a level 2 service can offer more intensive support to people to meet their needs; this may be relational and/or adapted environments and procedures (Commissioner Guidance for Adult Mental Health Rehabilitation Inpatient Services, 2024).

28. Overall, with the implementation of an Enhanced Rehabilitation Team, the Trust will require less level 1 inpatient beds across the county. Worcestershire has two units Cromwell House in Worcester and Keith Winter House in Bromsgrove. The Trust would consider the closure of Cromwell House over Keith Winter House for the following rationale:

a) Issues surrounding estates and appropriateness of accommodation.

b) Keith Winter Close has a bigger bed base (15 bed compared to 10)

c) The trust has a further service on the Keith Winter site.

29. In addition, the Trust plan to provide a level 2 inpatient rehabilitation unit in Worcestershire, and where possible patients will be repatriated closer to home.

Community impact

30. Set out any considerations relating to community impact including contribution made to corporate plan / health and wellbeing strategy or other local or national strategies or policies.

31. Set out links to integrated evidence base / needs assessment (Understanding Herefordshire) including community / user engagement / feedback and specify the evidence base supporting the decision to be taken. Set out any partnership considerations.

32. Consider whether the recommended decisions within this report will have any direct or indirect effect on the lives of children in care; care leavers to care experienced children and young people.

33. The term 'corporate parent' means the collective responsibility of the council, elected members, employees, and partner agencies, for providing the best possible care and safeguarding for children who are looked after by the council. Being a good corporate parent means we should; accept responsibility for children in the council's care; make their needs a priority; and seek for them the same outcomes any good parent would want for their own children.

34. Corporate parenting responsibilities are not confined to elected members. All officers share the responsibility to promote the needs of looked after children. Key responsibilities of all officers are: to promote the life chances of looked after children and care leavers in their area of responsibility; and to consider the impact of decision making on looked after children and care leavers.

Environmental Impact

35. Whilst this is a decision on back-office functions and will have minimal environmental impacts, consideration has been made to minimise waste and resource use in line with the council's Environmental Policy.

Equality duty

36. The Public Sector Equality Duty requires the Council to consider how it can positively contribute to the advancement of equality and good relations, and demonstrate that it is paying 'due regard' in our decision making in the design of policies and in the delivery of services.

37. The mandatory equality impact screening checklist has been completed for this project/decision/activity and it has been found to have no/low/high impact for equality.

38. Due to the potential impact of this project/decision/activity being low, a full Equality Impact Assessment is not required. However, the following equality considerations should be taken into account when making a decision about this activity/project:

a) The report will use plain English.

Resource implications

39. This report constitutes part of the typical function of this committee. There is no resource implication in its consideration.

Legal implications

40. The remit of the scrutiny committee is set out in part 3 section 4 of the constitution and the role of the scrutiny committee is set out in part 2 article 6 of the constitution.

41. The Local Government Act 2000 requires the council to deliver the scrutiny function.

Risk management

42. As this report is for information only, there are no risks identified in its consideration.

Appendices

- Appendix 1 Rehabilitation Redesign Options
- Appendix 2 NHS England 2024: *Commissioner guidance for adult mental health rehabilitation inpatient services*
- *Appendix 3* NHS England 2024: *Commissioning framework for mental health inpatient services*

Background papers

None identified.

Report reviewers used for appraising this report:

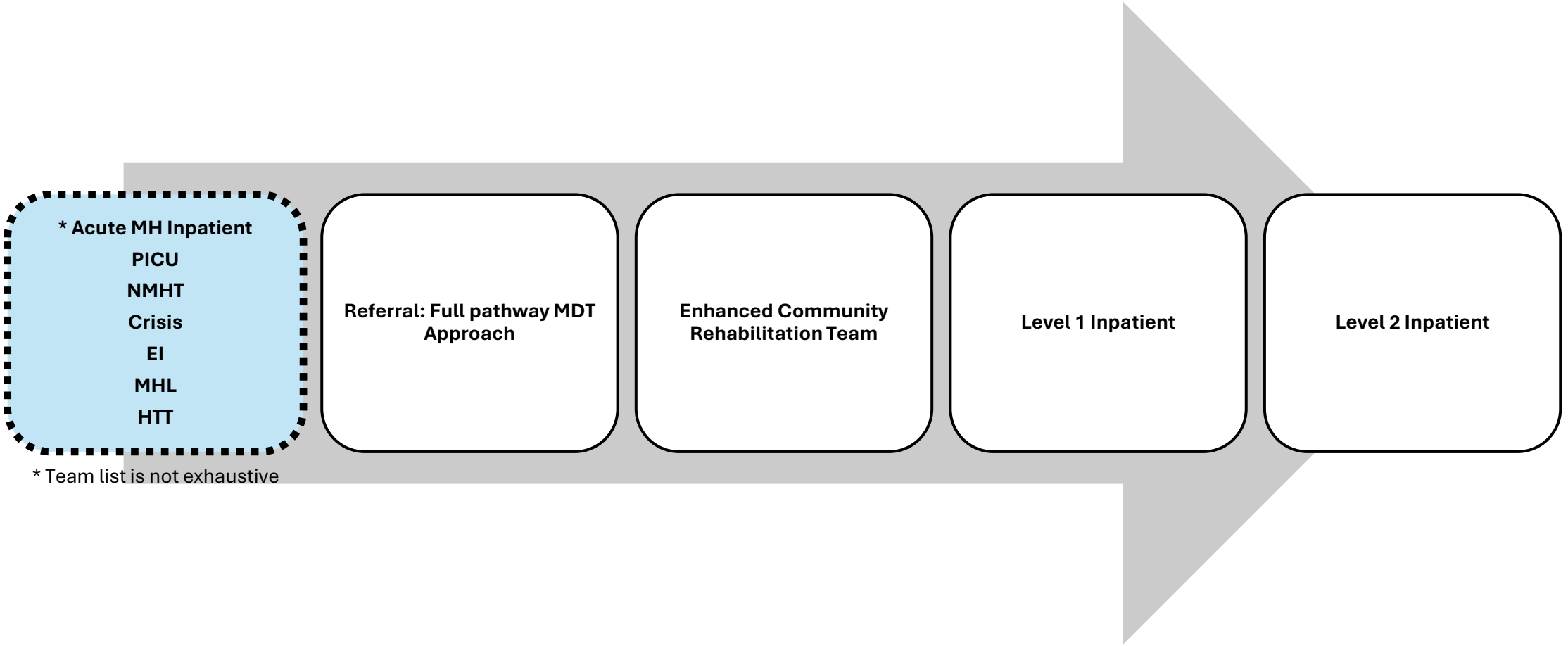
Please note this section must be completed before the report can be published		
Governance	Danial Webb	Date 09/05/2025
Finance	Click or tap here to enter text.	Date Click or tap to enter a date.
Legal	Click or tap here to enter text.	Date Click or tap to enter a date.
Communications	Click or tap here to enter text.	Date Click or tap to enter a date.
Equality Duty	Click or tap here to enter text.	Date Click or tap to enter a date.
Procurement	Click or tap here to enter text.	Date Click or tap to enter a date.
Risk	Click or tap here to enter text.	Date Click or tap to enter a date.

Approved by	John Coleman	Date 09/05/2025

Adult Mental Health Rehabilitation Redesign & Acute Inpatient Improvement Programme

Rehabilitation Redesign Options

Rehabilitation Pathway for all Options



* Team list is not exhaustive

cares

Patient Journey Example - 1

*** Subject to change as clinical model and delivery are being worked through as part of the Major Change Process**

The Rehabilitation Pathway promotes a system approach and diminishes unwarranted variation across services.

Where it is identified with the patient and care team that there is a rehabilitation need, a referral is sent to the rehabilitation pathway for consideration of **Level 1, Level 2**, enhanced community rehabilitation team or 'out of county' where a placement is required to be highly specialised and unable to manage the need in county. An MDT approach - from all areas of the rehabilitation teams - is needed to decision make with the referrer.

A pathway which meets the need of the patient best is chosen and discussed with the patient. Each pathway will have differing offers, based upon NICE guidance, commissioning guidance and patient need.

Level 2 will be provided as inpatient facility; this will provide a higher level of support to patients requiring this care. The care previously would be "out of county" and now would be closer to home to promote supportive relationships in the local community and access to local amenities.

The key difference between **Level 1** and **Level 2** mental health rehabilitation inpatient services is that a **Level 2** service can offer more intensive support to people to meet their needs; this may be relational and/or adapted environments and procedures.

(Commissioner Guidance for Adult Mental Health Rehabilitation Inpatient Services, 2024).

At the point of working towards discharge, agencies will be brought together to support this process (including the patient). If being discharged from a **Level 1** rehabilitation unit, the **Enhanced Rehabilitation Community Team** will provide 'step down' support for a transition period.

Patient Journey Example - 2

*** Subject to change as clinical model and delivery are being worked through as part of the Major Change Process**

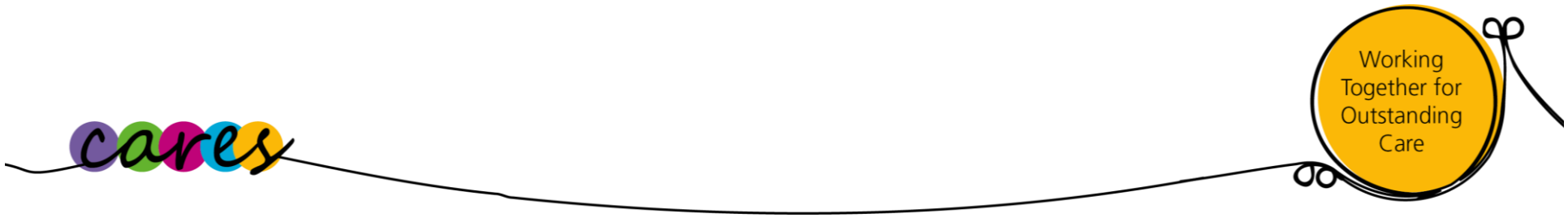
Following this piece of work, the care will be transferred to a Neighbourhood Mental Health Team (or a specialist team) dependent upon the needs of the patient.

If a patient is discharged to supported accommodation or a care facility, the Enhanced Rehabilitation Community Team will provide support and training to the provider to fully ensure they are able to manage the needs of the patient, to promote sustainability of the placement and ensure patient need is fully met.

This will promote mental health stability, reduce future admissions, and prevent placement failure.

Care will be individual to the patient and trauma informed.

Option 1



Option 1

Herefordshire & Worcestershire Adult MH Inpatient & Rehabilitation System

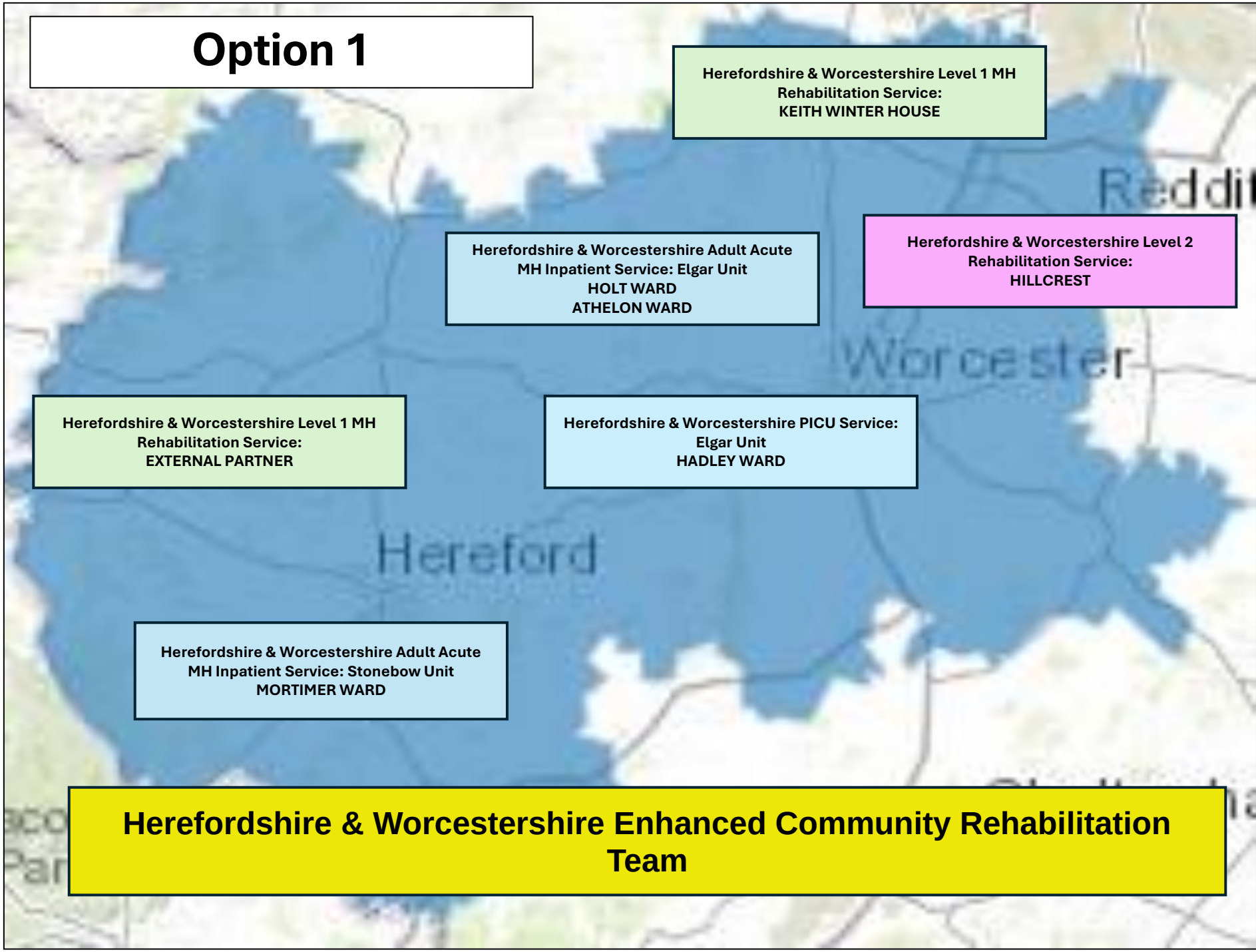
Herefordshire & Worcestershire PICU Service

Herefordshire & Worcestershire Adult Acute MH Inpatient Service

Herefordshire & Worcestershire Level 2 Rehabilitation Service

Herefordshire & Worcestershire Level 1 MH Rehabilitation Service

Herefordshire & Worcestershire Enhanced Community Rehabilitation Team



Herefordshire & Worcestershire Level 1 MH Rehabilitation Service: KEITH WINTER HOUSE

Herefordshire & Worcestershire Adult Acute MH Inpatient Service: Elgar Unit HOLT WARD ATHELON WARD

Herefordshire & Worcestershire Level 2 Rehabilitation Service: HILLCREST

Herefordshire & Worcestershire Level 1 MH Rehabilitation Service: EXTERNAL PARTNER

Herefordshire & Worcestershire PICU Service: Elgar Unit HADLEY WARD

Herefordshire & Worcestershire Adult Acute MH Inpatient Service: Stonebow Unit MORTIMER WARD

Herefordshire & Worcestershire Enhanced Community Rehabilitation Team

Option One: Further Details

There will be two centralised hubs where acute mental health wards will be based. They will be on transformed and developed sites in Herefordshire and Worcestershire.

The Psychiatric Intensive Care Unit (PICU) on Hadley Ward will remain the same, covering the remit of both counties as it currently does.

Rehabilitation will be provided as a complete pathway, consisting of **Level 1** inpatient, a community offer and a **Level 2** offer.

Level 1 rehabilitation beds will be provided in one unit in Worcestershire.

The **Level 1** rehabilitation unit in Herefordshire will close, which would result in the county having no dedicated mental health inpatient rehabilitation beds.

As a result, it is proposed that the Trust should explore alternative solutions in partnership with external providers.

Rather than incurring the costs of purchasing or constructing a new facility, the Trust should aim to collaborate with a partner to secure access to suitable beds or a building that can fulfil the county's rehabilitation needs.

This approach would ensure continuity of care while avoiding substantial capital investment and promotes partnership working.

Option One : Further Details

In addition, there will be the development of an Enhanced Community Rehabilitation Team to serve both counties which will provide stepped rehabilitation care for patients leaving a rehabilitation inpatient unit ('step–down') and as a 'step-up' approach from a community team for patients who may require a more "bespoke" package, or enhanced care to see if inpatient rehabilitation is required.

Community hubs can be utilised across Herefordshire and Worcestershire to reduce travel burden.

A **Level 2** inpatient unit will be developed to serve both counties.

The resource from the closed units, will be utilised for a **Level 1** Enhanced Community Rehabilitation Team in addition to the **Level 2** inpatient offer.

The workforce implications and training required will need to be considered as part of the full appraisal.

Option 2

OPTION 2

Herefordshire & Worcestershire Adult MH Inpatient & Rehabilitation System

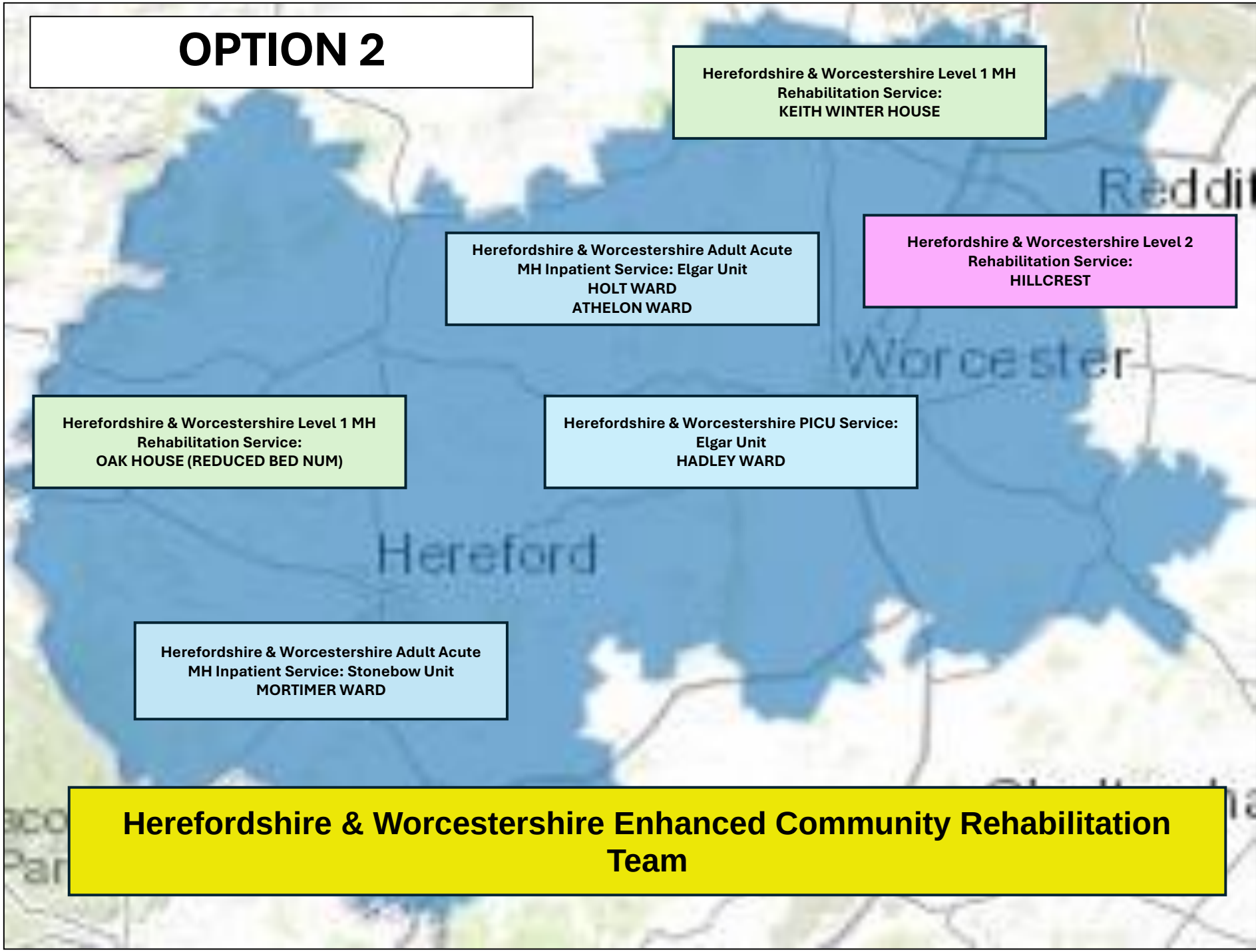
Herefordshire & Worcestershire PICU Service

Herefordshire & Worcestershire Adult Acute MH Inpatient Service

Herefordshire & Worcestershire Level 2 Rehabilitation Service

Herefordshire & Worcestershire Level 1 MH Rehabilitation Service

Herefordshire & Worcestershire Enhanced Community Rehabilitation Team



Herefordshire & Worcestershire Level 1 MH Rehabilitation Service: KEITH WINTER HOUSE

Herefordshire & Worcestershire Adult Acute MH Inpatient Service: Elgar Unit HOLT WARD ATHELON WARD

Herefordshire & Worcestershire Level 2 Rehabilitation Service: HILLCREST

Herefordshire & Worcestershire Level 1 MH Rehabilitation Service: OAK HOUSE (REDUCED BED NUM)

Herefordshire & Worcestershire PICU Service: Elgar Unit HADLEY WARD

Herefordshire & Worcestershire Adult Acute MH Inpatient Service: Stonebow Unit MORTIMER WARD

Herefordshire & Worcestershire Enhanced Community Rehabilitation Team

Option Two : Further Details

There will be two centralised hubs where acute mental health wards will be based. They will be on transformed and developed sites in Herefordshire and Worcestershire.

The Psychiatric Intensive Care Unit (PICU) on Hadley Ward will remain the same, covering the remit of both counties as it currently does.

Rehabilitation will be provided as a complete pathway, consisting of **Level 1** inpatient in two counties, a community offer in addition to a **Level 2** offer.

Level 1 rehabilitation beds will be provided across both counties. The **Level 1** rehabilitation unit in Herefordshire will provide a reduced number of **Level 1** beds.

In addition, there will be the development of an Enhanced Community Rehabilitation Team to serve both counties which will provide stepped rehabilitation care for patients leaving a rehabilitation inpatient unit ('step–down' approach) and as a 'step-up' approach from a community team for patients who may require a more 'bespoke' package, or enhanced care to see if inpatient rehabilitation is required.

Community hubs can be utilised across Herefordshire and Worcestershire to reduce travel burden.

A **Level 2** inpatient unit will be developed to serve both counties.

The resource from the closed unit, will be utilised for a **Level 1** Enhanced Community Rehabilitation Team in addition to the **Level 2** inpatient offer.

The workforce implications and training required will need to be considered as part of the full appraisal.

Option 3

Option 3

Herefordshire & Worcestershire Adult MH Inpatient & Rehabilitation System

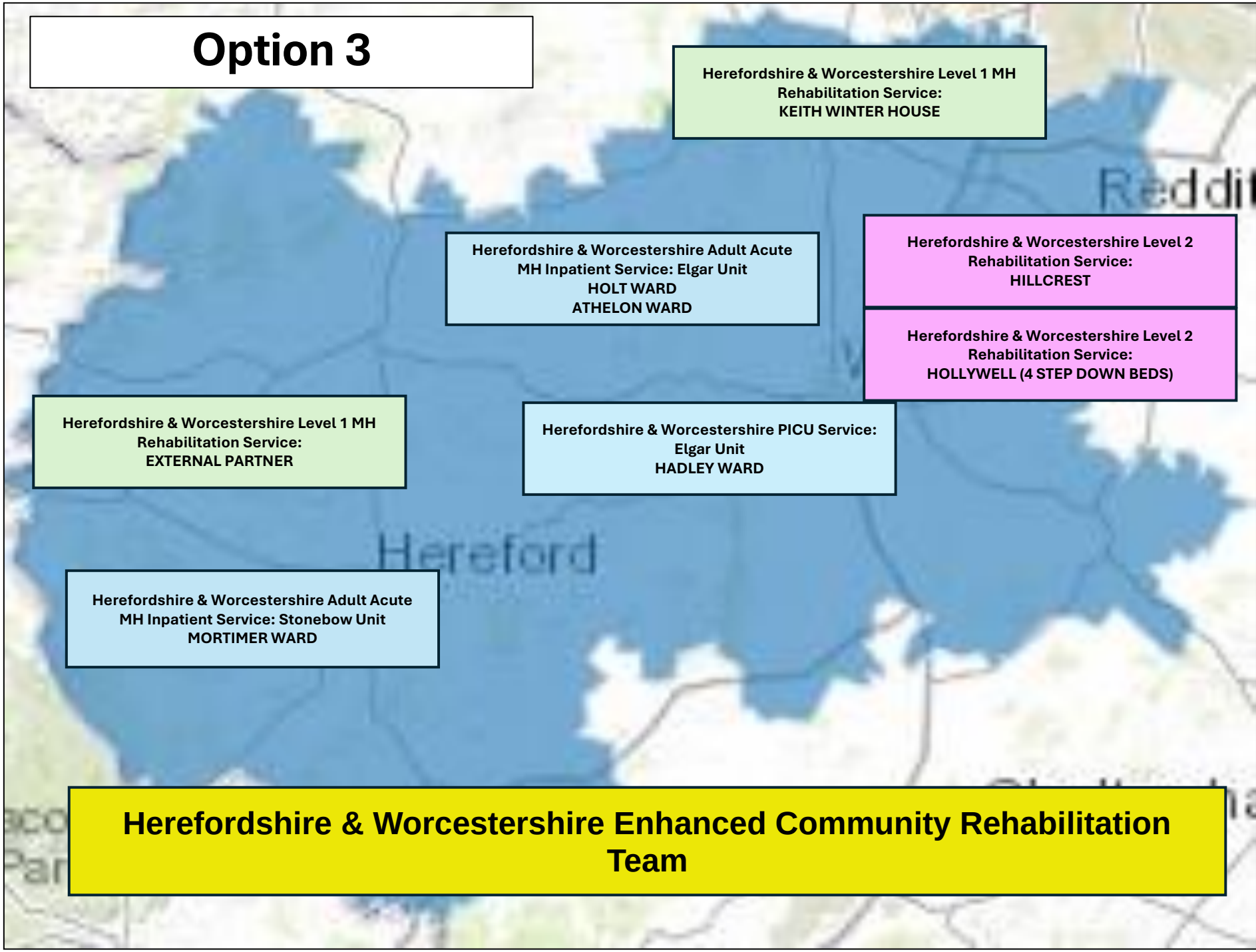
Herefordshire & Worcestershire PICU Service

Herefordshire & Worcestershire Adult Acute MH Inpatient Service

Herefordshire & Worcestershire Level 2 Rehabilitation Service

Herefordshire & Worcestershire Level 1 MH Rehabilitation Service

Herefordshire & Worcestershire Enhanced Community Rehabilitation Team



Option Three : Further Details - 1

There will be two centralised hubs where acute mental health wards will be based, and they will be on transformed and developed sites in Herefordshire and Worcestershire.

The Psychiatric Intensive Care Unit (PICU) on Hadley Ward will remain the same, covering the remit of both counties as it currently does.

Level 1 rehabilitation beds will be provided for the two counties.

The **Level 1** rehabilitation unit in Herefordshire will close, which would result in the county having no dedicated mental health inpatient rehabilitation beds.

As a result, it is proposed that the Trust should explore alternative solutions in partnership with external providers.

Rather than incurring the costs of purchasing or constructing a new facility, the Trust should aim to collaborate with a partner to secure access to suitable beds or a building that can fulfil the county's rehabilitation needs. This approach would ensure continuity of care while avoiding substantial capital investment and promotes partnership working.

A **Level 1** Enhanced Community Rehabilitation Team.

This will include a community outreach model, this would be a small team of staff working closely with housing and supported living providers to ensure the right accommodation is sourced for individual needs and supporting the providers with resources and skills, in addition to providing short term intervention to the patient for a transition period.

The outreach model will work with and support VCSE in providing services within the community for patients with rehabilitation needs.

The Trust has a similar resource in the form of the PARTNER Service; however, their remit would need to be expanded to facilitate the offer.

Option Three : Further Details - 2

The development of an Enhanced Community Rehabilitation Team to serve both counties which will provide stepped rehabilitation care for patients leaving a rehabilitation inpatient unit ('step–down' approach).

It would provide a 'step-up' approach from a community team for patients who may require a more "bespoke" package, or enhanced care to see if inpatient rehabilitation is required.

Community hubs can be utilised across Herefordshire and Worcestershire to reduce travel burden.

Level 2 rehabilitation would serve the two counties, within the ICS footprint. In addition, four step down beds will be provided locally to aid a community placement transition.

The resource from the closed units, will be utilised for a **Level 1** Enhanced Community Rehabilitation Team in addition to the **Level 2** inpatient offer.

The workforce implications and training required will need to be considered as part of the full appraisal.

Date published: 9 January, 2024
Date last updated: 9 January, 2024

Commissioner guidance for adult mental health rehabilitation inpatient services

Publication (/publication)

Content

1. Introduction

This guidance supports the planning and commissioning of local mental health rehabilitation inpatient services as part of a whole pathway, to meet the identified need of local populations. Standardising the approach to the commissioning of these services should identify and reduce inequalities and improve quality, ensuring services are safe, effective, evidence based and informed.

This is based on the premise that 'all means all'. Services will be commissioned so that everyone who presents with a mental health rehabilitation need requiring an inpatient service should be able to access this locally, when they need it and in a way that is flexible and responsive to their needs.

Mental health rehabilitation inpatient services provide care and treatment for adults and older adults who have an identified mental health rehabilitation need. This includes people who may also have a learning disability, who are autistic or who have been given a diagnosis of personality disorder. People may be detained under the Mental Health Act (MHA), and some may be restricted under section 37/41 (MHA) (HM Prison and Probation Service, 2011 (https://www.gov.uk/government/collections/working-with-restricted-patients)). The decision to admit will be based on a comprehensive clinical assessment.

These inpatient services assess and treat mental ill health, with the core objective of providing hope, maximising quality of life and social inclusion, promoting independence and supporting the development of skills, so that people can return to live in the community (Killaspy et el, 2005 (https://www.tandfonline.com/doi/abs/10.1080/09638230500060144)).

A number of the quality failings in both NHS and independent sector hospitals have occurred in services that were described as mental health rehabilitation inpatient services of some kind. The Care Quality Commission (CQC) has highlighted specific concerns in relation to 'locked rehabilitation' services (CQC, 2017 (http://www.cqc.org.uk/publications/major-report/state-care-mental-health-services-2014-2017)). Commonly, these are often spot purchased by multiple commissioners, with people from different geographic areas, with additional and varied diagnoses and needs, disconnected from local pathways, all in one service.

This commissioner guidance is underpinned by the overarching commissioning framework for mental health inpatient services (https://future.nhs.uk/system/login?nextURL=%2Fconnect%2Eti%2FCYPQualityImprovTaskforce%2Fview%3FobjectID%3D45208880). It draws on the following learning, standards and guidance, corroborated and developed through workshops and visits to mental health inpatient rehabilitation services.

- GIRFT (2022) Mental health – rehabilitation national report (https://gettingitrightfirsttime.co.uk/medical_specialties/mh-rehab/)
- NICE (2020) NICE guideline [NG181] Rehabilitation for adults with complex psychosis (https://www.nice.org.uk/guidance/ng181/chapter/Recommendations#who-should-be-offered-rehabilitation)
- Royal College of Psychiatrists (2022) Standards for inpatient mental health rehabilitation services, 4th edition (https://www.rcpsych.ac.uk/improving-care/ccqi/quality-networks-accreditation/rehabilitation-services/resources)
- Royal College of Psychiatrists (2023) Standards for mental health inpatient rehabilitation services for adults with a learning disability (https://www.rcpsych.ac.uk/improving-care/ccqi/quality-networks-accreditation/learning-disabilities-service-inpatients/resources)
- NHS England (2019) Community mental health framework for adults and older adults (https://www.england.nhs.uk/publication/the-community-mental-health-framework-for-adults-and-older-adults/)

In developing this guidance, we spoke to over 100 people from a variety of stakeholder groups, including experts by experience (patients, families and carers), commissioners, mental health providers, operational managers, clinicians (NHS and independent sector), the Care Quality Commission (CQC), the Voluntary and Community, Faith and Social Enterprise (VCFSE) sector, and national and regional teams from NHS England.

This guidance is for those who have commissioning responsibility for the mental health needs of their local population, recognising that commissioning can be carried out by different individuals and organisations, separately and collaboratively, and it can be delegated depending on local arrangements. The commissioner of mental health rehabilitation inpatient services could be:

- an integrated care board (ICB)
- a provider collaborative
- an NHS-led provider collaborative

The guidance also has relevance for mental health providers, professionals and partnership organisations across integrated care systems (ICSs), including:

- local authority commissioners
- commissioners of specialised mental health, learning disability and autism services, and health and justice services
- mental health community and hospital healthcare providers, both NHS and independent sector
- VFCSE
- People who use services, their families and carers, and the organisations that advocate for, and represent them.

2. Scope

The scope of this guidance is mental health rehabilitation inpatient services for all adults and older adults; that is people aged 18 years and over. This includes anyone who has additional diagnoses and/or needs; for example, people who also have a learning disability or who are autistic, and people who have been given a diagnosis of personality disorder. Also included are those who may transition from children and young people's (CYP) mental health inpatient services. It incorporates people detained under the MHA, including those detained under section 37/41 of the MHA.

Community mental health transformation is at the heart of the NHS Long Term Plan for Mental Health (https://www.longtermplan.nhs.uk/areas-of-work/mental-health/). All areas are expected to develop dedicated adult community mental health rehabilitation services as part of their transformation of community mental health provision, reducing the reliance on inpatient care and to support people in the least restrictive setting.

Wherever possible mental health rehabilitation needs should be met in the community. However, where someone's needs exceed what can be safely and effectively treated in the community, admission to a mental health rehabilitation inpatient service may be required. This should always be local and consider the least restrictive option, which should be kept under review.

Whilst the scope of this commissioning guidance focusses on mental health rehabilitation inpatient services, it is important to recognise the interfaces between these services and other mental health services, the most common are:

- acute inpatient mental health care for adults and older adults (https://www.england.nhs.uk/long-read/acute-inpatient-mental-health-care-for-adults-and-older-adults/)
- acute mental health inpatient services specifically for adults with a learning disability and autistic adults
- adult medium, low secure inpatient and specialist community forensic services (NHS England, 2018 (https://www.england.nhs.uk/publication/service-specification-medium-secure-mental-health-services-adult/) and NHS England, 2018 (https://www.england.nhs.uk/publication/service-specification-low-secure-mental-health-services-adult/))
- community mental health services, including early intervention in psychosis (EIP) teams
- community learning disability and autism teams
- CYP mental health inpatient and community services.

Policy context relevant to all mental health inpatient services, including adult rehabilitation, is described in the overarching commissioning framework for mental health inpatient services (https://future.nhs.uk/system/login?nextURL=%2Fconnect%2Eti%2FCYPQualityImprovTaskforce%2Fview%3FobjectID%3D45208880).

3. Key messages

3.1 Language and terminology – describing mental health rehabilitation inpatient services

The variation in the language and terminology used to describe mental health rehabilitation inpatient services is confusing and persists despite previous attempts to tackle it. Stakeholders identified this as the most important issue to address in this guidance, the GIRFT report on mental health rehabilitation (https://gettingitrightfirsttime.co.uk/medical_specialties/mh-rehab/) supports the need for clarification and 'standardisation of rehabilitation care'.

Mental health rehabilitation inpatient services should be commissioned and described as:

Level 1 mental health rehabilitation inpatient services

Level 1 services have many of the characteristics of inpatient services described elsewhere/previously as 'community rehabilitation units' (RCPsych, 2019 (https://www.rcpsych.ac.uk/docs/default-source/members/faculties/rehabilitation-and-social-psychiatry/mental-health-inpatient-rehabilitation-services-typology-table-20-3-19.pdf?sfvrsn=8fc19480_2)).

- These services are needs led and locally based, serving a local population.
- These services exist to meet the needs of people who have a mental health rehabilitation need that can only be treated within an inpatient environment.
- Level 1 services are normally accessed via an adult acute mental health inpatient service, including those specifically for adults with a learning disability, or who are autistic.
- As with adult acute mental health services, the default position for autistic people and those who have a learning disability, with a mental health need, would be to access mainstream mental health rehabilitation inpatient services. However, it is recognised that some people's needs cannot be met well in a mainstream service, even with reasonable adjustments. Commissioned services may include mental health inpatient rehabilitation services that are specifically for people with a learning disability, or who are autistic.
- Level 1 services are part of a clear, agreed pathway that includes community mental health rehabilitation teams and wider general and specialist teams, such as primary care, community learning disability, autism or mental health
- They are staffed by a multidisciplinary team that have the appropriate training, skills and knowledge in mental health rehabilitation and should meet specialist need as required, for example, drug and alcohol support.
- These services should be firmly connected to the wider resources and agencies within the community, for example, employment support, housing and welfare.

Level 2 mental health rehabilitation inpatient services (higher support needs)

Level 2 services have many of the characteristics of services described elsewhere/previously as 'high dependency rehabilitation units' (RCPsych, 2019 (https://www.rcpsych.ac.uk/docs/default-source/members/faculties/rehabilitation-and-social-psychiatry/mental-health-inpatient-rehabilitation-services-typology-table-20-3-19.pdf?sfvrsn=8fc19480_2)).

- All the points above for level 1 services apply to level 2 services.
- Level 2 services neither support nor encompass inpatient provision that may be described as 'locked rehabilitation', and they are not long-term placements, continuing care, or a 'home' by default.
- The key difference between level 1 and level 2 mental health rehabilitation inpatient services is that a level 2 service can offer more intensive support to people to meet their needs; this may be relational and/or adapted environments and procedures.
- Commissioning arrangements for level 2 services will be locally determined and will depend on the size and assessed need of the population in each ICS footprint.
- Level 2 services are part of the same pathway of care as level 1 services and may on occasion be accessed via a level 1 service.
- Level 2 services may accept people who need their mental health rehabilitation needs met at a pace that is individually and clinically appropriate for them. These services should be commissioned to do this while ensuring that lengths of stay are appropriate and reviewed regularly, to avoid stays in hospital that are longer than absolutely necessary.

Commissioners must be clear, based on their population needs' assessment, what services they need to commission and plan accordingly using this two-level approach for all mental health rehabilitation inpatient services. They should commission the right types of service to meet agreed local need. Section 7: The service (https://www.england.nhs.uk/long-read/commissioner-guidance-for-adult-mental-health-rehabilitation-inpatient-services/#7-the-service); provides more information to underpin this key message.

3.2 Local services

Mental health rehabilitation inpatient services must be commissioned as locally as possible. The GIRFT national report for mental health rehabilitation (https://gettingitrightfirsttime.co.uk/medical_specialties/mh-rehab/) reported in 2022, that half the 3,500 people who used inpatient mental health rehabilitation beds in England were placed out of their local area, mainly in independent sector mental health providers.

Accessing mental health rehabilitation inpatient services that are at a distance from a person's home makes it harder for people to reconnect with their communities, receive visits from family and friends, and access support networks. This makes it more challenging for the inpatient clinical team to deliver critical aspects of the care and treatment required for mental health rehabilitation. The person's community team cannot engage as easily, and commissioners cannot fulfil their responsibility effectively. Length of stay is generally longer and discharge planning more complicated for all involved.

Where mental health rehabilitation inpatient services admit people from different geographical areas, the inpatient clinical team cannot work efficiently. Despite best efforts the team will not have the local knowledge of and connections to all these areas.

> "I felt like I had been put somewhere and left, forgotten about, only when I started to get well that my home team got involved, but it was too late."
>
> "Yes, I've got community leave, but this isn't my community."
>
> "I'm going to have to do all this again when I'm discharged as this isn't where I'm going to live when I leave hospital."
>
> "Try to do something, but your team aren't in the area so can't come to meetings, or they won't help because they're not in the area."
>
> "I have been in and out of services since I was 10 years old. This recent admission has seen me in 6 placements in 11 months."
>
> People currently accessing mental health rehabilitation inpatient services.

3.3 Data for mental health rehabilitation inpatient services

GIRFT national report for mental health rehabilitation (https://gettingitrightfirsttime.co.uk/medical_specialties/mh-rehab/) has identified the need for "accurately and consistently coded" data about the use of mental health rehabilitation inpatient services. Commissioners need data about everyone who requires access to a mental health rehabilitation inpatient service, including waiting times and outcomes. Increasing the oversight and awareness of where people are placed is critical in tackling the quality and safety challenges within mental health inpatient settings; this is particularly true for people accessing rehabilitation services.

Commissioners need to have the same level of visibility and scrutiny of activity, cost, and outcomes for mental health rehabilitation inpatient services as they do for all other inpatient settings. These services are a crucial part of the mental health pathway, so accurate and reliable data that is universally understood is critical. This will support planning (NHS England, 2023 (https://future.nhs.uk/CYPQualityImprovTaskforce/view?objectID=45208880)), escalation of delays and issues related to throughput and flow. Commissioners must ensure that mental health providers are supported to develop rehabilitation data dashboards to improve inpatient services and their related pathways where needed.

3.4 Purpose of admission

The purpose of admission to a mental health rehabilitation inpatient service must always be collaboratively agreed and articulated. Commissioners need to be assured that the purpose of admission is understood by everyone involved and that there is a clear description of how this will be achieved. This is important for staff in the inpatient service, the community team, commissioners, and particularly so for the person accessing the service, their families and carers.

> "In the past rehabilitation inpatient services have been seen to do everything, but not been able to do a lot."
>
> "There must be a shift from patients going to rehabilitation inpatient services because nothing else has worked… and these services being expected to mop up gaps elsewhere in the pathway."

“Rehabilitation inpatient services are not a last resort .. admission should be a positive decision.”

Clinicians working in mental health rehabilitation inpatient services.

4. Specific considerations

4.1 All means all

To ensure all those with mental health rehabilitation needs that require an inpatient admission can access an appropriate service, services must be planned and commissioned with everyone in mind and the ‘all means all’ principle as described in the commissioning framework for mental health inpatient services (https://future.nhs.uk/CYPQualityImprovTaskforce/view?objectID=45208880) applies (see section 5 of the framework). Local commissioning plans must ensure that the services commissioned meet the assessed needs of the total population and can deliver the care and treatment required. It is not appropriate for people to be placed out of area because local services have not been planned with them in mind.

Commissioners of mental health rehabilitation inpatient services need to take a systematic approach to knowing their local communities, to understand who is over and underrepresented in these services, and who has poorer experiences and outcomes. They should work with relevant stakeholders to address identified local discrimination and inequalities within these services.

Mental health rehabilitation inpatient services should not develop exclusion criteria that would prevent some patients from accessing the treatment they need.

Where people have additional diagnoses or needs, expertise and support should be sought from relevant specialists who should work alongside the mental health rehabilitation inpatient team, offering interventions, advice and support as required.

4.2 Supporting people with a learning disability or who are autistic

Mainstream mental health rehabilitation inpatient services should make necessary reasonable adjustments (Equality Act 2010 (https://www.legislation.gov.uk/ukpga/2010/15/contents)) based on identified needs. These will vary but may include:

- environmental sensory adaptations
- availability of different communication tools and materials
- staff with relevant training to support people who are autistic or have a learning disability, and to champion this support on the wards
- an advocacy service with relevant skills.

Where people are clinically assessed as requiring more than reasonable adjustments, mental health rehabilitation inpatient services that can provide specifically for people who also have a learning disability or who are autistic should be commissioned. Commissioning guidance for acute mental health inpatient services for adults with a learning disability and autistic adults differentiates between mainstream and more specific services. The same principles would apply when considering mental health rehabilitation inpatient services. The standards developed for mental health rehabilitation inpatient services for adults with a learning disability (RCPsych, 2023 (https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/learning-disability-rehab/qnld---standards-for-inpatient-learning-disability-services-(rehabilitation)---1st-edition.pdf?sfvrsn=42f8b8b7_4)) should be included, where applicable, in contracts with mental health providers and monitored.

In summary, commissioners should ensure that for all mental health rehabilitation inpatient services that provide specifically for people who have a learning disability or who are autistic:

- the workforce is appropriately qualified and knowledgeable to provide the right support
- training is offered to ensure clinical teams have the right values, skills and capabilities
- policies relevant to these inpatient services and pathways are implemented; for example, in respect of Care (Education) and Treatment Reviews (C(E)TRs) (https://www.england.nhs.uk/learning-disabilities/care/ctr/care-education-and-treatment-reviews/) and Dynamic Support Registers (DSR), discharge planning (https://www.england.nhs.uk/publication/dynamic-support-register-and-care-education-and-treatment-review-policy-and-guide/), personalised care and support plans (https://www.england.nhs.uk/personalisedcare/pcsp/)
- therapeutic interventions are tailored to specific needs
- the appropriateness of the physical environment is considered.

Exactly how these specific mental health rehabilitation services are commissioned for each ICS population will depend on the local geography, numbers involved and how frequently these services are required.

4.3 Considerations for people who have a diagnosis of personality disorder

It is important to note that there are currently some mental health inpatient services registered with CQC as 'rehabilitation' services, which are commissioned for people who have received a diagnosis of personality disorder, specifically a diagnosis of borderline personality disorder. The provision of such services is not in line with NICE guidelines (https://www.nice.org.uk/guidance/cg78/chapter/1-Guidance#inpatient-services) for the care and treatment of people who have received this diagnosis and as per the recommendations of GIRFT national report for mental health rehabilitation (https://gettingitrightfirsttime.co.uk/medical_specialties/mh-rehab/), should not be described or commissioned as such. This misuse of the term 'rehabilitation' is unhelpful and confusing for everyone but particularly for the people themselves, their families and carers.

The needs of this group who are currently being admitted to these types of services should be met locally, through co-produced alternative, community services which provide therapeutic, least restrictive and trauma informed care and support. Commissioners will want to consider the development of trauma-specific services to meet the needs of people who are currently admitted to these inpatient services given the majority of them will have experienced significant trauma and adversity.

However, the additional diagnostic label of personality disorder should not preclude admission where there is an identified mental health rehabilitation need. During stakeholder engagement, people accessing services and staff working in them explained that mental health rehabilitation inpatient services for people who have received diagnosis of personality disorder should deliver specific evidence-based treatment, with the whole inpatient team trained and able to deliver this approach collaboratively and consistently. These commissioned services should not be overly restrictive and should focus on relational approaches to safety as the most effective way to keep the person safe.

> "It is important that I feel people haven't forgotten about me, and I am still valued."
>
> "Sometimes you just need someone to sit and talk to you, not just take away your stuff."
>
> "…that feels like punishment, when you're already punishing yourself."
>
> People currently accessing a mental health rehabilitation inpatient service.

Again, how these services are commissioned in each area will depend on the number of people who require access, efficiency of whole pathways and level of need. These specific services may need to be commissioned for more than one ICS, across neighbouring ICS footprints.

4.4 Considerations for people with other additional needs

Each person is an individual and there may be other needs to consider in addition to the assessed mental health rehabilitation need. These may be relating to physical health, degenerative neurological conditions or acquired brain injuries for example. Commissioners should make commissioning decisions based on analysis of their local population need, size of population, historical activity, geography and accessibility.

5. Commissioning arrangements

Mental health rehabilitation inpatient services should be commissioned locally for populations in a planned and proactive way, with a move away from spot purchasing from multiple mental health rehabilitation inpatient services across the country, or commissioning on a cost per case basis.

The configuration of mental health rehabilitation inpatient services for each ICS population should be articulated in a way that everyone can understand, particularly those who may access services, their families and carers.

Where numbers across a large geography are particularly small, commissioning services across more than one ICS footprint may be the right strategy. Robust systems must be in place to ensure commissioners and relevant community teams can work closely with people who access these services, their families and carers, and the inpatient multi-disciplinary team (MDT) .

The contract should be held by one commissioner, normally the host commissioner, and placing commissioners should use this contract to commission the respective mental health rehabilitation inpatient service for their population. All mental health rehabilitation inpatient services should have an identified host commissioner.

The placing commissioner will continue to be responsible for individual placement oversight and ensuring the pathway is being managed effectively, regardless of the geographical distance from the person's local area. Plans should always be made for commissioners to visit services in person on a regular basis; exclusive use of virtual meetings is not acceptable as part of the oversight for anyone placed outside the ICS footprint.

> "No one had an overview. I was the only one keeping tabs on what was happening…it shouldn't have been me doing it." Family member of relative placed out of area.
>
> "I don't see my case manager or commissioner in person. If I do see them, it is usually a meeting on the screen."
>
> Person placed out of area in a mental health rehabilitation inpatient service.

The host commissioner for each mental health rehabilitation inpatient services should fulfil the commissioning requirements in terms of assuring quality and safety for the service. This function should be undertaken whenever possible face to face and never exclusively virtually.

There must be robust and established lines of communication between the placing and host commissioner prior to and during any admission and placement. Commissioners need to assure themselves they are not commissioning services that by their very nature are at an increased risk of delivering unsafe and poor quality care.

6. Care pathway and interdependencies

6.1 Whole pathway approach

Commissioners should ensure that a whole pathway approach is taken so that services work collaboratively, transitions are kept to a minimum and movement across the pathway is seamless and efficient. ICBs should describe the pathway between related services in the commissioning strategy for their population.

Good practice principles should be considered when transition is required from a CYP mental health community or inpatient service to an adult mental health rehabilitation inpatient service.

6.2 Community mental health, learning disability and autism teams

Local care co-ordinator or named key worker

It is the responsibility of the identified community mental health, learning disability, or autism team to remain engaged throughout the whole mental health rehabilitation inpatient stay. This maintains local relationships and also means the inpatient clinical team will be aware of what is available locally for each person.

This is usually the responsibility of the local care co-ordinator or named key worker, and wherever possible their role should be consistent and relevant to the person's presenting need. Their visits or attendance at reviews should be in person, face to face. While this may not be as easy when someone is placed away from their local area, it is in these instances even more important. These visits support active discharge planning and where appropriate ensure that repatriation is being considered and pursued.

> "When planning discharge constant changes in staff members from the community team made it difficult."
>
> A family member.

Community mental health rehabilitation teams

The NHS Long Term Plan for Mental Health (https://www.longtermplan.nhs.uk/areas-of-work/mental-health/) states that all systems should provide support for people with severe mental illness, with the development of new and integrated models of primary and community mental health care. This includes care, support and treatment for individuals with specific needs, including mental health rehabilitation needs.

Stakeholders reported positive experiences where there was a dedicated community mental health rehabilitation team, able to work closely with the inpatient clinical team and particularly where this was an integrated team. The elements that work well are:

- the assertive and flexible approach
- consistency of clinical team members
- reduction in transitions
- connection to the community.

6.3 Interdependencies

Commissioners need to work with providers of mental health rehabilitation inpatient services and other stakeholders to ensure that local partnerships are developed and supported. Key interdependencies with mental health rehabilitation inpatient services include, but are not limited to:

- VFCSE
- independent sector providers
- local authorities
- housing and accommodation providers
- Mental Health Case Work Section (MHCS) – His Majesty's Prison and Probation Service (HMPPS).

7. The service

7.1 What should the service feel like?

People who use services, their families and carers were clear about what mental health rehabilitation inpatient services should feel like.

- hopeful
- empathic
- respectful
- compassionate
- safe
- community facing
- diverse
- inclusive
- person centred
- caring
- equality focused
- local
- trauma informed
- empowering
- kind
- recovery focused

7.2 Mental health rehabilitation services are not 'locked rehab'.

"A high number of wards continued to identify as locked rehabilitation – this is against the least restrictive principle and potentially represents a breach of human rights." CQC, 2020.

As described in section 3: Key messages (https://www.england.nhs.uk/long-read/commissioner-guidance-for-adult-mental-health-rehabilitation-inpatient-services/#3-key-messages), the different descriptions used for mental health rehabilitation inpatient services are confusing and can be misleading:

- 'locked rehabilitation' (not recognised but still used)
- 'high dependency rehabilitation'
- 'longer term high dependency rehabilitation'
- 'highly specialist high dependency rehabilitation'
- 'complex care rehabilitation'
- 'longer stay rehabilitation'.

The case for change in relation to 'locked rehabilitation' services is clear and in future the commissioning of services described as such should cease.

Mental health rehabilitation inpatient services should not be 'locked' so that every person is prevented from leaving. Services can operate a controlled access and egress system, for example, use of programmed fobs. The appropriate level of access for each person should be determined based on an individual clinical assessment, and there should be a robust process in place to ensure that this is regularly reviewed.

Mental health rehabilitation inpatient services are not adult secure services, which have a specific function that is described in service specifications (NHS England, 2018 (https://www.england.nhs.uk/publication/service-specification-medium-secure-mental-health-services-adult/) and NHS England, 2018 (https://www.england.nhs.uk/publication/service-specification-low-secure-mental-health-services-adult/)). Adult medium and low secure services are commissioned to 'prevent' and 'impede' escape from hospital, due to the risk of harm to others. Mental health rehabilitation inpatient services should not be commissioned on this basis.

A definitive description of mental health rehabilitation inpatient services is needed, and all such services should use the same language to describe themselves. Section 3, Key messages (https://www.england.nhs.uk/long-read/commissioner-guidance-for-adult-mental-health-rehabilitation-inpatient-services/#3-key-messages), describes the two-level approach which should be used.

The impact of moving to this approach for the commissioning of mental health rehabilitation inpatient services will need to be assessed locally, and collaboratively planned and managed with relevant stakeholders. For example, in some areas this will need to include NHS-led provider collaboratives of adult secure services where 'locked rehabilitation' may for some people be accessed as part of a forensic pathway, or where an access assessment recommends it as an alternative to admission to a secure service.

7.3 How should the service work?

Commissioners should ensure that the standards for mental health rehabilitation inpatient services, including those for services specifically for people with a learning disability and people who are autistic, are reflected in service specifications within the contracts they hold with providers.

Stakeholders described what they felt were the most important components of the inpatient service. These are described under the stages of the inpatient pathway; they are included here to support commissioners and strengthen the existing published standards.

Assessment and admission

Referrals to the service should state the reason for admission and the identified mental health rehabilitation needs, to support an appropriate assessment by the inpatient clinical team. Admissions should be planned, and pre-admission visits are considered good practice.

> "Our son was admitted with 1 days' notice from an acute MH ward. This was the first time we knew that a MH rehabilitation ward was being considered."
>
> Parents of someone accessing a mental health rehabilitation inpatient service.

The purpose of admission should describe the specific assessments and interventions required, anticipated length of stay and estimated date of discharge. These should be agreed collaboratively at the earliest opportunity with the person accessing the service, their families and carers, the inpatient MDT, community team and commissioner. This information should be clearly articulated to make explicit what is expected from the admission.

Care and treatment

All MDT reviews, ward rounds, care programme approach meetings and C(E)TRs must centre around the person. People in services should be supported and empowered to attend throughout and where possible to lead their reviews.

> "We use a dialogical model. During MDT reviews the conversation stops when the patient is no longer in the room.
>
> Everything is discussed with the patient including risk issues." Ward manager in a mental health rehabilitation inpatient service.
>
> "I have had a good experience of reviews; the language used should be human, not clinical and not rushed."

Family member of someone accessing a mental health rehabilitation inpatient service.

The purpose of admission, specific interventions required, anticipated length of stay and estimated date of discharge should be regularly reviewed, and any changes to the original position should be documented with reasons for the changes.

All therapeutic interventions and activities should focus on relationships; they should be holistic, needs led, trauma-informed and diverse.

Activities and leave from the ward should be planned individually for each person. Structured activity programmes should be co-designed with people on the ward to ensure they reflect the activities they request, and feel will be helpful. Co-facilitation of activities and groups by people accessing services and staff are described positively by those leading sessions and those attending. Activities should happen in line with NICE guidelines (https://www.nice.org.uk/guidance/ng181/chapter/Recommendations#who-should-be-offered-rehabilitation) and be available 7 days a week and not restricted, for example, to 9am to 5pm.

"The focus of the service and staff should be on independence, rather than dependence and on fixing people."

"One to ones with staff who work with me all the time and know me well are the most important thing. I'd support more of these."

"I had never cooked for myself before; I have been in hospital a long time. I started with one meal a week and now I'm building up a list of things I can cook for myself."

"When thinking about activities remember it's okay to have fun. Children can have fun, why can't adults?"

People accessing mental health inpatient rehabilitation services.

Vocational and employment opportunities are important to help people think about options, with an emphasis on appropriately knowledgeable and skilled staff providing education and support. Returning to their previous occupation is not an option for many people and therefore to help their recovery they will need to be supported to think about what transferrable skills they have.

"See everyone in their own context. This leads to thinking about their individual goals."

Clinician in a mental health rehabilitation inpatient service.

Peer support should be encouraged; making friends in services is really important to people, their families and carers.

"Friends are a big part of my recovery, making friends with other patients mustn't be seen as a bad thing."

"Support from my peers on the ward is a big thing."

People accessing mental health rehabilitation inpatient services.

Appropriate and accessible support for substance misuse while an inpatient needs to be available.

Physical exercise options need to be individually planned and varied These need to be available on and off the ward, accessible opportunities in the community is positive.

Primary and secondary physical health needs should be understood and met. People described a sense that not all staff were confident in this area and needed more appropriate training. Support while in hospital and a better understanding of how to self-manage physical health in the community is valued by people accessing these services.

Adaptation of the 'red to green days (https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2016/12/rig-red-green-bed-days.pdf)' approach, a tool developed for emergency care settings, has been suggested for mental health rehabilitation inpatient services; its adaption for mental health inpatient services is recommended in the adult acute mental health inpatient guidance (https://www.england.nhs.uk/long-read/acute-inpatient-mental-health-care-for-adults-and-older-adults/).

Discharge and transition

Early person-centred discharge planning is crucial. Discussions about the purpose of admission, interventions required, length of stay and estimated date of discharge should inform this from the point of admission. In some instances, this may be considered earlier, at the point of the pre-admission assessment to inform the admission.

NICE guidance (https://www.nice.org.uk/guidance/ng53) emphasises the need for people and their social networks to be actively involved in discharge planning, with good information provided about available support. Transitions are difficult times for people, their family and carers; multiple transitions can be particularly problematic. Those accessing services feel it is important to maintain continuity by being able to work with some members of the MDT on an ongoing basis, from the inpatient service to the community. They also view contact with their community team, ideally a community mental health rehabilitation team, throughout admission as crucial to supporting and facilitating earlier and more collaborative discharge planning.

People want gradual discharge planning and don't want to feel rushed as this can be a particularly anxious time. NICE guidance (https://www.nice.org.uk/guidance/ng181/chapter/Recommendations#who-should-be-offered-rehabilitation) recommends appropriately paced discharge planning and periods of phased leave with a gradual move to independence.

> "If the pathway works well it should be easy in and easy out."
>
> "I need support to prepare. How will the world see me after being detained for so long?"
>
> "Don't just say – 'now you are fine'; structure it, discharge needs lots of planning." People in mental health rehabilitation inpatient services.
>
> "Transitions are bumpy at best, traumatic at worst." Family member.
>
> "Early visible in and outreach with good discharge planning avoids readmission."
>
> Clinician working in a mental health rehabilitation inpatient service.

7.4 Physical environment

The commissioned service needs to be delivered in a physical environment that is conducive to mental health rehabilitation. It should be clean and well maintained, light and homely, not too clinical or sterile. While we recognise that access to capital can be limited, where care and attention has been paid to the co-design, co-production and physical condition of wards, these environments feel better for people accessing them and staff working in them. People view the opportunity with the right resource to be creative and personalise bedrooms and communal areas as important.

> "If ward surroundings resemble penal institutions, it must be really difficult for inpatients not to feel that they are being punished for being ill." Family member.
>
> "In poor physical environments how can individuals be expected to feel that they are valued or believe that society cares about them?"
>
> Family member.

Mental health rehabilitation inpatient services should have appropriate signage, soft furnishings and flooring, and be sensory friendly to meet the diverse needs of the people who access the services, including those who may be older, have physical and/or sensory impairments, or have a learning disability or are autistic.

Some rooms and areas within mental health rehabilitation inpatient services have a specific emphasis and requirement, for example:

- Activity space inside and outside – while people will be accessing activities off the ward in the community, facilities are also needed on the ward for flexible use
- Kitchens – need to support different levels of self-catering and risk management
- Treatment rooms – need to support progression to self-medication
- Physically and procedurally access to and egress from the ward should be facilitated easily, especially as it is expected that people are able to move off the ward frequently to access the community.

Access to reliable Wi-Fi in hospital is essential, particularly for people engaging in rehabilitation activities. If Wi-Fi connections on wards are unreliable people have to use their own mobile phones and personal data, this is unaffordable for many and creates inequalities.

> "If ward surroundings resemble penal institutions, it must be really difficult for inpatients not to feel that they are being punished for being ill." Family member.
>
> "In poor physical environments how can individuals be expected to feel that they are valued or believe that society cares about them?"
>
> Family member.

The shared experience of someone in a mental health rehabilitation inpatient service

What makes things work well?

How everyone treats you with respect. They are people that want to help you. When you explain what has happened to you they do their best to understand and create a plan catered to you so you can get the best experience.

Having staff to talk to you and remind and help you with basic needs, to take medication, personal hygiene, food and fluids, engage with you, get you back on your feet.

Psychology gives me different views from a different perspective to understand myself better, helps with confidence.

OT amazing, they are there to engage with you all the time. They know how to talk with people to make them feel relaxed.

When you have a troubling time you can always go to the doctors and talk with them.

Everyone on the ward has their own personal space.

The staff always encourage you to complain when you are dissatisfied with something and try to troubleshoot so other people don't have to face the issue.

Enjoy how clean the facilities are, cleaners come every day.

What doesn't work quite so well?

When there are not enough staff so it is difficult for them to engage with you, eg activities or having a small chat.

When there's not much to do on the ward.

Some staff members work just to get paid, not bothered about whether people get better or not. Even when you try to get help they give you a vague answer so they can do paperwork and go home; don't feel as supported then.

Patients sometimes feel a bit too uncomfortable with how much is taken away from them. Restricts your growth as coming out of hospital you learn from your mistakes because there is always going to be hazards.

The internet is really, really bad.

What would improve things?

Most of us stay in our rooms which gets us into a cycle of just thinking, getting out more would improve our mental state… more facilities to keep patients busy.

Not a fan of division between males and females because on the outside we are going to be mixed anyway.

Exercise classes – a lot of hoops to get a simple thing done, got to go to management, risk assessment, it would take at least a month to get a small activity in.

It can get really hot, there is no real way to turn the heating off. Put some time into updating the building into a modern standard.

Furniture could be improved, it's uncomfortable, never find myself sitting comfortably, always slouching.

Would like the food to be a bit better, meets the nutrients standards, but sometimes it doesn't look appetising. Not much variety, not much flavour. It would be nice if staff could eat with the patients… would like to listen to music or watch TV when we eat, you can just hear cutlery.

8. Involvement, co-production and advocacy

This section describes the aspects of involvement and co-production that commissioners should consider in the contracts for mental health rehabilitation inpatient services.

Everyone accessing these services should be supported to have a voice in their care. Valuing lived experience and respecting people's perspectives is crucial. People in services, their families and carers need to be supported to make shared decisions about their care (NICE, 2021 (https://www.nice.org.uk/guidance/ng197)).

Families and carers describe varying levels of involvement in the care of their relative. It is important to ensure that both the right support and appropriate feedback mechanisms are in place not only from members of the mental health rehabilitation inpatient clinical team but also other interfaces, e.g., community teams. Families talk about wanting support from the MDT to feel hopeful about their relative's recovery and pathway out of inpatient services. Cited examples of good practice are family/carer champions on mental health rehabilitation wards and family engagement workers as part of the inpatient MDT.

People, their families and carers (with appropriate consent) should be present, empowered and involved. Increased access to members of the inpatient MDT is highlighted as important, and this access should be as flexible as possible, such that contact can be made in the evening and at weekends if required.

It is vital that mental health rehabilitation inpatient services are part of a local pathway of care that promotes inclusion, strengthens individual's rights, and is orientated towards citizenship. Inpatient mental health rehabilitation inpatient services provide for many people who may face discrimination in their daily lives, because of their race, class, gender or sexuality. Efforts should be made to address disparities and improve outcomes by seeking to understand local populations, assess trends and act on over and under representation of certain communities of people. For this it is essential that people, families and carers from racialised, ethnically and culturally diverse communities have increased opportunities for shared decision-making (NHS England, 2023 (https://www.england.nhs.uk/mental-health/advancing-mental-health-equalities/)).

Mental health rehabilitation inpatient services vary considerably in the extent to which they consult those with lived experience and involve them in co-production, as well as remuneration for this experience and expertise. It is essential that mental health rehabilitation inpatient services should be commissioned to recognise these contributions by making consistent and appropriate payments.

Mental health rehabilitation inpatient services must be commissioned to ensure that people, irrespective of their legal status, have access to and are supported to meet with independent advocates who are culturally appropriate and aware, and have the right skills and experience.

A recent review of advocacy for people with a learning disability and autistic people who are inpatients in mental health hospitals found that:

"The behaviour, culture and values of the hospital can undermine or strengthen advocacy, dependent on whether advocacy is genuinely welcomed and seen as an integral part of upholding rights, inclusion of the person and ensuring patient safety, or whether it is treated with suspicion, or not prioritised as a right to be supported. There was evidence of some hospital settings welcoming advocacy support and working hard to proactively facilitate people's access to advocacy and other instances where hospitals created barriers to effective advocacy support being available to the person. For example, the reviewers heard of instances where, by not ensuring information was shared with the person in a timely way, people didn't get the support they needed to prepare for and attend meetings about their care, treatment or discharge. Reviewers heard many examples where advocacy was not welcomed or valued by the hospital. There is concern that this perpetuates the occurrence of closed cultures within institutional settings."

There is also evidence that advocacy works well when there is a culture that values the inclusion of people's voices, and champions person-led approaches. This provides important learning and should be considered for all commissioned mental health rehabilitation inpatient services.

9. Workforce

The GIRFT (2022) Mental health – rehabilitation national report (https://gettingitrightfirsttime.co.uk/medical_specialties/mh-rehab/) highlights the need for good MDT working and the value of different roles as part of, and working with mental health rehabilitation inpatient clinical teams. It recognises the importance of investing in an appropriately skilled workforce, with a core rehabilitation training offer that includes trauma informed care.

Of the essential roles within this inpatient workforce, specific mental health rehabilitation training is currently only offered for psychiatrists and occupational therapists. All staff who work in mental health rehabilitation inpatient services require appropriate training, they need to be skilled and motivated, with a recovery focused approach embedded in their culture and values, including through diversity training.

Stakeholders describe positively experiences of different disciplines undertaking the role of the responsible clinician. For example, where a social worker is the responsible clinician, the approach is led with a social prescribing model. This contributes to enhanced personalisation as people engage in more community-based interventions that increase their social functioning and test relapse plans while having full access and support from the clinical team.

Stakeholders view experiences positively where the MDT includes or has access to skilled staff who deliver creative outlets including art and drama.

> "I was studying art at university before becoming unwell. I am able to attend art and drama therapy which I find really helpful for me."
>
> Person in a mental health rehabilitation inpatient service.

Working towards a more competency-based workforce who recognise the value and benefits of substance misuse expertise, and housing and financial support is also seen as vital.

People, their families, carers and staff working in services describe the benefit of peer support workers who are part of the MDT. They highlight that this approach offers a unique type of support and that there should be more opportunities for people with lived experience to take on such roles. .

Some providers of mental health rehabilitation inpatient services partner with a VCFSE organisation to provide a varied and diverse inpatient MDT in terms of skills and experience. Roles undertaken by, or in partnership with VCFSE include peer support workers, pathway managers, family engagement workers, and housing and accommodation support workers. This approach is described positively, enabling shared learning and increased opportunities.

For a mental health rehabilitation inpatient service to thrive, stakeholders feel staff need to better know and understand the area they have chosen to work in. Equally staff should be representative of the local community. The GIRFT Mental health – rehabilitation national report (https://gettingitrightfirsttime.co.uk/medical_specialties/mh-rehab/) states that mental health rehabilitation inpatient services should have the necessary numbers of permanent staff with the right experience, skills, training and development opportunities to support people sensitively and effectively.

> "Staff who are redeployed to rehab wards because they might be injured, they don't have the right skills."
>
> "We should have experienced staff who work in rehab all the time."
>
> "Staff can hold you back if they don't know what is available in the community."
>
> People in mental health rehabilitation inpatient services.

10. Quality

The Commissioning framework for mental health inpatient services (https://future.nhs.uk/system/login?nextURL=%2Fconnect%2Eti%2FCYPQualityImprovTaskforce%2Fview%3FobjectID%3D45208880) describes how services should be commissioned to achieve high quality, safe and effective mental health inpatient services. The 'I and We'

statements from the framework, referenced in appendix 1, provide a ‘scaffold’ for the commissioning of all mental health inpatient services.

Fundamentally commissioners need to understand and recognise what good looks like for mental health rehabilitation inpatient services. This must be informed locally by people who access services, their families and carers, and those who work within and interface with these services. Ensuring this has been achieved and areas of improvement appropriately identified must be undertaken collaboratively with those who have direct, current and relevant experience of mental health rehabilitation inpatient services. This can be done by co-producing specific mental health rehabilitation patient, family and carer reported outcome and experience measures.

Applying specific local, co-produced standards and outcomes that relate directly to mental health rehabilitation inpatient services to the principles described in the overarching commissioning framework will enable these services to be commissioned safely and effectively.

Specific measures should include, for example, recording of progress against:

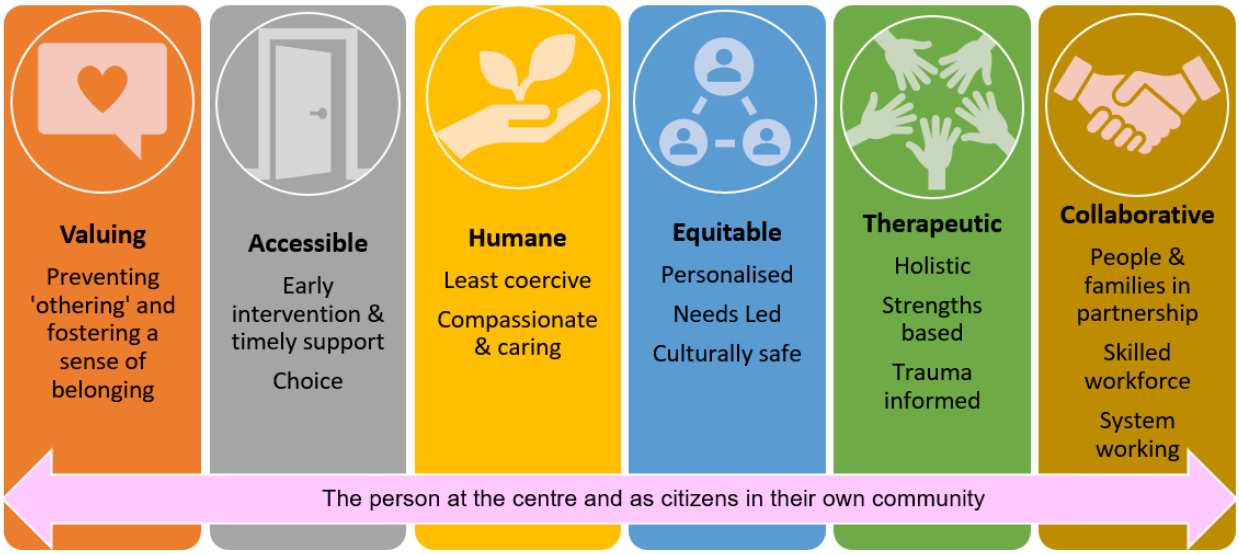
- the articulated purpose of admission
- estimated date of discharge and related length of stay
- access to the service, including waiting times for admission and discharge, and the reasons for any delays.

As explained in Section 3: Key messages (https://www.england.nhs.uk/long-read/commissioner-guidance-for-adult-mental-health-rehabilitation-inpatient-services/#3-key-messages) of this guidance, robust data collection that is universally understood by all is vital to understanding mental health rehabilitation inpatient activity and flow. Commissioners must use data to drive up quality and improve outcomes for those who use services, their families and carers.

Commissioners should use existing levers and tools within contracts to support performance management and quality improvement; for example, compliance with mental health rehabilitation inpatient service specifications and adherence to nationally mandated standards. Commissioners should access and use all available information to understand the services that they commission and ensure they are safe, compliant, and provide high quality care and treatment. This information should include, but not be limited to:

- RCPsych relevant Quality Network peer review visits, reports and provider action plans
- CQC inspections and reports of organisations and specifically the mental health rehabilitation inpatient services, and provider action plans
- specifically for services where people are placed who have a mental health rehabilitation need and a learning disability or who are autistic, C(E)TR themes (https://www.england.nhs.uk/learning-disabilities/care/ctr/care-education-and-treatment-reviews/), and information collated through ‘sit and see’ 8-week visits (NHS England, 2023 (https://www.england.nhs.uk/long-read/learning-disability-and-autism-host-commissioner-guidance/#:~:text=%E2%80%9CWhere%20someone%20with%20a%20learning,monitor%20the%20quality%20of%20c

Appendix 1: ‘I and we’ statements



(https://www.england.nhs.uk/wp-content/uploads/2024/01/Commissioning-principles.png)

Image text:

1. Valuing: preventing ‘othering’ and fostering a sense of belonging

2. Accessible: early intervention and timely support. Choice
3. Humane: Least coercive. Compassionate and caring
4. Equitable: Personalised. Needs led. Culturally safe
5. Therapeutic: Holistic. Strengths based. Trauma informed
6. Collaborative: People and families in partnership. Skilled workforce. System working.

The person at the centre and as citizens in their own communities.

Valuing

I Statements

- I am valued as a person, and my individual needs and wishes are respected.
- I feel listened to and that my voice is heard.
- I have a sense of belonging and feel part of my own community.

We Statements

- We will ensure that the people who experience inpatient services and the staff who work within them, feel valued and cared for, benefitting from a culture that lives its values.
- We will work to ensure we can hear the voice of people who may need to call on mental health services and their families, we employ a range of communication methods to reflect individual preferences and needs.
- We will commission and provide services that are part of a local pathway of care which promotes inclusion, strengthens individuals' rights, and is orientated towards citizenship.
- We will work with people in ways that prevent othering, foster a sense of belonging, reduce stigma, and enable people to maintain their social ties.
- We respect people as citizens and valued members of their community. We are here for all our people when they need us, irrespective of where they live, their background, age, ethnicity, sex, gender, sexuality, disability, or health conditions.

Accessible

I Statements

- I can access services based on my need and I do not feel excluded or stigmatised by my diagnosis.

We Statements

- We provide services that are needs led, accessible to all who need them, and are proactive in facilitating choice.
- We will ensure that admissions are appropriate, purposeful, therapeutic, and timely.
- We will employ interventions designed to avoid unnecessary admission to hospital, but when inpatient care is appropriate, it will not be impeded, nor regarded as the 'last resort'.

Humane

I Statements

- I am first and foremost treated as a human being.
- I am cared for in an environment that is considerate of my individual strengths and needs.
- I am supported by staff who talk with me, not to me, using a way of communication that is preferred by me.
- I am supported to plan and prepare for important changes such as transitions between services, or discharge home.

We Statements

- We are unwavering in our commitment to commission inpatient services that are least restrictive and where people are not confined in conditions of greater security than required.
- We will plan discharge with each person at the very start of their admission, mitigating the risk of delays and ensuring that transitions between services are carefully considered.
- We are person-centred in our approach and staff are supported to respond to people's distress with compassion.
- We will pay attention to our hospital environment and the impact it has on the wellbeing of people experiencing inpatient services and the staff working within them.

Equitable

I Statements

- I feel valued and respected for who I am.
- I can be myself around peers and staff.
- I am not discriminated against for who I am and the choices I make.
- I feel difference is understood, respected, and celebrated.
- I feel that my cultural needs and preferences are respected by all the staff who support me.

We Statements

- We will commission and deliver services where everyone counts, are treated with dignity and are safe. Where a person's identity is not contested, their individuality is recognised and who they are and what they need is respected.
- We will work with people (and those who know and love them) to identify 'what matters to them' and make sure that the care they receive is personalised, needs led and respects their human rights.
- We will work with people to make sure we share decision making, acknowledging that even when people are acutely unwell, they are experts in their own lives and have valuable contributions to make about the support they need.
- We will be relentless in our pursuit to identify and address inequalities that exist within our local pathway. We are committed to ensuring everyone is valued irrespective of where they live, their background, age, ethnicity, sex, gender, sexuality, disability, or health conditions.
- We will strive to achieve parity of esteem, valuing mental health equally to physical heath, enabling people living with a mental health condition to have an equal chance of a long and fulfilling life.
- We ensure our environments are inclusive and accessible for everyone. We are thoughtful about people's cultural needs and people with disabilities. We pay close attention to people's individual sensory needs, particularly for autistic people and trauma survivors.

Therapeutic

I Statements

- I will be able to access a range of support that meets my need.
- I feel I have the time and space to form trusting relationships with the people involved in my care.

We Statements

- We know that therapeutic relationships are the strongest predictor of good clinical outcomes, so we will support staff to prioritise building relationships with people and enable continuity of care.
- We recognise that many people who are admitted to inpatient services will have experienced trauma at some point in their lives. Therefore, we will place emphasis on creating physical and emotional environments that promote feelings of safety and therapeutic relationships that are based on trust, respect, and compassion.
- We will invest in inpatient services that demonstrate a holistic, strengths based, integrated approach to care and make sure that mental and physical health conditions are considered, managed, and monitored.
- We will undertake assessments, interventions, and treatments that are evidence-based and delivered in a timely way.
- We are committed to delivering services that demonstrate therapeutic benefit. This includes continuous improvement of the inpatient pathway, co-producing service developments, making best use of data and

using quality improvement methodology.
- We will develop a workforce that is in line with national workforce profiles and has the right skills and knowledge to ensure people have access to a full range of multi-disciplinary interventions and treatments.

Collaborative

I Statements

- I have a voice and I feel my views and choices are respected.
- I am able access independent advocacy if I want to.
- I can make use of peer support as I wish.

We Statements

- We respect the views and advanced choices of the people we serve and the contribution of people who know and care for them.
- We will invest in peer support and facilitate easy access to independent advocacy.
- We understand that safe and high quality inpatient mental health care relies on staff being able to 'be with' and work in partnership with people in a high state of distress. We will provide support for our staff to enable them to do this compassionately, safely, and respectfully.
- We are committed to providing the right resources for all our staff to ensure their time is protected to care, and that they can respond appropriately to the therapeutic aspects of their work.
- We will work in partnership across our system to ensure that locally, there is a range of services to support people within their local communities.
- We are committed to the working together so that no-one is inappropriately admitted to hospital or experiences a delayed discharge.

Support people as citizens

I Statements

- I am supported to access the things that matter to me.
- I feel my hopes, dreams, and plans for the future, are heard.
- I have a sense of belonging with the community I identify with.

We Statements

- We will actively work to promote the social inclusion of adults, children, and young people with mental health need.
- We will ensure that mental health services, by their design and activities, support the active participation of people in their local community.
- We respect everyone's rights and responsibilities as citizens, supporting them to make real their hopes and aspirations, to contribute and to lead fulfilling lives.

Appendix 2: key resources

- Care Quality Commission (2017; updated May 2022) The state of care in mental health services 2014-201 (https://www.cqc.org.uk/publications/major-report/state-care-mental-health-services-2014-2017)
- Department of Health and Social Care and Department for Education (2021) The national strategy for autistic children, young people and adults: 2021-2026 (https://www.gov.uk/government/publications/national-strategy-for-autistic-children-young-people-and-adults-2021-to-2026)
- Getting It Right First Time (2022) Mental health – Rehabilitation (https://gettingitrightfirsttime.co.uk/medical_specialties/mh-rehab/)
- NHS England (2023) Acute inpatient mental health care for adults and older adults (https://www.england.nhs.uk/long-read/acute-inpatient-mental-health-care-for-adults-and-older-adults/)

- NHS England (2020) Advancing mental health equalities strategy (https://www.england.nhs.uk/publication/advancing-mental-health-equalities-strategy/)
- NHS England (2019) The community mental health framework for adults and older adults (https://www.england.nhs.uk/publication/the-community-mental-health-framework-for-adults-and-older-adults/)
- NHS England (2018) Service specification: low secure mental health services (https://www.england.nhs.uk/publication/service-specification-low-secure-mental-health-services-adult/#:~:text=This%20service%20specification%20describes%20low,needs%20and%20existing%20service%20provisi
- NHS England (2018) Service specification: medium secure mental health services (https://www.england.nhs.uk/publication/service-specification-medium-secure-mental-health-services-adult/#:~:text=This%20service%20specification%20describes%20medium,needs%20and%20existing%20service%20pr
- NHS England (2019) NHS Long Term Plan (https://www.longtermplan.nhs.uk/)
- NHS England (2021) Monitoring the quality of care and safety for people with a learning disability and/ or autism (https://www.england.nhs.uk/publication/monitoring-the-quality-of-care-and-safety-for-people-with-a-learning-disability-and-or-people-who-are-autistic-in-inpatient-care/)
- NHS England (2022) 2023/24 Priorities and operational planning guidance (https://www.england.nhs.uk/publication/2023-24-priorities-and-operational-planning-guidance/)
- NHS England (date) Commissioning framework for mental health inpatient services (https://future.nhs.uk/CYPQualityImprovTaskforce/view?objectID=45208880)
- NHS England Rapid improvement guide: red to green bed days (https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2016/12/rig-red-green-bed-days.pdf)
- NICE (2020) NICE guideline [NG181] Rehabilitation for adults with complex psychosis (https://www.nice.org.uk/guidance/ng181)
- NICE (2021) NICE guideline [NG197] Shared decision making (https://www.nice.org.uk/guidance/ng197/chapter/Recommendations)
- RCPsych Mental health inpatient rehabilitation services typology table (https://www.rcpsych.ac.uk/docs/default-source/members/faculties/rehabilitation-and-social-psychiatry/mental-health-inpatient-rehabilitation-services-typology-table-20-3-19.pdf?sfvrsn=8fc19480_2)
- RCPsych Learning disability inpatient rehabilitation services (https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.rcpsych.ac.uk%2Fimproving-care%2Fccqi%2Fquality-networks-accreditation%2Flearning-disabilities-service-inpatients&data=05%7C01%7Clouise.davies10%40nhs.net%7Ca7fdd828449742cf7cbb08db81c743c0%7C37c354b285
- RCPsych Rehabilitation services (https://www.rcpsych.ac.uk/improving-care/ccqi/quality-networks-accreditation/rehabilitation-services)
- NHS England Care, Education and Treatment Reviews (CETRs) (https://www.england.nhs.uk/learning-disabilities/care/ctr/care-education-and-treatment-reviews/)
- NHS England Personalised care and support planning (https://www.england.nhs.uk/personalisedcare/pcsp/)
- NHS England (2023) Learning disability and autism – host commissioner guidance (https://www.england.nhs.uk/long-read/learning-disability-and-autism-host-commissioner-guidance/#:~:text=%E2%80%9CWhere%20someone%20with%20a%20learning,monitor%20the%20quality%20of%20c
- HM Prison and Probation Service (2011; last updated March 2023) Working with restricted patients (https://www.gov.uk/government/collections/working-with-restricted-patients)
- Equality Act 2010 (https://www.legislation.gov.uk/ukpga/2010/15/contents)

Appendix 3: acknowledgements

The input of stakeholders in many different ways has been considerable. The commitment and investment of time from those who commission, work in or with mental health rehabilitation inpatient services has been invaluable.

Particular acknowledgement must be given to the people in services, their families and carers who contributed, sharing their experiences, thoughts and ideas so openly and honestly.

The Mental Health Rehabilitation Inpatient Task and Finish Group has steered the development of the guidance:

Adult Mental Health Rehabilitation Inpatient Task and Finish Group Membership

- Sri Kalidindi (co-chair) – GIRFT and South London and Maudsley NHS Foundation Trust
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- Keir Shillaker – West Yorkshire Health and Care Partnership ICB
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- Thelma Goddard – National Learning Disability and Autism Team, NHS England
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- Helen Souter – Mental Health Casework Section, His Majesty's Prison and Probation Service
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Commissioning framework for mental health inpatient services

Publication (/publication)

Content

1. Key messages for those responsible for the commissioning of mental health inpatient services

1.1 As well as improving experience and outcomes, this will support people to strengthen their relationships, sense of belonging and connection to local services.

1.2 Creating this strategic plan and achieving its aims will require strong collaboration, particularly with local authorities and public health, and the harnessing of local information such as that within the Joint Strategic Needs Assessment. This framework summarises the issues the plan will need to address as a minimum.

1.3 The strategic plan also needs to identify how data will be collected, reported, and used to monitor progress across NHS and independent sector providers. This will include how services will be commissioned with models of care that mitigate the risks identified in this guidance, including those associated with placing people at distance.

1.4 Local strategies need to cover within them how they will cease the practice of sending people to inpatient services at distance from their home and/or to outdated or risky models of provision. This includes acute and rehabilitation inpatient services.

1.5 Localising care will require a phased implementation approach, which may include shortening stays, preventing inappropriate readmissions to inpatient services and redirecting resources from poor quality, and outdated inpatient provision towards the community.

1.6 Achieving the vision of ‘what good looks like’ will require new relationships, the shifting of resources and power and reshaping of the provider market. Provision across the NHS and Independent Sector needs to be balanced, achieving the right outcomes for local people and represent good quality. This includes making appropriate use of the skills and expertise within Voluntary, Community, Faith and Social Enterprise organisations.

1.7 Commissioners of mental health inpatient services will need to forge strong networks within and across systems, recognising their interdependency with a range of services across the community including social care, education and health and justice agencies.

1.8 Building community services, including housing and support, will be crucial in enabling people to return to the place they call home. Thorough planning with people, particularly those who have been in hospital and/or out of area for a long time, will be important to determine where, how and with whom they would like to live.

1.9 New models of care and support should be co-designed with people with recent lived experience of inpatient provision, families, and advocates, those who work within them, as well as the wider community. This will include working together to reduce the risks associated with transitions across multiple interfaces experienced by people and families.

1.10 The speed of change locally will depend on the availability of a skilled and competent workforce, including specialist professionals who can work across the system. Ensuring the capability, capacity as well as the wellbeing and safety of the inpatient workforce is paramount. This includes recognising and mitigating the risk of compassion fatigue, and continued action to address longstanding problems such as staff shortages.

1.11 To deliver a local workforce who can localise provision will require a system-wide approach to workforce planning; one that includes all NHS commissioned services including those within the independent and voluntary sectors.

1.12 Future commissioning, design and delivery of mental health inpatient services should meet the requirement for inclusive, local, high quality, effective and compassionate care. Barriers to delivering the right care and support at the right time need to be removed.

1.13 Integrated care systems and providers of inpatient mental health services are required to use data and intelligence to inform improvement and decision making, setting clear standards of what high quality care and outcomes look like (NHS England, 2021 (https://www.england.nhs.uk/publication/national-quality-board-shared-commitment-to-quality/)). This includes identifying and monitoring groups within their local population who have poorer access, experience, and outcomes from care.

1.14 Commissioners are required to evaluate the outcomes, effectiveness, and safety of current inpatient provision (both local and out of area services) with a particular focus on the experience of people and families.

> "If we are going to truly change things for the better, we need to think about people as a whole – what makes their lives, and their needs, wants and ambitions… these varied and personal needs must be reflected in the support and treatment we receive from public services too. Here we should be striving for needs-based not diagnosis-based care and treatment… we also need to empower and enable clinicians to work with us to understand our needs as a whole before agreeing a course of actions to keep us well. We need choice and to practice shared decision-making." Person with lived experience.

2. Introduction

2.1 Mental health inpatient services form a vital part of a landscape of care, treatment and support for individuals who are experiencing mental ill health. This includes primary care, social care, and specialist healthcare teams.

2.2 Many mental health inpatient services across the country are delivering good care and outcomes. They show what is possible and achievable.

2.3 However, while significant progress has been made, some parts of the country still over rely on certain types of bed-based provision (including out of area placements) and the use of poor quality and outdated services (RCPsych, 2022 (https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2022/04/11/shameful-practice-of-out-of-area-placements-devastating-for-mental-health-patients); GIRFT, 2022) (https://gettingitrightfirsttime.co.uk/medical_specialties/mh-rehab/).

2.4 Recent high-profile quality failings in both NHS and independent sector hospitals have rightly sharpened the focus of providers, commissioners, and regulators on mental health inpatient provision (The Independent, 2022 (https://www.independent.co.uk/news/health/mental-health-nhs-patient-deaths-b2148501.html); Department of Health and Social Care, 2023 (https://www.gov.uk/government/publications/rapid-review-into-data-on-mental-health-inpatient-settings-final-report-and-recommendations); Samuel M, 2022 (https://www.communitycare.co.uk/2022/10/07/trust-rated-inadequate-for-learning-disabilities-after-cqc-finds-blame-culture-and-excessive-restraint/)).

2.5 In 2022/23 the NHS England mental health, learning disability and autism quality transformation team (https://www.england.nhs.uk/mental-health/mental-health-learning-disability-and-autism-inpatient-quality-transformation-programme/) undertook an extensive engagement exercise with key stakeholders. The aim of this exercise was to gather the views and expertise of individuals concerned with the commissioning, delivery, and improvement of mental health inpatient services. This included clinicians and people with lived experience of inpatient services and their families. In doing so, identifying key themes and priorities where intervention and support to improve quality could be employed to best effect.

2.6 This 'ask' included a clear request for a shared understanding of 'what good looks like' for mental health inpatient services and a call to action. To support commissioners and providers to build on existing good practice to ensure that every person who is admitted to an inpatient service, experiences safe, personalised, effective, and compassionate care.

2.7 This guidance forms part of that support, which is comprised of several workstreams, including work focussed on improving the culture of inpatient services and existing commitments such as those contained within the NHS Patient Safety Strategy (https://www.england.nhs.uk/publication/nhs-patient-safety-strategy-2021-update/). It is aimed at improving the quality and safety of care that people experience in mental health, learning disability and autism inpatient settings.

2.8 This guidance is about how integrated care boards can use the funds they are currently investing in inpatient care to provide better services which are tailored to patient need, not about additional funding. If we collectively shift our investment from services which do not help people get better to more proactive support for all, we should be able to achieve better results within our existing funding.

Aims of the framework

The overarching framework summarises the commissioning guidance relating to mental health inpatient provision. It aims to:

- Provide guidance for those responsible for the commissioning of mental health inpatient services and within this, advance the system-wide requirement to ensure that services are local, inclusive and deliver safe, personalised, and therapeutic care.
- Support systems to develop local plans for change, so that inpatient provision better fits the needs of the population, makes more effective use of the funds available, and protects and improves the lives of citizens in the locality.

2.9 The detailed guidance is comprised of:

a) Acute inpatient mental health services for adults and older adults (https://www.england.nhs.uk/mental-health/adults/crisis-and-acute-care/)
b) National guidance to support integrated care boards to commission acute mental health inpatient services for adults with a learning disability and autistic adults (https://www.england.nhs.uk/publication/national-guidance-to-support-integrated-care-boards-to-commission-acute-mental-health-inpatient-services-for-adults-with-a-learning-disability-and-autistic-adults/)
c) Commissioner guidance for adult mental health rehabilitation inpatient services (https://www.england.nhs.uk/publication/commissioner-guidance-for-adult-mental-health-rehabilitation-inpatient-services/)

2.10 The detailed guidance documents were developed with frontline clinicians and people with lived experience of inpatient services, either directly or as a carer. This included visits to inpatient provision, workshops, reference and task and finish groups. In addition, the design and content of this overarching framework has been informed by a commissioner advisory group whose membership represents regional, system and provider collaborative commissioners (see Appendix 4).

Audience

2.11. This framework has been developed for use by those who have commissioning responsibility for the mental health needs of their local population. For this guidance, it is recognised that commissioning is a function and can be carried out by different individuals and organisations, separately and collaboratively, depending on local arrangements. For ease, within this document, those with commissioning responsibility will be referred to as “the commissioner”.

2.12. The commissioner of mental health inpatient services may vary nationally, and could be:

- An integrated care board (ICB)
- A provider collaborative
- An NHS-led provider collaborative

2.13. The framework also has relevance for mental health providers, professionals, and partnership organisations across Integrated Care Systems and may include:

- Local Authority Commissioners
- Commissioners of Specialised Mental Health, Learning Disability and Autism Services and Health and Justice Services
- Providers of community and hospital healthcare provision both NHS and independent sector
- Voluntary, Community, Faith and Social Enterprises (VCFSE)
- People with lived experience and organisations that advocate for and represent them.

Scope

2.14. The scope of this framework (Table 1) was determined by the views of stakeholders and shaped by work underway or planned, e.g., within clinical reference groups, and by reviewing the evidence for serious quality failings in those types of services that have recently and frequently featured in such reports.

Table 1: Scope of the commissioning framework

Scope	Adults
Included	Acute mental health inpatient services including services for people with a learning disability or who are autistic, and psychiatric intensive care units. Mental health rehabilitation inpatient services including services for autistic people and people with a learning disability – open and 'locked'.
Excluded	All adult secure Adult eating disorder services Mother and baby units Adult D/deaf Obsessive-compulsive disorder, body dysmorphic disorder services

2.15 While the primary focus of this framework is inpatient provision, improved models and pathways will depend to a large degree on the capacity and capability within the local community, its assets and strengths. Alongside this is the need for relevant expertise to lead the design.

2.16 It is therefore essential that local system partners forge strong relationships and collaborate to establish joined up, effective pathways and transitions, and share knowledge, skills and support.

2.17 Central to this is addressing the way we directly care for people, and specifically what is often called the 'therapeutic relationship' (O'Brien L, 2001 (https://pubmed.ncbi.nlm.nih.gov/11493289/)). One definition of this is a "partnership that promotes safe engagement and constructive, respectful, and non-judgemental intervention" (McCormack B, McCance T, 2016). The primary importance of the therapeutic relationship, and the culture of care more broadly, will be covered through the Culture of care standards for mental health inpatient services (https://www.england.nhs.uk/long-read/culture-of-care-standards-for-mental-health-inpatient-services/).

3. Case for change

> Too many people are detained on wards that are far below the standards anyone would want for themselves or their loved ones. Sir Simon Wessely: Independent Review of the Mental Health Act 2018.

3.1 The views of stakeholders, including clinicians, providers, commissioners, regulators and, specifically, people with lived experience, confirm the case for change.

3.2 Reports continue to detail quality failings within mental health inpatient services, including those specifically for people with learning disabilities and autistic people (House of Commons Health and Social Care Committee, 2021 (https://committees.parliament.uk/publications/6669/documents/71689/default/)).

3.3 Detentions under the Mental Health Act have been rising alongside increasing concerns about the use of long-term segregation, seclusion, restraint, and other coercive measures.

3.4 Many people who have experienced poor or abusive mental health inpatient care share characteristics that make them more susceptible to discrimination and inequality NHS Race and Health Observatory, 2022 (https://www.nhsrho.org/research/ethnic-inequalities-in-healthcare-a-rapid-evidence-review-2/)). This includes people given a particular diagnosis such as 'personality disorder' (Klein P, Fairweather AK, Lawn S, 2022 (https://ijmhs.biomedcentral.com/articles/10.1186/s13033-022-00558-3)) and/or who are labelled as 'challenging' and/or 'complex' (Cambridge P, Beadle-Brown J, Milne A, Mansell J, Whelton B, 2007 (https://research.kent.ac.uk/tizard/wp-content/uploads/sites/2302/2019/01/cambridge_2006_tizardadultprotection.pdf)). They may find themselves denied access to mental health services and even be at risk of criminalisation. (https://www.england.nhs.uk/long-read/nhs-england-position-on-serenity-integrated-mentoring-and-similar-models/)

3.5 Recent inquiries and rapid reviews (NHS England, 2023 (https://www.england.nhs.uk/long-read/nhs-england-position-on-serenity-integrated-mentoring-and-similar-models/)) into mental health inpatient services, including those specifically for people with a learning disability and autistic people, have identified particular 'setting conditions' and/or characteristics of service models that are associated with serious quality failings (see paragraph 3.12 below). These factors can undermine the delivery of high quality, person-centred care and also increase the risk of a 'closed culture' developing.

3.6 The CQC describes a closed culture as “a poor culture in a health or care service that increases the risk of harm. This includes abuse and human rights breaches. The development of closed cultures can be deliberate or unintentional – either way it can cause unacceptable harm to a person and their loved ones.” (Care Quality Commission, 2022 (https://www.cqc.org.uk/guidance-providers/all-services/how-cqc-identifies-responds-closed-cultures)).

3.7 Understanding this picture is imperative as the design of some inpatient service models mean that people are more likely to be at risk of deliberate or unintentional harm. Even when care is deemed acceptable, it may be a service model that represents poor value for money, limited or non-existent outcomes as seen within inpatient mental health rehabilitation services (Care Quality Commission, 2020) (https://www.cqc.org.uk/publications/themed-work/mental-health-rehabilitation-inpatient-services-%E2%80%93-2019-update).

> “No-one had an overview. I was the only one keeping tabs on what was happening… it shouldn’t have been me doing it.” Family carer of someone placed out of area.

3.8 Sending people away from their home communities risks dislocating their care and increasing their length of stay and sense of isolation; however, this is something experienced by all too many people.

3.9 People who are admitted to an out of area hospital have, on average, longer lengths of stay (Crossley N, Sweeney B, 2022), poorer clinical outcomes (including increased risk of suicide (Royal College of Psychiatrists, 2022 (https://www.cqc.org.uk/publications/themed-work/mental-health-rehabilitation-inpatient-services-%E2%80%93-2019-update)) and poorer experience of care (GIRFT, 2022 (https://gettingitrightfirsttime.co.uk/medical_specialties/mh-rehab/)).

3.10 The Getting It Right First Time (GIRFT) national report for mental health rehabilitation (https://gettingitrightfirsttime.co.uk/medical_specialties/mh-rehab/) noted that half of the 3,500 people who use inpatient mental health rehabilitation beds in England receive care outside their local area, mainly from independent providers, away from their families and support network.

3.11 A 2021 NHS England report (https://www.england.nhs.uk/long-read/safe-and-wellbeing-reviews-thematic-review-and-lessons-learned/) detailing the lessons learned from safe and wellbeing reviews, noted that 57% of people with a learning disability and autistic people were placed outside their originating ICS or transforming care partnership. Several factors are leading to this situation, not least a lack of locally available alternatives.

3.12 The design and location of specific service models can exacerbate this position, by their design and location. The types of hospital that often feature in reports detailing quality failings commonly:

- make use of ‘spot contracts’
- admit people from across the country
- are disconnected from local pathways
- are in single site, often isolated, locations
- admit into one service people with different diagnosis but who are often described as ‘challenging’ and/or ‘complex’.

3.13 Moreover, once someone is detained within an inpatient service, they may be subject to further coercive and restrictive practices including seclusion, segregation, and restraint, as identified in the CQC review Out of sight – who cares? (2020). (https://www.cqc.org.uk/publications/themed-work/rssreview)

3.14 Involuntary admission to hospital can be a traumatic, frightening, and confusing experience for people. The case for reducing compulsion is inarguable and set out in detail in the Independent Review of the Mental Health Act (https://www.gov.uk/government/groups/independent-review-of-the-mental-health-act) and the proposed reforms in the Draft Mental Health Bill (https://www.gov.uk/government/publications/draft-mental-health-bill-2022).

3.15 The number of people detained in hospital continues to rise year on year and there is disproportionate use across the population; in the year to March 2022, black people were almost five times as likely as white people to be detained under the Mental Health Act (https://www.ethnicity-facts-figures.service.gov.uk/health/mental-health/detentions-under-the-mental-health-act/latest#:~:text=Based%20on%20the%20providers%20who%20submitted%20good%20quality,March%202020%20and%2([18]

3.16 People with learning disability and autistic people are disproportionately likely to experience restrictive interventions while in hospital, illustrated, for example, by the high number of autistic people in long-term segregation (Department of Health and Social Care, 2021 (https://www.gov.uk/government/publications/independent-care-education-and-treatment-reviews/thematic-review-of-the-independent-care-education-and-treatment-reviews)).

3.17 Legislation requires mental health inpatient services to increase transparency, accountability and reduce the use of restrictive practice. The Mental Health Units (Use of Force) Act (https://www.gov.uk/government/publications/mental-health-units-use-of-force-act-2018), commonly known as Seni's Law, gained Royal Assent in 2018, but despite this progress in reducing restrictions has been patchy.

3.18 In 2020 the CQC published a report on the use of restraint, seclusion and segregation for autistic people, people with a learning disability and/or mental health condition, noting that of those subject to these restrictions: "Almost 71% had been segregated or secluded for three months or longer. A few people we met had been in hospital for more than 25 years, but how long they had been in segregation or seclusion had not been recorded beyond 13 years." (CQC, 2020 (https://www.cqc.org.uk/publications/themed-work/rssreview)).

3.19 Without a concerted effort to localise and realign inpatient services in a way that harnesses the potential of people and communities, people may continue to find themselves:

- stranded in hospital when they are ready to leave, often for many months or years
- sent away to services at distance from home and the people who care about them
- subject to overly restrictive practice, including the use of long-term segregation
- susceptible to poor and abusive care
- stigmatised and discriminated against and at risk of criminalisation.

3.20 We know that the design of services has a major role in creating the setting conditions for people who experience, and those who work within, inpatient services to flourish.

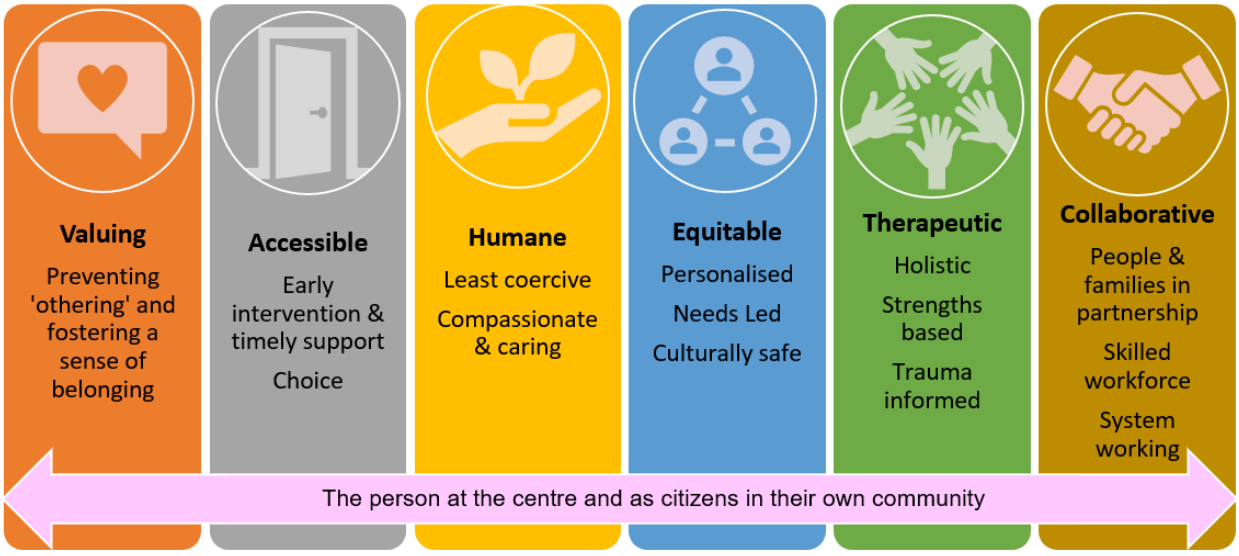
3.21 It is vital that service models are intentionally and primarily designed around the needs of people who experience them and are not driven by market or other external forces.

3.22 Maintaining the status quo is not an option as some service models are hindering rather than helping the delivery of high quality, safe and compassionate care. It is imperative that the commissioned inpatient provision meets our legal, moral and ethical obligations, and systems can co-produce a bold and radical vision for the future; one that not only delivers inpatient services that are the best that they can be, but also helps people feel they belong and are recognised as full citizens with all the rights and responsibilities that denotes.

4. Commissioning to achieve 'what good looks like'

4.1 Each of the detailed mental health inpatient service documents provides the specific vision and key principles for that service, but there is common ground between them across the descriptors of 'what good looks like' as described in Figure 1 below:

Figure 1: What good looks like principles



(https://www.england.nhs.uk/wp-content/uploads/2024/01/Commissioning-principles.png)

The person at the centre and as citizens in their own community

- Valuing: preventing 'othering' and fostering a sense of belonging
- Accessible: early intervention and timely support. Choice
- Humane: least coercive. Compassionate and caring

- Equitable: personalised. Needs led. Culturally safe
- Therapeutic: Holistic. Strength based. Trauma informed
- Collaborative: People and families in partnership. Skilled workforce. System working

4.2 This emphasis on the descriptors of a good service rather than an overly prescriptive structure or 'best practice' model recognises that the configuration of services should be determined by local systems and co-produced with experts by experience. They provide a scaffold for the commissioning of inpatient mental health services, including those specifically for people with a learning disability and autistic people.

4.3 Complementary to this are the Culture of care standards for mental health inpatient services (https://www.england.nhs.uk/long-read/culture-of-care-standards-for-mental-health-inpatient-services/).

4.4 We know that across the country there are services already working to a similar vision, descriptors and commissioning principles, using the investments provided in the NHS Long Term Plan to bring about change. Therefore, the content of later focused sections on acute inpatient services, rehabilitation inpatient services may be familiar to people with experience within the sector.

I and We statements

4.5 Below we embellish these descriptors of 'what good looks like' with 'I and we' statements. 'I' statements describe what good looks like from an individual perspective and 'we' statements are indicators or signposts for commissioners on how they can work together with people, families, staff and other stakeholders to achieve the vision of 'what good looks like' in mental health inpatient care. Good mental health inpatient services are;

Valuing: Preventing 'othering' and fostering a sense of belonging

I statements

- I am valued as a person, and my individual needs and wishes are respected.
- I feel listened to and that my voice is heard.
- I have a sense of belonging and feel part of my own community.

We statements

- We will ensure that the people who experience inpatient services and the staff who work within them, feel valued and cared for, benefitting from a culture that lives its values.
- We will work to ensure we can hear the voice of people who may need to call on mental health services and their families; we employ a range of communication methods to reflect individual preferences and needs.
- We will commission and provide services that are part of a local pathway of care that promotes inclusion, strengthens individuals' rights, and is orientated towards citizenship.
- We will work with people in ways that prevent othering, foster a sense of belonging, reduce stigma, and enable people to maintain their social ties.
- We respect people as citizens and valued members of their community. We are here for all our people when they need us, irrespective of where they live, their background, age, ethnicity, sex, gender, sexuality, disability, or health conditions.

Accessible: Early intervention and timely support

I statements

- I can access services based on my need and I do not feel excluded or stigmatised by my diagnosis.

We statements

- We provide services that are needs led and accessible to all who need them, and we are proactive in facilitating choice.
- We will ensure that admissions are appropriate, purposeful, therapeutic, and timely.
- We will employ interventions designed to avoid unnecessary admission to hospital, but when inpatient care is appropriate, it will neither be impeded nor regarded as the 'last resort'.

Humane: Least coercive; compassionate and caring

I statements

- I am first and foremost treated as a human being.
- I am cared for in an environment that is considerate of my individual strengths and needs.

- I am supported by staff who talk with me, not to me, using a way of communication that is preferred by me.
- I am supported to plan and prepare for important changes such as transitions between services, or discharge home.

We statements

- We are unwavering in our commitment to commission inpatient services that are least restrictive and where people are not confined in conditions of greater security than required.
- We will plan discharge with each person from the very start of their admission, mitigating the risk of delays and ensuring that transitions between services are carefully considered.
- We are person-centred in our approach and staff are supported to respond to people's distress with compassion.
- We will pay attention to our hospital environment and the impact it has on the wellbeing of people experiencing inpatient services and the staff working within them.

Equitable: Personalised, needs led, culturally safe

I statements

- I feel valued and respected for who I am.
- I can be myself around peers and staff.
- I am not discriminated against for who I am and the choices I make.
- I feel difference is understood, respected, and celebrated.
- I feel that my cultural needs and preferences are respected by all the staff who support me.

We statements

- We will commission and deliver services where everyone counts, is treated with dignity and is safe. Where a person's identity is not contested, their individuality is recognised and who they are and what they need is respected.
- We will work with people (and those who know and love them) to identify 'what matters to them' and make sure that the care they receive is personalised, needs led and respects their human rights.
- We will work with people to make sure we share decision making, acknowledging that even when people are acutely unwell, they are experts in their own lives and have valuable contributions to make about the support they need.
- We will be relentless in our pursuit to identify and address inequalities that exist within our local pathway. We are committed to ensuring everyone is valued irrespective of where they live, their background, age, ethnicity, sex, gender, sexuality, disability, or health conditions.
- We will strive to achieve parity of esteem, valuing mental health equally to physical heath, enabling people living with a mental health condition to have an equal chance of a long and fulfilling life.
- We ensure our environments are inclusive and accessible for everyone. We are thoughtful about people's cultural needs and people with disabilities. We pay close attention to people's individual sensory needs, particularly for autistic people and trauma survivors.

Therapeutic: Holistic, strengths based, trauma informed

I statements

- I will be able to access a range of support that meets my need.
- I feel I have the time and space to form trusting relationships with the people involved in my care.

We statements

- We know that therapeutic relationships are the strongest predictor of good clinical outcomes, so we will support staff to prioritise building relationships with people and enable continuity of care.
- We recognise that many people who are admitted to inpatient services will have experienced trauma at some point in their lives. Therefore, we will place emphasis on creating physical and emotional environments that promote feelings of safety and therapeutic relationships that are based on trust, respect, and compassion.
- We will invest in inpatient services that demonstrate a holistic, strengths based, integrated approach to care and make sure that mental and physical health conditions are considered, managed, and monitored.
- We will undertake assessments, interventions, and treatments that are evidence-based and delivered in a timely way.
- We are committed to delivering services that demonstrate therapeutic benefit. This includes continuous improvement of the inpatient pathway, co-producing service developments, making best use of data and using quality improvement methodology.
- We will develop a workforce that is consistent with national workforce profiles and has the right skills and knowledge to ensure people have access to a full range of multidisciplinary interventions and treatments.

Collaborative: People and families in partnership, skilled workforce and system working

I statements

- I have a voice and I feel my views and choices are respected.
- I am able to access independent advocacy if I want to.
- I can make use of peer support as I wish.

We statements

- We respect the views and advanced choices of the people we serve and the contribution of people who know and care for them.
- We will invest in peer support and facilitate easy access to independent advocacy.
- We understand that safe and high quality inpatient mental health care relies on staff being able to 'be with' and work in partnership with people in a high state of distress. We will provide support for our staff to enable them to do this compassionately, safely, and respectfully.
- We are committed to providing the right resources for all our staff to ensure their time is protected to care, and that they can respond appropriately to the therapeutic aspects of their work.
- We will work in partnership across our system to ensure that locally, there is a range of services to support people within their local communities.
- We are committed to working together so that no-one is inappropriately admitted to hospital or experiences a delayed discharge.

Support people as citizens: The person at the centre and as citizens within their own communities

I statements

- I am supported to access the things that matter to me.
- I feel my hopes, dreams, and plans for the future, are heard.
- I have a sense of belonging with the community I identify with.

We statements

- We will actively work to promote the social inclusion of people with mental health need.
- We will ensure that mental health services, by their design and activities, support the active participation of people in their local community.
- We respect everyone's rights and responsibilities as citizens, supporting them to make real their hopes and aspirations, to contribute and to lead fulfilling lives.

> "Being able to make decisions about one's life, including the right to choose one's own healthcare – is key to a person's autonomy and personhood." (World Health Organisation (2022) (https://www.who.int/news-room/feature-stories/detail/autonomy-was-the-key-to-my-recovery)).

5. All means all

5.1 A core value enshrined in the NHS Constitution (https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england) is that 'everyone counts', that nobody is excluded, discriminated against or left behind. There is also a national strategy to advance mental health equalities (https://www.england.nhs.uk/mental-health/advancing-mental-health-equalities/).

5.2 However, we know that many of the problems and issues identified in section 3 apply disproportionately to some groups, and that our fundamental duty to promote equality and respect human rights is not universally upheld.

5.3 Inpatient mental health services need to work for everyone and be committed to meeting the responsibilities under the Equality Act 2010 (https://www.gov.uk/guidance/equality-act-2010-guidance), including the duty to make reasonable adjustments using tools such as the Reasonable Adjustment Flag (https://digital.nhs.uk/services/reasonable-adjustment-flag#reasonable-adjustments-an-overview) and the The Reasonable Adjustment Digital Flag action checklist) (https://www.england.nhs.uk/long-read/the-reasonable-adjustment-digital-flag-action-checklist-what-you-need-to-do-to-achieve-compliance/).

5.4 Adjustments should meet the needs of the individual, not of any characteristics or conditions used to describe the person. Any required adjustments should be identified through personalised care and support planning (https://www.england.nhs.uk/personalisedcare/pcsp/) conversations around what matters to the person and what good support looks like to them. The person may already have a plan that can be reviewed and amended to include information about reasonable adjustments.

5.5 Inpatient services also need to demonstrate that they are anti-racist to counter systemic racism; that is, go beyond increasing access and ensuring culturally sensitive and competent provision.

5.6 Mental health inpatient services serve people who face discrimination in their daily lives, based on their race, class, gender or sexuality. These forms of discrimination often intersect, amplifying their detrimental effects; and people who face discrimination may also be alcohol or drug dependent, have other health needs and/or disabilities.

5.7 The use of particular diagnostic labels and descriptions attributed to some people and their relationship with services such as people who are labelled as having a 'personality disorder' or described as 'high users', can further exacerbate the discrimination they face (NHS England, 2023 (https://www.england.nhs.uk/long-read/nhs-england-position-on-serenity-integrated-mentoring-and-similar-models/)).

5.8 It is essential that locally agreed plans are in place to manage transitions between services, agencies and localities, safely and effectively. Transitions between services can present significant risks for people of all ages, as often several interfaces need to be crossed – between different providers as well as different health, social care, education and criminal justice agencies. Sometimes, 'boundary disputes' occur at these points of transition and/or where partnership working is weak, adding to the stress for the person and their families.

5.9 A guiding principle is that access to mental health services should be premised on the needs of the individual, and not determined by exclusion criteria. The use of mainstream mental health services must always be the 'default' position, including for people with a learning disability and autistic people.

5.10 Where people require reasonable adjustments or have additional needs that fall outside the remit of inpatient mental health services, expertise and support may be sought from specialists, e.g. learning disability, autism, and drug and alcohol services.

5.11 Mental health inpatient wards should have appropriate signage, soft furnishings and flooring, and be sensory friendly (https://www.england.nhs.uk/publication/sensory-friendly-resource-pack/) to meet the diverse needs of the people who access inpatient provision, including people who may be older, have physical and/or sensory impairments or sensitivities, have a learning disability or who are autistic people. Further guidance on meeting autistic adults needs can be found here: NHS England » Meeting the needs of autistic adults in mental health services (https://www.england.nhs.uk/long-read/meeting-the-needs-of-autistic-adults-in-mental-health-services/).

5.12 Communication preferences should be understood and accommodated, including by providing access to interpreters and information in a range of formats, using augmentative and alternative communication, and meeting the requirements of the Accessible Information Standard (//www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/accessibleinfo/).

5.13 Ward environments need to be in line with the guidance on same-sex accommodation (https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2021/05/NEW-Delivering_same_sex_accommodation_sep2019.pdf), which includes ensuring trans individuals are cared for on the appropriate gendered ward.

5.14 Inpatient services need to make sure that people have access to and are supported to meet with independent advocates who are culturally appropriate and peer support workers, regardless of the legal status of their admission.

5.15 Staff within inpatient provision should be representative of the local community and be sufficient in number and have the skills and training to support people sensitively and effectively.

5.16 We need to take a systematic approach to understanding the communities we serve, who is over and under-represented in our services, and who has poorer experiences and outcomes. Actions to address discrimination and inequalities within services need to be taken in partnership with marginalised communities as described in the NHS England » Patient and carer race equality framework (https://www.england.nhs.uk/long-read/patient-and-carer-race-equality-framework/). Detailed information on and resources for advancing health equality are provided in Appendix 3.

> "Every single person working in mental health has a role to play in making our services and systems fairer and challenging racism in all its forms." Dr Jacqui Dyer, Mental Health Equalities Advisor, NHS England

6. Acute inpatient mental health care for adults and older adults

6.1 This section summarises the detailed guidance on 'what good looks like' in Acute inpatient mental health care guidance for adults and older adults (https://www.england.nhs.uk/mental-health/adults/crisis-and-acute-care/), with emphasis given to the information of relevance to commissioners.

- **Care is personalised** to people's individual needs, and mental health professionals work in partnership with people to provide choices about their care and treatment, and to reach shared decisions.
- **Admissions are timely and purposeful** – When a person requires care and treatment that can only be provided in a mental health inpatient setting and cannot be provided in the community, they receive prompt access to the best hospital provision available for their needs, which is close to home so that they can maintain their support networks and community links. The purpose of the admission is clear to the person, their carers, the inpatient team and any supporting services.
- **Hospital stays are therapeutic** – People receive timely access to the assessments, interventions, and treatments that they need, so that their time in hospital delivers therapeutic benefit. Care should be delivered in a therapeutic environment and in a way that is trauma-informed, working with people to understand any traumatic experiences they have had and how in hospital they can be supported in a way that minimises re-traumatisation.
- **Discharge is timely and effective** – People are discharged to a less restrictive setting as soon as the purpose of their admission is met and they no longer require care and treatment that can only be provided in hospital. For this to happen, discharge planning needs to start on admission. A range of community support available and supported living options also need to be available to meet different needs and enable people to maintain their wellbeing and live as independently as possible after discharge.
- **Care is joined up across the health and care system** – Inpatient services work in a cohesive way with partner organisations at admission, during a person's inpatient stay and to support effective discharge, so that people are supported to stay well when they leave hospital.
- **Services actively identify and address inequalities** that exist within their local inpatient pathway, in partnership with people from affected groups and communities. This must include ensuring that people are not prevented from accessing or receiving good quality acute mental health inpatient care simply because of a disability, diagnostic label or any other protected characteristic.
- **Services grow and develop the acute inpatient mental health workforce** in line with national workforce profiles (https://www.longtermplan.nhs.uk/publication/nhs-mental-health-implementation-plan-2019-20-2023-24/), so that inpatient services can offer a full range of multidisciplinary interventions and treatment. Staff wellbeing, training and development should be supported, so that inpatient services are a great place to work and staff are enabled to offer compassionate, high quality care.
- There is **continuous improvement of the inpatient pathway** – services strive to improve by making the best use of data, regularly developing, testing and refining change ideas using quality improvement methodology, and ensuring that service improvements are co-produced with people with experience of inpatient services and their carers

6.2 This section applies to all people who use acute inpatient services for adults and older adults including people with a learning disability and autistic people, people who have experienced trauma and people from racialised communities.

6.3 Further guidance on adjustments to acute mental health inpatient care for adults with a learning disability and autistic people can be found on the NHS England website (https://www.england.nhs.uk/learning-disabilities/) including guidance on acute mental health inpatient services specifically for adults with a learning disability and autistic adults.

6.4 There are also tools such as the Green Light Toolkit (https://www.ndti.org.uk/resources/green-light-toolkit) that can help services think about the improvements that they could make to support people with a learning disability and autistic people.

6.5 In general, these specific acute mental health inpatient services will be staffed by specialist professionals with the skills and knowledge to deliver appropriate care and treatment to people whose needs would not be met in a mainstream service. For example, a multi-disciplinary team that includes registered learning disability nurses, and other clinicians with relevant expertise to support people with a learning disability and autistic people.

6.6 These services are also likely to have been designed specifically for people with a learning disability and autistic people in mind and therefore have more flexibility in terms of the environment and staffing requirements. This means offering a choice, e.g., of shared space and a cautious approach to environments that may become segregated 'by default' e.g., individual suites.

6.7 Specific policy requirements, guidance and resources relating to the care and treatment of people with learning disabilities and autistic people are detailed in Appendix 2.

The following diagram illustrates the key elements that underpin effective acute mental health inpatient care. The 4 key principles and the 2 key enablers apply across the inpatient pathway and the 3 key stages relate to pre-admission, inpatient stay, and discharge.

Key elements of the inpatient pathway

(https://www.england.nhs.uk/wp-content/uploads/2024/01/image-4.png)

Four key principles

1. Personalised care and shared decision making
2. Trauma-informed care
3. Joined up partnership working
4. Care that advances health equality

Three key stages

Purposeful admissions

People are only admitted to inpatient care when they require assessments, interventions or treatment that can be provided in hospital, and if admitted, it is to the most suitable available bed for the person's needs and there is a clearly stated purpose for the admission.

Therapeutic inpatient care

Care is planned and regularly reviewed with the person and their chose carer/s, so that they receive the therapeutic activities, interventions and treatments they need each day to support their recovery and meet their purpose of admission.

Proactive discharge planning and effective post-discharge support

Discharge is planned with the person and their chosen carer/s for the start of their inpatient stay, so that they can leave hospital as soon as they no longer require assessments, interventions or treatments that can only be provided in an inpatient setting, with all planned post-discharge support provided promptly on leaving hospital.

Two key enablers

1. A fully multidisciplinary, skilled and supported workforce.

2. Continuous improvement of the inpatient pathway. Using data, co-production and quality improvement methodology.

Key stages of the acute inpatient pathway

Key stage 1. From the point of presentation to within 72 hours of admission

- Holistic assessment conducted to understand the person's needs. This assessment should build on information contained within the person's electronic patient record (EPR), including any recorded advanced choices and reasonable adjustments.
- Decision reached, considering as fully as possible the person's preferences, including any advanced choice documents (ACDs), those of their chosen carer/s, and the views of relevant partner services, that the person's needs can only be met in an inpatient setting and cannot be supported in the community. For people with a learning disability and autistic people, a care, education, and treatment review C(E)TR should take place pre-admission to support this decision (or if this is not possible, within 28 days of admission).
- Purpose of admission discussed and agreed with the person and their chosen carer/s and uploaded to the person's electronic patient record (EPR).
- Prompt access facilitated to the most suitable hospital provision available for the person's needs.
- Formulation review completed to gain an in-depth understanding of the person, the circumstances leading up to their admission and what will help them to recover.
- This, together with recorded ACDs and the findings of a C(E)TR (for people with a learning disability and autistic people), should be used as the basis to co-develop a personalised care plan with the person and their chosen carer/s, which should then be uploaded to the person's EPR.
- Discharge planning begun with person and their chosen carer/s, including identifying any factors that could delay discharge (e.g., housing, social care), agreeing an estimated date of discharge (EDD) and an intended discharge destination, and uploading these to the person's EPR.
- Interventions and treatment for physical and mental health conditions commenced or maintained, and a physical health check completed.

Key stage 2. During the hospital stay

- Daily reviews (e.g., using the Red to Green approach) completed to check the person is receiving prompt access to the assessments, interventions and treatment they require, in line with their purpose of admission and care plan. Assessments, intervention, and treatment should be adapted to meet reasonable adjustments and the needs of people from groups who experience health inequalities.
- Purpose of admission, care plan, discharge plan and EDD reviewed and updated regularly with the person and their chosen carer/s. If the purpose of admission is close to being met, additional focus should be given to discharge planning.
- Any factors that could delay discharge, (e.g., the need for step down provision, home adaptations, housing, supported living or care home placement) reviewed every two to three days and proactively addressed with partner services.
- Monitoring visits completed by commissioners every eight weeks for adults with a learning disability and autistic people, and every six weeks for young people aged up to 25, who have an Education, Health, and Care (EHC) plan.

Key Stage 3. At and following discharge

- Person centred discharge plan refined with the person and their chosen carer/s. The plan should set out who is responsible for providing the assessments, interventions, and treatments that the person will receive after leaving hospital and when the person can expect this support.
- Discharge facilitated promptly once a decision is reached that the person is clinically ready for discharge (CRFD) (i.e., the person does not require any further assessments, interventions and/or treatments, which can only be provided in the current inpatient setting), and that it is possible to discharge them (i.e. because the planned discharge support is available at that time). If a person is CRFD, but it is not possible to discharge them, they should continue receiving interventions, activities and support in hospital so that they remain CRFD and can be discharged as soon as planned support is in place.
- At least 48 hours' notice of the decision to discharge given to the person, their chosen carer/s and any services (e.g., community based mental health and learning disability teams, Crisis Resolution Home Treatment Teams (CRHTTs), housing services, social services) that will be involved in the persons ongoing care.
- Risk assessment updated and uploaded to the person's EPR which includes information on how any risks to self or others will be managed once the person is discharged.
- Follow up meeting arranged pre-discharge, including providing written details of when, where and who the follow up will take place with.
- Clear information provided to the person and their chosen carer/s about how to access crisis support after discharge (including direct contact details for CRHT.
- Prompt access provided to all planned post discharge support including in the person's discharge plan. The person should also be supported to develop advanced choice documents and a crisis plan.
- Follow up completed (face to face wherever possible) within 72 hours of discharge for all adults discharged (NB this has been included in the NHS Standard Contract since 2020/21). If the follow up indicates additional support is required, action is taken promptly to put this in place.
- Relevant information relating to a person's discharge (which may include a copy of the person's discharge plan) shared with the services involved in the person's ongoing care and treatment. Discharge summary shared with the persons GP and other relevant parties, where appropriate, within a week of discharge.

- Multi-Agency Discharge Events used where there are complex discharges requiring agreement across multiple partners and follow locally agreed escalation procedures where there are concerns about delayed discharges.

7. Adult mental health rehabilitation inpatient services

7.1 GIRFT (2020) Mental Health – Rehabilitation – Getting It Right First Time – GIRFT (https://gettingitrightfirsttime.co.uk/medical_specialties/mh-rehab/) describes modern mental health rehabilitation as: “A whole system approach to recovery from mental ill health which maximises an individual’s quality of life and social inclusion by encouraging their skills, promoting independence and autonomy in order to give them hope for the future and which leads to successful community living through appropriate support.”

7.2 Wherever possible mental health rehabilitation needs should be met in the community. However, where someone’s needs exceed what can be safely and effectively treated in the community, admission to a mental health rehabilitation inpatient service may be required. This should always be local and consider the least restrictive option, which should be kept under review.

7.3 Mental health rehabilitation inpatient services provide care and treatment for adults and older adults who have an identified mental health rehabilitation need. This includes people who may also have a learning disability, who are autistic or who have been given a diagnosis of personality disorder. People may be detained under the Mental Health Act (1983), and some may be restricted under Section 37/41 (MHA). The decision to admit will be based on a comprehensive clinical assessment.

7.4 NICE (2009) Clinical guideline Borderline personality disorder: recognition and management (https://www.nice.org.uk/guidance/cg78/chapter/1-Guidance#inpatient-services)) contain the following set of principles for mental health rehabilitation inpatient services, in that they should:

- Be embedded in a local comprehensive mental healthcare service.
- Provide a recovery-orientated approach that has a shared ethos and agreed goals, a sense of hope and optimism, and aims to reduce stigma.
- Deliver individualised, person-centred care through collaboration and shared decision making with service users and their carers involved.
- Be offered in the least restrictive environment and aim to help people progress from more intensive support to greater independence through the rehabilitation pathway.
- Recognise that not everyone returns to the same level of independence they had before their illness and may require supported accommodation (such as residential care, supported housing or floating outreach) in the long term.

7.5 This section summarises ‘what good looks like’ in mental health rehabilitation inpatient services, emphasising the information relevant to commissioners. It applies to all people who have a mental health rehabilitation need, including those with a learning disability, or who are autistic and those who have experienced trauma and those from racialised communities.

7.6 Each person is an individual and there may be other needs to consider in addition to the assessed mental health rehabilitation need. These may be relating to physical health, degenerative neurological conditions or acquired brain injuries for example. Commissioners should make commissioning decisions based on analysis of their local population need, size of population, historical activity, geography and accessibility.

7.7 It is important to note that there are currently some mental health inpatient services registered with CQC as ‘rehabilitation’ services, which are commissioned for people who have received a diagnosis of personality disorder, specifically a diagnosis of borderline personality disorder. The provision of such services is not in line with NICE guidelines (https://www.nice.org.uk/guidance/cg78/chapter/1-Guidance#inpatient-services) for the care and treatment of people who have received this diagnosis and as per the recommendations of GIRFT national report for mental health rehabilitation (https://gettingitrightfirsttime.co.uk/medical_specialties/mh-rehab/), should not be described or commissioned as such. This misuse of the term ‘rehabilitation’ is unhelpful and confusing for everyone but particularly for the people themselves, their families and carers. The needs of this group who are currently being admitted to these types of services should be met locally, through co-produced alternative, community services which provide therapeutic, least restrictive and trauma informed care and support. Commissioners will want to consider the development of trauma-specific services to meet the needs of people who are currently admitted to these inpatient services given the majority of them will have experienced significant trauma and adversity.

7.8 However, the additional diagnostic label of personality disorder should not preclude admission where there is an identified mental health rehabilitation need. These commissioned services should not be overly restrictive and should focus on relational approaches to safety as the most effective way to keep the person safe.

7.9. The principles described in section 4 of this framework apply to all mental health rehabilitation inpatient services. The information that follows focusses on types of mental health rehabilitation inpatient services and stages of the pathway.

7.10. The variation in the language and terminology used to describe mental health rehabilitation inpatient services is confusing and persists despite previous attempts to tackle it. Stakeholders identified this as the most important issue to address in this guidance, the GIRFT report on mental health rehabilitation (https://gettingitrightfirsttime.co.uk/medical_specialties/mh-rehab/) supports the need for clarification and 'standardisation of rehabilitation care'.

7.11 Mental health rehabilitation inpatient services should be commissioned and described as:

Level 1 mental health rehabilitation inpatient services

Level 1 services have many of the characteristics of inpatient services described elsewhere/previously as 'community rehabilitation units' (Royal College of Psychiatry, 2019 (https://www.rcpsych.ac.uk/docs/default-source/members/faculties/rehabilitation-and-social-psychiatry/mental-health-inpatient-rehabilitation-services-typology-table-20-3-19.pdf?sfvrsn=8fc19480_2)).

- These services are needs led and locally based, serving a local population.
- These services exist to meet the needs of people who have a mental health rehabilitation need that can only be treated within an inpatient environment.
- Level 1 services are normally accessed via an adult acute mental health inpatient service, including those specifically for adults with a learning disability, or who are autistic.
- As with adult acute mental health services, the default position for autistic people and those who have a learning disability, with a mental health need, would be to access mainstream mental health rehabilitation inpatient services. However, it is recognised that some people's needs cannot be met well in a mainstream service, even with reasonable adjustments. Commissioned services may include mental health inpatient rehabilitation services that are specifically for people with a learning disability, or who are autistic.
- Level 1 services are part of a clear, agreed pathway that includes community mental health rehabilitation teams and wider general and specialist teams, such as primary care, community learning disability, autism or mental health
- They are staffed by a multidisciplinary team that have the appropriate training, skills and knowledge in mental health rehabilitation and should meet specialist need as required, for example, drug and alcohol support.
- These services should be firmly connected to the wider resources and agencies within the community, for example, employment support, housing and welfare.

Level 2 mental health rehabilitation inpatient services (higher support needs)

Level 2 services have many of the characteristics of services described elsewhere/previously as 'high dependency rehabilitation units' (RCPsych (2019 (https://www.rcpsych.ac.uk/docs/default-source/members/faculties/rehabilitation-and-social-psychiatry/mental-health-inpatient-rehabilitation-services-typology-table-20-3-19.pdf?sfvrsn=8fc19480_2)).

- All the points above for level 1 services apply to level 2 services.
- Level 2 services neither support nor encompass inpatient provision that may be described as 'locked rehabilitation', and they are not long-term placements, continuing care, or a 'home' by default.
- The key difference between level 1 and level 2 mental health rehabilitation inpatient services is that a level 2 service can offer more intensive support to people to meet their needs; this may be relational and/or adapted environments and procedures.
- Commissioning arrangements for level 2 services will be locally determined and will depend on the size and assessed need of the population in each ICS footprint.
- Level 2 services are part of the same pathway of care as level 1 services and may on occasion be accessed via a level 1 service.
- Level 2 services may accept people who need their mental health rehabilitation needs met at a pace that is individually and clinically appropriate for them. These services should be commissioned to do this while ensuring that lengths of stay are appropriate and reviewed regularly, to avoid stays in hospital that are longer than absolutely necessary.

7.12 Commissioners must be clear, based on their population needs' assessment, what services they need to commission and plan accordingly using this two-level approach for all mental health rehabilitation inpatient services. They should commission the right types of service to meet agreed local need.

7.13 It is important to note that services described as 'locked rehabilitation' are not mental health rehabilitation services and that these locked services remain a concern, as illustrated by these quotes:

> "More than 50 years after the movement to close asylums and large institutions, we were concerned to find examples of outdated and sometimes institutionalised care. We are particularly concerned about the high number of people in 'locked rehabilitation wards'… In the 21st century, a hospital should never be considered 'home' for people with a mental health condition." (CQC, 2017 (https://www.cqc.org.uk/publications/major-report/state-care-

mental-health-services-2014-2017))

> "Too often, locked rehabilitation wards are in fact long stay wards that institutionalise rather than rehabilitate people and that such wards are against the least restrictive principle and potentially represents a breach of human rights." (CQC (2020 (https://www.cqc.org.uk/publications/themed-work/mental-health-rehabilitation-inpatient-services-%E2%80%93-2019-update)).

> "I was put somewhere and left; I was forgotten about!" A person in a mental health rehabilitation inpatient service.

7.14 Similarly, the Royal College of Psychiatrists (RCPsych) has expressed its increasing concern about the use of locked rehabilitation wards, a term not recognised by the Rehabilitation or Social Psychiatry Faculty: "… there remain concerns about the high number of wards continuing to identify as 'locked rehabilitation'. This goes against the least restrictive principle that mental health services should be using." (CQC, 2020) (https://www.cqc.org.uk/publications/themed-work/mental-health-rehabilitation-inpatient-services-%E2%80%93-2019-update).

7.15 The case for change in relation to 'locked rehabilitation' services is clear and in future, the commissioning of services described as such should cease.

7.16 The impact of moving to this approach for the commissioning of mental health rehabilitation inpatient services will need to be assessed locally, and collaboratively planned and managed with relevant stakeholders. For example, in some areas this will need to include NHS-led provider collaboratives of adult secure services where 'locked rehabilitation' may for some people be accessed as part of the forensic pathway, or where an access assessment recommends it as an alternative to a secure service.

How should mental health rehabilitation inpatient services work?

> "There must be a shift from patients going to rehabilitation inpatient services because nothing else has worked….and these services being expected to mop up gaps elsewhere in the pathway" (clinician working in a mental health rehabilitation inpatient service). Clinician working in a mental health rehabilitation inpatient service

7.17 A lot of work has already been undertaken to describe what good looks like in mental health rehabilitation inpatient settings, including published standards, guidance and reports (GIRFT, 2022 (https://gettingitrightfirsttime.co.uk/medical_specialties/mh-rehab/); NICE, 2020 guideline [NG181] (https://www.nice.org.uk/guidance/ng181/chapter/Recommendations#who-should-be-offered-rehabilitation); Booker C, Rahman-Ali F, Paget S, eds, 2020 (https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/rehabilitation-wards-aims-rehab/aims-rehab-4th-edition-inpatient-standards-publishable-document92cc04b5644442cc9fa9356dbd0848dc.pdf?sfvrsn=c38846a5_2); CQC, 2019 (https://www.cqc.org.uk/sites/default/files/20201016_MH-rehab_report.pdf)). Commissioners should ensure that these are reflected in service specifications and contracts they hold with providers of mental health rehabilitation inpatient services.

7.18 Stakeholders described what they felt were the most important components of the inpatient service. These are described under the states of the inpatient pathway, they are included here to support commissioners and strengthen the existing published standards.

Assessment and admission

> "Our son was admitted with 1 days' notice from an acute mental health ward. This was the first time we knew a mental health rehabilitation ward was being considered."Parents of a person in a mental health rehabilitation inpatient service.

7.19 Referrals to the service should state the reason for admission and the identified mental health rehabilitation needs, to support an appropriate assessment by the inpatient clinical team. Admissions should be planned, and pre-admission visits are considered good practice.

7.20 The purpose of admission should describe the specific assessments and interventions required, anticipated length of stay and estimated date of discharge. These should be agreed collaboratively at the earliest opportunity with the person accessing the service, their families and carers, the inpatient MDT, community team and commissioner. This information should be clearly articulated to make explicit what is expected from the admission.

Care and treatment

> *"*I have had a good experience of reviews, the language used should be human, not clinical and not rushed". Family member of a person accessing a mental health rehabilitation inpatient service.

7.21 All MDT ward rounds; care programme approach meetings and Care Education and Treatment Reviews must centre around the person. People in services should be supported and empowered to attend throughout and where possible to lead their reviews.

7.22 The purpose of admission, specific interventions required, anticipated length of stay and estimated date of discharge should be regularly reviewed, and changes to the original position should be clearly documented with reasons for the changes.

7.23 All therapeutic interventions and activities should focus on relationships, they should be holistic, needs led, trauma informed and diverse.

7.24 Activities and leave from the ward should be planned individually for each person. Structured activity programmes should be co-designed with people on the ward to ensure they reflect the activities they request, and feel will be helpful. Co-facilitation of activities and groups by people accessing services and staff are described positively by those leading sessions and those attending. Activities should happen in line with NICE guidelines (https://www.nice.org.uk/guidance/ng181/chapter/Recommendations#who-should-be-offered-rehabilitation) and be available 7 days a week and not restricted, for example, to 9am to 5pm.

7.25 Vocational and employment opportunities are important to help people think about options, with an emphasis on appropriately knowledgeable and skilled staff providing education and support. Returning to their previous occupation is not an option for many people and therefore to help their recovery they will need to be supported to think about what transferrable skills they have.

7.26 Peer support should be encouraged; making friends in services is really important to people, their families and carers.

7.27 Appropriate and accessible support for substance misuse while an inpatient needs to be available.

7.28 Physical exercise options need to be individually planned and varied. These need to be available on and off the ward, accessible opportunities in the community are positive.

7.29 Primary and secondary physical health needs should be understood and met. People described a sense that not all staff were confident in this area and needed more appropriate training. Support while in hospital and a better understanding of how to self-manage physical health in the community is valued by people accessing these services.

Discharge and transition

7.30 Early discharge planning is crucial. Discussions about the purpose of admission, interventions required, length of stay and estimated date of discharge should inform this from the point of admission. In some instances, this may be considered earlier, at the point of the pre-admission assessment to inform the admission.

7.31 Transitions are difficult times for people, their family and carers; multiple transitions can be particularly problematic. Those accessing services feel it is important to maintain continuity by being able to work with some members of the MDT on an ongoing basis, from the inpatient service to the community. They also view contact with their community team, ideally a community mental health rehabilitation team, throughout admission as crucial to supporting and facilitating earlier and more collaborative discharge planning. People want gradual discharge planning and don't want to feel rushed as this can be a particularly anxious time.

Key lines of enquiry for commissioners of local acute and rehabilitation inpatient services

Do you have services that:

- Serve everyone locally?
- Advance mental health equalities (https://www.england.nhs.uk/publication/advancing-mental-health-equalities-strategy/)?
- Provide safe personalised care (https://www.england.nhs.uk/personalisedcare/)?
- Can be reasonably adjusted for autistic people and people with a learning disability?
- Are trauma informed (https://www.gov.uk/government/publications/working-definition-of-trauma-informed-practice/working-definition-of-trauma-informed-practice)?
- Enable shared decision-making (https://www.england.nhs.uk/personalisedcare/shared-decision-making/)?
- Offer independent advocacy? (https://www.nice.org.uk/guidance/NG227)
- Offer therapeutic benefit to the people they serve?
- Connect to the whole care pathway so that all people can come into hospital when they need to and can leave as soon as they are ready?

Appendix 1: Policy context and system working

The NHS Long Term Plan (https://www.longtermplan.nhs.uk/) (2019) heralded an unprecedented investment and expansion in mental health services, and set out a vision for a place-based community mental health model and whole-person, whole-population health approaches.

The task of modernising community services is supported by the Community mental health framework for adults and older people, (https://www.england.nhs.uk/publication/the-community-mental-health-framework-for-adults-and-older-adults/) the National Strategy (https://www.gov.uk/government/publications/national-strategy-for-autistic-children-young-people-and-adults-2021-to-2026/the-national-strategy-for-autistic-children-young-people-and-adults-2021-to-2026) for autistic children, young people and adults: 2021 to 2026, and Building the right support (https://www.england.nhs.uk/learning-disabilities/natplan/), the national plan for people with a learning disability and autistic people.

However, while maintaining a strong focus on community mental health transformation are at the heart of the NHS Long Term Plan and the Mental Health Implementation Plan (https://www.england.nhs.uk/publication/nhs-mental-health-implementation-plan-2019-20-2023-24/) (MHIP), the latter includes ambitions specific to inpatient services:

- Eliminate all inappropriate adult acute mental health out of area placements.
- Improve the therapeutic offer from inpatient mental health services by enhancing access to therapeutic interventions and activities.
- Increase the level and mix of staff on acute mental health inpatient wards, including improving access to peer support workers, psychologists, occupational therapists, social workers, housing experts and other relevant professionals during admission.
- Reduce avoidable long lengths of stay in adult acute mental health inpatient settings (including for people with a learning disability and autistic people), so that people are not staying in hospital any longer than necessary.
- Reduce the number of people with a learning disability and autistic people in mental health settings, so that by March 2024 there are no more than 30 adults with a learning disability and/or autism in an inpatient setting, per one million adults.
- Ensure that all inpatient care commissioned by the NHS meets the Learning Disability Improvement Standards. (https://www.england.nhs.uk/learning-disabilities/about/resources/the-learning-disability-improvement-standards-for-nhs-trusts/)

Across the delivery of these commitments, consideration must also be given to reducing the associated inequalities, involving people in decisions about their care and adapting interventions and activities to meet individual needs and preferences.

Recent changes in legislation and organisation (https://www.legislation.gov.uk/ukpga/2022/31/contents/enacted) offer new potential for working in ways that promote collaboration and integration of services and support, including with the voluntary, community, faith, community and social enterprise (VCFSE) sector. Many people who experience inpatient services will need support beyond healthcare. This VCFSE sector has always supported the NHS, including by supporting community voices to be heard and being partners in strategy development.

Importantly, each system will also have provider collaboratives, which are partnerships of health providers who agree to work together to achieve benefits by working at scale for their population.

Appendix 2: Key resources

- NHS England Mental Health, Learning Disability and Autism Quality Transformation Programme (https://www.england.nhs.uk/mental-health/mental-health-learning-disability-and-autism-inpatient-quality-transformation-programme/)

- NHS England position on serenity integrated monitoring and similar models (https://www.england.nhs.uk/long-read/nhs-england-position-on-serenity-integrated-mentoring-and-similar-models/)
- How CQC identifies and responds to closed cultures (https://www.cqc.org.uk/guidance-providers/all-services/how-cqc-identifies-responds-closed-cultures)
- CQC Mental health rehabilitation 2019 update (https://www.cqc.org.uk/publications/themed-work/mental-health-rehabilitation-inpatient-services-%E2%80%93-2019-update)
- GIRFT national report for mental health rehabilitation (https://gettingitrightfirsttime.co.uk/medical_specialties/mh-rehab/)
- Safe and wellbeing reviews: thematic review and lessons (https://www.england.nhs.uk/long-read/safe-and-wellbeing-reviews-thematic-review-and-lessons-learned/)
- Out of sight – who cares? (https://www.cqc.org.uk/publications/themed-work/rssreview)
- Detentions under the Mental Health Act (https://www.ethnicity-facts-figures.service.gov.uk/health/mental-health/detentions-under-the-mental-health-act/latest#:~:text=Based%20on%20the%20providers%20who%20submitted%20good%20quality,March%202020%20an
- Independent review of the Mental Health Act (https://www.gov.uk/government/groups/independent-review-of-the-mental-health-act)
- Draft Mental Health Bill 2022 (https://www.gov.uk/government/publications/draft-mental-health-bill-2022)
- Thematic review of Independent Care (Education) and Treatment Reviews (https://www.gov.uk/government/publications/independent-care-education-and-treatment-reviews/thematic-review-of-the-independent-care-education-and-treatment-reviews)
- The NHS Constitution for England (https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england)
- Equality Act 2010 (https://www.gov.uk/guidance/equality-act-2010-guidance)
- Personalised care and support planning (https://www.england.nhs.uk/personalisedcare/pcsp/)
- NHS England » Accessible Information Standard (https://www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/accessibleinfo/)
- Delivering same-sex accommodation (https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2021/05/NEW-Delivering_same_sex_accommodation_sep2019.pdf)

Advancing mental health equalities

- NHS England » Patient and carer race equality framework (https://www.england.nhs.uk/publication/patient-and-carer-race-equality-framework/)
- Personalised care (https://www.england.nhs.uk/personalisedcare/)
- Working definition of trauma-informed practice (https://www.gov.uk/government/publications/working-definition-of-trauma-informed-practice/working-definition-of-trauma-informed-practice)
- Shared decision-making (https://www.england.nhs.uk/personalisedcare/shared-decision-making/)
- Advocacy services for adults with health and social care needs (https://www.nice.org.uk/guidance/NG227)

NHS-led provider collaboratives

- FutureNHS Platform (https://future.nhs.uk/system/login?nextURL=%2Fconnect%2Eti%2Fhome%2Fgrouphome)
- Learning disability improvement standards for NHS trusts (https://www.england.nhs.uk/learning-disabilities/about/resources/the-learning-disability-improvement-standards-for-nhs-trusts/)
- NHS Mental Health Implementation Plan 2019/20 – 2023/24 (https://www.england.nhs.uk/publication/nhs-mental-health-implementation-plan-2019-20-2023-24/)
- The NHS Long Term Plan (https://www.longtermplan.nhs.uk/)

Community mental health framework

- The national strategy for autistic children, young people and adults: 2021 to 2026 (https://www.gov.uk/government/publications/national-strategy-for-autistic-children-young-people-and-adults-2021-to-2026/the-national-strategy-for-autistic-children-young-people-and-adults-2021-to-2026)
- Building the right support (https://www.england.nhs.uk/learning-disabilities/natplan/)
- NHS England 2023/24 priorities and operational planning guidance (https://www.england.nhs.uk/wp-content/uploads/2022/12/PRN00021-23-24-priorities-and-operational-planning-guidance-v1.1.pdf)
- Health and Care Act 2022 (https://www.legislation.gov.uk/ukpga/2022/31/contents/enacted)
- Section 75 of the National Health Act 2006 (https://www.legislation.gov.uk/ukpga/2006/41/section/75)
- Better Care Fund (https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/better-care-fund/)
- A shared commitment to quality for those working in health and care (https://www.england.nhs.uk/wp-content/uploads/2021/04/nqb-refreshed-shared-commitment-to-quality.pdf)

Additional resources

- NHS England Care, Education and Treatment Reviews (CETRs) (https://www.england.nhs.uk/learning-disabilities/care/ctr/care-education-and-treatment-reviews/)
- NHS England Dynamic support register and Care (Education) and Treatment Review policy and guide (https://www.england.nhs.uk/publication/dynamic-support-register-and-care-education-and-treatment-review-policy-and-guide/)
- Rapid improvement guide to red and green bed days (https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2016/12/rig-red-green-bed-days.pdf)
- Safewards (https://www.safewards.net/)
- HOPE(S) Model: Mersey Care NHS Foundation Trust (https://www.merseycare.nhs.uk/hopes-model)
- Blanket restrictions toolkit (https://restraintreductionnetwork.org/restraint-reduction-network-launches-blanket-restrictions-toolkit-in-partnership-with-nhs-england/)
- Debriefing guidance (https://restraintreductionnetwork.org/rrn-launches-post-incident-debriefing-and-support-toolkit/#:~:text=The%20new%20RRN%20Post-Incident%20Debriefing%20and%20Support%20Toolkit,and%20learn%20from%20a%20crisis%2C%20reducing%20rest
- NIHR – The experience of children and young people cared for in mental health, learning disability and autism inpatient settings (https://evidence.nihr.ac.uk/themedreview/children-young-people-mental-health-learning-disability-autism-inpatient-settings/)
- Our rights, our voices Young people's views on fixing the Mental Health Act and inpatient care (https://www.mind.org.uk/media/yridl3hl/our-rights-our-voices-report_final.pdf?v=3)
- A review of advocacy – NDTi (https://www.ndti.org.uk/resources/research-project/a-review-of-advocacy-october-2023)
- collaboRATE (http://www.glynelwyn.com/collaborate.html) – measure of shared decision making in mental health care.
- National plan – Building the right support (https://www.england.nhs.uk/learning-disabilities/natplan/)
- NHS Long Term Workforce Plan (https://www.england.nhs.uk/ltwp/)

Reducing health inequalities

- Ethnic inequalities in healthcare: A rapid evidence review (https://www.nhsrho.org/research/ethnic-inequalities-in-healthcare-a-rapid-evidence-review-2/)
- NHS England » RightCare physical health and severe mental illness scenario (https://www.england.nhs.uk/long-read/rightcare-physical-health-and-severe-mental-illness-scenario/)
- Learning Disability Annual Health Check Toolkit – NDTi (https://www.ndti.org.uk/resources/publication/learning-disability-annual-health-check-toolkit)
- Green Light Toolkit – NDTi (https://www.ndti.org.uk/resources/green-light-toolkit)
- "It's Not Rocket Science" – NDTi (https://www.ndti.org.uk/resources/publication/its-not-rocket-science)
- NHS England Sensory-friendly resource pack (https://www.england.nhs.uk/publication/sensory-friendly-resource-pack/)

Appendix 3: Acknowledgements

We would like to acknowledge the essential support of the Commissioner Advisory Group (CAG) in producing of this framework:

- Sahil Dodhia (Co-Chair) – Mental Health, Learning Disability and Autism Quality Transformation Team, NHS England
- Debra Moore (Co-Chair) Mental Health, Learning Disability and Autism Quality Transformation Team, NHS England
- Tonita Whittier – Mental Health, Learning Disability and Autism Quality Transformation Team, NHS England
- Richard Watson – Suffolk and North East Essex ICB
- Claire Swithenbank – NHS England North West
- Giles Tinsley – NHS England Midlands
- Keir Shillaker – West Yorkshire Health and Care Partnership ICB
- Mel Watson – Midlands Partnership NHS Foundation Trust
- Gavin Thistlethwaite – NHS England South East
- Sarah Mansuralli – North Central London ICB
- Lauretta Kavanagh – North Central London ICB
- Lisa Ryland – NHS Hampshire and Isle of Wight ICB
- Mark Humble – North East Commissioning Support Unit
- Karen Drabble – Thames Valley and Wessex Adult Secure Provider Collaborative
- Catherine Nolan – Association of Directors of Adult Social Services
- Louise Davies – Independent Expert Advisor – Commissioning
- Di Domenico – Independent Expert Advisor – Commissioning

In addition, the guidance has built on broader engagement through workshops, stakeholder and task and finish groups and visits to inpatient services across the country. We are particularly grateful to the people with lived experience of mental health services and their families who gave their time and shared their stories, insights and expertise so generously.

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AGENDA ITEM 9

Herefordshire Council

Title of report: Work programme 2024/5

Meeting: Health, Care and Wellbeing Scrutiny Committee

Meeting date: 19 May 2025

Report by: Statutory Scrutiny Officer

Classification

Open

Decision type

This is not an executive decision

Wards affected

All Wards

Purpose

To consider the draft work programme for Herefordshire Council's scrutiny committees for the municipal year 2024/25.

Recommendation(s)

That:

a) The committee agree the draft work programme for Health, Care and Wellbeing Scrutiny Committee contained in the work programme report attached as appendix 1, which will be subject to monthly review, as the basis of their primary focus for the remainder of the municipal year.

b) The committee note the work programme for the other scrutiny committees, and identify any opportunities for collaboration or alignment of work.

Alternative options

1. The committee could decline to agree a work programme for its future committee meetings. This would likely result in unstructured and purposeless meetings.

2. The committee could also decline to identify areas of potential collaboration or alignment of work with other committees. This could result in duplication or overlap of work.

Key considerations

3. A fundamental part of good scrutiny is planning and agreeing a programme of work for the committee to undertake. A well-considered work programme:

a. identifies priorities for the committee's work that align with corporate and partnership priorities, as well as reflecting community concern;

b. ensures that each identified topic has clear objectives that focus the committee's work;

c. creates a timetable for the committee's programme of work so that the committee carry out its work at the optimal time; and

d. provides officers and partners with requirements for evidence that will support the committee in providing evidence-based scrutiny

4. To prepare this work programme, the committee chairs have met with officers of the council to identify potential priority areas of work for the committee. These priority areas have been scheduled within the work programme to ensure the committee considers topics when it is most useful to do so. A draft of this work programme has then been circulated to the council's corporate leadership team and other key senior directors, alongside committee chairs, for further comment and refinement.

5. There has been a review of the council's scrutiny function, the findings of which will be considered by Council on 23 May 2025. The recommendations from this review, if agreed by Council, will have a significant impact on how scrutiny carries out its work. This committee's work programme is therefore likely to undergo significant revision before it is agreed again by this committee.

6. Attached as Appendix 2 to this report is the council's most recently published forward plan of key decisions.

Community impact

7. Effective scrutiny enables the committee to reflect community concern, one of the four purposes of scrutiny as outlined by the Centre for Governance and Scrutiny.

Environmental impact

8. This report contains no direct environmental impacts. However, the work that the committee will undertake resulting from agreeing this work programme may have direct impacts. Reports arising from or supporting this work will outline their potential environmental impact.

Equality duty

9. The public sector equality duty (specific duty) requires us to consider how we can positively contribute to the advancement of equality and good relations and demonstrate that we are paying 'due regard' in our decision making in the design of policies and in the delivery of services. This report contains no direct equality impacts. However, the reports and issues that the committee will consider may have direct impacts. Reports arising from or supporting this work will outline the any associated equality impacts for committee consideration.

Resource implications

10. This report constitutes part of the typical function of this committee. Similarly, a programme of work undertaken by committee is an integral part of the council's 'business as usual'. There is no resource implication in setting or agreeing a work programme. However agreed topics in the work programme, in particular any requests for bespoke research or the involvement of outside experts or community groups, may incur resource costs. These will be contained in any reporting or planning of agreed topics within this work programme.

Legal implications

11. The remit of the scrutiny committee is set out in part 3 section 4 of the constitution and the role of the scrutiny committee is set out in part 2 article 6 of the constitution.

12. The Local Government Act 2000 requires the council to deliver the scrutiny function.

Risk management

13. There are no risks identified in the committee agreeing an effective and timely programme of work. However there is a risk to the council's reputation if committees fail to set a work programme, or set a programme of work that does not address local authority, partnership or community priorities.

Consultees

14. In drafting this work programme, consideration has been given to:

    a. The previous work of scrutiny committees;

    b. Priorities suggested by members of the committee; and

    c. Work with Herefordshire Council officers to develop topics and agree optimum timings to bring items for consideration.

15. This work programme is subject to ongoing review, which may involve additional consultees.

Appendices

Appendix 1 – Committee work programme 2024/25 May 2025
Appendix 2 – Herefordshire Council Forward Plan 9 May 2025

Background papers

None

Herefordshire Council

Health Care and Wellbeing Scrutiny Committee

Committee Meeting

19 May 2025 report deadline 9 May 2025 pre meeting lines of enquiry planning 15 May 2025

Topic and Objectives	Evidence required	Attendees*
Adult Mental Health Inpatient and Rehabilitation Services Redesign • Scrutinise the redesign of the adult mental health inpatient and rehabilitation services in Herefordshire and Worcestershire.	• Overview of redesigns • Options appraisal • NHS Commissioner guidance and framework for adult mental health rehabilitation inpatient services	• Director of Strategy and Partnerships, Herefordshire and Worcestershire Health and Care NHS Trust • Deputy Programme Director, Adult Mental Health Rehabilitation Redesign and Acute Inpatient improvement Programme, Herefordshire and Worcestershire Health and Care NHS Trust
All-age carers' strategy action plan – recommendations of the working group • Discuss and agree recommendations of the proposed working group.	• Working group report and draft recommendations	• All-age carers' steering group chair • Senior commissioning officer
Work programme • Review work programme	• Draft work programme	• **Statutory Scrutiny Officer**

Committee Meeting

28 July 2025 report deadline 16 July 2025 pre meeting lines of enquiry planning TBC

Topic and Objectives	Evidence required	Attendees*

Adult Social Care demand task and finish group
• Agree terms of reference for a task and finish group to explore:
  ○ The drivers of demand for social care services.
  ○ How partners and other local authorities can reduce demand and provide earlier support.
	• Evidence to be agreed	• Attendees to be agreed

Work programme • Review work programme	• Draft work programme	• **Statutory Scrutiny Officer**

Committee Meeting

29 September 2025 report deadline 17 September 2025 pre meeting lines of enquiry planning TBC

Topic and Objectives	Evidence required	Attendees*
Safeguarding Adults Board annual report • Objectives to be agreed.	• Evidence to be agreed	• Attendees to be agreed
Work programme • Review work programme	• Draft work programme	• **Statutory Scrutiny Officer**

*The Corporate Director, Community Wellbeing and Cabinet Member Adults, Health and Wellbeing, both have a standing invitation to the meeting.

HEREFORDSHIRE COUNCIL FORWARD PLAN

This document, known as the Forward Plan, sets out the decisions which are expected to be taken during the period covered by the Plan by either Cabinet as a whole, or by individual Cabinet Members. The Plan is updated regularly and is available on the Herefordshire Council website (www.herefordshire.gov.uk) and from Council Offices. This edition supersedes all previous editions.

The council must give at least 28 days' notice of key decisions to be taken. A key decision is one which results in the council incurring expenditure or making savings of £500,000 or more, and/or is likely to be significant in terms of the strategic nature of the decision or its impact, for better or worse, on the amenity of the community or quality of service provided by the council to a significant number of people living or working in the locality affected.

Current cabinet members are listed below. For more information and links papers for Cabinet meetings please visit https://councillors.herefordshire.gov.uk/mgCommitteeDetails.aspx?ID=251

Councillor Jonathan Lester	Corporate Strategy and Budget (Leader of the Council)
Councillor Elissa Swinglehurst	Environment (Deputy Leader of the Council)
Councillor Carole Gandy	Adults, Health and Wellbeing
Councillor Ivan Powell	Children and Young People
Councillor Harry Bramer	Community Services and Assets
Councillor Graham Biggs	Economy and Growth
Councillor Pete Stoddart	Finance and Corporate Services
Councillor Barry Durkin	Roads and Regulatory Services
Councillor Philip Price	Transport and Infrastructure

Documents submitted in relation to each decision will be a formal report, which may include one or more appendices. Reports will usually be made available on the council website at least 5 clear working days before the date of the decision. Occasionally it will be necessary to exempt part or all of a decision report from publication due to the nature of the decision, for example if it relates to the commercial or business affairs of the council. Other documents may be submitted in advance of the decision being taken and will also be published on the website unless exempt.

To request a copy of a decision report or related documents please contact governancesupportteam@herefordshire.gov.uk or telephone 01432 261699.

FORWARD PLAN FOR 1 June 2025 ONWARDS

The following information is provided for each entry in the Forward Plan:

Heading	Contains
Report title and purpose	A summary of the proposal
Decision Maker and Due date	Who will take the decision and the date the decision is expected to be made
Lead cabinet member and officer contact(s)	The cabinet member with responsibility for this decision and the officers producing the decision report.
Directorate	The directorate of the council responsible for the decision.
Date uploaded onto plan	The date the decision was first uploaded and the notice period started for key decisions.
Decision type, exemptions and urgency	Whether the decision is a Key or Non-Key decision, if the report is expected to be fully open, partly exempt or fully exempt and if urgency procedures are being followed.

Decisions to be taken by Cabinet at a formal meeting are listed first, ordered by date, and include both Key and Non-Key decisions. Decisions to be taken by individual Cabinet Members are then listed, grouped by portfolio area and sorted by date. These include Key decisions only.

Report title and purpose	Decision Maker and Due date	Lead cabinet member and officer contact(s)	Directorate	Date uploaded onto plan	Decision Type, exemptions and urgency
Cabinet decisions by date (Key and Non-key listed)					
Q4 2024/25 Budget Report To report the provisional financial outturn position for 2024/25 for revenue and capital budgets, subject to external audit.	Cabinet 5 June 2025	Cabinet member finance and corporate services Rachael Sanders, Director of Finance Rachael.sanders@herefordshire.gov.uk Tel: 01432 383775	Corporate Support Centre	2 May 2025	**Non Key** Open
Q4 Performance Report Review performance for Q4 2024/25; and agree any outstanding key milestones in Appendix A to be carried forward to the Delivery Plan 2025/26.	Cabinet 5 June 2025	Cabinet member finance and corporate services Jessica Karia, Head of Corporate Performance and Intelligence jessica.karia@herefordshire.gov.uk Tel: 01432 260976	Corporate Support Centre	2 May 2025	**Non Key** Open

Report title and purpose	Decision Maker and Due date	Lead cabinet member and officer contact(s)	Directorate	Date uploaded onto plan	Decision Type, exemptions and urgency
Risk Management Strategy To approve the Risk Management Strategy.	Cabinet 5 June 2025	Cabinet member finance and corporate services Rachael Sanders, Director of Finance Rachael.sanders@herefordshire.gov.uk Tel: 01432 383775	Corporate Support Centre	9 May 2025	**KEY** Open
Domestic Abuse Strategy for Herefordshire 2025 to 2028 To approve the new strategy for reducing the prevalence of and preventing domestic abuse throughout the county.	Cabinet 17 July 2025	Cabinet member adults, health and wellbeing Kayte Thompson-Dixon, Contracts officer Kayte.Thompson-Dixon@herefordshire.gov.uk Tel: 01432 260727	Community Wellbeing	2 May 2025	**KEY** Open

Report title and purpose	Decision Maker and Due date	Lead cabinet member and officer contact(s)	Directorate	Date uploaded onto plan	Decision Type, exemptions and urgency
New care facility To consider and agree the business case to invest in and develop the council's own care facility in Herefordshire to meet future demand	Cabinet 25 September 2025	Cabinet member adults, health and wellbeing Hilary Hall, Corporate Director Community Wellbeing, Hayley Doyle, Service Director - All Age Commissioning Hilary.Hall@herefordshire.gov.uk, Hayley.Doyle@herefordshire.gov.uk Tel: 01432 260832	Community Wellbeing	2 May 2025	**KEY**
Cabinet Member Decisions (Key decisions only)					
Portfolio: adults, health and wellbeing					
Portfolio: children and young people					

Report title and purpose	Decision Maker and Due date	Lead cabinet member and officer contact(s)	Directorate	Date uploaded onto plan	Decision Type, exemptions and urgency
Housing related support for children in care and care leavers aged 16-25 To seek approval to commission, by means of a competitive tender process in line with the council's contract procedure rules, a housing related support service for 16–25-year-old children in care and care leavers	Cabinet member children and young people 4 July 2025	Cabinet member children and young people Wendy Dyer, Commissioning Officer Communities Wendy.Dyer@herefordshire.gov.uk Tel: 01432 261673	Community Wellbeing	2 May 2025	**KEY** Open
Portfolio: community services and assets					
Play Area Investment The purpose of this report is to set out how the £1 million for Play Area Investment is proposed to be spent and to seek the necessary approvals to do so.	Cabinet member community services and assets 23 May 2025	Cabinet member community services and assets Ed Bradford, Head of Highways and Traffic Edward.Bradford@herefordshire.gov.uk Tel: 01432 260786	Economy and Environment	2 May 2025	**KEY** Open

Report title and purpose	Decision Maker and Due date	Lead cabinet member and officer contact(s)	Directorate	Date uploaded onto plan	Decision Type, exemptions and urgency
Retaining of the swimming pool at Peterchurch Primary School To approve the retention of and structural improvements to the swimming pool at Peterchurch Primary School	Cabinet member community services and assets 22 May 2025	Cabinet member community services and assets Quentin Mee, Head of Educational Development Quentin.Mee@herefordshire.gov.uk	Children and Young People	2 May 2025	**Non Key** Open
Bromyard Employment Land and Leominster Business Hub Development To seek approval to allocate and spend the Employment Land capital budget to bring forward detailed designs and accompanying business case for the development of business space on the former Bromyard Depot site, and to establish a business hub facility on the ground floor of the Buttercross Building in Leominster.	Cabinet member community services and assets Before 30 May 2025	Cabinet member economy and growth David Wright, Head of Economy and Regeneration David.Wright3@herefordshire.gov.uk Tel: 01432 383039	Economy and Environment	2 May 2025	**KEY** Open

Report title and purpose	Decision Maker and Due date	Lead cabinet member and officer contact(s)	Directorate	Date uploaded onto plan	Decision Type, exemptions and urgency
Property Services Estate Capital Building Improvement Programme 2025/28 To agree the proposed programme of works as set out in appendices incorporating a series of planned project works to enable Council to deliver on its obligations to maintain buildings fit for purpose.	Cabinet member community services and assets 30 May 2025	Cabinet member community services and assets Michael Griffin, Head of Major Projects, Anthony Oliver, Interim Director of Commercial Services Michael.Griffin2@herefordshire.gov.uk, anthony.oliver@herefordshire.gov.uk Tel: 01432 383519	Economy and Environment	2 May 2025	**KEY** Open
Portfolio: economy and growth					
Hereford Enterprise Zone Retained Business Rates – Herefordshire Growth Programme To approve the expenditure of the retained business rates from the Hereford Enterprise Zone, to deliver a county wide business growth, skills and inward investment programme	Cabinet member economy and growth 23 May 2025	Cabinet member economy and growth Roger Allonby, Service Director Economy and Growth Roger.Allonby@herefordshire.gov.uk Tel: 01432 260330	Economy and Environment	2 May 2025	**KEY** Open
Portfolio: environment					

Report title and purpose	Decision Maker and Due date	Lead cabinet member and officer contact(s)	Directorate	Date uploaded onto plan	Decision Type, exemptions and urgency
Malvern Hills National Landscape Management Plan To consider and adopt the new management plan for the Malvern Hills National Landscape.	Cabinet member environment 12 May 2025	Cabinet member environment James Bisset, Principal Countryside Officer, Ben Boswell, Head of Environment, Climate Emergency and Waste Services bboswell@herefordshire.gov.uk Tel: 01432 261930	Economy and Environment	2 May 2025	**KEY** Open
Wye Valley National Landscapes - acceptance of grant funding This report seeks approval to accept a number of confirmed and indicative funding awards, allocations and bids from National Grid, DEFRA, Welsh Government and Natural Resources Wales for the future management and duties of the Wye Valley National Landscape, an Area of Outstanding Natural Beauty (AONB). This report also seeks approval to delegate the review of the AONB Management Plan and the renewal of a Memorandum of Understanding between the 4 constituent local authorities, on account of the complex nature of the cross-border designation.	Cabinet member environment 23 May 2025	Cabinet member environment Ben Boswell, Head of Environment, Climate Emergency and Waste Services bboswell@herefordshire.gov.uk Tel: 01432 261930	Economy and Environment	2 May 2025	**KEY** Open
Portfolio: finance and corporate services					

Report title and purpose	Decision Maker and Due date	Lead cabinet member and officer contact(s)	Directorate	Date uploaded onto plan	Decision Type, exemptions and urgency
Debt Enforcement Contract Award (amended to non key due to monetary amount) To award the debt enforcement contract	Cabinet member finance and corporate services 23 May 2025	Cabinet member finance and corporate services Rachael Sanders, Director of Finance Rachael.sanders@herefordshire.gov.uk Tel: 01432 383775	Corporate Support Centre	2 May 2025	**Non Key** Open
Portfolio: roads and regulatory services					
Portfolio: transport and infrastructure					
Road Safety Schemes The purpose of this report is to set out how the £3.0 million for Road Safety Schemes is proposed to be spent and to seek the necessary approvals to do so.	Cabinet member transport and infrastructure 23 May 2025	Cabinet member roads and regulatory services Ed Bradford, Head of Highways and Traffic Edward.Bradford@herefordshire.gov.uk Tel: 01432 260786	Economy and Environment	2 May 2025	**KEY** Open

Report title and purpose	Decision Maker and Due date	Lead cabinet member and officer contact(s)	Directorate	Date uploaded onto plan	Decision Type, exemptions and urgency
Bus Service Improvement Plan capital funding The purpose of this report is to set out how the £1.1 million of Bus Service Improvement Plan capital spend is proposed to be spent and to seek the necessary approvals to do so.	Cabinet member transport and infrastructure 23 May 2025	Cabinet member transport and infrastructure David Land, Head of Transport and Access Services david.land@herefordshire.gov.uk Tel: 01432 383484	Economy and Environment	2 May 2025	**KEY** Open
Capability and Ambition Fund 2025/26 allocation The purpose of the report is to confirm what Herefordshire Council will deliver with the Capability and Ambition Fund grant	Cabinet member transport and infrastructure 23 May 2025	Cabinet member transport and infrastructure Ffion Horton, Transport Planning Services Manager, Scott Tompkins, Delivery Director - Infrastructure, Richard Vaughan, Sustainability & Climate Change Manager ffion.horton@herefordshire.gov.uk, scott.tompkins@herefordshire.gov.uk, Richard.Vaughan@herefordshire.gov.uk Tel: 01432 260192	Economy and Environment	2 May 2025	**Non Key** Open

Report title and purpose	Decision Maker and Due date	Lead cabinet member and officer contact(s)	Directorate	Date uploaded onto plan	Decision Type, exemptions and urgency
Herefordshire Flood Risk Mitigation The purpose of this report is to set out how the £2.055 million for Herefordshire Flood Risk Mitigation is proposed to be spent and to seek the necessary approvals to do so.	Cabinet member transport and infrastructure 23 May 2025	Cabinet member transport and infrastructure Ed Bradford, Head of Highways and Traffic Edward.Bradford@herefordshire.gov.uk Tel: 01432 260786	Economy and Environment	2 May 2025	**KEY** Open
Local Transport Grant allocation To delegate authority to the Corporate Director, Economy and Environment to spend the Local Transport Grant, Local Transport Resource Fund and Integrated Transport Block funding from the Department for Transport	Cabinet member transport and infrastructure May 2025	Cabinet member transport and infrastructure Scott Tompkins, Delivery Director - Infrastructure scott.tompkins@herefordshire.gov.uk	Economy and Environment	2 May 2025	**KEY** Open Urgent