

Agenda

Health, Care and Wellbeing Scrutiny Committee

Date: **Monday 27 July 2026**

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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If you would like help to understand this document, or would like it in another format, please call Henry Merricks-Murgatroyd, Democratic Services Officer on 01432 260239 or e-mail Henry.Merricks-Murgatroyd@herefordshire.gov.uk in advance of the meeting.

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

Membership

Chairperson	Councillor Pauline Crockett
Vice-chairperson	Councillor Rebecca Tully

Councillor Simeon Cole
Councillor Dave Davies
Councillor Mark Dykes
Councillor Richard Thomas
Councillor Kevin Tillet

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 To receive the minutes of the meeting held on Monday 27 April 2026. HOW TO SUBMIT QUESTIONS The deadline for the submission of questions for this meeting is 5.00 pm on Tuesday 21 July 2026. Questions can be submitted via the Online questions portal Further information and guidance is available at Get involved - Herefordshire Council Accepted questions and the response to them will be published as a supplement to the agenda papers prior to the meeting. Full details about asking questions and the deadlines at public meetings can be found here: constitution of the council . Guidance for questions being submitted for scrutiny can be found here	11 - 16
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 REHABILITATION REDESIGN - UPDATE To provide an update on Herefordshire and Worcestershire Health and Care NHS Trust's adult mental health rehabilitation services redesign.	17 - 78
8. HEREFORDSHIRE'S JOINT STRATEGIC NEEDS ASSESSMENT AND NEIGHBOURHOOD PROFILES To review Herefordshire's Joint Strategic Needs Assessment (JSNA) and neighbourhood health profiles.	79 - 168
9. ADULT SOCIAL CARE BUDGET OUTTURN To receive a verbal update on adult social care budget outturn.	

10. WORK PROGRAMME 2026-7

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To consider the draft work programme for Herefordshire Council's scrutiny committees.

11. DATE OF THE NEXT MEETING

Date of the next scheduled meeting: Monday 14 September 2026, 2.00 pm.

The public's rights to information and attendance at meetings

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

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
Simeon Cole	Conservative Party
Pauline Crockett (Chairperson)	Independents for Herefordshire
Dave Davies	Conservative Party
Mark Dykes	Liberal Democrats
Richard Thomas	Conservative Party
Kevin Tillett	Liberal Democrats
Rebecca Tully (Vice-Chairperson)	The Green 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.

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 27 April 2026 at 2.00 pm

Committee members present in person and voting:

Councillors: Simeon Cole, Pauline Crockett (Chairperson), Dave Davies, Richard Thomas and Kevin Tillet (Vice-Chairperson)

Others in attendance:

J Burgess	Commissioning Manager	Herefordshire Council
Z Clifford	Director of Public Health	Herefordshire Council
M Evans	Democratic Services Officer	Herefordshire Council
Councillor C Gandy	Cabinet Member Adults, Health and Wellbeing	Herefordshire Council
J Jeffery	Director of Midwifery	Wye Valley NHS Trust
H Merricks-Murgatroyd	Democratic Services Officer	Herefordshire Council
S Nicholls	Chair	Carers' Partnership Board
S Shingler	Managing Director	Wye Valley NHS Trust
Councillor R Tully		Herefordshire Council
D Webb	Statutory Scrutiny Officer	Herefordshire Council

10. APOLOGIES FOR ABSENCE

Apologies for absence were received from Cllr Mark Dykes.

11. NAMED SUBSTITUTES

There were no named substitutes.

12. DECLARATIONS OF INTEREST

The Chairperson noted that she is a member of the Carers' Partnership Board.

13. MINUTES

The minutes of the previous meeting were received.

Resolved: That the minutes of the meeting held on 11 February 2026 be confirmed as a correct record and be signed by the Chairperson.

14. QUESTIONS FROM MEMBERS OF THE PUBLIC

A document containing a question received from a member of the public and the response given was included in Supplement 2 to the agenda.

15. QUESTIONS FROM MEMBERS OF THE COUNCIL

No questions were received from councillors.

16. CARERS' PARTNERSHIP BOARD ANNUAL REPORT 2025

The committee considered a report on the Carers' Partnership Board Annual Report 2025 item.

The principal points of the subsequent discussion are summarised below:

1. The Commissioning Manager explained that the unpaid carers strategy for Herefordshire was published in July 2024 and that one of its first key aims was to establish a Carers' Partnership Board, with the first official meeting taking place in January 2025.
2. It was noted that the annual report was the first report to scrutiny on the work of the board and highlighted progress made over the previous year against the action plan.
3. The committee heard that one of the main areas of progress had been carers' assessments in adult social care, which are now required to be completed as standalone assessments through the Mosaic IT system rather than being combined with the assessment of the cared-for person. It was added that this would enable unpaid carers to speak privately about their circumstances and would also improve the council's ability to identify unpaid carers and maintain better data on the support they may need.
4. The Commissioning Manager reported that work was also taking place with children's services on a "no wrong door" approach for young carers, including use of a screening tool and an intended launch around possibly September.
5. The Chair of the Carers' Partnership Board emphasised the importance of hearing directly from carers with lived experience and noted that more carers were now contributing to the board, despite the difficulties many carers face in leaving the person they care for in order to attend meetings. It was also noted that events had been held to bring together carers, the board and the wider public in order to identify what support was missing and how life for carers could be improved.
6. It was noted that there is a subgroup for young carers, known as the Young Carer Support Squad, which aims to raise awareness of young and young adult carers, strengthen relationships with schools, coordinate awareness activity, and support national campaigns such as Young Carers Action Day.
7. In response to a question about membership of the board, the committee was advised that work had been undertaken to confirm membership reflects those people who wish to attend and do attend. It was noted that carers with lived experience are offered pre-meetings in advance of board meetings so that they can raise issues and feel more confident in contributing.
8. In response to a question about Healthwatch representation, it was noted that the future national position remained unclear, but that the board would continue to seek an independent voice able to work across health and social care and act as a critical friend.
9. The Chair of the Carers' Partnership Board added that if Healthwatch ceases to be involved there would be a need for stronger NHS links within the board, as carers' issues span health, social care and wider day-to-day support needs.

10. It was noted that transport remains a significant barrier for some young carers in attending groups and events, particularly for those living outside Hereford or the market towns, although online support continues alongside in-person provision.
11. The committee also heard that work was continuing on identification cards for carers and young carers, including options for production, funding and practical use, and that related work was also taking place on an emergency card for adults.
12. It was noted that identification cards could be useful in settings such as schools and pharmacies and may also provide wider practical benefits, although further development work was still required.
13. In response to a question about legal support, the Commissioning Manager noted that a future board meeting in July would include a speaker on lasting power of attorney so that information and advice could be shared more widely.
14. Committee members commented on the importance of improving public awareness so that more people recognise themselves as carers and understand that support is available.
15. The Cabinet Member Adults, Health and Wellbeing suggested that parish councils could be used more to help publicise support available to carers, including through parish council reports, parish magazines and noticeboards, and that councillors could assist in sharing key contact details and information locally.
16. The Commissioning Manager noted that the strategy and action plan included work to support Herefordshire Council to become a carer-friendly organisation. It was added that the recent staff survey had included a question on caring responsibilities and that 20% of respondents had identified themselves as carers, with further work potentially needed on updating policies, procedures, manager training and wider support.

Resolved

- 1. To support the introduction of a carers' card for all carers.**

17. HOME BIRTH SERVICES

The committee considered a report on the Home Birth Services item.

The principal points of the subsequent discussion are summarised below:

1. The committee considered the item following concerns raised by residents regarding the suspension of the home birth service.
2. In introducing the item, the chairperson noted that a trust can suspend a home birth service where it concluded that the service could not be provided safely and that patient choice had to be balanced with patient safety, staffing levels and clinical governance.
3. The Director of Midwifery Wye Valley Trust explained that the review of the service had followed a high-profile case in Manchester and the publication of a prevention of future deaths notice, which identified key areas of concern including

the absence of national guidance, issues relating to training and competence, and variation in service models.

4. It was noted that NHS England had formally asked the trust to undertake a review of its home birth provision, including the operational model, care planning and risk assessment, and the governance and oversight of the service.
5. The review, which began early in 2026, identified a decline in the home birth rate and, as a consequence, reduced exposure to home birth practice for some newer and longer-standing members of staff, creating concerns about maintaining competence.
6. It was also noted that changes to neonatal life support (NLS) guidance had also highlighted the need for additional equipment to support neonatal resuscitation while awaiting the arrival of paramedic colleagues.
7. The trust had completed the review and had taken action to increase staff exposure to intrapartum care, order the required equipment, begin training in its use, and strengthen operating procedures to support women in making informed choices about place of birth.
8. The Director of Midwifery Wye Valley Trust explained that the remaining step before recommending reinstatement of the service to the board was completion of training in neonatal resuscitation, although the timing remained dependent in part on the arrival of nationally sourced equipment.
9. In response to a question on timescales, the committee was advised that some of the required equipment had already been received and that a small number of midwives would be trained once the remaining equipment arrived, with the trust indicating that the process should take a number of weeks rather than months.
10. The Managing Director Wye Valley Trust advised that, once the equipment was available, training can begin and a recommendation would then be made to the board to reconvene the service, although a definitive date could not be given because the timing of equipment supply was outside the trust's control.
11. It was noted that women considering a home birth were encouraged to contact the trust directly so that individual advice and support could be provided.
12. In response to questions about information for expectant mothers, the committee was advised that discussions about place of birth begin at the booking appointment and continue throughout the maternity pathway, with risks, benefits and alternatives considered as part of birth planning. It was also noted that information for families is now largely provided electronically, which enables written guidance and leaflets to be updated more easily.
13. The Director of Midwifery Wye Valley Trust added that work had been commissioned across the foundation group to develop a framework to support women to have personalised care.
14. In response to questions about future equipment availability, the committee heard that the trust intended to hold three emergency bags across the county, with spare equipment included, so that the necessary equipment would be available for home births.

15. The committee was advised that approximately 25 staff would require training and that this would be delivered in small groups so that the programme could be implemented promptly while maintaining community maternity services.
16. In relation to risk, the Director of Midwifery Wye Valley Trust explained that, where a woman had experienced a straightforward pregnancy and previous birth, it was statistically safer to have a second baby at home, whereas a first birth carried greater risk.
17. The Chairperson asked the trust to keep the committee updated on progress towards resuming the service.

18. ADULT SOCIAL CARE BUDGET OUTTURN

The committee received a verbal update on the Adult Social Care budget outturn item.

The principal points of the subsequent discussion are summarised below:

1. The Cabinet Member Adults, Health and Wellbeing noted that the quarter three reports, which had been considered by Cabinet and Scrutiny Management Board, showed a forecast overspend of £5.9 million across the Community Wellbeing directorate. It was noted that £2.8 million of this would be allocated from the budget resilience reserve, leaving a projected overspend of £3.1 million.
2. It was identified that the cause of the overspend is increased demand in adult social care, both in terms of the number of people requiring support and the complexity of their care needs. The committee heard that there were approximately 185 households in temporary accommodation and that this represented a significant cost pressure.
3. It was reported that year-end close-down processes for 2025/26 are in process now and that early indications suggested the overspend position was likely to remain broadly in line with that reported at quarter three, although the final outturn position would not be available until after quarter four reporting in mid-May.
4. The Cabinet Member Adults, Health and Wellbeing also noted that Community Wellbeing had a savings target of £3.9 million for 2025/26 and that early indications have suggested this target would be achieved, subject to final confirmation. It was also noted that some measures being introduced to deliver savings in 2026/27 were already contributing towards savings in 2025/26.
5. In response to the budget pressures experienced during 2025/26, significant work was said to be underway to strengthen the adult social care front door so that people contacting the service could be signposted more effectively, including where their needs did not meet adult social care criteria.
6. The committee heard that further work was also being undertaken around prevention and the transformation of care commissioning, including reducing reliance on spot purchasing at short notice.
7. A suggestion was also raised that technology enabled care should be promoted more actively, including through displays in community hospital reception areas, in order to help residents and families understand what support might be available to keep people safe at home for longer.

8. The Director of Public Health noted that demand for adult social care is returning towards pre-Covid levels and that the complexity of care needs had also increased, requiring a range of responses including prevention, cost control, income generation and efficiencies.
9. In relation to prevention, the Director of Public Health added that this included both upstream public health activity, such as health checks and identifying hypertension early, and work at the adult social care front door to address lower-level needs before they escalated.
10. It was added that there was potential for a neighbourhood health approach to support closer working across services, although this work remained at an early stage.
11. The Chairperson identified a number of outstanding questions for future consideration, including the final outturn compared with the approved budget, the size of any overspend in cash and percentage terms, comparisons with the previous year, the point at which the overspend became clear, and whether any one-off items, reserve movements or accounting changes had affected the final position.

19. WORK PROGRAMME 2026-7

The Statutory Scrutiny Officer presented the draft work programme for the Health, Care and Wellbeing Scrutiny Committee.

20. DATE OF THE NEXT MEETING

The date of the next meeting is Monday 27 July 2026, 2.00 pm.

The meeting ended at 3.49 pm

Chairperson



Title: Adult Mental Health Rehabilitation Redesign - Update

Meeting: Health, Care and Wellbeing Scrutiny Committee

Meeting date: Monday 27 July 2026

Report by: Herefordshire and Worcestershire Health and Care NHS Trust

Classification

Open

Report purpose

To provide an update on Herefordshire and Worcestershire Health and Care NHS Trust's adult mental health rehabilitation services redesign.

Background

1. The Health, Care and Wellbeing Scrutiny Committee scrutinised options for the trust's adult mental health rehabilitation services redesign at its meeting on 19 May 2025. The report provided to that meeting is appended as **Appendix 1**.
2. At this meeting, the committee recommended that "the Herefordshire and Worcestershire Health and Care NHS Trust should set out the pros and cons of each of the three redesign options against the six "and we" criteria in the NHS Commissioner Guidance for adult mental health rehabilitation inpatient services".
3. The trust replied that it would "agree with the recommendation", noting that "this will be evidenced and fully described within the options appraisal process, in addition this will form part of the pre-consultation business case as part of the NHSE Major Change Process." The trust has subsequently confirmed that this will be included in section 11.6.5 of the soon to be finalised pre-consultation business case.
4. The trust has subsequently asked to attend this meeting to provide the committee with an update on its work.

Meeting objectives

5. To review Herefordshire and Worcestershire Health and Care NHS Trust's adult mental health rehabilitation services redesign, including assurance that the committee's recommendation was acted upon.

Report information

Further information on the subject of this report is available from
 Danial Webb, Statutory Scrutiny Officer, email: Danial.Webb@herefordshire.gov.uk

6. 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.
7. It was 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.
8. 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.
9. 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'.
10. 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.
11. GIRFT methodology is being utilised to drive change, and the Trust has 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.
12. The overall objectives for the programme are:
 - a. Reduce unwarranted variation identified within rehabilitation services.
 - b. The redesign of Adult Mental Health Rehabilitation Services, will strive to ensure that patients who have a level of rehabilitation need are served within our local community, thus reducing out of area placements.
 - c. Adult Rehabilitation will have a defined purpose, ensuring appropriate purposeful admission with clear evidence-based treatment pathways that all staff across providers understand.

- d. A Community Rehabilitation Team will become an additional focussed pathway aligning inpatient services with community mental health transformation.
- e. Align with the NHS *Fit for the Future 10 Year Health Plan*: “From hospital to community: more care will be available on people’s doorsteps and in their homes”.
- f. Ensure the Trust no longer use any high-cost agency staff in Adult Mental Health Rehabilitation Services.
- g. Ensure person-centred care and co-production of care plans is standard practice.
- h. Capture and analyse the impact of interventions to assess risks and benefits as part of evidence-based practice.
- i. Develop and report robust ways for capturing interventions and outcomes for services that are heavily linked into partnership working.
- j. Ensure workforce are trained to work across the rehabilitation pathway which enables and maintains a skilled and sustainable workforce with staff experience being measured through an improvement identified in the staff survey.
- k. 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.
- l. Implementing 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

- 13. Admission to a rehabilitation unit 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.
- 14. The Trust’s current Community Rehabilitation Units are at Oak House in Hereford (8 beds), Keith Winter House in Bromsgrove (15 beds) and Cromwell House in Worcester (10 beds) - 33 beds in total.

Adult Rehabilitation Redesign Programme – Progress Update

- 15. This update on the Adult Mental Health Rehabilitation Redesign Programme informs the committee that a ‘preferred option’ has been identified.
- 16. Following the initial Clinical Modelling Workshops, we were left with 7 ideas. Hurdle Criteria sessions were held with stakeholders, and the 7 ideas were reduced to 4 (one of the ideas that was discounted was the ‘do nothing’ idea).
- 17. Desirable criteria was devised by stakeholders and then weighted by stakeholders. The remaining ideas were then rated against the desirable criteria by stakeholders. None of the ideas passed.
- 18. We took on feedback about this process and in our most recent engagement sessions, we utilised a Nominal Group Ranking (NGR) technique to rank the remaining 4 ideas.
- 19. As a result, the lowest ranked idea was eliminated, and we were left with 3 options. The remaining options were subject to topic specific expert review panels.

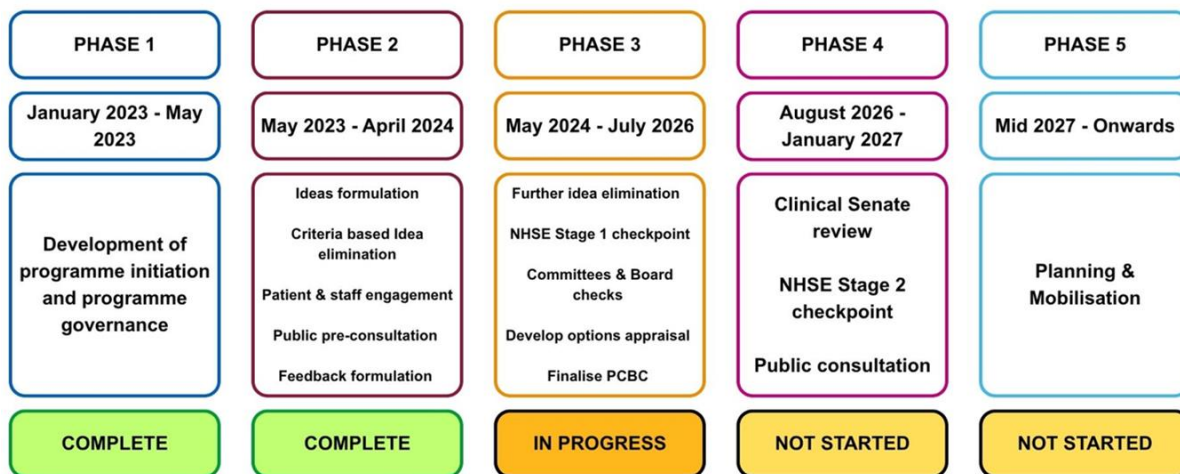
20. These panels were made up of experts in specific areas and were attended by a range of external stakeholders, including Healthwatch, the voluntary, community, and social enterprise sector, local authority and Integrated Care System representatives and participation partners, as well as a range of internal stakeholders:
 - a. **Panel 1: Quality of Care for All** - This panel was engaged to establish whether the options provide quality care for all
 - b. **Panel 2: Access to Care for All** - This panel was engaged to establish whether the options provide access to care for all
 - c. **Panel 3: Workforce** - This panel was engaged to establish whether the options provide sustainable workforce levels, and which option will impact the workforce the most.
 - d. **Panel 4: Deliverability** - This panel was engaged to establish the deliverability of each of the options
 - e. **Panel 5: Environment** - This panel was engaged to establish the environmental requirements of each option
 - f. **Panel 6: Affordability and Value for Money (Final Panel)** - This panel was engaged to rank the options on affordability.
21. Whilst they were not part of any of the above panels, we have also engaged with Public Health, and they have supported us with some population health data requirements and understanding our local population need.
22. As a result of this work, a preferred option was identified, and this has been supported by numerous Trust Boards, Committees and Integrated Care System forums. The Secretary of State has also been notified.
23. Staff at affected sites have been informed that a preferred option has been identified and each of these sessions were facilitated by a Trust Board member, programme member, clinical leader and were supported by a human resources representative.
24. A clear communication plan is in place for internal and external stakeholders.
25. The service redesign Equality and Health Inequalities Impact Assessment is attached as **Appendix 3** to this report.
26. It is important to note that in late 2025, the programme was paused to explore emerging opportunities to work with external providers to potentially provide Level 1 and Level 2 rehabilitation. The exploration was ultimately unsuccessful.

Preferred Option

27. Rehabilitation would be delivered as a complete pathway as described in national guidance. This would consist of a Level 1 inpatient rehabilitation offer, a Level 1 community rehabilitation offer, and a Level 2 rehabilitation offer.
28. Level 1 rehabilitation beds would be provided as a system, based in Worcestershire, for both Herefordshire and Worcestershire people. As part of this option, two units would close – Cromwell House and Oak House.
29. There would be a development of an Enhanced Community Rehabilitation Team which would serve both Herefordshire and Worcestershire.
30. A Level 2 rehabilitation offer would be developed to serve both counties; however, this is not available locally and will be sourced through block booking or joining a West Midlands

procurement framework within the Integrated Care Board cluster (Herefordshire, Worcestershire, Coventry and Warwickshire).

High Level Timeline



Next Steps

31. We will share a draft plan explaining the proposed changes (Pre-Consultation Business Case) with an expert group of clinicians from across the NHS (the Clinical Senate) to check it is safe, effective, and evidence-based
32. In August 2026, the Clinical Senate will visit the rehabilitation units in person and write a detailed report giving feedback and recommendations on the proposal.
33. The Trust and ICS will then need to review and consider the Clinical Senate's findings and respond.
34. In November 2026, the Trust and Integrated Care System will be subject to a NHSE Stage 2 Gateway Assurance Checkpoint meeting.
35. Assuming all relevant checks are completed, and the proposal meets the required standard, Public Consultation will likely start in early 2027 for 12 weeks.
36. The Trust will then need to consider the findings of the public consultation.
37. The Trust will begin to plan the mobilisation of the implementation of the preferred option in mid-2027.
38. The Trust offers to attend a meeting of the Health, Care and Wellbeing Scrutiny Committee following public consultation in May 2027, to update committee of the findings and next steps.

Consultees

39. No consultation took place in the process of producing this report.

Appendices

Appendix 1 – *Adult Mental Health Inpatient and Rehabilitation Services Redesign*, presented to Health, Care and Wellbeing Scrutiny Committee, 19 May 2025

Appendix 2 – NHS England 2024: *Commissioner guidance for adult mental health rehabilitation inpatient services*

Appendix 3 - Service Redesign Equality and Health Inequalities Impact Assessment

Background papers and resources

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

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.
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Risk	Click or tap here to enter text.	Date Click or tap to enter a date.
Approved by	John Coleman	Date 09/05/2025

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

Commissioner guidance for adult mental health rehabilitation inpatient services

[Publication \(/publication\)](#)

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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 al, 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/) (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) (<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) (<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) (<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/) (<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/) (<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/) (<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) (<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/) (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) (<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/) (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/) (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) (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) (<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) (<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) ([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](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/) (<https://www.england.nhs.uk/learning-disabilities/care/ctr/care-education-and-treatment-reviews/>) and [Dynamic Support Registers \(DSR\)](https://www.england.nhs.uk/publication/dynamic-support-register-and-care-education-and-treatment-review-policy-and-guide/), [discharge planning](https://www.england.nhs.uk/publication/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/>), [personalised care and support plans](https://www.england.nhs.uk/personalisedcare/pcsp/) (<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) (<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/) (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/) (<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 \(https://www.england.nhs.uk/long-read/commissioner-guidance-for-adult-mental-health-rehabilitation-inpatient-services/#3-key-messages\)](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) (<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) (<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/) (<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) (<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) (<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:

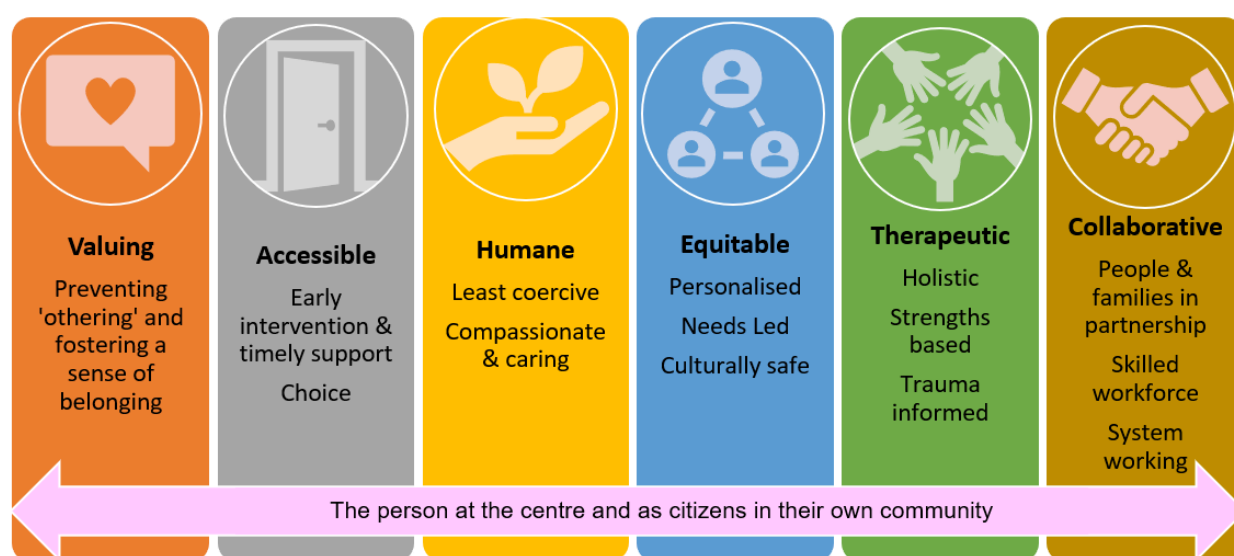
- the articulated purpose of admission
- estimated date of discharge and related length of stay
- access to the service, including waiting times for admission and discharge, and the reasons for any delays.

As explained in [Section 3: Key messages \(https://www.england.nhs.uk/long-read/commissioner-guidance-for-adult-mental-health-rehabilitation-inpatient-services/#3-key-messages\)](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 \(https://www.england.nhs.uk/learning-disabilities/care/ctr/care-education-and-treatment-reviews/\)](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](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 health, 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 2014-2017](https://www.cqc.org.uk/publications/major-report/state-care-mental-health-services-2014-2017) (<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-2021-2026) (<https://www.gov.uk/government/publications/national-strategy-for-autistic-children-young-people-and-adults-2021-2026>).
- Getting It Right First Time (2022) [Mental health – Rehabilitation](https://gettingitrightfirsttime.co.uk/medical_specialties/mh-rehab/) (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/) (<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%2Fcqi%2Fquality-networks-accreditation%2Flearning-disabilities-service-inpatients&data=05%7C01%7C Louise.davies10%40nhs.net%7Ca7fdd828449742cf7cbb08db81c743c0%7C37c354b28f>)
- 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%9CWwhere%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
- Louise Davies (co-chair) – Independent Expert Advisor – Commissioning
- Deb Moore – Mental Health, Learning Disability and Autism Quality Transformation Team, NHS England
- Tonita Whittier – Mental Health, Learning Disability and Autism Quality Transformation Team, NHS England
- Hirila Rose – Certitude London
- Jo Lomani – Mental Health, Learning Disability & Autism Quality Transformation Team, NHS England
- Di Domenico – Independent Expert Advisor – Commissioning
- Emily Williams – National Learning Disability and Autism Team, NHS England
- Roger Banks – National Learning Disability and Autism Team, NHS England
- Geoff Heyes – National Mental Health Team, NHS England

- Tristan Batten – Leeds and York Partnership NHS Foundation Trust
- Su Pashley – Norfolk and Suffolk NHS Foundation Trust
- Kate Oldfield – Rotherham, Doncaster, and South Humber NHS Foundation Trust
- Clair Haydon – Cheshire and Wirral Partnership NHS Foundation Trust
- Victoria Burns – Devon Partnership NHS Trust
- Keir Shillaker – West Yorkshire Health and Care Partnership ICB
- Dean Howells – Black Country Healthcare NHS Foundation Trust
- Mayura Deshpande – NHS England and Southern Health NHS Foundation Trust
- Kelly Fenton – Leicestershire Partnership NHS Trust
- Jenny Wilkes – Care Quality Commission
- Becs Daddow – National MH Specialised Commissioning Team, NHS England
- Thelma Goddard – National Learning Disability and Autism Team, NHS England
- Sheridan McKiniry – National Learning Disability and Autism Team, NHS England
- Ruth Davies – National Mental Health Team NHS
- Elan Davidson – GIRFT and Cheshire and Wirral Partnership NHS Foundation Trust
- Helen Souter – Mental Health Casework Section, His Majesty's Prison and Probation Service
- Kathryn Nichols – Mental Health Casework Section, His Majesty's Prison and Probation Service

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EHIA Form Pro-forma – Policy and Activity Review

Title of activity
ADULT MENTAL HEALTH REHABILITATION REDESIGN

Section 1: Service area

County Wide Community Services	Primary Care and Community Mental Health Service	Integrated Community Services	Specialist Mental Health and Learning Disabilities Services	Children Young People and Families	Corporate and Administrative Services (please specify which directorate)
			X		

Senior Responsible Officer (Associate Director or Executive Director) / Lead for the Activity		
Name: John Devapriam	Job Title: Medical Director	E-mail address: john.devapriam1@nhs.net
Details of individual completing this assessment, please include name, job title and email contact (must be minimum of 2 persons completing this EHIA)		
Name: Alison Marshall	Job Title: Working Age Inpatient and Rehabilitation Service Manager Adult Mental Health & LD Service Delivery Unit	E-mail address: alison.marshall28@nhs.net
Name: Sian Westaway	Job Title: Deputy Programme Director	E-mail address: sian.westaway@nhs.net
Date assessment completed		
14 th August 2025		
Attended EAG 15/10/2025 – Report updated in line with discussion.		

Section 2 – The activity

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)
Programme of work: Adult Mental Health Rehabilitation Redesign
Brief summary of the proposal in a few sentences. What is/are the aim, purpose and/or intended outcomes of this activity?
Purpose: - To design a system wide rehabilitation pathway which meets the requirements all individuals needing mental health rehabilitation and support. The service redesign will consider a full range of opportunities in line with national guidance, to include: - Level 1 Community Enhanced Rehabilitation team - Level 1 Inpatient Rehabilitation - Level 2 Inpatient Rehabilitation. Outcomes: <u>Rehabilitation Pathway:</u> 1. A Robust, Evidence-Based Clinical Pathway: A clearly defined, end-to-end rehabilitation pathway that aligns with national guidance, patient needs, and service objectives. 2.Enhanced Community Rehabilitation Team Integration: Specifications for the role and functions of the community rehabilitation team, ensuring effective coordination with inpatient services, outpatient supports, and community-based interventions. 3. Informed by Best Practice and Benchmarking: Incorporation of lessons learned from other successful rehabilitation services, ensuring the pathway is both innovative and contextually appropriate. 4. Patient-Centred Improvements: Documented patient input and feedback used to tailor the pathway, resulting in more responsive, accessible, and person-focused care interventions. 5. Clarity on Partnership Agency Involvement: A clearly defined strategy for involving external providers in Level 1 rehabilitation, including identified benefits, challenges, and recommended collaborative arrangements. 6. A Roadmap for Implementation: A finalised pathway ready to guide resource allocation, staff training, service planning, and subsequent implementation steps in the adult mental health rehabilitation redesign programme.
Is this a review of an existing activity, new activity, planning to withdraw or reduce a service, activity, or presence?

Review of EHIA as good practice whilst following the Getting Right First-Time methodology as part of the major change process.

This consists of a review and quality improvement of an existing service, in addition to review of rehabilitation which requires changes to the current service provision based upon commissioning guidance.

- [NHS England » Commissioner guidance for adult mental health rehabilitation inpatient services](#)

Which stakeholders will be affected by the development & implementation of this activity? Service user, staff, patient, communities, partner organisation

Service Users

Staff

Partner Organisations

Communities

Families / Carers / Loved Ones

Section 3 – Sources of evidence and engagement

What information and evidence have you reviewed to help inform this assessment? (Please name sources, e.g. demographic information for patients / services / staff groups affected, complaints etc.)

Services affected:

Rehabilitation Units:

- Cromwell House Inpatient Level 1 rehab unit
- Keith Winter House Inpatient Level 1 rehab unit
- Oak House Inpatient Level 1 rehab unit

Staffing groups affected: Nursing, Occupational Therapy, Medical, Psychology, Administration, students.

Patient cohort affected:

- Adult (over age 18yrs) mental health rehabilitation service users across Herefordshire and Worcestershire, in addition to service users placed out of county in Level 2 rehabilitation facilities.

Evidence reviewed:

- Evidence from established services across the UK utilising MDT full pathway models.
- National Benchmarking report 2022
- GIRFT reports on Rehabilitation and Adult Crisis and Acute Mental Health Care.
- Rehabilitation NICE guidelines (NG181) Rehabilitation for adults with complex psychosis
- Standards for Community Mental Health Rehabilitation Services (1st Edition), (Royal College of Psychiatry, 2022)
- Standards for Inpatient Mental Health Rehabilitation Services (4th Edition), (Royal College of Psychiatry 2020).
- NHSE Commissioning guidance for adult mental health rehabilitation inpatient services (2024).
- NHSE Commissioning guidance for adult mental health community rehabilitation services (2025)
- Published research – literature reviews

- Staff complaints, compliments, PALs and other surveys
- NHS Mental Health Implementation Plan
- NHS Long Term Plan
- National Institute for Health and Care Excellence guidance
- National Institute for Health and Care Excellence (NICE) Rehabilitation for Adults with Complex Psychosis
- Prescribing Observatory for Mental Health (POMH)
- National Confidential Inquiry into Suicide and safety in mental Health (NCISH)
- National Clinical Audit of Psychosis (NCAP)
- Site visits of partner agencies who can provide L1 & L2 Rehabilitation services.

Summary of engagement or consultation undertaken (e.g. who and how have you engaged, or why do you believe this is not required). If engagement is required, please contact the Public and Patient Engagement Experience and Participation team (whcnhs.ehia@nhs.net) who can advise and support you.

Engagement:

- There has been engagement with stakeholders since the programme was first initiated in 2023. There has been a public pre-consultation events where a report has been completed.
- The programme has two participation partners, who are active within working groups, steering group and Programme Board.
- Stakeholders who attend Programme Board and Steering Group include:
 - ICB
 - WCC
 - VCSE
- Stakeholders, throughout the trust, ICB, and GP colleagues have been regularly visited and updated in addition to regular drop ins and communication.
- Health Overview Scrutiny Committee (HOSC) has been attended on two occasions. NHSE and Clinical Senate are supporting the major change process.
- Clinical Rehabilitation Pathway workshop incorporating systemwide partners to contribute to the redesign.

Summary of relevant findings

The programme is following the following schedule:

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 & service improvement. (June 2026 – October 2026)	Not started
Phase 4	Implementation.	Not started

It is evident from both the commissioning guidance and further evidence bases that Adult Mental Health inpatient wards are requiring an improvement approach; Adult Mental Health Rehabilitation Service require transformation.

The case for change:

NHS

Herefordshire and Worcestershire
Health and Care

NHS Trust

Case for Change & Benefits

Challenges in terms of the current workforce - necessity to develop new workforce models that ensure sustainability and resilience over the next ten years.

Need to provide stability through clarity of roles and responsibilities for staff and a clear purpose of the various inpatient functions

Must ensure that staffing levels and provision are safe and effective, alongside strengthened clinical leadership.

Need to establish a positive culture that incorporates both staff and patients.

The Trust has nearly completed a physical redesign of the inpatient estate which has created opportunities and better environments for patients.

This programme will explore further estate opportunities with a focus on efficiency and modernising the inpatient offer through a redeveloped rehabilitation experience.

Reducing out of county (OOC) placements
Reducing length of stay (LOS)

National Commissioning Guidance for Adult Acute Inpatients & Rehabilitation

Evolving patient needs

Technological advancements

Financial pressures & best use of resources

CQC inspection

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

Personalised care with a trauma informed approach.

Improving partnership working

Significantly improving health outcomes and reducing inequalities

The need to improve data metrics to understand the day-to-day operations of the services, demand and capacity and patient flow.

The need to reduce unwarranted variations

The Community Mental Health Transformation programme has developed new ways of working, in partnership across several providers including the Voluntary, Community and Social Enterprise (VCSE) and Social Care.

It is a logical next step to consider the mental health acute and rehabilitation care that people receive alongside the community service including interventions they can access to ensure the clinical approach is purposeful and evidence based.

The overall purpose is to ensure that all who access our services receive evidence based, quality care in all our services without variation to their experience.

The project will examine the current estate where the environment is deemed 'not fit for purpose' based on national standards.

In addition, digital opportunities that support inpatient care will also be a reviewed to ensure that they support and enhance the efficiency of processes.

The positive outcomes or advantages that this programme is *expected* to deliver.

Improved Treatment Outcomes

Enhanced Patient Safety

Increased Comfort and Privacy

Access to Advanced Technologies

Improved Mental Health Environment

Enhanced Patient Engagement and Autonomy

Reduced Stigma

Better Family and Visitor Support

Evidenced based care and optimised Recovery Rates

Cultural Sensitivity and Inclusivity

Accessibility Improvements

Integrated Care Delivery

Community Integration

Reduced unwarranted variations

Improved Measuring of Outcomes for Patients & Systems

The programme has already undertaken, hurdle criteria, and nominal group ranking sessions. The programme has three remaining options which an options appraisal will take place.

The introduction could have a positive impact upon patient experience by:

- Minimising out of county placements for level 2 rehabilitation
- Increasing the number of people able to access rehabilitation services.
- Introducing a community focused rehab offer – which will be beneficial to the largest cohort of patients.
- Increase efficiency of current level 1 rehab beds by allowing streamlined transition.
- Improve patient experience and outcomes.
- Increased cost effectiveness
- Reduce reliance on inpatient acute beds and inappropriate length of stays.
- Requires redesign of staff roles to adapt to the provision of community rehab.
- Eradication of unwarranted variation across units.

EHIA Pro forma/version 1.0

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Section 4 – Potential impacts on the Protected Characteristics

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. Please put an x in one or more impact box below for each Equality Group and explain your rationale. Please note the potential impact can be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, the public, patients, carers, etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral, or negative impact identified
Age - People from different age groups		x	x	Neutral Impacts This is standard practice: The Rehabilitation services will be for adults age 18yrs with no upper age cap. At the upper end of the age range, Access & Mobility: Redesigned services must consider physical accessibility, transport, and digital literacy. Complex Needs: Older patients often have multiple conditions requiring integrated care. There will be which is decided on a patient-by-patient basis and where their needs are best met. Positive Impacts: Negative Impacts: Redesign of a Level 1 provision to a single location (should this be the final option supported) means partners or carers may need to travel further to be treated as an inpatient. This is counter balanced by the ability to move into the community in a timelier manner and for patients to be treated within their own home.
Armed forces (as per the Armed forces act 2021) The Armed Forces Act 2021 introduced a new requirement for some public bodies, including the NHS and local authorities, to pay due regard to the principles of the Covenant		x		Positive Impacts: Neutral Impacts: Redesign of services will not change the current access to services for this equality group. Negative Impacts:

Disability - People with visible and hidden disabilities; physical attitudinal and societal impacts	x	x	x	Positive Impacts: The offer of community rehabilitation will mean improved engagement in a person's home/ community environment meaning inclusion of care planning to suit individualised needs. Delivering care in the community will better integration with communities and carers/ families. Standard Practice: Learning Disability / Autism: All staff are required to complete Oliver McGowan Training. In addition, each area will have a Green Light Champion. Patients identified as having a learning disability or an autism diagnosis will have a Care and Treatment Review (CTR). A CTR is independent, person-centred reviews for autistic individuals with a learning disability in the UK who are in, or at risk of being admitted to, a mental health or learning disability hospital. Yearly Patient Led Assessments of the Care Environment (PLACE) Audit is the system for assessing the quality of the patient environment, this assesses privacy and dignity, food, cleanliness and general building maintenance and, more recently, the extent to which the environment is able to support the care of those with dementia or with a disability. Hidden Disabilities: Standard Practice: There is currently no braille signage on the wards. There is currently no hearing loops installed on the wards – The service lead is looking to manage this and where possible installation. This is currently being costed for Keith Winter House, but not as yet for CWH or Oak until the redesign has clear outcomes based on cost vs benefit at this late stage in the process. All patients who require interpretation services can access these.
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Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral, or negative impact identified
				The Trust is in the process of offering British Sign Language sessions for all staff. This will require engagement from staff across the organisation, and operational manager will require a strategy to build engagement and attendance. Neutral Impacts: Negative Impacts: Redesign of a Level 1 provision to a single location (should this be the final option supported) means partners or carers may need to travel further to engage. This is counter balanced by the ability to transition into the community in a timelier manner, in addition to patients being treated in their home environment. Current Level 1 rehab units are not able to cater for people with some physical disabilities due to the structure of buildings. There is no ability to change current building structures to accommodate need. There is minimal ability to influence environments for out of county level 2 beds in the current service provision currently, however this is being explored as part of the programme.

Ethnicity/Race/Nationality - Black and minority ethnic people; Gypsy and Traveller people, different ethnic groups; language	x	x	x	Positive Impacts: An introduction of a community rehabilitation service can allow increased opportunity and access for people with BAME backgrounds – engaging in community integration and social inclusion. A community offer will be needs specific which includes a focus on religious/ cultural or other needs specifically linked to the racial or religious needs - including supporting attendance at religious institutes and re-integration into their community-based belief systems or engaging with community groups/ projects specifically orientated towards meeting same needs. Standard Practice: Current Rehabilitation services are not fully orientated to adapt to people's ethnic/ Race/ Nationality requirements and units make adaptations on an ad-hoc basis. The ability to address is primarily based on environment - example prayer rooms are added into "lounges" as needed - as this is environmental teams mitigate where possible. The organisation also offers the following staff networks: Armed Forces network was created in recognition of the challenges faced by people who serve or have served in the armed forces, and are now working in an alternative, civilian workplace. The Trust will work collaboratively with the network on any matters relating to the Armed Forces Covenant and anything related to the armed forces. Carers network has been set up to provide a supportive forum for staff who are working carers or staff who want to understand how best to support their carer colleagues. ENRICH (Equality Network for Race Inclusion and Cultural Heritage) network consists of a range of staff whose aim is to work with the Trust at all levels, to provide an effective and autonomous voice for ethnic minority communities, through inclusion, diversity, and equality.
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Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral, or negative impact identified
				Faith and Spiritual Network: This is a multi-faith network with the purpose of bringing together representatives from different religions and beliefs to appropriately address and debate the religious/non-belief and spiritual needs of our staff which impact on better outcomes for our patients. It is also a forum to address and share good practices of religious/beliefs that have a positive impact on people's health. Please contact Charles Stubbings, Lead Chaplain and Pastoral Support, for more information. IADA (I Am Differently Abled) network provides a forum for disabled staff to share knowledge and experience in a safe and supportive environment and use a collective voice to contribute to the Trusts disability agenda. LGBT+ (Lesbian, Gay, Bisexual, Trans, and others) network was developed to provide a safe, supportive, and open environment to all LGBT+ staff, and all staff who are enthusiastic and committed to driving change and advancing Equality and Diversity, in keeping with the Trust's message of inclusiveness: 'Together We Can'. Patient and Public Engagement, Experience and Participation Team can support units with queries / questions in relation to ethnicity/race/ nationality based on their role within the organisation Neutral Impacts: Negative Impacts: Redesign of a Level 1 provision to a single location (should this be the final option supported) may impact accessing local religious groups which a patient may be affiliated to – however support would be offered to attend these with supporting travel.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral, or negative impact identified
Gender Reassignment - Gender Identity and Gender expression, Transgender and Transexual people	X	x		Neutral Impact: Standard Practice The trust is working towards a policy, which will align with National Guidance in 2025. Risk assessments undertaken with all other patients for safety and trauma reasons. There is a Sexual safety policy and Sexual safety awareness training and literature is being developed. Positive Impacts: Introduction of a community rehabilitation service will enable adaptations to include specific and patient identified social inclusion and community engagement to meet gender needs. The community offer increases access by allowing for rehabilitation needs in a community space with access to more aligned activities. Reduced beds will enable community activity to happen which cannot currently. Negative Impacts:

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral, or negative impact identified
Marriage & Civil Partnerships -People who are married or in a same sex or heterosexual civil partnership –	x	x	x	Positive Impacts: The introduction of a community rehabilitation team allows the flexibility of treating patients in their own home without the requirement of an inpatient provision. As with all care, carer/family impact will be assessed with every referral which will allow for appropriate decision of where patients need are best served. Based upon engagement feedback the experience of patients being separated from loved ones can be very difficult, a community offer ensures there is no separation. Also taking into consideration “think family” approach and carers needs. Neutral Impacts: The redesign of services will not change the current access to services for this equality group. Negative Impacts: Redesign of a Level 1 provision to a single location (should this be the final option supported) means partners or carers may need to travel further to visit loved ones.

Pregnancy & Maternity - Women and people who are pregnant or on maternity leave		x	x	Neutral Impacts: Standard Practice Community rehabilitation services will afford mothers engagement with social and communities as well as remain focused on family life in a supported manner. Early pregnancy managed within current mental health services following a risk assessment. Acuity of the wards would be reviewed and establish an appropriate placement for a pregnant woman based upon risk to patient and unborn. Should the environment be deemed too high risk to the mother alternative placements can be sought. In the third trimester, there should be consideration of transfer to a mother and baby unit (where appropriate), these services would be involved from the start to ensure transfer of care is seamless. Perinatal mental health services would be considered during pregnancy and in the postnatal period and referral where appropriate. Pregnancy tests undertaken when clinically indicated. Patients who are an acute ward will receive support from perinatal mental health team and maternity (where required), where required a mother and baby unit would be considered. There is continuous assessment of risk to mother and baby. Positive Impacts: Negative Impacts: Redesign of a Level 1 provision to a single location (should this be the final option supported) means partners or carers may need to travel further to visit loved ones. This is counter balanced by the ability to move into the community in a timelier manner and offer treatment in their home environment. Where an inpatient bed is required for a mother and baby a specialised unit would be sourced if this were to be considered appropriate by the Perinatal Mental Health Team.
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Religion & Belief - People with / of different religions or those with strongly held philosophical beliefs or no belief	x	x	x	Positive Impacts: An introduction of a community rehabilitation service can allow increased opportunity and access for people with BAME backgrounds – engaging in community integration and social inclusion. A community offer will be individual need and a focus on religious/ cultural or other needs specifically linked to the racial or religious needs - including supporting attendance at religious institutes and re-integration into their community-based belief systems or engaging with community groups/ projects specifically orientated towards meeting same needs. A community offer can have positive effect for those who struggle to engage with mental health services, this offer can adapt the approach based on individual and family need and see patients in differing locations where the patient would consider this to be more acceptable. Neutral Impact Standard Practice: Current Rehabilitation services are not fully orientated to adapt to people's ethnic/ Race/ Nationality requirements and units make adaptations on an ad-hoc basis. The ability to address is primarily based on environment - example prayer rooms are added into "lounges" as needed - as this is environmental teams mitigate where possible. Patients and staff have access to the chaplaincy service, who can connect with other religious leaders and cultural leads to support patients. Multi-faith rooms or areas are available in some hospitals and more are planned. Where there is no dedicated room available, we provide a multi-faith provision for most mainstream faiths, and we aim to respond to any spiritual needs you may require. Multi-faith rooms also provide a quiet space for reflection. The organisation recognises national inclusion week, Founded by Inclusive Employers, National Inclusion Week (NIW) is a week dedicated to
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Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral, or negative impact identified
				celebrating inclusion and taking action to create inclusive workplaces. Neutral Impacts: Redesign of services will not change the current access to services for this equality group. Negative Impacts: Redesign of a Level 1 provision to a single location (should this be the final option supported) may impact accessing local religious groups which a patient may be affiliated to – however support would be offered to attend these with supporting travel.
Sex - Women, men, non-binary	x	x		Positive Impacts: Introduction of a community rehabilitation service will enable adaptations to include specific and patient identified social inclusion and community engagement to meet gender needs. The community offer increases access by allowing for rehabilitation needs in a community space with access to more aligned activities. Reduced beds will enable community activity to happen which cannot currently. Neutral Impacts: Redesign of services will not change the current access to services for this equality group. Standard Practice: The trust is working towards a policy, which will align with National Guidance in 2025. Risk assessments undertaken with all other patients for safety and trauma reasons. There is a Sexual safety policy and Sexual safety awareness training and literature is being developed. Negative Impacts:

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral, or negative impact identified
Sexual Orientation: Lesbian, gay, straight, or heterosexual, bisexual, other	x	x		Positive Impacts: Introduction of a community rehabilitation service will enable adaptations to include specific and patient identified social inclusion and community engagement to meet gender needs. The community offer increases access by allowing for rehabilitation needs in a community space with access to more aligned activities. Reduced beds will enable community activity to happen which cannot currently. Neutral Impacts: The trust is working towards a policy, which will align with National Guidance in 2025. Risk assessments undertaken with all other patients for safety and trauma reasons. There is a Sexual safety policy and Sexual safety awareness training and literature is being developed. Redesign of services will not change the current access to services for this equality group. Negative Impacts:

Other identified groups Consider and detail and include the source of any evidence on different socio-economic groups, area of inequality, income, resident status Refugees, asylum seekers or those experiencing modern slavery (migrants) and other groups experiencing disadvantage and barriers to access. These include Looked after children and young people, Carers of patients: unpaid, family members. People involved in the criminal justice system: offenders in prison/on probation, ex-offenders. Homeless people. People on the street; staying temporarily with friends /family; in hostels or B&Bs.	X	X	X	Positive Impacts: Rehabilitation services are designed to be person centred and cater to the individual needs/ wishes/ backgrounds/ characteristics of a person. The introduction of community rehabilitation service will enable access to closer community engagement and social inclusion opportunities, thereby meeting a person's holistic needs. In addition, VCSE offers would be promoted (Carers and beyond). VCSE will an important element of the Rehabilitation Pathway and have been engaged throughout the programme and further engagement will be required when at implementation and mobilisation stage. Homeless patients– Complex Discharge Facilitators and Housing support will be an element of the rehabilitation pathway. In addition, the team will “in reach” into providers (supported accommodation etc) to support the placement and offer early intervention , education and preventative work. Neutral Impacts: Standard Practice: The service is anticipated to have no exclusion criteria providing there is an identified mental health need. Homeless patients– Complex Discharge Facilitators within the Patient Flow Team liaise with local housing authority – emergency accommodation sought, and no one is discharged without somewhere to go. Carers are considered within every assessment and revisited during patient care where onward referrals / carers assessments may be required. Sign posting is also utilised for application of carers allowance. There will be a “Think Family” approach. Services engage with other organisations a patient may be involved with i.e. Criminal Justice to ensure clear communication and care planning.
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Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral, or negative impact identified
				Across rehabilitation units, carer focussed sessions are held, these are educational and Peer. This would be replicated in a community offer. In addition, VCSE offers would be promoted. VCSE will be part of the Rehabilitation Pathway. Negative Impacts: Redesign of a Level 1 provision to a single location (should this be the final option supported) means partners or carers may need to travel further to engage. This is counter balanced by the ability to move into the community in a timelier manner and allow patients to be treated in their own home with their families, loved ones and social networks.

Public Sector Equality Duty

The Public Sector Equality Duty came in to force in April 2011 (s.149 of the Equality Act 2010) and public authorities like the NHS are now required, in carrying out their functions, to have due regard to the need to achieve the objectives set out under s149 of the Equality Act 2010 to:

- eliminate discrimination, harassment, victimisation, and any other conduct that is prohibited by or under the Equality Act 2010;
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Is your assessment that your proposal will support compliance with the Public Sector Equality Duty?
 Please add an x to the relevant box below.

	Reducing inequalities in access to health care	Reducing inequalities in health outcomes
The proposal will support?		
The proposal may support?	x	x
Uncertain if the proposal will support?		

This proposal **may support** reducing inequalities in health care and health outcomes by providing a wider level of support across Herefordshire and Worcestershire. There is an acknowledgement of a bed reduction, however this has been anticipated within the service redesign and is based upon a successful Leicestershire NHS model. The new pathway will seek to improve care, providing care where possible in patients own homes which positively impact recovery rates and onward recovery. It is acknowledged as a system there may be only one Level 1 inpatient setting, and there will be an impact on families/carers and loved ones visiting sites, to note that the sites are on public transport routes.

Level one providers have been assessed and evaluated in Herefordshire, with no possible outcome at this time.

Level 2 beds, which are currently outside of the ICB footprint (Local trust do not offer Level 2 beds) the programme is looking an options to source this closer to home with one / two providers – this is exploratory and not confirmed as a decision.

Section 5 – Negative Impacts, Mitigations and Risks

Risk	What mitigations will be put in place to address each negative impact?	Who will be the owner and be responsible for the delivery of each mitigation?	How will you monitor these actions for each mitigation?	Please give details of how this is a risk to the organisation and how those risks will be mitigated.
Redesign of staffing roles - potential loss of staff during process	Staff are engaged and involved within the redesign process, with opportunity to make comment of contribute via identified routes of communication. Staff will be engaged with HR processes as early as possible to understand future employment roles / offers.	Programme Team Clinical Services Manager	Staff feedback Risk register and Ulysses reporting – specially to employment and retention of staff. Workforce data	Risk to the organisation by an inability to retain staff due to changes. Continued engagement and communication with staff.
Finance	Potential that redesigned pathway is financially not viable.	Finance	Robust options appraisals will include financial impact/ consequences	Robust options appraisals will include financial impact/ consequences. Redesign can be reviewed based on outcome of options appraisal
Patients/ families and carers having to travel to one system provided resource for Level one (if the options appraisal chooses this option)	Patients would be supported to access their local community with staff support where this is required. Patients will now have a possibility to be treated at home (where clinically appropriate). Level one unit in Worcestershire and Herefordshire are on local transport routes.	Operational / Clinical teams	Patient/ Family feedback Staff Feedback Outcome measures	Risk to the organisation is the family/loved one accessibility to patients who may be placed in one unit for the system. Engagement with public, in addition HOSC.
Ethnic Groups accessing services due	Where there are identified groups that will struggle to adapt or engage with services, the community rehabilitation team will	Clinical Teams	Patient/ Family feedback Staff Feedback	A community rehabilitation model allows further adaptation to meet the needs of patients / carers and loved ones which an inpatient

to beliefs held.	have the ability to adapt their approach on a need's basis. This will also include use of language and providing information in an accessible way.			facility is unfortunately unable to provide due to the nature of care needing to be delivered.
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Review of EHIA

When will you review this EHIA? (e.g. in a service redesign, this EHIA should be revisited regularly throughout the design & implementation phase)

Please include expected dates.

The programme will be due to be completed as follows

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 & service improvement. (June 2026 – October 2026)	Not started
Phase 4	Implementation.	Not started

The options appraisal will require review of the EHIA.

The EHIA will be reviewed a minimum of 6 monthly throughout the process

Please indicate which committee will this go through (*the SRO will be responsible for advising the committee and updating them*)

Which committee will this go through (*the SRO will be responsible for advising the committee and updating them*)

Programme Steering Group, Programme Board and Trust Programme Management Board.

As part of business as usual this will go through integrated governance, quality and safety reporting.

Section 7 - Please read and agree to the following Equality Statement**1. Equality Statement**

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the nine protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

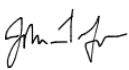
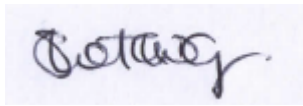
1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc., and as such treat them and members of the workforce respectfully, paying due regard to the nine protected characteristics.

1.4 Our organisations are expected to use the appropriate interpreting, translating or preferred method of communication for those who have language and/or other communication needs. Practitioners will need to assess that the Adult Mental Health Rehabilitation Redesign and Acute Inpatient improvement is fair and equitable for all groups covered under the Equality Act 2010 and that they are implementing the Accessible Information Standard and have considered health inequalities.

1.5. Herefordshire and Worcestershire Health and Care NHS Trust must meet its statutory duty to reduce inequalities of access and outcomes, as set out in the NHS Act 2006 (as amended). As a result, the Herefordshire and Worcestershire Health and Care NHS Trust aims to design and implement policy documents that seek to reduce any inequalities that already arise or may arise from any new policy. Therefore, Herefordshire and Worcestershire Health and Care NHS Trust will consciously consider the extent to which any policy reduces inequalities of access and outcomes.

1.6. Any change to a service will require a conscious effort from the author(s) of that change to actively consider the impact that this will have on any Protected group(s) and act due diligently. Where an impact on any of the Equality groups is realised after the implementation of the Project/Service, the commissioners and or Providers, who are implementing the said Project and or service will seek to minimise such an impact and simultaneously conduct a full review.

Signature of Senior Responsible Officer / Lead for the Activity	 John Devapriam, Medical Director
Date signed	14/08/2025 Originally agreed 14/08/2025, review at EAG and updated following discussion, re agreed: ???2025
Signature of Author completing the EHIA	 Alison Marshall – Clinical Service Manager 

	Sian Westaway – Deputy Programme Director
Date signed	Originally agreed 14/08/2025, review at EAG and updated following discussion, re agreed: 16/10/2025
Organisational Sign Off (Director of People / Director of Strategy and Partnerships)	 Sue Harris, Director of Strategy, People & Culture
Date signed	09/07/2026
Organisational Sign Off (Director of Patient Experience, Digital and Innovation)	 Gemma Artz, Director of Patient Experience, Digital and Innovation
Date signed	09/07/2026

Once complete, please e-mail a copy to whcnhs.ehia@nhs.net



Title: Herefordshire's Joint Strategic Needs Assessment and Neighbourhood Profiles

Meeting: Health, Care and Wellbeing Scrutiny Committee

Meeting date: 27 July 2026

Report by: Zoe Clifford, Director of Public Health

Classification

Open

Report purpose

To provide the committee with:

- a. an overview of Herefordshire's Joint Strategic Needs Assessment (JSNA)
- b. a summary of the purpose and development of neighbourhood health profiles as part of the JSNA
- c. a sample neighbourhood full neighbourhood profile and
- d. summary neighbourhood profiles for the four primary care network neighbourhood areas.

Background

1. The committee has identified neighbourhood health strategy as a priority for its works programme. Neighbourhood health is a focus for the One Herefordshire Partnership as it develops its plans as one of the 43 pathfinder partnerships developing its plans as part of the National Neighbourhood Health Implementation Programme.
2. The committee intends to scrutinise this work later in the year. As development of the neighbourhood profiles is an important component of this programme, the committee has asked to review the work to develop the profiles. This will inform its scrutiny of the implementation programme in December 2026.

Meeting objectives

3. To review work to develop neighbourhood profiles as part of the joint strategic needs assessment framework for Herefordshire, supporting the work to implement the objectives of the National Neighbourhood Health Implementation Programme.

Report information

What is a Joint Strategic Needs Assessment?

4. The Joint Strategic Needs Assessment (JSNA) provides a structured approach to understanding the current and future health and wellbeing needs of Herefordshire's population. Rather than being a single report, it is a comprehensive and continually evolving body of evidence that helps the council, NHS partners, the Health and Wellbeing Board (HWBB), and other organisations identify priorities, target resources and improve outcomes for residents.
5. The JSNA is a statutory requirement for every Health and Wellbeing Board, although there is no nationally prescribed format. The JSNA should be "*a continuous process of assessment of the current and future health and social care needs of the local community that can be influenced by the council, NHS and local partners.*"
6. Importantly, the JSNA is not solely concerned with health services or medical conditions. It takes a broad view of health and wellbeing, recognising that outcomes are influenced by a wide range of social, economic and environmental factors. Wider determinants such as employment, housing, education, income, environment and social circumstances are as important to population health as healthcare services and individual behaviours. See figure 1 below which illustrates the range of factors that determine health.

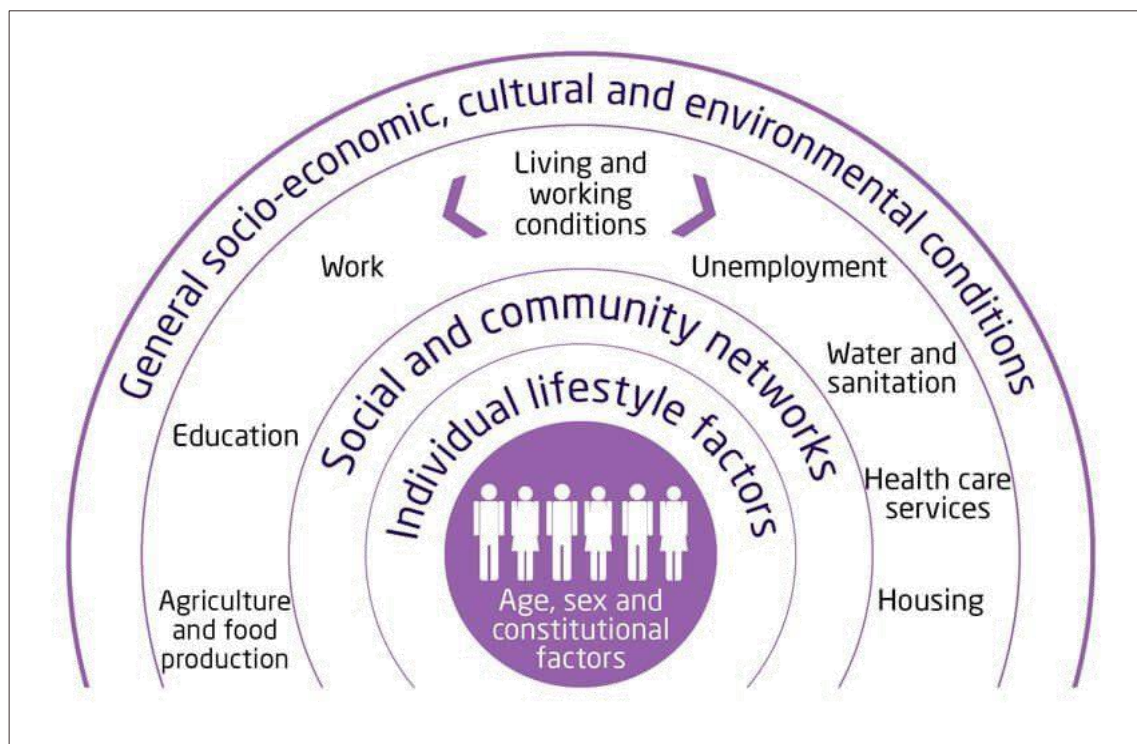


Figure 1: the determinants of health

7. The JSNA provides an evidence base that supports decision-making across the whole council, not just within health and social care. It enables organisations to understand needs, identify inequalities, anticipate future demand and direct resources where they can have the greatest impact

8. An effective JSNA should not be viewed as a static document. Instead, it should be a live process of data collection, analysis and intelligence gathering that drives change and informs strategic decision-making. As such, Herefordshire Council's JSNA is structured in a way that supports this ongoing process.
9. To facilitate this ongoing process, Herefordshire's JSNA is not a single publication. Instead, it is best understood as a portfolio of documents, assessments, monitoring tools and intelligence briefings, all of which contribute to a shared understanding of local need. This approach reflects the fact that no single report could adequately capture the complexity of Herefordshire's population, health outcomes, inequalities and emerging challenges. Different products within the portfolio fulfil different functions, ranging from long-term strategic planning to detailed thematic analysis and routine performance monitoring.
10. The portfolio model also allows the JSNA to remain responsive. New evidence can be incorporated through thematic needs assessments, dashboards and surveillance tools without waiting for a major publication cycle. As a result, the JSNA becomes a continuous programme of work rather than a periodic report.

Component Elements of Herefordshire's JSNA

11. There are three broad components that together make up Herefordshire's JSNA.
12. **Overarching Strategic Documents**
These documents provide the high-level strategic framework. The key output is the **JSNA Summary**. Produced every three years, this document provides high-level insights about the county and should inform the strategic priorities of the Health and Wellbeing Board and partner organisations. The most recent summary was published in 2025. Other relevant strategic documents include the **Director of Public Health Annual Report** (An annual assessment that highlights key public health issues and emerging priorities for the county) and the **Health and Wellbeing Strategy (produced every ten years)** - the long-term strategy setting out priorities for improving health and wellbeing across Herefordshire.
13. Together, these documents establish strategic priorities and provide direction for partners across the system.
14. **Rolling Programme of Needs Assessments**
Alongside the overarching documents, Herefordshire undertakes thematic assessments focused on specific topics or population groups. Examples include:
 - a. special educational needs and disabilities (SEND)
 - b. domestic violence and abuse
 - c. supported exempt accommodation
 - d. sexual health
 - e. armed forces community
 - f. children and young people
 - g. oral health
15. These assessments provide deeper analysis of particular issues and help identify opportunities for intervention and service improvement.

16. **Monitoring and Surveillance Products**

The third component consists of ongoing monitoring tools and intelligence products, including for example:

- a. general practitioner inequalities dashboard
- b. health outcomes dashboards
- c. ward profiles and
- d. quick facts datasets

- 17. These resources enable continuous monitoring of trends, outcomes and inequalities, ensuring that decision-makers have access to up-to-date evidence.
- 18. Together, these three elements create a comprehensive evidence system in which strategic documents set direction, needs assessments provide detailed analysis, and monitoring products track change over time.

Neighbourhood health profiles and their purpose

- 19. The UK government's plan for neighbourhood health is driven by the [Neighbourhood Health Framework](#) and the [10 Year Health Plan for England](#), which aim to shift healthcare out of hospitals and into local communities. The key policies include rolling out a national network of Neighbourhood Health Centres and forming Integrated Neighbourhood Teams to focus on proactive care and illness prevention.
- 20. The government's neighbourhood health strategy centres on three foundational system shifts:
 - a. **Hospital to Community:** Expanding local access to urgent care, mental health services, virtual wards, and rehabilitation.
 - b. **Treatment to Prevention:** Proactive, personalized care plans designed to keep people well at home and tackle health inequalities.
 - c. **Analogue to Digital:** Upgrading digital infrastructure to identify at-risk populations, coordinate care, and streamline services.
- 21. The phased rollout includes backing for initial Neighbourhood Health Centres and establishing core governance for Integrated Care Boards (ICBs) and local councils to pool resources and align services locally.
- 22. To support delivery of these reforms, NHS England has established the [National Neighbourhood Health Implementation Programme](#) (NNHIP), which is testing and accelerating neighbourhood health models across the country. As part of the first phase, 43 areas in England have been selected as “pathfinder” sites, providing an opportunity to develop, evaluate and share new approaches to community-based, integrated care.
- 23. Herefordshire has been selected as one of these 43 pathfinder areas, reflecting the strength of local partnership arrangements and the county's experience of integrated working through the [One Herefordshire Partnership](#). Pathfinder status provides access to national expertise, coaching, learning networks and implementation support, enabling local partners to shape and influence the future development of neighbourhood health services.
- 24. Within the programme, Herefordshire is focusing on strengthening coordinated support for residents with the most complex health and care needs, particularly older people, those living with long-term conditions and individuals at greater risk of poor health outcomes. The aim is to improve independence, reduce health inequalities and ensure people can access the right support at the right time within their local communities.

25. The work is being delivered through the One Herefordshire Partnership, whose core membership is:
- Herefordshire Council
 - Herefordshire and Worcestershire Health and Care NHS Trust
 - Wye Valley NHS Trust
 - Herefordshire General Practice
 - St Michael's Hospice
 - Herefordshire Healthwatch
 - Herefordshire and Worcestershire Integrated Care Board

to design and deliver more joined-up neighbourhood health and care services.

26. To support the approach to neighbourhood health, the JSNA Strategic Partnership Group agreed to focus on area-based needs assessment through neighbourhood profiles, rather than undertaking another topic-based programme of work.

Defining our neighbourhoods

27. The Integrated Care System generally defines neighbourhoods in terms of Primary Care Networks (PCNs), serving populations of approximately 30,000–50,000 people. However, Herefordshire recognised that these areas are often too large and diverse to tell a meaningful story just on their own.
28. Local stakeholders therefore agreed to produce four neighbourhood profiles based on the county's four PCN areas:
- Hereford City (a combination of the Hereford Medical Group and WBC Primary Care Networks)
 - East
 - North and West
 - South and West

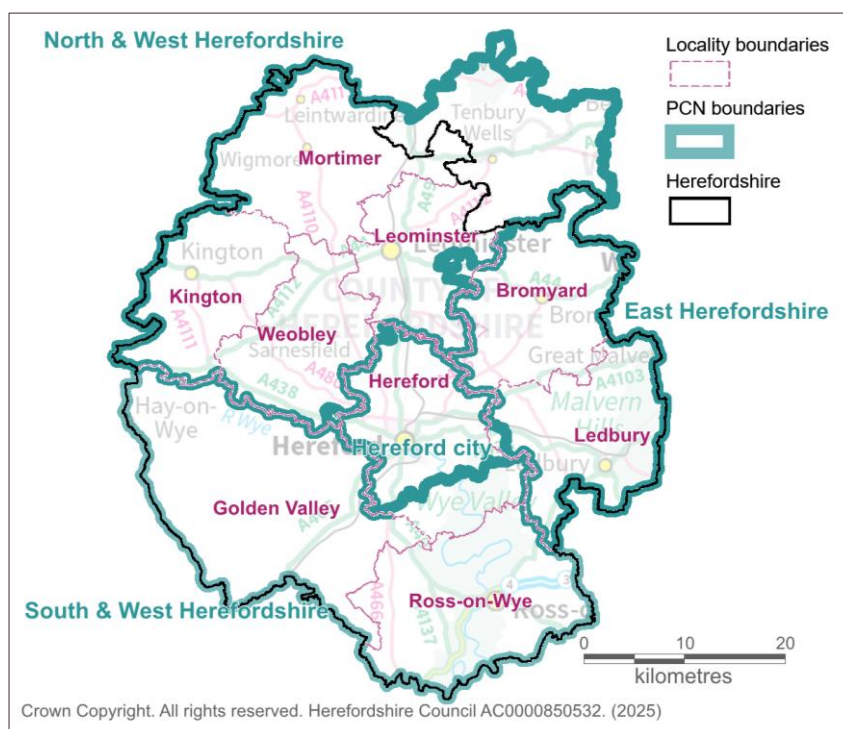


Figure 2: Map of PCN neighbourhoods and localities

29. Within each profile, information is further broken down according to the county's nine established localities, allowing local variation to be understood and preventing important differences from being masked at PCN level.
30. The definition of these four PCN areas recognises that there is a difference between patients who are registered with GPs who make up a Primary Care Network, and the people who live in an area broadly served by these GPs. Data on healthy lifestyles and the prevalence of disease is available for GP patients, but wider socio-demographic data is needed to understand the wider context. This is generally available for the people who live in a particular area.

Neighbourhood Profiles

31. Within the existing JSNA framework, numerous data tools already exist, including population health dashboards, Office for National Statistics resources and Herefordshire area profiles. However, these tools primarily present data and indicators. What they generally do not provide is interpretation.
32. The neighbourhood profiles are intended to fill this gap. Rather than becoming another dashboard, each profile will be a narrative document that:
 - a. summarises the key characteristics of an area
 - b. highlights significant differences from the county average
 - c. identifies major challenges and opportunities
 - d. brings together evidence from multiple sources
 - e. provides interpretation and strategic insight and
 - f. helps readers with little prior knowledge understand the locality.
33. The profiles are not intended to be a new "super-tool" that combines every available dataset, but instead to develop concise, accessible documents that draw together the most important evidence and translate it into clear strategic insights. These profiles will focus on identifying the distinctive characteristics of each neighbourhood, highlighting where local circumstances differ from the county picture, and providing a clear narrative about the issues that matter most for local decision-making. They will bring together data available for the GP-registered population with data about the area and the people who live there.
34. To ensure the profiles are both practical and valuable, the content focuses on readily available data and on topics that offer the greatest insight into prevention, inequality and future service demand. Areas of coverage include:
 - a. population demographics
 - b. health status
 - c. long-term conditions
 - d. health service utilisation
 - e. social care need
 - f. causes of death
 - g. lifestyles and
 - h. the wider determinants of health such as
 - i. education
 - ii. employment and
 - iii. the environment.

35. The profiles will also examine deprivation and other inequalities, identify significant variations within neighbourhoods and between different population groups, and seek to recognise local community assets. In doing so, the profiles aim to support a better understanding of neighbourhoods and help partners target action where it can have the greatest impact.
36. Appendix 1 provides the full Neighbourhood Profile for The North and West Primary Care Network neighbourhood. Appendices 2-5 provide summary neighbourhood profiles for the four Primary Care Network neighbourhoods.

Consultees

37. The Corporate Performance and Intelligence Service, Herefordshire Council, have produced the neighbourhood profiles appended to this report.

Appendices

38. Appendix 1 – North and West Herefordshire Neighbourhood Primary Care Network Full Profile
 Appendix 2 – North and West Herefordshire Primary Care Network Summary Neighbourhood Profile
 Appendix 3 – South and West Herefordshire Primary Care Network Summary Neighbourhood Profile
 Appendix 4 – East Herefordshire Primary Care Network Summary Neighbourhood Profile
 Appendix 5 – Hereford City Primary Care Network Summary Neighbourhood Profile

Background papers and resources

39. The following resources provide background to the policy driving the shift to neighbourhood health profiling:
 - a. Department for Health and Social Care [Neighbourhood Health Framework](#), March 2026
 - b. Department for Health and Social Care [10 Year Health Plan for England](#), July 2025
 - c. Department for Health and Social Care, [National Neighbourhood Health Implementation Programme](#), September 2025



**Understanding
Herefordshire**
People and places

North and West Herefordshire Neighbourhood Profile

Herefordshire Council Intelligence Unit
July 2026

DRAFT

Version 0.08 - Full



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If you need help to understand this document, or would like it in another format or language, please contact us on 01432 261944 or e-mail researchteam@herefordshire.gov.uk

1. Introduction

About the neighbourhood profiles

This profile aims to provide key insights into those living under the North and West Herefordshire Primary Care Network (PCN) area. *By highlighting key differences between localities and neighbourhoods within the area on a variety of topics such as population, health and wellbeing, mortality and the wider determinants of health, areas with high concentrations of deprivation and poorer outcomes can be identified. This can then inform effective commissioning and place-based, targeted planning.*

A rate that is relatively high or low in a local context may not have the same interpretation when compared elsewhere in the country. To remain focused on highlighting key differences across the PCN area, a statement about every dataset analysed is not provided.

Links to data sources used to create this neighbourhood profile are located throughout the document and key sources are provided in the appendix.

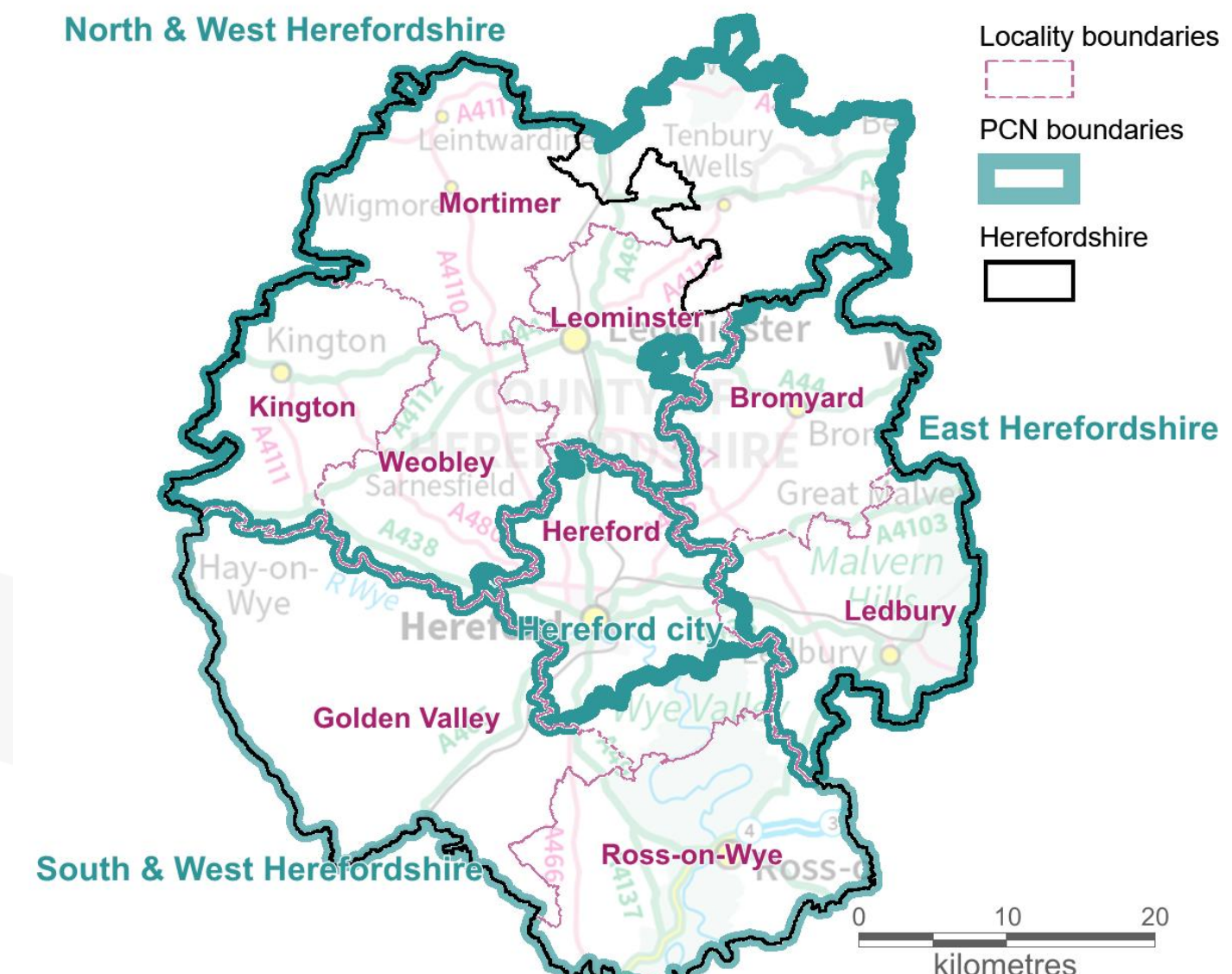
How have we defined a neighbourhood?

'Neighbourhoods' can be defined in different ways i.e. PCN, a Lower Super Output Areas (LSOA) or ward. In this profile, a 'neighbourhood' refers to localities within a PCN. This includes capturing data on the residents who live in each PCN and the patients who are registered with the General Practitioners (GPs) in the PCN.

Both are captured because the data between the two can differ. For example, most health statistics are based on patients who are registered with a GP surgery in the county, which may differ or not relate to their 'usual residence', where people are counted at their family home.

The boundaries used in this neighbourhood profile may differ to those used elsewhere. The North and West PCN boundary is represented below, complete with the localities situated within this PCN.

Figure 1: Map of Herefordshire showing PCN areas and locality boundaries



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2. North and West Herefordshire PCN Area: overview

The North and West Herefordshire PCN area covers the market towns of Leominster and Kington and the wholly rural localities of Mortimer and Weobley. It also includes the Worcestershire town of Tenbury, since Tenbury Wells Surgery is one of the five GP practices which work together as the North and West PCN. The others are the Herefordshire practices of Kington Medical Practice, Ryeland Surgery, Mortimer Medical Practice and Weobley and Staunton on Wye Surgeries.

With 12,000 residents, Leominster is Herefordshire's largest market town, and local services are concentrated here as well as in Tenbury (4,000 residents) and Kington (3,200). Ludlow and Presteigne in the bordering counties of Shropshire and Powys are also service centres for people who live in the area. Weobley, Eardisley, Pembridge and neighbouring villages make up Herefordshire's famous medieval 'black and white trail'.

The North and West PCN area is the largest geographically, and is home to 26% of the county's population. There were 52,900 residents in 2024 and a total of 51,800 patients were registered with the five GP practices as of April 2025, although not all will live in the area (and some residents will be registered with other GPs).

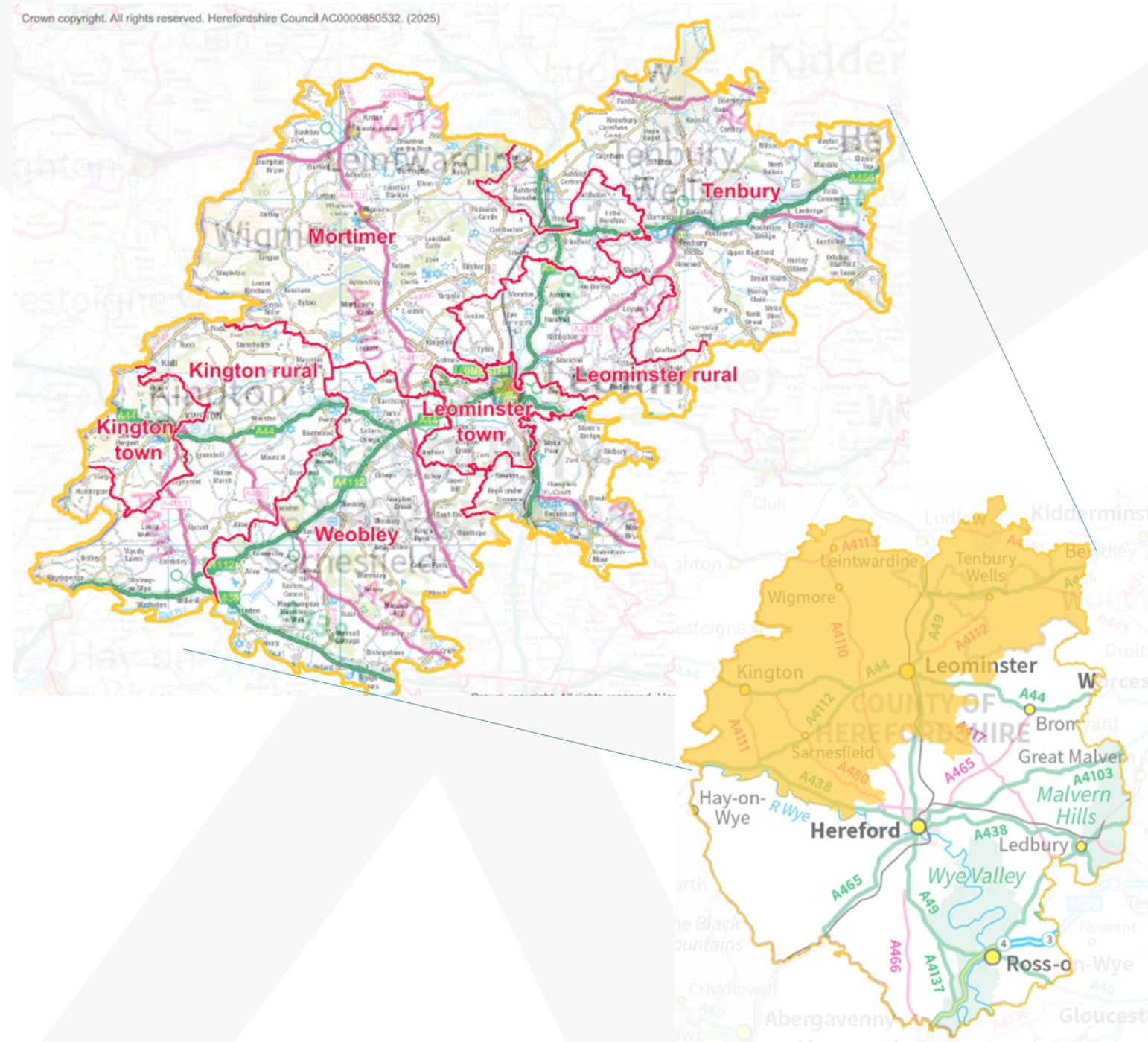
North and West Herefordshire's landscape is characterised by rolling, often wooded, hills to the north, which give way to wider, intensively farmed river valleys as you travel west and to the south. The rivers Lugg and Arrow run through this part of Herefordshire, whilst the Teme flows through Tenbury Wells. The Lugg catchment is a Special Area of Conservation, and high phosphate levels in recent years put a hold on all new housing developments.

A note on Tenbury

As Tenbury lies outside Herefordshire, some datasets used throughout this profile are unavailable at locality level. Whilst Tenbury is included wherever possible, evidence is more comprehensive for the Herefordshire localities within the PCN.

Figure 2: Map of North and West Herefordshire, complete with localities in comparison to the county

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PCN at a glance

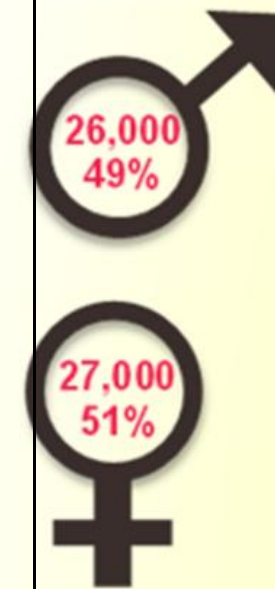


Total GP patient population:
51,800



Resident population:
52,900

6%
ide
than



Population by age



2018-2024

Total deaths
8,000

1,500 AVOIDABLE

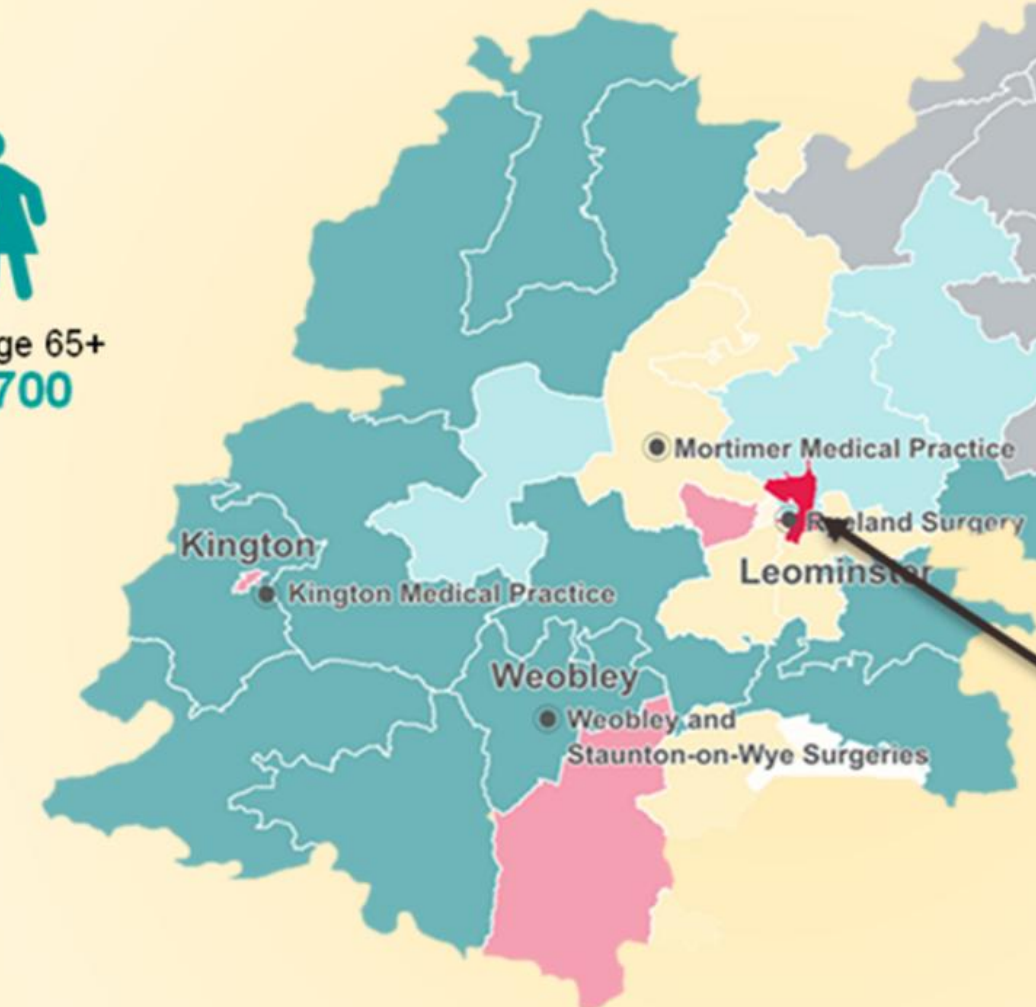
Most common causes



Diseases of the Circulatory System



Cancer



10,600

20% of patients have Hypertension

6,300

14% of patients are obese



5,800

13% of patients smoke



392 square miles

Key geographical



Rivers Lugg & Arrow



Mor

Understanding North and West: insights for decision-makers

The North & West neighbourhood profile contains a wide range of information on the area's population, health and wellbeing, wider determinants of health and community characteristics. The insights below summarise the most important themes emerging from the profile. They are intended to help readers understand the story of the area and identify the factors most likely to influence future population wellbeing and demand for services.

Patterns of need, outcomes and service demand vary considerably across North & West Herefordshire. Understanding these local differences is essential for effective planning and commissioning. Note that the evidence available for Tenbury is more limited than for other parts of the PCN area because the locality sits outside Herefordshire administrative boundaries.

1. A predominantly rural and ageing area, with modest population growth concentrated in market towns such as Tenbury Wells and Leominster

North & West is the county's most rural area and in common with the rest of the county has an older population profile than England. Together, rurality, ageing and modest town-led growth provide the overall context for demand for and access to services.

- North and West has the lowest population density in Herefordshire, and 79% of its 53,000 residents live in rural areas.
- 31% of residents are aged 65 or over, compared with 27% in Herefordshire overall; the oldest age profiles are seen in Tenbury Wells and rural localities.
- The population grew by 2% over the last decade, mostly in the market towns with Tenbury Wells having the highest growth, followed by Leominster.

2. Leominster, Kington and the rural hinterland experience different forms of need

Around a quarter of North and West residents (12,000) live in Leominster which has a younger, more diverse age profile than surrounding rural areas. Whilst overall, multiple deprivation is generally low across the PCN, long-standing pockets are present in Kington and the three Leominster areas of Ridgemoor, Grange and Gateway. Deprivation in rural areas is more commonly associated with access to housing and services.

- Ridgemoor, Grange and Gateway are amongst the 20% most deprived neighbourhoods in England in terms of overall multiple deprivation; Ridgemoor is *the* most deprived area in Herefordshire and among the 10% most deprived nationally.
- Ridgemoor and Gateway have younger populations and higher levels of child and family need, whilst Grange has a larger working-age population, higher levels of private renting and different patterns of disadvantage – including a particularly high risk of digital exclusion due to skills.
- With 3,200 residents, Kington is the smallest and most remote of Herefordshire's five market towns. In common with the others, its town centre (Kington Central) is amongst the 20% most deprived areas of the county.
- In contrast, many rural areas experience place-based deprivation, particularly around housing, transport and access to services.

These patterns highlight three distinct experiences within the PCN: concentrated but not homogeneous deprivation in parts of Leominster, a more localised pocket of need in Kington, and widespread rural challenges relating to access, transport and services.

3. Overall, health outcomes are comparable to the county, but mask large inequalities within the area

Overall health outcomes across North and West are similar to or better than Herefordshire averages, reflecting relatively good health in many rural communities. However, areas of Leominster experience significantly poorer outcomes:

- Male life expectancy in South Leominster (Gateway and Grange) is almost four years lower than the county overall (75.6 years compared to 79.9).
- Mortality rates in the most deprived neighbourhoods are around 70% higher than in the least deprived areas, compared with around 40% across Herefordshire overall.
- Emergency hospital admissions are more common in Leominster Gateway, Ridgemoor, Grange and Kington Central, reflecting a wider geography of unmet need than deprivation measures alone might suggest.
- Long-term sickness, disability and Personal Independence Payment (PIP) claims are also concentrated in the most deprived neighbourhoods, with Ridgemoor having the highest number of PIP claimants.

4. Need among children, families and working-age adults is concentrated within the most deprived neighbourhoods, reflecting overlapping and intergenerational disadvantage

- Ten North and West areas - around one third of all those identified across Herefordshire - have significantly higher rates of need among children under five. The highest levels of need are in Leominster Ridgemoor, Grange and Gateway where multiple indicators are elevated including Children in Need, Early Help, Free School Meals and SEND.
- Overall SEND prevalence is highest in Leominster Ridgemoor and Greater Weobley.
- Economic activity rates are similar to the county overall but:
 - The rate of people claiming out of work benefits in Leominster East Ward is consistently among the highest in the county.

- Economic inactivity due to ill-health or disability is concentrated in the most deprived areas.

5. Housing and fuel poverty shape everyday living conditions

Several cross-cutting factors shape living conditions across North and West:

- Housing stock is more likely to be older, off the gas network and less energy efficient than nationally.
- Higher levels of excess cold hazards and some of the highest fuel poverty levels in the county
 - Clear rural-urban divide in fuel poverty across the area, with the highest levels of fuel poverty concentrated in the rural sub-localities of Mortimer, Weobley and Kington (both town and rural) and the surrounding rural area of Leominster.
 - Leominster Ridgemoor has higher rates of households with no central heating.

6. Along with the rest of Herefordshire, North and West has strong community cohesion but people are less likely to feel safe after dark, with crime an issue in areas of Leominster and Kington

Adults living in North & West Herefordshire are strongly attached to their local area, with the highest levels of satisfaction with their area as a place to live in the county. However, there are some challenges which signal areas for preventative and community-based action:

- Around one in five residents report feeling lonely some or all of the time.
- Feelings of safety after dark are significantly lower than the county average. Alongside Hereford City, North and West has significantly lower levels of feeling safe after dark (69%) than East and South and West (both <80%).
- Several neighbourhoods in both Leominster and Kington are amongst the most deprived in the county for crime, contributing to lower perceptions of safety than might typically be expected in an otherwise largely rural area.

Areas of deprivation

Health inequalities are unfair and avoidable differences in health outcomes caused by the differing conditions in which people grow, live, work and age. One important driver is living in areas of deprivation. The Indices of Deprivation measure small areas across seven domains - income, employment, education, health, crime, housing and services, and the living environment - to create the overall Index of Multiple Deprivation (IMD).

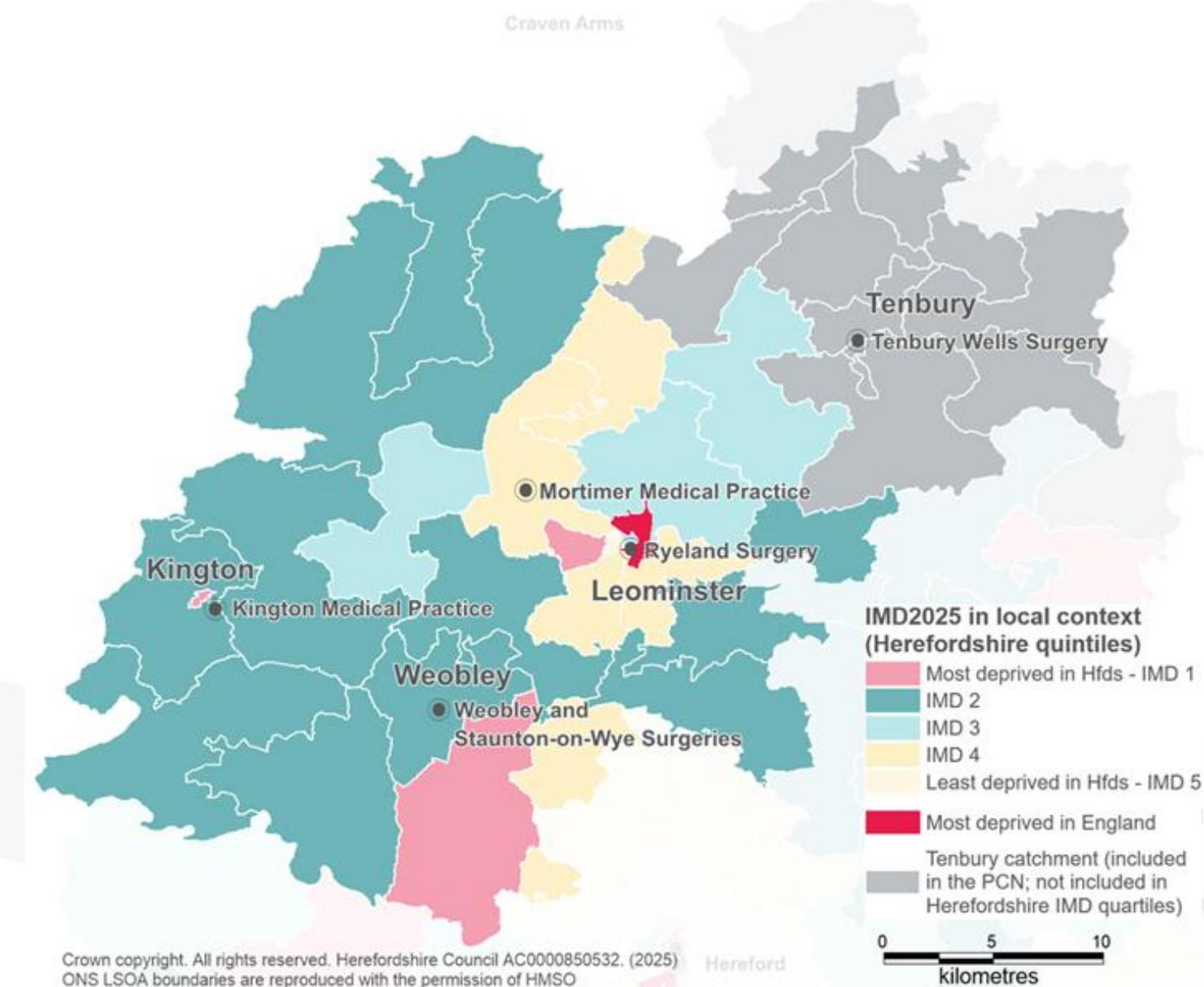
Overall, Herefordshire experiences average levels of multiple deprivation, but there are persistent pockets, mainly in the city and market towns. This includes Leominster's Ridgemoor, Grange and Gateway neighbourhoods, which were **three of only nine** county areas amongst the 20% most deprived in England in the 2025 IMD. Ridgemoor was *the* most deprived area of the county, and the only one amongst the 'top 10%' in England.

Three other areas of North & West were also amongst Herefordshire's 20% most deprived (IMD1): Leominster Barons Cross, Kington Central and Greater Foxley.

Individual types of deprivation are covered in relevant sections of this profile, but to summarise:

- Urban areas tend to be more deprived on the people-based measures of deprivation. In North & West, Leominster's Ridgemoor, Grange, Gateway and Barons Cross fall within the 20% most deprived in the county for income, employment, health and disability, education and skills and crime. Ridgemoor was the most deprived area of the county on income, employment and education and skills.
- Rural areas tend to be more likely to experience place-based deprivation; over half of the LSOAs in this PCN, inclusive of Tenbury, are amongst the 10% most deprived in England for geographical barriers to housing and services and the living environment. Lindridge and Baldridge fall within the 10% most deprived for living environment and barriers to services, whilst Greater Docklow, Aymestrey Horseshoe, Tollbridge, Knillshall, Middleton, Greater Foxley, Tin Hill and Eardishill fall within the 20% most deprived in the county.

Figure 3: Map of overall local deprivation in 2025 across North and West Herefordshire



Deprivation scores for GP practices are included in OHID's [National General Practice Profiles on Fingertips](#).

Focus on areas of deprivation: Leominster Ridgemoor, Grange and Gateway

The adjoining neighbourhoods of Leominster Ridgemoor, Gateway and Grange constitute a concentrated cluster of deprivation within the North and West PCN. The 4,700 residents of these areas are some of the most likely in Herefordshire to experience multiple forms of deprivation, especially across people-based measures. However, because they live in a market town, they are comparatively less deprived in relation to geographical barriers to housing and access to services.

Leominster Ridgemoor ranks as the most deprived neighbourhood in the county, followed by Grange as the second, and Gateway as the seventh.

A **quarter** of North and West's residents live in Herefordshire's 10% most deprived neighbourhoods. Half (51%) of the residents of Ridgemoor live in income deprivation, as does over a third of residents of Gateway (40%) and Grange (36%). Almost all residents (95%) are registered with Ryeland's GP surgery.

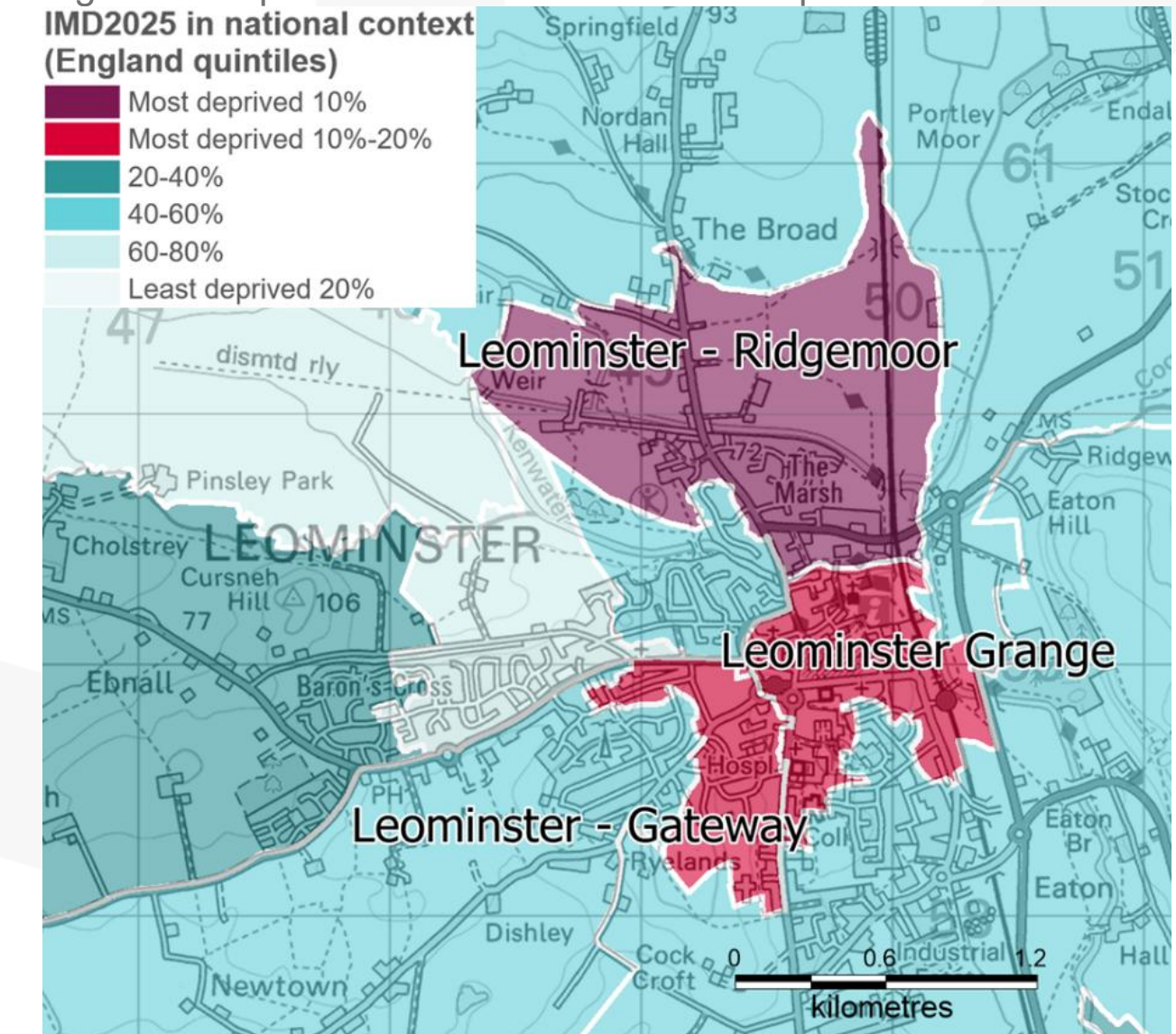
Ridgemoor and Gateway have relatively young populations, with notably high numbers of children and high proportions of lone parents. In contrast, Grange has a high proportion of working aged, particularly middle-aged residents.

Other observations include:

- Higher levels of people with a disability significant enough to need help with daily living that meets the threshold for benefits such as PIP, attendance allowance and disability living allowance.
- Higher levels of people with low income who meet the threshold for benefits such as housing, pension credit and universal credit.
- Higher levels of people who are unemployed and claiming out-of-work benefits, alongside high levels of people with no formal qualifications and high levels working in routine occupations.
- Higher levels of renting - particularly social renting in Ridgemoor and Gateway. Private renting is more common in Grange, where there are also a large number of houses of multiple occupation in comparison to the county.
- High rates of emergency hospital admissions
- High rates of under 5s identified as Children in Need, and of families needing Early Help intervention with Gateway and Grange having high rates of children under 5 eligible for Free School Meals.
- Ridgemoor has a high proportion of children and young people recorded as having special educational needs and disabilities (SEND)

- Grange is most at risk for digital exclusion with both Grange and Ridgemoor identified as being highest risk for 'digital deprivation', with Gateway seventh.

Figure 4: Map of Leominster's three most deprived areas
IMD2025 in national context (England quintiles)



Data source: [Indices of deprivation 2025](#)

3. Who lives here: Population

Resident population

ONS estimates for mid-2024 indicated that North & West Herefordshire had a total population of **53,400**. The majority of these residents (42,100; 79%) lived in rural locations, with most (33,200; 62% of the total population) living in the most rural areas, characterised by small settlements and scattered countryside communities.

Nearly **one-quarter** (23%) of the population lived in the county’s largest market town, Leominster (approximately 12,000 residents). A further 7% (4,000 residents) lived in Tenbury town and 6% (3,200 residents) lived in Kington town.

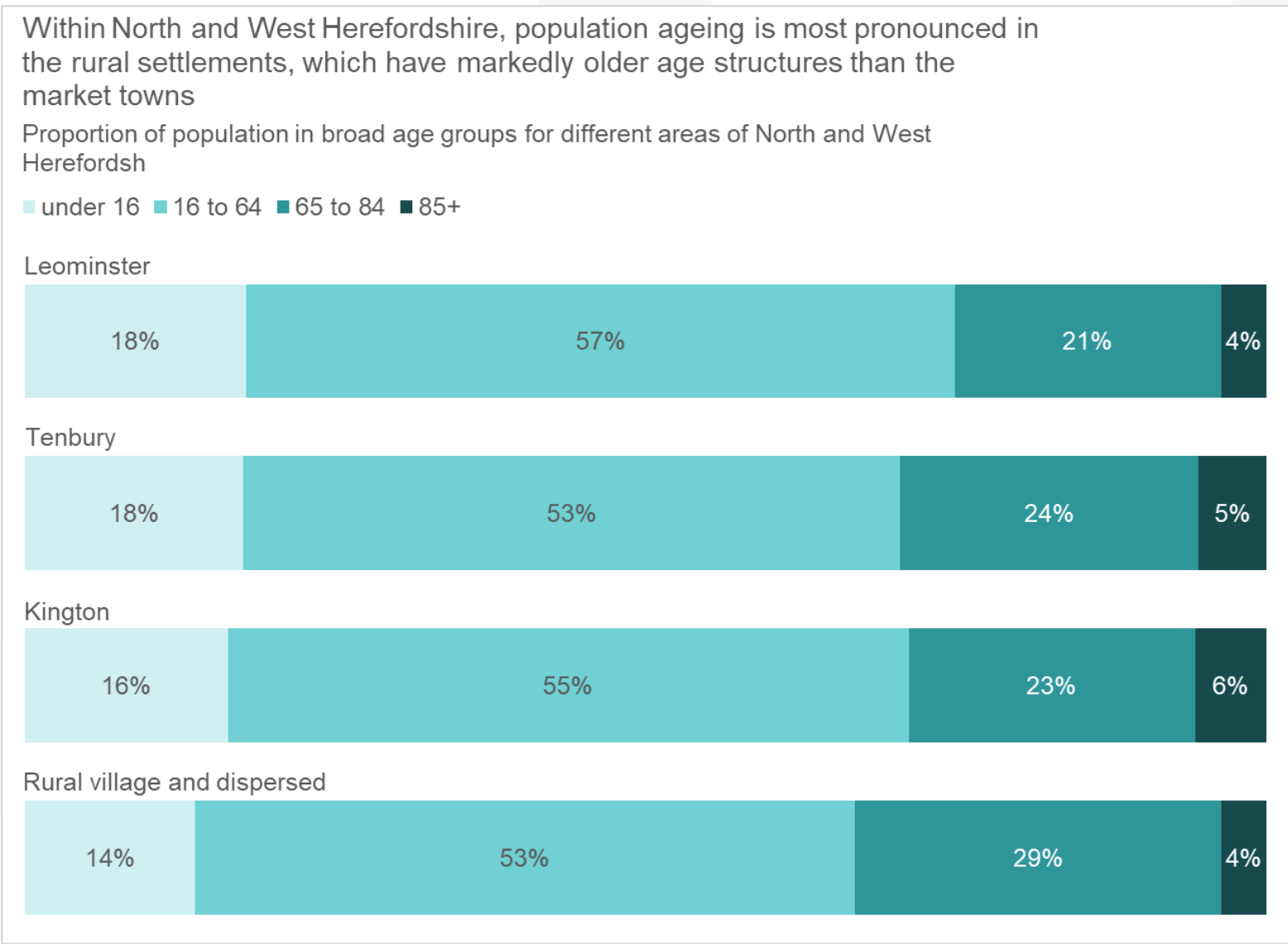
Reflecting this rurality, the PCN area has an overall population density of 53 people per square kilometre, compared to 85 people per square kilometre across Herefordshire.

Age profile

North & West Herefordshire had an age profile that is broadly comparable to the rest of the county outside the Hereford city locality. In contrast, Hereford city had a noticeably younger population, with higher proportions of children and younger working-age adults (aged 16 to 44).

Leominster town had the youngest age profile of all the market towns, second only to Hereford City, with proportionally more children and younger working-aged adults. Although, the Buckfield area of Leominster had the highest proportion of older residents and the lowest proportion of children in the county, resulting in the oldest age structure in Herefordshire. Leominster Ridgemoor and Lesser Credenhill both

had comparatively high concentrations of children. In contrast, Tenbury Wells had the oldest age profile of the localities within North & West Herefordshire.



Data source: [Mid-2024 population estimates for small areas](#). Office for National Statistics. Last accessed 12 May 2026

GP registered population

Official population estimates are based on a definition of ‘usual residence’, with people counted at their main family home.

Many health statistics for example disease prevalence are not based on population estimates and instead are calculated from patients who are registered with a GP surgery in the county.

The two population groups can differ with some residents choosing to register to a GP surgery that is not part of the PCN they live under.

Throughout this profile, **topics will include information that are based on both official population estimates and GP patient data**. Most of the GP patient data that informs the topics described throughout this document comes from GP practice profiles available on Fingertips.

When using GP patient data in these profiles, we will be using data collected from all patients at one or all of the five GP practices that are part of the North & West Herefordshire PCN.

Table 1: Proportions of GP registered population in 2025 across North and West Herefordshire. Shading represents quintiles for all England

Quintiles: Low High

Location	0-4 years	<18 years	65+ years	75+ years	85+ years
England	4.6	20.7	18.0	8.9	2.4
N&W Herefordshire	3.5	17.0	31.3	16.1	4.0
The Mortimer Medical Practice	3.0	16.3	34.8	17.3	4.0
Kington Medical Practice	3.8	16.2	33.0	17.3	4.8
Tenbury Surgery	3.2	16.6	32.7	17.3	4.1
Weobley & Staunton-on-Wye Surgeries	3.0	16.6	35.4	17.7	3.9
Ryeland Surgery	4.0	18.1	27.0	14.0	3.6

Source: National General Practice Profiles Last accessed 17th March 2026

Population growth: recent and future

Recent population growth is closely linked to the location of housing development

Overall **resident population growth** in North & West Herefordshire over the last decade **has been modest**, at approximately 2%.

While rural and urban areas experienced similar proportional population growth, rural areas saw a significantly faster increase in residents aged 65 and over, particularly in Mortimer and the rural areas surrounding Tenbury. At the same time, rural areas experienced a sharper decline in the proportion of children, notably in Kington Rural, Tenbury Rural and Mortimer. Working-aged adults declined across both rural and urban areas.

The market towns experienced the largest absolute population increases. Tenbury Wells grew by around 400 residents, while Leominster increased by approximately 200. Tenbury Wells experienced the highest growth rate (11%) and was the only settlement to record an increase in the proportion of children (24%).

Recent trends closely reflect patterns of housing development. According to the Local Authority Monitoring Report, of the 6,800 new homes built in the county between 2011 and 2022, the wider Leominster Housing Market Area (HMA) accounted for 682 (11%) of net completions and Kington HMA accounted for 108 (4%) (see note below).

Planned future housing growth is set out in the [Local Plan Core Strategy 2011-2031](#), which focuses development on Hereford City and other sustainable market towns. All areas are expected to receive increased allocations in the emerging Core Strategy for 2021-2041.

Note: For housing development purposes, Herefordshire is divided into seven Housing Market Areas (HMAs) - six are centred on the main settlements of Hereford City, Bromyard, Kington, Ledbury, Leominster and Ross-on-Wye, including their surrounding rural hinterlands. The seventh covers the broader Golden Valley region. Tenbury is not included. See [Housing Market Area Needs Assessment. Icen Projects Limited on behalf of Herefordshire Council, July 2021](#).

Future population

It is currently very difficult to predict the future population. Fluctuations in recent growth make it hard to determine appropriate trends on which to base assumptions. New housing targets will strongly influence migration levels, but their impact is not yet known.

No detailed small-area projections are currently available for areas within Herefordshire. However, the Office for National Statistics (ONS) 2022-based Sub-National Population Projections indicate a continued ageing of the county's population, with steady growth in the number of residents aged 65 and over.

New housing development targets mean that future population growth is currently unknown

Housing growth targets are set out in the Local Plan Core Strategy 2011–2031, which is currently being updated to 2041. National planning reforms introduced in December 2024 increased Herefordshire's housing target by approximately 70%, although the implications for future population growth has yet to be modelled.

Over the next five years, North & West Herefordshire is expected to deliver around 22% of the county's outstanding housing commitments from the prevailing planning framework. Nearly half of this remaining development is concentrated in the Barons Cross area to the west of Leominster, with the rest to be dispersed across the more rural parts of the PCN area.

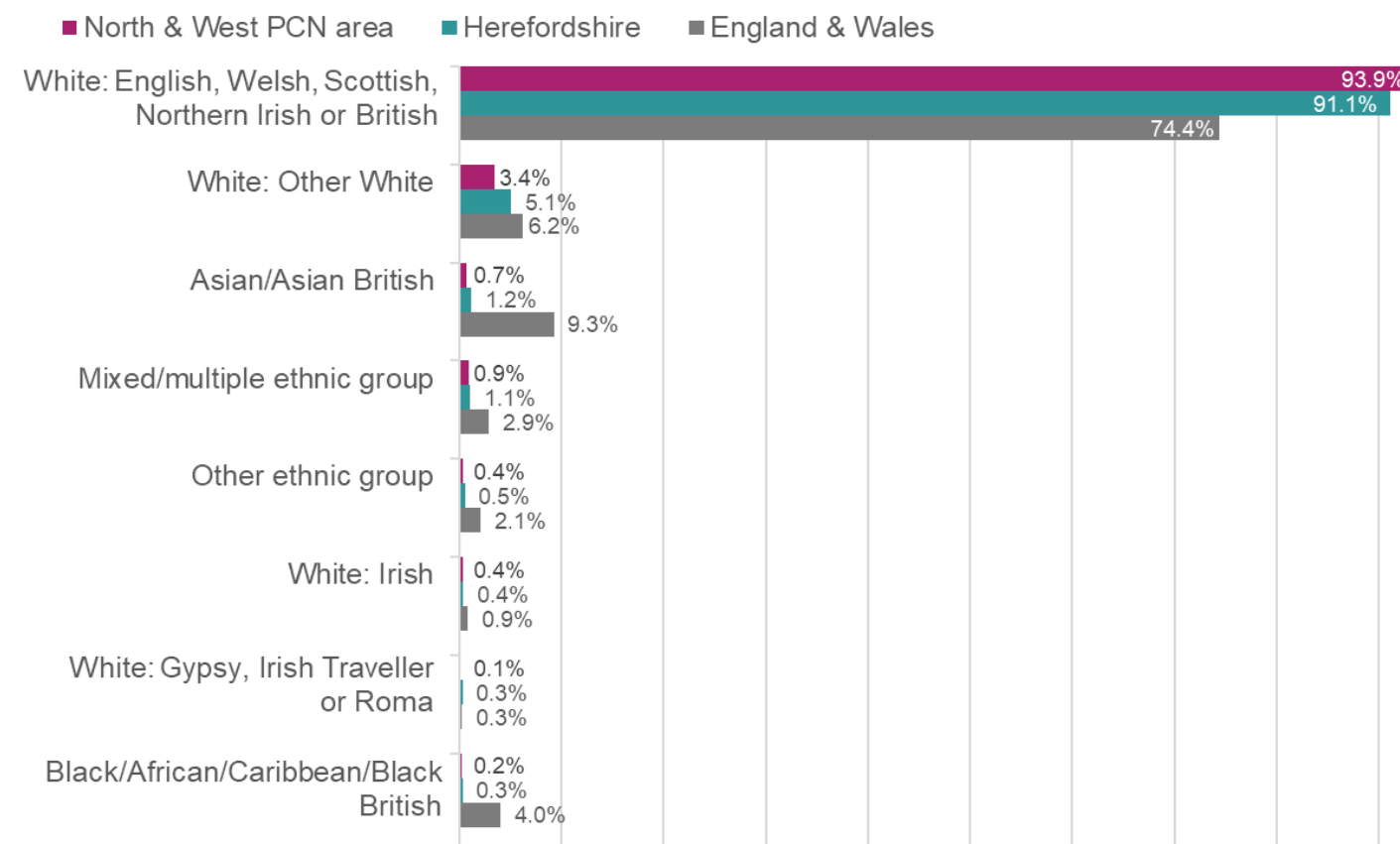
Longer-term growth includes around 1,500 new homes as part of Leominster's major strategic southern expansion area. This development is still at an early stage, requiring significant new infrastructure and is unlikely to contribute to short-term population growth. Kington town is not expected to accommodate future development.

Ref - Five Year Housing Land Supply (2025 - 2030) Annual Position Statement at 1 April 2025 October 2025. Herefordshire Council.

Who lives here: ethnicity

In the [2021 Census](#), most North & West residents identified themselves as being 'White: British' (**93%**). 2,500 (**6%**) residents identified themselves as being of other ethnicities. This is slightly but not significantly lower than Herefordshire as a whole (9%), which itself was very low compared to England and Wales (26%).

North & West has a less ethnically diverse population than the rest of Herefordshire, with fewer people identifying as other than White British
Percentage of residents by ethnic group, 2021 Census



Data source: [2021 Census data: Ethnic group](#). Last accessed 12 May 2026.

Leominster town had the highest proportion of residents from an ethnic group other than 'White: British' (9%). There were notably higher clusters of White: Irish residents in Aymestrey Horseshoe, Greater Docklow and Cleobury Neen Sollars.



The largest minority group in the N&W is 'White: Other' at **4%** (1,877 people) compared to **5%** county-wide.



92 (0.2%) of people in the N&W identify as 'White: Gypsy or Irish Traveller or White: Roma'

Nationally, 'Asian or Asian British' is the largest minority group (9% compared to <1% in N&W). Half of residents identifying as White Gypsy/Irish Traveller or Roma (a historically significant minority group with [poorer health outcomes](#)), lived in Weobley.

ENGLISH-SPEAKING HOUSEHOLDS



97% of households in North and West speak English as a main language, compared to **95%** county-wide.

4% of Leominster Town households do not speak English as a main language, compared to **3%** in North and West.

ORIGIN AND ARRIVAL OF NON-UK BORN RESIDENTS



Europe

4%

Middle East or Asia

0.9%



3% arrived between the ages of **16-29**



3% arrived before **2001**

Smaller proportions of residents arrived from Africa (0.6%) and the Americas and the Caribbean (0.4%). Arrivals from non-UK born residents have declined every five years or so since 2001.

Who lives here: protected and other important characteristics

The Equality Act 2010 protects in law people who have, or are associated with someone who has, any of nine characteristics where evidence shows that significant discrimination and inequalities exist. They are:



Although not explicitly protected by law, there are some other groups of people who may experience disadvantage. These groups can also be considered within an equality impact assessment, so have been included in the table. Examples include, but are not limited to carers and Armed Forces (including veterans and families)

Table two on the right presents the available data for North & West; some topics are analysed in other sections: for example, the age and sex profile of the area is covered on p.9, ethnic group on p.12 and disability on p.20. Those that aren't, are covered on the next page.

Protected characteristic	Number of residents of N&W	Proportion of population of N&W
Age (mid-2024)		
Under 16	8,014	15%
16 to 64	28,816	54%
65 and over	16,532	31%
Sex (mid-2024)		
Male	26,094	49%
Female	27,268	51%
Disability (2021 Census)		
Disabled under Equality Act	10,153	19%
Not disabled	42,731	81%
Ethnic group (2021 Census)		
'White: British'	49,898	94%
Other than 'White: British'	3,001	6%
Religion (2021 Census)		
Christian	29,438	56%
Other religion	691	1%
No religion	19,006	36%
Marital status (2021 Census)		
Married or in a Civil Partnership: opposite sex	23,438	52%
Never married or in a Civil Partnership	12,504	28%
Separated/divorced/dissolved Civil Partnership	5,285	12%
Widowed / surviving partner of a Civil Partnership	3,427	8%
Sexuality (2021 Census)		
Married or in a civil Partnership: same-sex couple	221	0.5%
Veteran: previously served in the UK armed forces (aged 16+)	3,015	6%
Carer: anyone who provides unpaid care to someone with a long-term illness or disability	4,897	10%

Data source: [PCN profiles](#). Understanding Herefordshire. Last accessed 12 May 2026

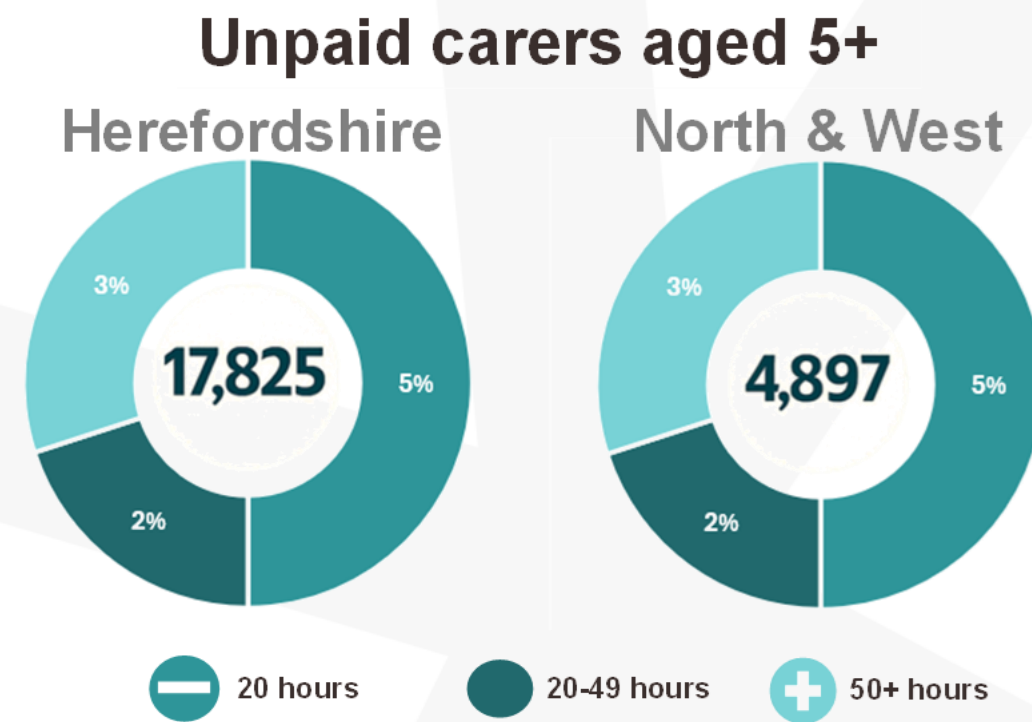
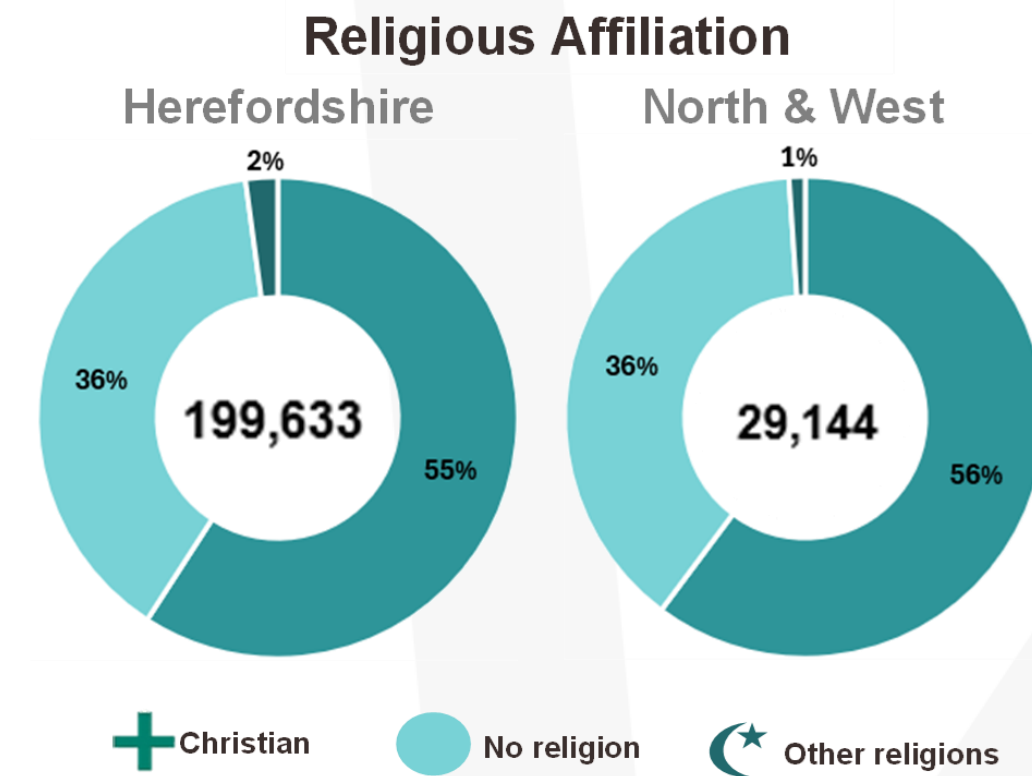
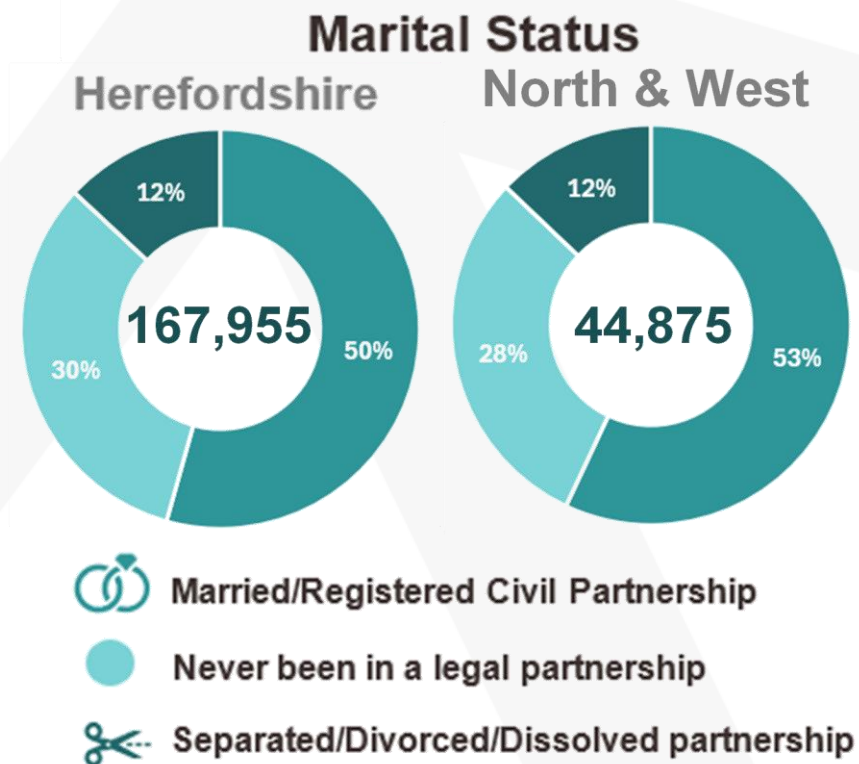
The following information is from the [2021 census](#) which can be viewed in greater detail on our [PCN area profiles](#).

Religious affiliation, Marital status and unpaid care

North & West Herefordshire had a similar profile to the county regarding religious affiliation, marital status and residents aged 5+ providing unpaid care.

Notable exceptions to this included:

- Leominster Ridgemoor had more residents not following a religion and more residents who had never been in a legal partnership.
- Leominster Grange had more residents who were divorced or separated.
- Leominster Buckfield had more residents following Christianity.
- Greater Docklow and Hopebodenham had more residents in a same sex marriage.
- Lesser Credenhill had less residents providing unpaid care.



Veterans of the armed forces

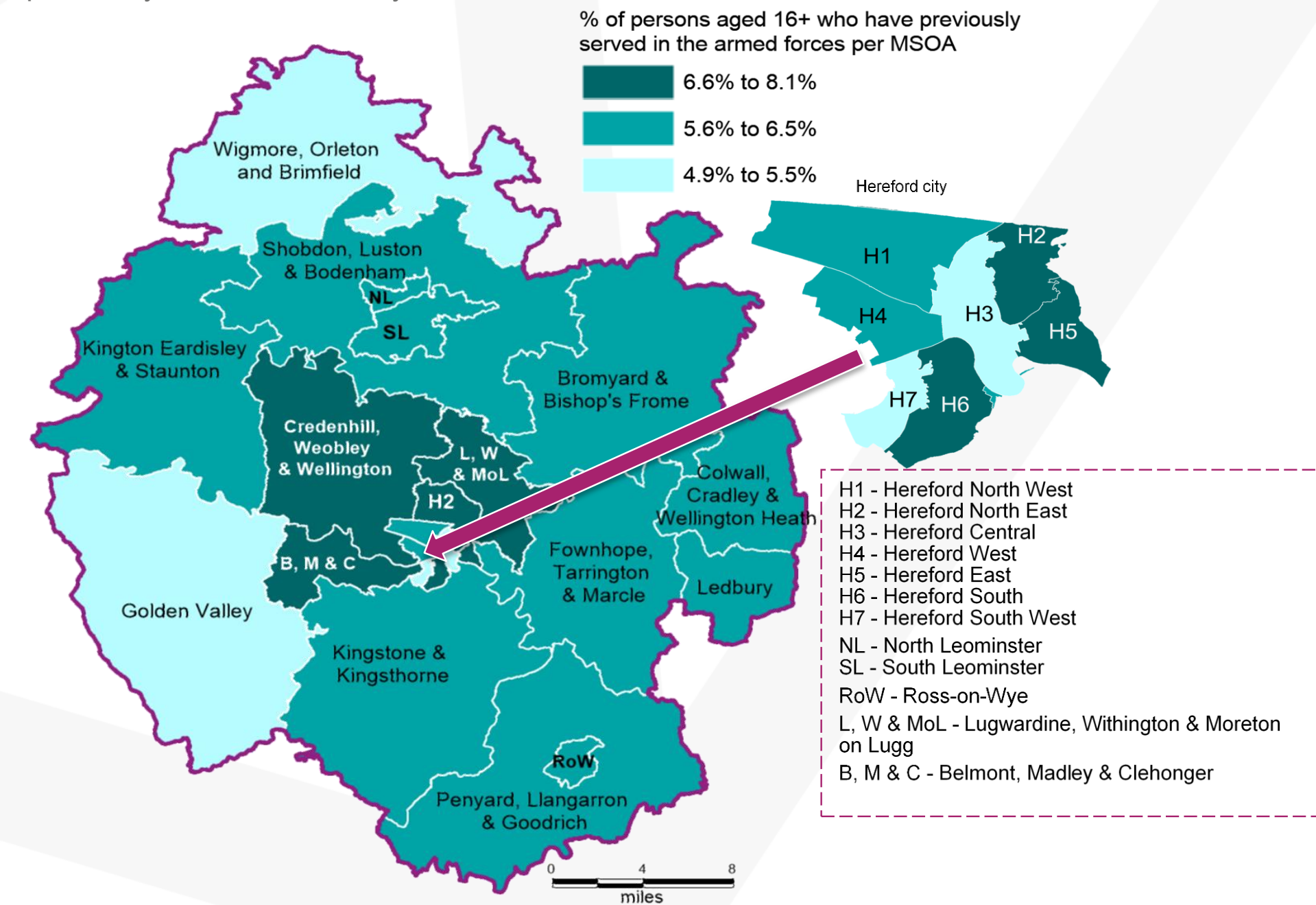
According to the 2021 Census, **10,100** Herefordshire residents aged 16 and over had previously served in either UK armed forces (regular or reserve).

This made up 6.1% of the 16+ population in Herefordshire, compared with 3.8% in England and Wales.

Around 3,000 of these residents (25%) were in North & West Herefordshire, 5.7% of the 16+ population.

The 'Credenhill, Weobley and Wellington' Middle Super Output Area (MSOA, much of which is in the North & West) had the largest veteran population (by proportion and number of veterans) and had the highest proportion of households (15%) where at least one veteran lived. The area is home to a large Army garrison, which further supports the idea that veterans may tend to stay in the areas which they were based.

Figure 5: MSOA Map showing the percentage of people aged 16+ who have previously served in the army across Herefordshire



Data source: [UK armed forces veterans](#). 2021 Census. Last accessed 12 May 2026

Who lives here: Households and living arrangements

Household composition and families

From the [2021 census](#), most households were a Single-family household (66%) in North & West Herefordshire, with the **most common** composition being a **66+ married couple with no children** (15%) which is similar to the county and aligns with the ageing population.



Most households were in built-up areas like Leominster Town (**5,435 households**) and Tenbury Wells (**5,556 households**).

However, **almost a third (29%)** of households contained a single person living alone, of which 17% were an older person (aged 66+) living alone.

Notable differences included:

- Leominster Ridgemoor had higher rates of lone parent households.
- Leominster Grange had higher rates of one-person households under 66 years of age and lower rates of couple-based households.
- Greater Weobley had higher rates of one-person households aged 66+.

Household composition

66% single family



15% are married with no children



70% of single-family households are in Weobley

39% of single person households are in Leominster

4% are lone parent



29% single person



17% are an older person



4. Population Health

Life expectancy

Life expectancy is calculated for MSOAs and GP practices, but not for an overall PCN area.

Most MSOAs in the North & West PCN area had a similar life expectancy to the county average: **79.9** for males and **83.6** for females (see table three below).

The exceptions to this were:

- ‘South Leominster’ MSOA (which includes the LSOAs of Gateway and Grange) had significantly lower life expectancy for both males (75.6) and females (81.3)
- ‘Shobdon, Luston and Bodenham’ had a significantly higher life expectancy than the county for females (83.6) – the highest in the county.

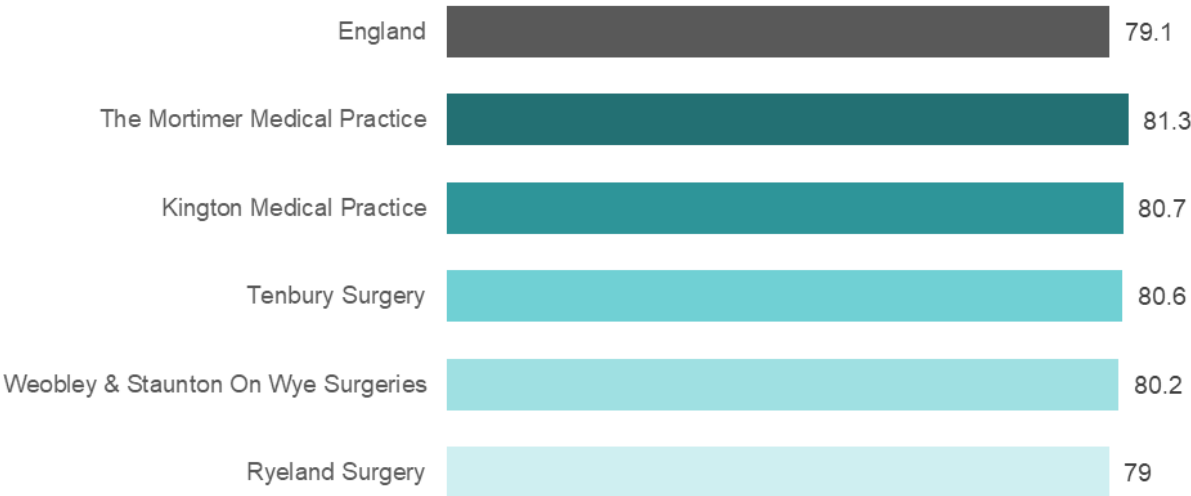
Table 3: Estimated life expectancy for males and females, MSOAs in the North and West PCN Area (2019-23)

Area name	Male	Female	comparison to England
England	79.1	83.0	
Herefordshire	79.9	83.6	significantly better than
Credenhill, Weobley & Wellington	80.1	82.7	no significant difference
Kington, Eardisley & Staunton	80.6	81.6	no significant difference
Leominster North	80.5	84.7	no significant difference
Leominster South	75.6	81.3	significantly worse than
Shobdon, Luston & Bodenham	81.4	86.9	significantly better than
Wigmore, Orleton & Brimfield	81.4	80.5	significantly better than for males; no significant difference for females

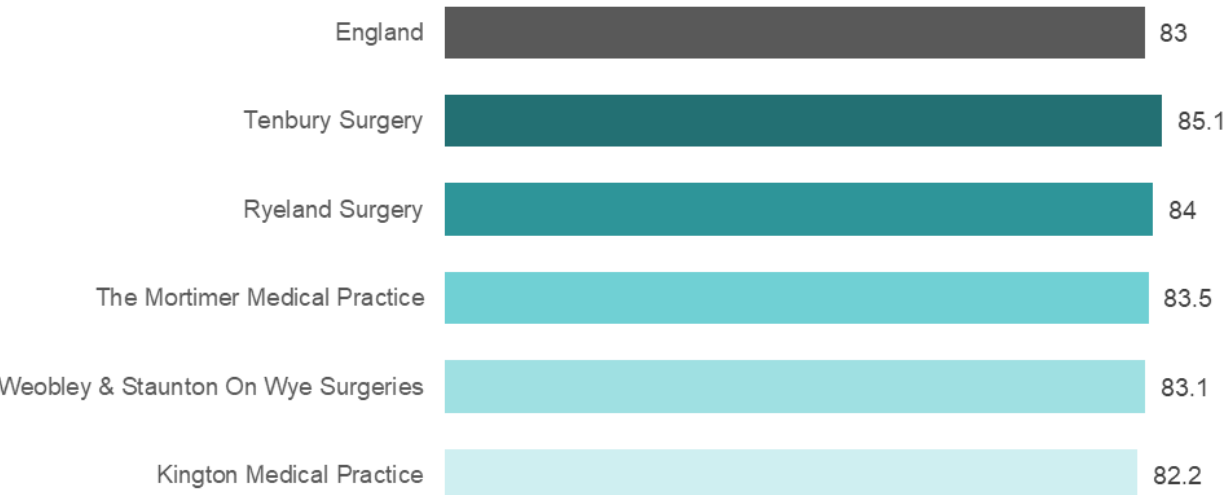
Source: [OHID Local Health Profiles](#), based on Office for National Statistics data. Last accessed 2 February 2026

Estimates of life expectancy for GP practices cannot be compared to each other in terms of statistical significance, only ordered from highest to lowest. They are shown below.

Estimated male life expectancy for GP practices, North and West PCN



Estimated female life expectancy for GP practices, North and West PCN



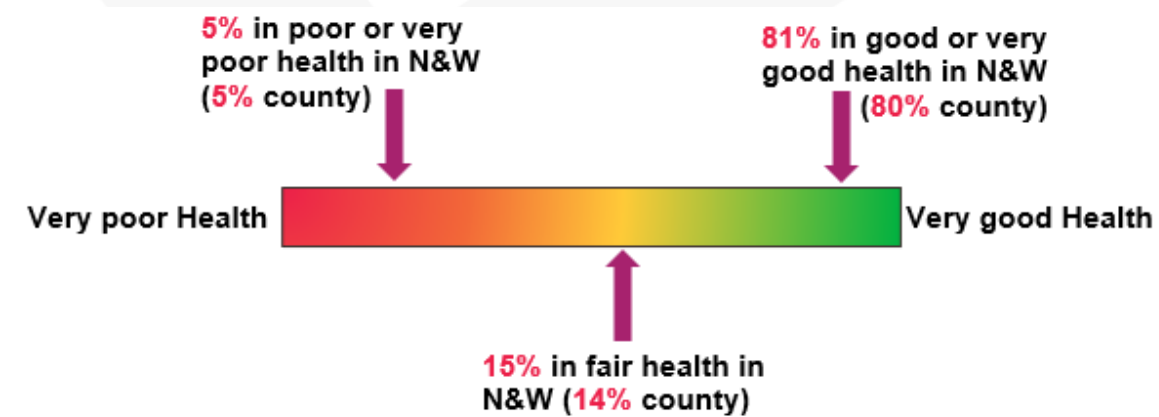
Source: [OHID National General Practice Profiles](#), based on Office for National Statistics data. Last accessed 2 February 2026

Population Health and Disability

The [2021 Census](#) explored resident health and disability through a series of questions. Risk of premature death and impairment of life quality through poor physical health can also be explored using the [2025 indices of deprivation](#).

General health

Similar to the county, people who lived in the more deprived areas in the North & West were more likely to report being in poor health, **2,200** residents lived in bad health and **500** in very bad health, 7% of these lived in both Leominster and Kington towns. Notably, whilst



Notable differences included:

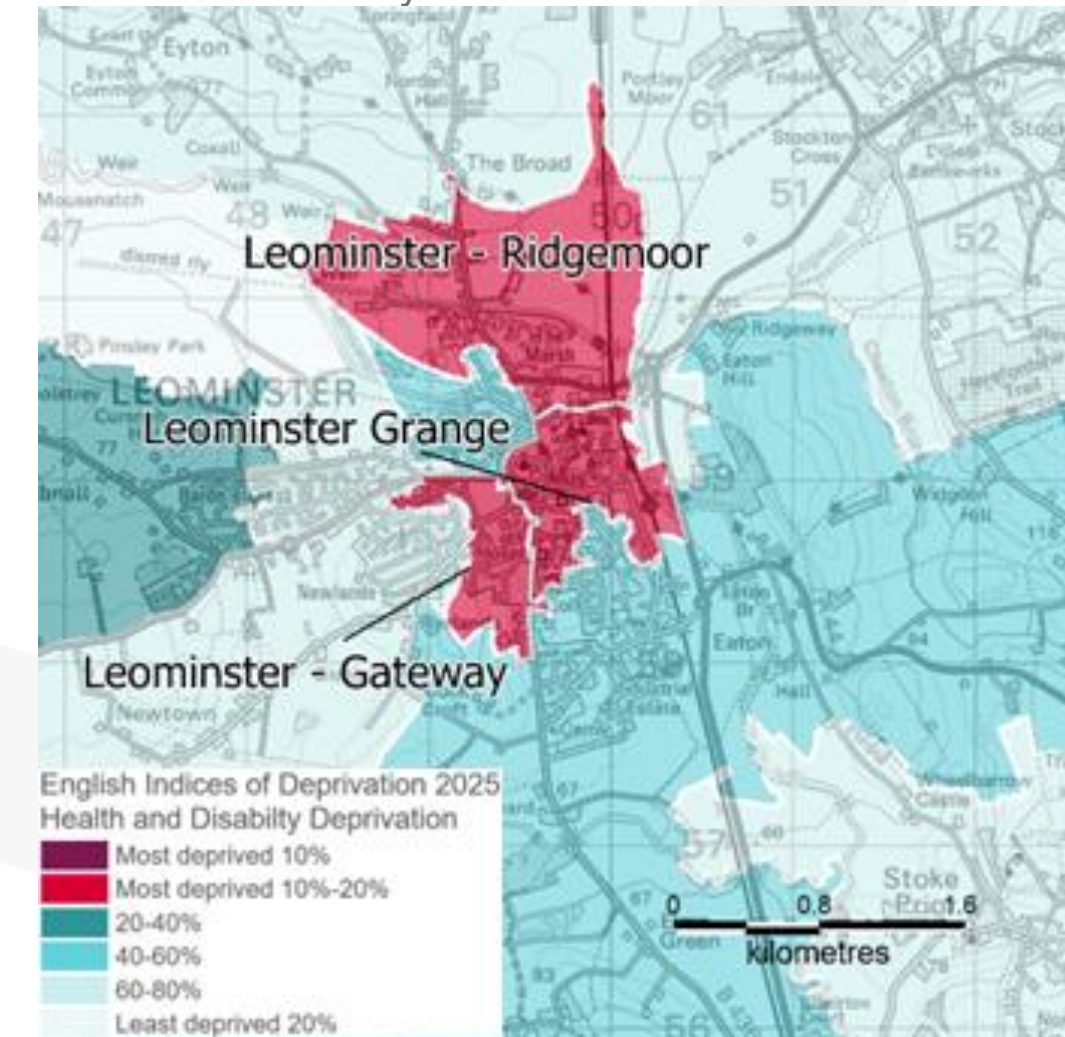
- Higher rates of good health in Cleobury Neen Sollars and Baldwin (in Tenbury Wells)
- Lower rates of good health and very bad health in Lesser Credenhill

The 2023 Community Wellbeing Survey showed that adults in the North & West were **significantly less likely to report their health as “excellent or good”** (45%, similar to Hereford City at 42%) when compared to adults in East Herefordshire (55%).

Health deprivation

Most of those experiencing the greatest health inequalities in 2025 lived in Leominster's Ridgemoor, Gateway and Grange LSOAs, all of which fell within the county's 10% most health-deprived areas and were the only LSOAs in the North & West ranked among the 20% most deprived in England for health and disability.

Figure 6: LSOA Map of the most deprived Leominster areas in England for the Health and disability domain



Data source: [Indices of deprivation 2025](#)

Disability

Around **10,200** residents in North & West Herefordshire (19%) were disabled under the Equality Act 2010 due to having a long-term condition, similar to county and national levels (19%). Of these, **8%** reported that their daily activities were limited 'a lot' and **12%** 'a little'.

Notably, there were lower rates of disability in Leominster Grange and Baldwin (two of only four areas in Herefordshire).

However, being disabled does not always mean poor health - around **one-third** reported good general health.

Self-reported long-term conditions are also measured in the GP Patient Survey and GP estimations are published in the [National General Practice Profiles](#) on Fingertips.

Those who have a disability may seek additional support through benefits.

Disability Living Allowance

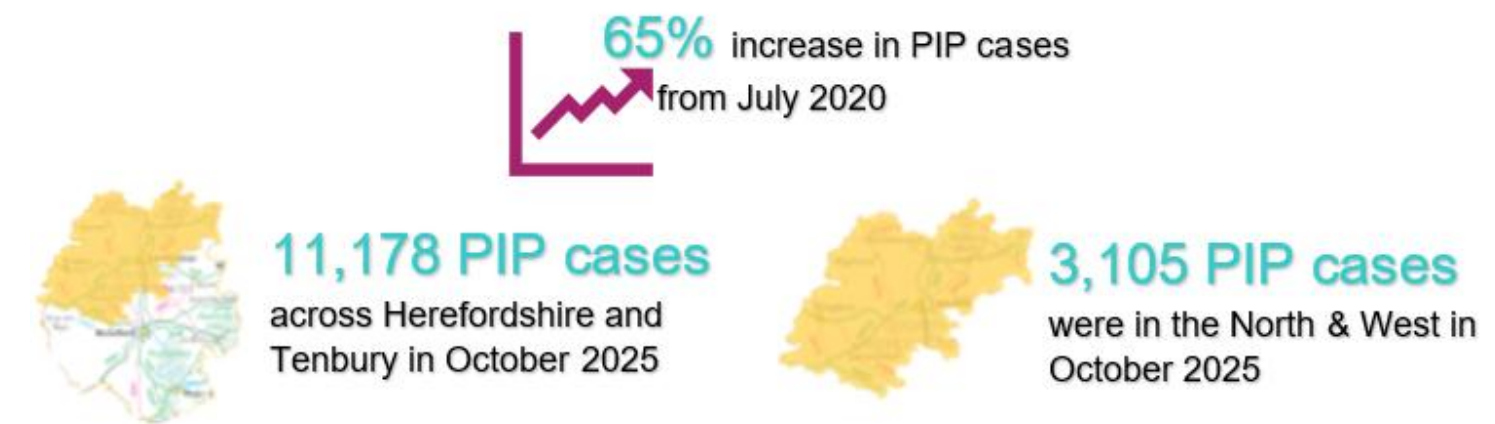
Disability living allowance is a non-means tested, tax free benefit for people with a disability who have care or mobility needs. Previously eligible for everyone, the benefit is now largely available to under 16's with Personal Independent Payments (PIP) replacing this benefit for adults.

In May 2025, there were **3,385 claimants** across Herefordshire and Tenbury, with **976** of those residing **in the North & West area**. Leominster Ridgemoor had the highest claimant count at 63 in the county.

Personal Independent Payments

Estimates of economic activity are not available at sub-county level. Personal Independence Payments (PIP) offers support for the extra costs associated with

long-term illness or disability for adults aged 16+. PIP is not means-tested and people can claim PIP and work, however, [a large proportion of claimants are not working](#) so it can give some indication of numbers of people who are economically inactive due to long-term illness or disability.



Increasing PIP levels across Herefordshire aligns with national statistics, with psychiatric disorders the most common reason for claiming PIP. In the North & West, **Leominster Grange had the highest number of cases at 193**, indicating a relationship between deprivation and need for PIP support.

Attendance Allowance

Attendance allowance is a non-means tested benefit for older people (66+) who require support to live safely due to severe physical or mental health conditions/disabilities. Knowing how many claimants there are gives an idea of demand for support services, including self-funded care across the area.

In August 2025, the North & West had the **highest claimant count** (2,063) of the county (6,496), although levels of need varied across the PCN area. Weobley (Lesser Credenhill) had the lowest claimants (31) whilst Tenbury (West) had the highest (100) with further concentrations in Kington Doughnut and Leominster – Buckfield.

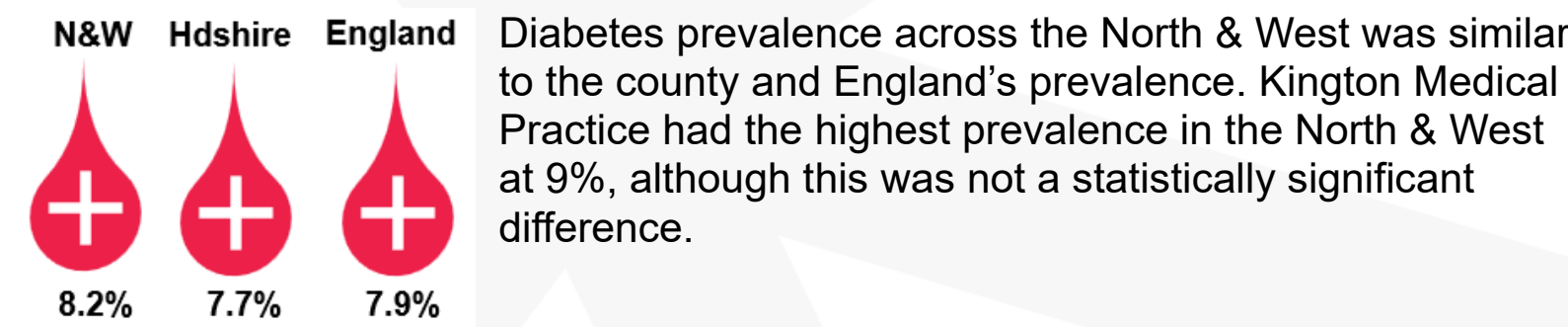
Long-term conditions

Long-term conditions (LTCs) currently have no cure and are managed with drugs and other treatment. ([Director of Public Health Annual Report 2023](#))

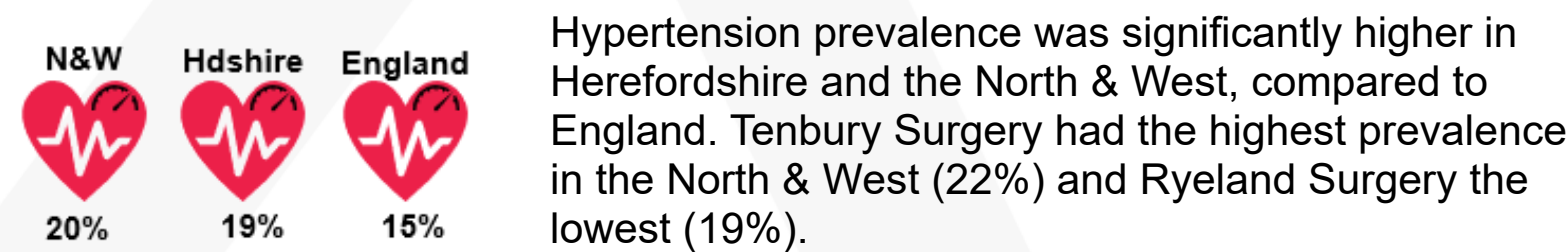
Table four on the right highlights the prevalence of diagnosed LTCS, based on [GP registers](#) for the ICS priority conditions in 2024-25 for North & West Herefordshire.

LTC prevalence was similar to Herefordshire overall, with increasing risk factors for mortality (see P.27) such as diabetes (3,600, 8%) and hypertension (10,600, 20%). The proportions with heart failure and COPD were above national rates which is to be expected as the rates do not account for the local older age profile.

High Blood Sugar



Hypertension



Diagnosed condition	Number of patients in 2024-25	Proportion of population in North and West	Trend	Proportion of population Herefordshire
ICS Priority Conditions				
Diabetes (17+years)	3,592	8.2%	↑	7.7%
Heart Failure	918	1.8%	↑	1.5%
Asthma (6+ years) (only includes those using medication during past year, much lower than recorded on GP systems)	3,556	7.2%	→	7.1%
COPD (all ages)	1,389	2.7%	→	2.5%
Other long-term conditions				
Hypertension (all ages)	10,589	20.4%	↑	19.2%
Depression (18+ years)	5,361	12.3%	-	13.9%
Chronic Kidney Disease (CKD, 18+ years)	3,191	7.3%	↑	6%
Chronic Heart Disease (CHD, all ages)	2,142	4.1%	→	3.6%
Atrial fibrillation (all ages)	2,002	3.9%	↑	3.2%
Stroke	1,514	2.9%	→	2.6%
Osteoporosis (50+ years)	316	1.1%	↑	1.6%
Rheumatoid arthritis (16+ years)	551	1.2%	→	1.1%
Mental health (all ages)	340	0.7%	→	0.9%

Note: The H&W ICS Strategy: Living well with Long-Term Conditions (2024) determined that its initial priorities would be cardiovascular diseases (including diabetes and heart failure) and respiratory diseases (including asthma and chronic obstructive pulmonary disease (COPD)). Data source: [QOF framework](#). Fingertips. Last accessed 12 May 2026

Emergency hospital admissions

Emergency hospital admissions can help measure the efficiency of primary care and identify health inequalities and pressures on urgent care services. The Herefordshire and Worcestershire ICB commissioned the Council’s Public Health team to identify the 20% of the population within each PCN area with the highest levels of unmet need based on three measures: all-cause admissions, cardiovascular disease, and respiratory disease.

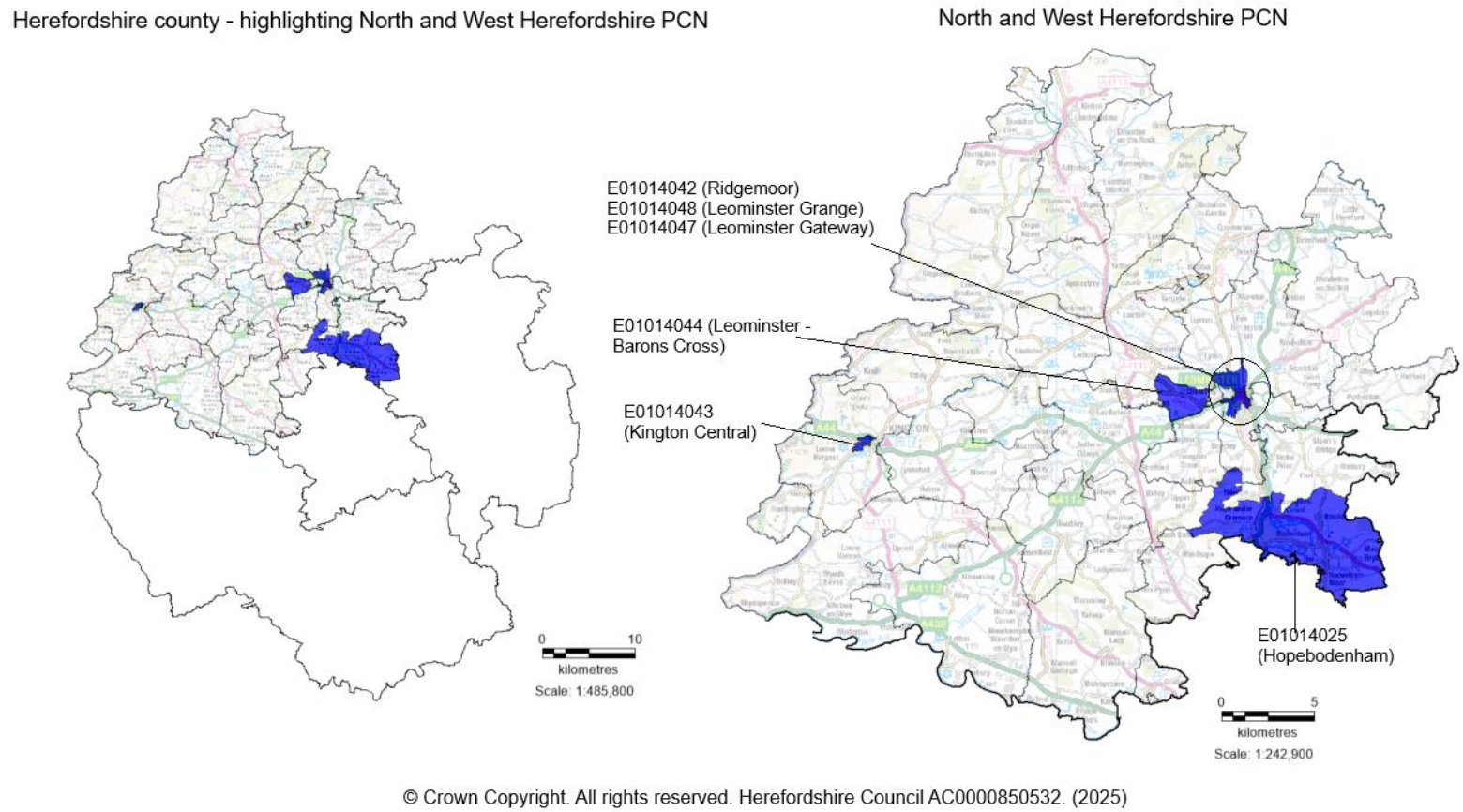
Across the North & West PCN, **23%** (9,850) of GP-registered patients experienced at least one emergency admission for any of the three causes between 2019-20 and 2023-24.

Certain areas noted higher prevalence of emergency admissions:

- Leominster Gateway had significantly higher prevalence across all three indicators; all-cause, cardiovascular, and respiratory admissions.
- Kington Central and Leominster Ridgemoor recorded significantly higher prevalence rates for all-cause and cardiovascular admissions.
- Leominster’s Baron’s Cross and Grange showed higher prevalence for all-cause and respiratory admissions.
- Hopebodenham showed significantly higher rates only for all-cause emergency admissions.

The maps on the right highlight these priority LSOAs in the North & West.

Figure 7: Maps highlighting the LSOAs with high rates of emergency hospital admissions in North and West Herefordshire (excluding Tenbury)



Data source: [Hospital Episode Statistics \(HES\), NHS England](#)

5. Mortality – what do people die of?

Total deaths and premature mortality

A total of **8,020 deaths** were registered from 2018-20 to 2022-24 in the North & West Herefordshire PCN area, with an average of 1,604 deaths during each three-year period.

The North & West PCN area had a similar age structure to the county, with a relatively higher number of older residents. Age Standardised Mortality Rates (ASMRs) take account of the population size and age structure of an area. Although the absolute number of deaths registered have increased since 2018-20, ASMRs have remained stable and are not significantly different to the county average.

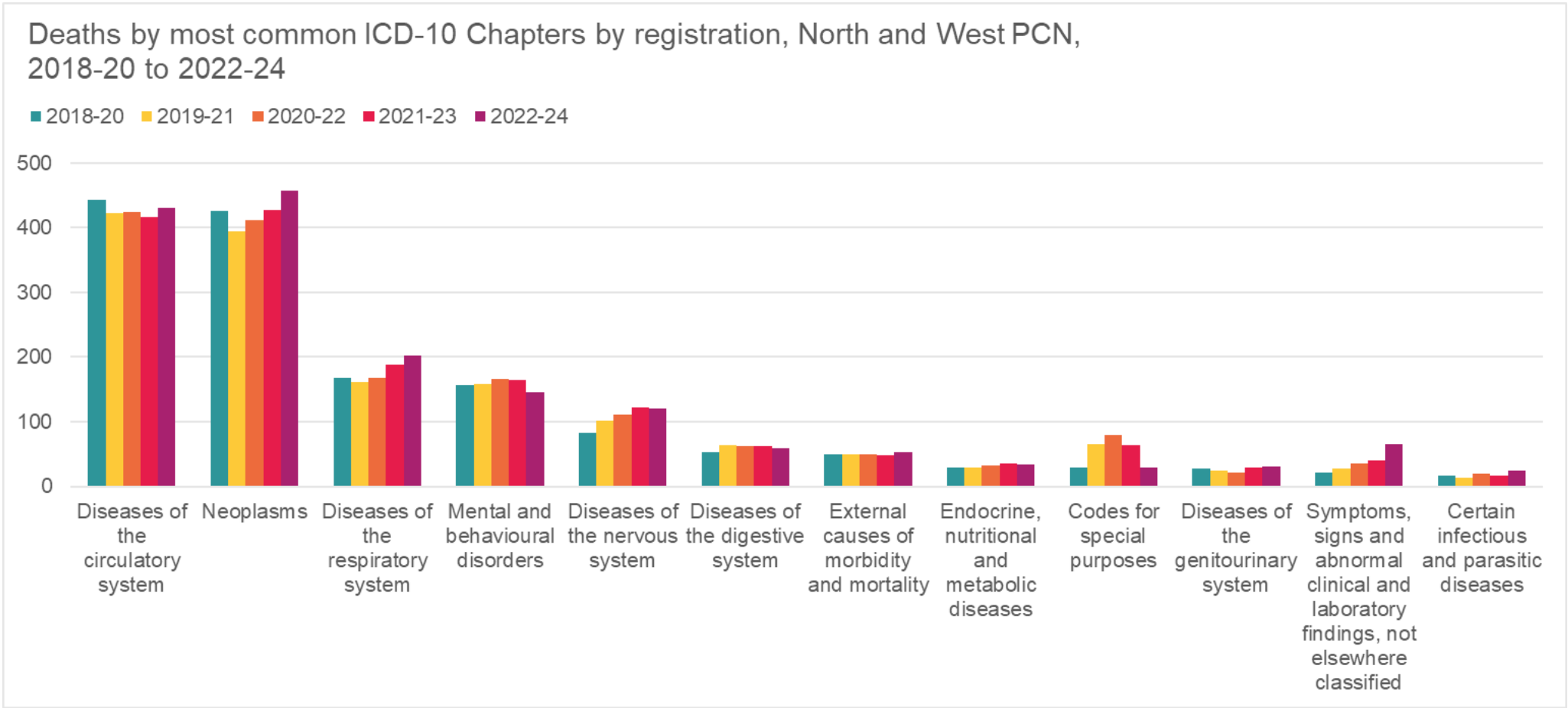
Out of the 8,020 deaths during this period, a total of **2,105 deaths were in under 75-year-olds** and considered premature. The ASMR for premature deaths in the area was about 31 deaths per 10,000 people during this period and was similar to the whole county rate (31 per 10,000).

Nationally and locally in Herefordshire, the total number of deaths and ASMRs for males have consistently been significantly higher than for females, and a similar pattern was seen in the North & West.

Underlying causes of death

The top three causes of death remain similar to what is observed across the county – diseases of the circulatory system, neoplasms (cancer) and diseases of the respiratory system.

Diseases of the circulatory system and cancer (neoplasm) accounted for **more than half the deaths registered** in the North & West from 2018-20 to 2022-24 (an average of 53% deaths). This is slightly higher than what is seen in Herefordshire, where these account for about 50% of the deaths. Deaths due to cancer have increased from 2019-21 to 2022-24.



Data source: Primary Care Mortality Database, NHS Digital. Downloaded March 2024.

Mortality and deprivation

People living in the most deprived areas (IMD quintile 1) of the North & West had a **significantly higher mortality rate** than the rest of the PCN area.

Mortality among those in the most deprived quintile was around **70% higher** than among those in the least deprived areas (IMD quintile 5). This inequality gap is far larger than the county-wide picture, where the difference between the most and least deprived quintiles is around 40%.

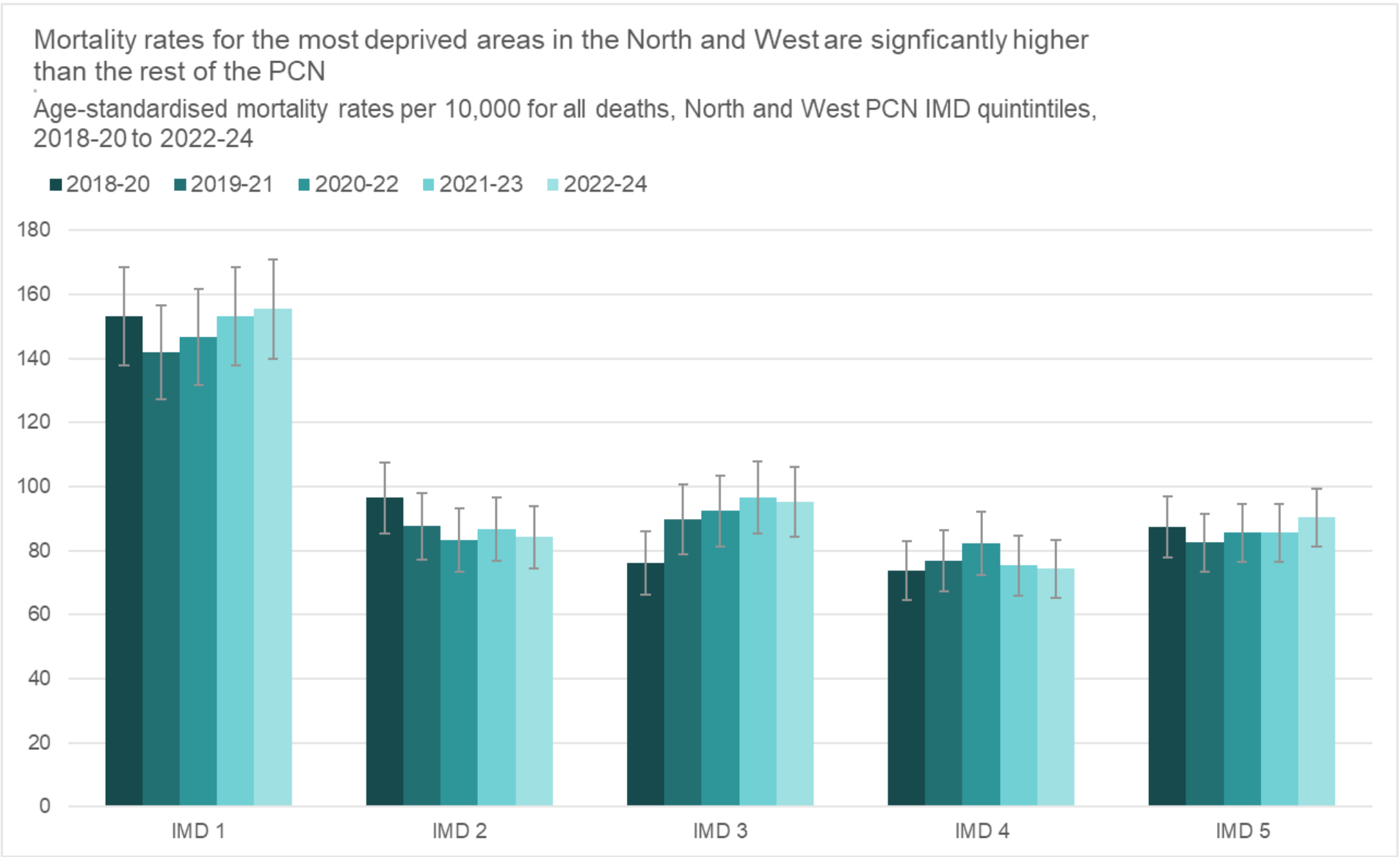
This pattern is different to that seen nationally, where mortality rates gradually increase with increasing levels of deprivation. However, this is similar to what is observed in the county, where all quintiles have fairly similar rates, apart from the most deprived, which is notably worse.

Avoidable mortality

Avoidable mortality relates to deaths of people aged under 75 where the cause of death is considered either preventable (through effective public health and primary prevention interventions) and/or treatable (through timely and effective healthcare interventions), based on an internationally agreed classification.

North & West Herefordshire had similar rates of avoidable mortality to the county.

The ASMR for avoidable deaths in the PCN area remained relatively stable, ranging from 20 to 23 per 10,000 population between 2018–20 and 2022–24. Of the 8,020 deaths registered during this period, a total of **1,460 (18%) were avoidable; 865 (11%) preventable** and **595 (7%) treatable**.



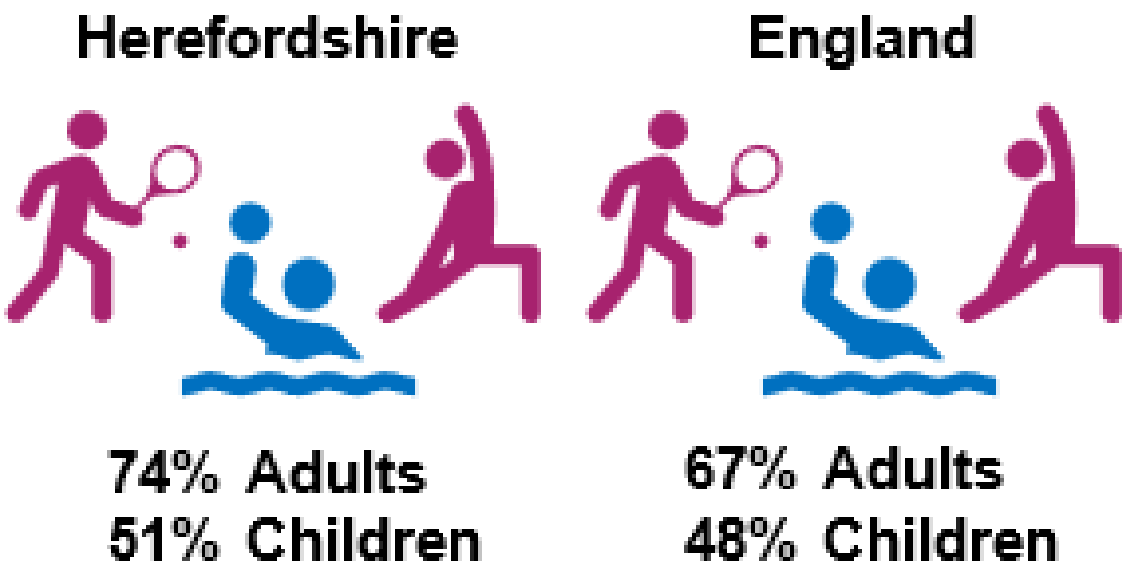
Data source: Primary Care Mortality Database, NHS Digital. Downloaded March 2024.

6. Risk factors for ill-health and mortality

Physical inactivity, obesity (high body-mass index), smoking and high blood sugar levels (fasting plasma glucose) have been the biggest [risk factors for disability in Herefordshire since 1990](#). They are also three of the four biggest risks for mortality, behind high blood pressure (hypertension). As diagnosed medical conditions, blood sugar and hypertension are covered on p.18 (long-term conditions).

Physical activity

Information on physical activity levels in Herefordshire is limited with estimates based on surveys, such as the [Sport England's national Active Lives Survey](#) whose sample is not large enough to analyse below county level.



In 2023-24, physical activity rates for adults and children in Herefordshire were higher than the West Midlands and England averages.

Adults are less likely to be overweight in Herefordshire than England

Whilst the proportion of adults who were overweight in Herefordshire (59%) was better than England (65%) in [2023-24](#), obesity levels were statistically similar (26.8% for Herefordshire and 26.5% for England).

In the North & West, obesity levels were even lower (14%) than the county with pockets of high obesity levels found in Leominster (16%), Kington and Tenbury (both 15%).

Smoking

Smoking prevalence comes from [GP registers](#). In 2024-25, the North & West had a lower prevalence compared to the county despite a significantly higher prevalence of smoking at Ryeland Surgery. Kington surgery had the highest rates of active smokers (18%), whilst Mortimer medical practice had the highest rates of former smokers (36%).



Mental health

Having 'good mental wellbeing throughout life' is one of the two priorities of Herefordshire's [Joint Health and Wellbeing Strategy](#). Current information regarding mental wellbeing and ill-health across Herefordshire is limited to county level information or data from [GP registers](#).

Mental wellbeing

Levels of personal wellbeing in Herefordshire were similar to national levels as outlined in the [2024 JSNA](#).

There was limited evidence in the 2023 Community Wellbeing survey to suggest that the wellbeing of adults differed greatly across the county.

A wellbeing score was calculated using the short Warwick Edinburgh Mental Wellbeing Scale which measures positive mental health and wellbeing in adults and teenagers. Different topics are scored from 1-5 with higher scores indicating greater positive mental wellbeing, with a score of 35 being the highest.

On average, Herefordshire adults scored 25.9 with adults in the North & West scoring similarly (25.8).

Mental ill-health

In 2024-25, mental ill-health prevalence (all ages) was significantly lower in North & West Herefordshire (0.8%), than the county (0.9%) and England (1.0%).

Ryeland Surgery had the highest prevalence in the area (0.8%, similar to national), whilst all other practices in the area had significantly lower prevalence, the lowest being 0.5% at The Mortimer Medical Practice.

11% of patients within the North & West were recorded as having a long-term mental health problem. GP patients at Tenbury Surgery had the highest prevalence at 24% whilst patients at Ryeland surgery have the lowest at 6%.

Regarding depression, the North & West had a significantly lower prevalence rate (12%) than the county and England (both 14%). Tenbury Surgery had statistically similar prevalence to the county (14%), whilst all other practices in the area had significantly lower prevalence rates, the lowest being 10% at Weobley and Staunton-on-Wye Surgeries.



7. Children and Young People

Overall, early years development in Herefordshire is generally positive. However, oral health and excess weight remain key areas of concern. Evidence shows that higher and more frequent consumption of sugars and sugar-containing foods and beverages is associated with an increased risk of dental cavities among children and adolescents ([Department of Health & Social Care](#)). In addition, [Public Health England](#) has highlighted that children are becoming overweight and obese at increasingly younger ages, with many remaining so into adulthood. Excess weight in childhood is a significant risk factor for the development of long-term conditions, including type 2 diabetes.

Oral Health

Current insights about oral health are limited to county level. Herefordshire has significantly higher rates of dental decay than nationally since the last two decades. In 2023-24, **31%** of Herefordshire five-year-olds had visually obvious dental decay, which was significantly above England (22%) and the **worst** amongst Herefordshire's CIPFA neighbours. The local rate has reduced but not significantly since the measure was first recorded in 2007-08, whilst England's has fallen from 31% and is statistically significant.

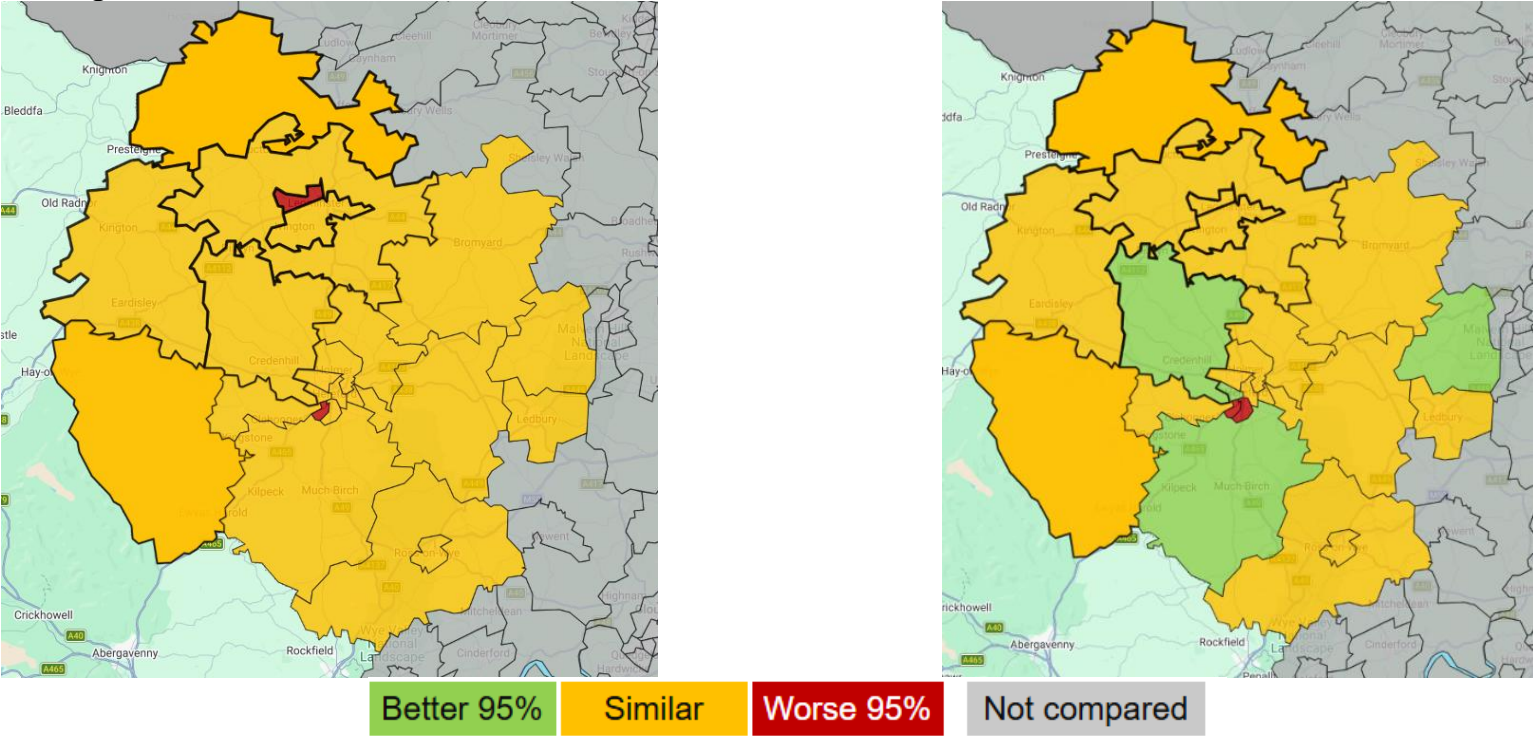
Excess weight

In 2024-25, 23% of reception-aged children across Herefordshire were overweight or living with obesity; similar to England's 24%. Although the recent trend indicates no significant change, this is the highest recorded locally since 2006-07 and a significant increase of 5% from the previous year. Among year 6 pupils, 35% were overweight or obese, similar to England (36%), with no significant change in the recent trend. Overall, children living in the most deprived areas of the county were more likely to be obese than those living in the least deprived.

In the North & West, Leominster North had the highest prevalence of reception-aged children being overweight or living with obesity in the county (30%), one of only two MSOAs in the county to have significantly higher rates than nationally. All other MSOAs in the PCN area were similar to the national average, with the lowest prevalence recorded in Shobdon, Luston & Bodenham (19%).

For children in year 6, most MSOAs in the North & West had similar prevalences to the national average, the highest being Leominster North at 42%. However, Credenhill, Weobley and Wellington had the lowest prevalence in the area (29%), which was significantly lower than the national average.

Figure 8: MSOA Map highlighting the prevalence of children who were overweight or obese in North & West Herefordshire (excluding Tenbury) in reception (left) and year 6 (right), compared to England



Data source: [Child BMI categories small area data](#). Fingertips. Last accessed 12 May 2026.

Areas with high rates of need for Under 5s

Some groups of children and young people will need more support, whether to keep them safe from harm or because they have additional needs or disability (SEND). Some are also more likely to experience poorer outcomes because they are economically disadvantaged.

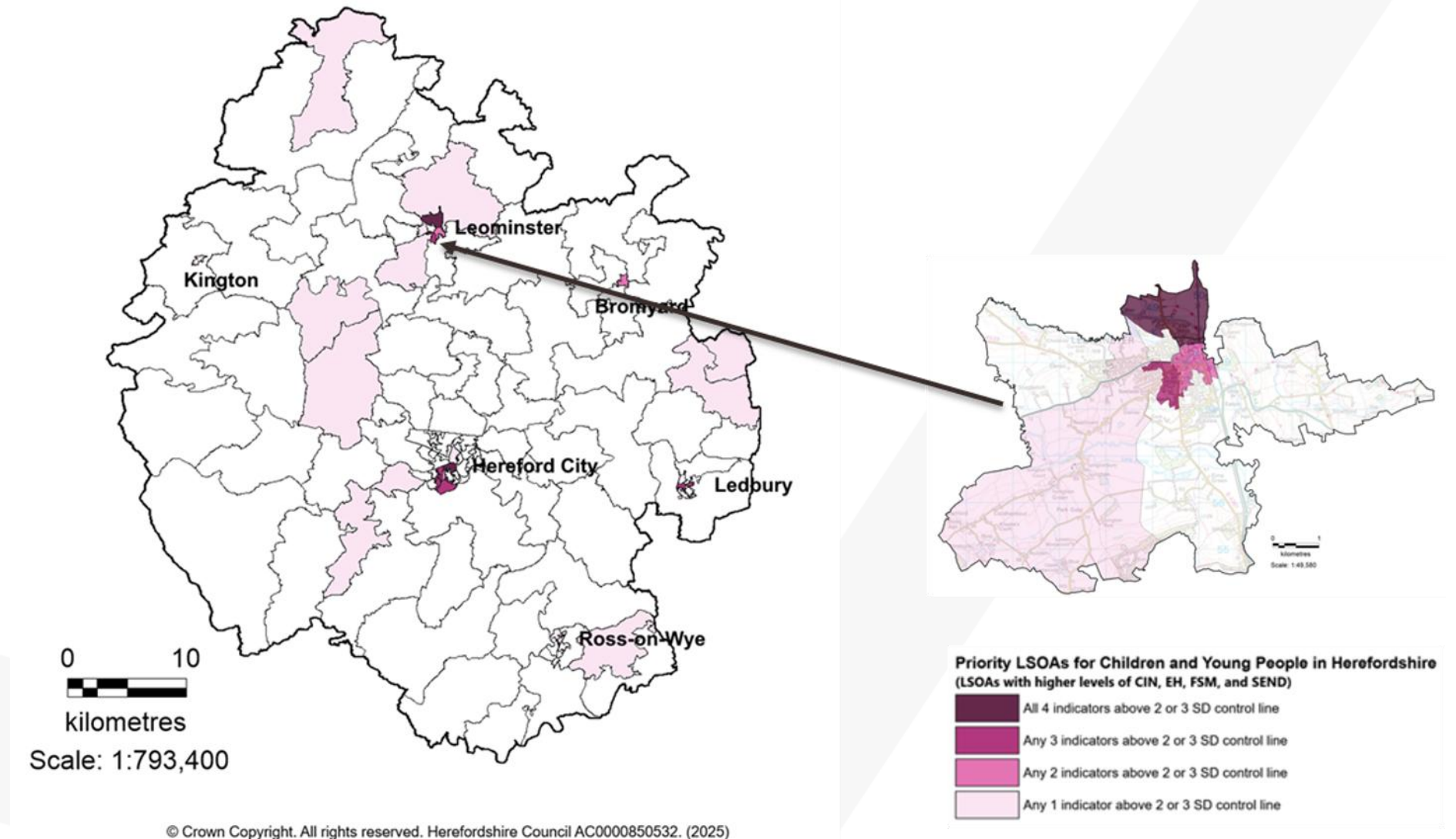
In 2025, analysis of five years' worth of data about children aged under 5 supported by different services identified areas of Herefordshire with particularly high rates of need. The data analysed were:

- Children in Need (CIN) - a child requiring local authority services to prevent significant impairment to their health or development, or a child who is disabled.
- Early Help (EH) – a whole family approach to provide extra support as soon as problems start to emerge, rather than waiting for them to become a crisis.
- Children receiving Free School Meals (FSM) – a common proxy indicator for economic hardship.
- Children with Special Educational Needs and Disabilities (SEND).

The analysis identified **30 LSOAs** across Herefordshire with significantly higher rates for at least one of these indicators; **ten of them** were in the North & West:

- Leominster Ridgemoor had high rates of CIN, EH, FSM, and SEND.
- Leominster Gateway had high rates of CIN, EH and FSM.
- Leominster Grange had high rates of CIN and EH.
- Greater Weobley and Leintadmore had high rates of FSM.
- Kington Central, Greater Foxley and Berrington had high rates of CIN.
- Leominster's Buckfields and Ryelands had high rates of EH.

Figure 9: LSOA Maps showing the Herefordshire areas with high need for children under five, spotlighting LSOAs in Leominster.



Data sources: [CIN](#), [SEND](#) and [FSM](#)

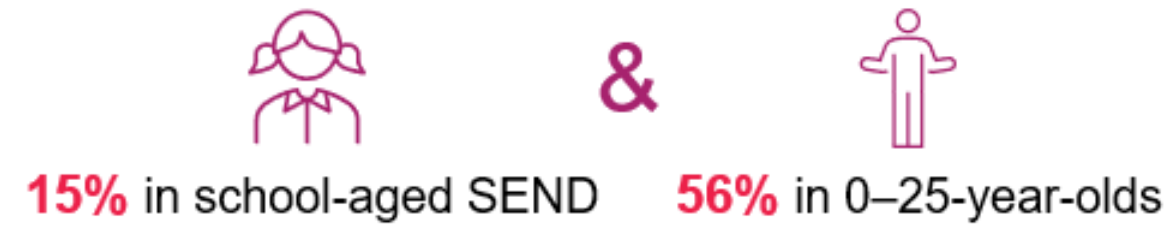
Children and young people with SEND (all ages)

A 2024 needs assessment looked at rates of children and young people (CYP) with special educational needs and disabilities around the county.

Around **5,200 statutory school aged CYP** (5-16 years) were recorded as having SEND.

Children with SEND in Herefordshire is a growing population

Between 2019 and 2024, Educational, Health and Care Plans (EHCP) have increased by:



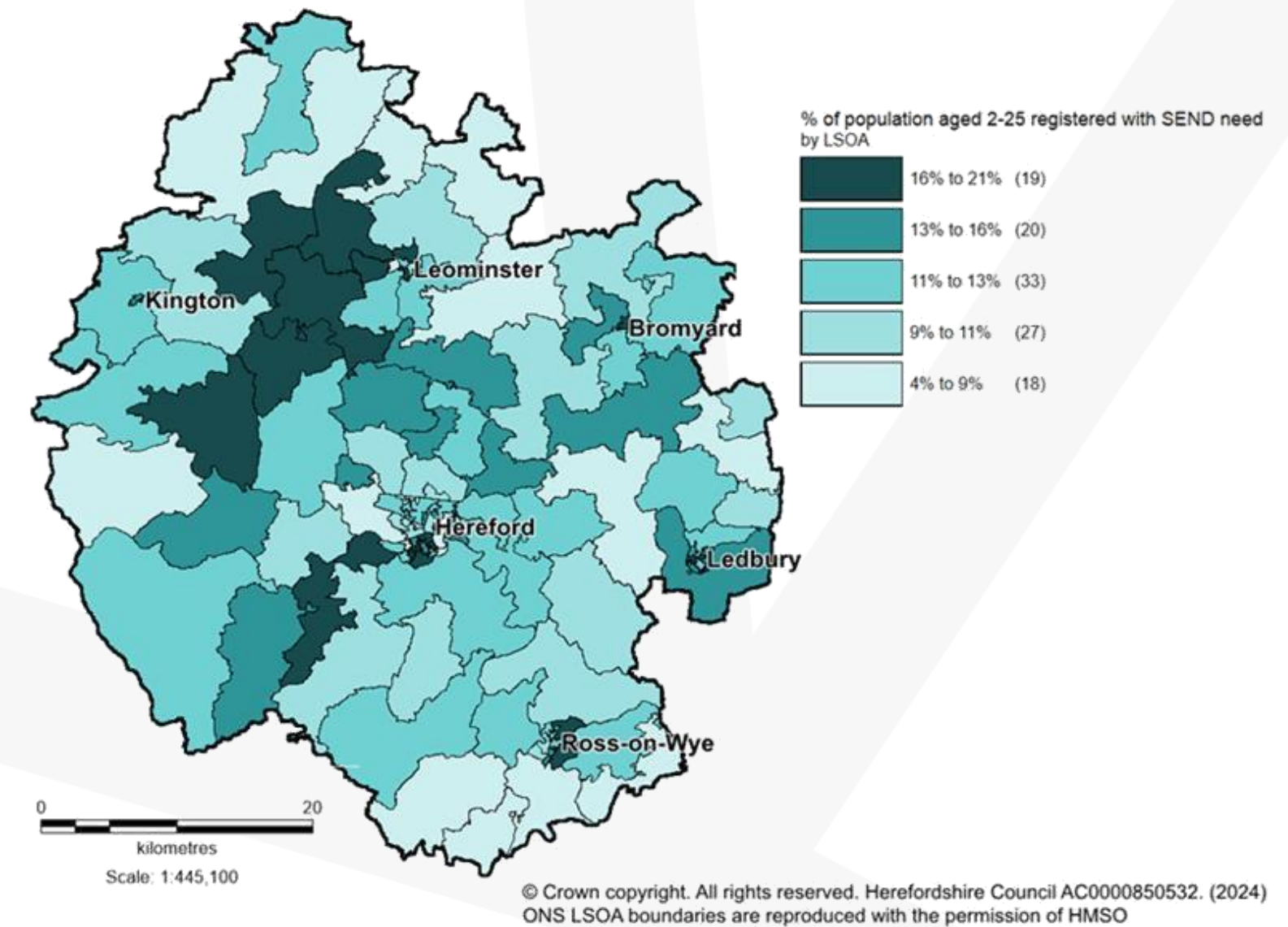
SEND rates were highest (18-21%) in areas of high deprivation and poverty. In North & West Herefordshire, Leominster Ridgemoor (21%) and Greater Weobley (20%) had the highest rates of SEND in the county.

Figure 8 shows the estimated population aged 2-25 years with an EHCP or receiving SEN support at LSOA level across Herefordshire.

The highest rates of CYP who receive an EHCP or SEN support lived in the most deprived areas of the county (30% and 27% respectively). Boys were more likely to have support in place than girls.

Learning difficulties (39%) were the most frequently reported primary need, followed by social, emotional and mental health needs (21%) and speech, language and communication needs (19%).

Figure 8: LSOA map showing the estimated population of where children and young people with SEND lived in Herefordshire in 2024



Data source: [SEND](#)

8. Adult social Care

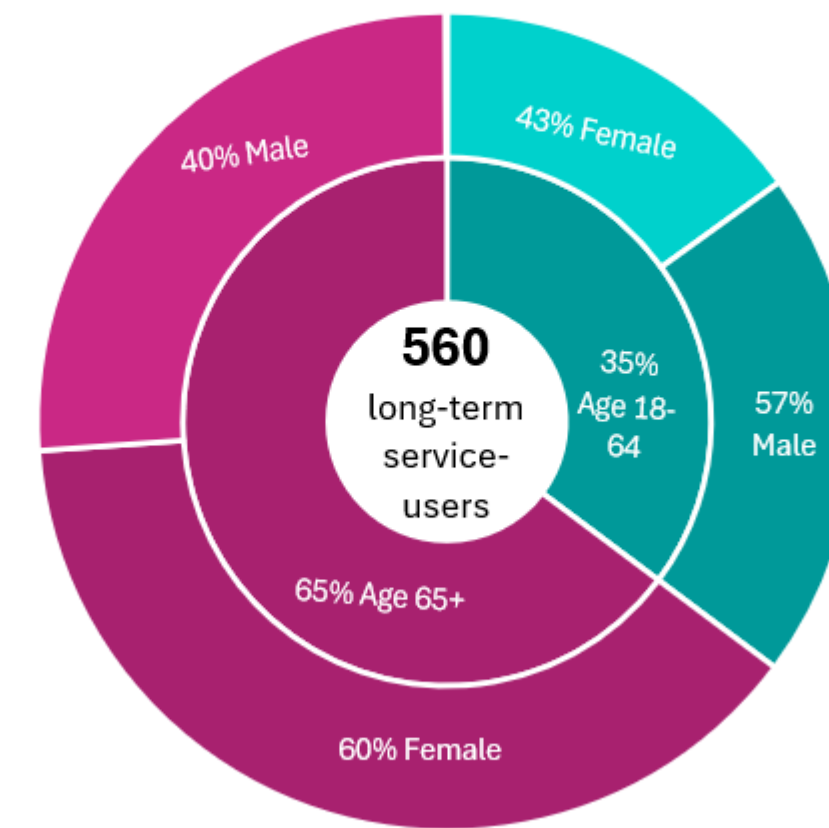
Please note: The data on this page is still being analysed, the information and graphs below may change, with additional information added.

Around 560 people a year in the North & West were supported by Herefordshire Council Adult Social Care (average based on the financial years 2023-24 to 2025-26). This represents just under a quarter of all long-term clients in the county (24%), broadly similar to the proportion of the adult population who live in the area (26%). The profile of clients by primary support need was also similar to that seen across the county as a whole.

Two-thirds of clients were aged 65 and over and one-third were aged 18 to 64. Overall, 54% were female, although this varied by age group: the younger age group had a more even gender split, while most clients aged 65 and over were female (61%).

People receiving long-term support form adults social care clients: two-thirds are over 65+ and female

Average annual numbers from 2023-24, 2024-25 and 2025-26



Data source:

9. Ageing well: health challenges affecting older people

As noted in the [2024 JSNA](#), people are more likely to experience ill-health as they get older. Locally, we only have data for dementia and Alzheimer’s meaning we can only discuss this topic in relation to ageing well.

Dementia and Alzheimer’s

[Dementia](#) is a group of symptoms affecting brain function. It affects a relatively small proportion of the population (3% in the UK) and, although more common in older people, dementia should not be considered an inevitable part of ageing.

[Estimated diagnosis rates](#) are only calculated for counties and Herefordshire is consistently significantly below both the national target of 68% and England’s overall rate (66%). In 2025 the rate for **Herefordshire** was 58% and **was the 16th lowest** of all upper-tier local authority areas in the country. It is therefore very likely that the true prevalence of this disease is underestimated across the county.

Diagnosed dementia rates are available for GPs (see table 5). Kington, Ryeland and Tenbury have some of the highest rates in England. The table also shows the percentage of patients reporting Dementia or Alzheimer’s per GP practice.

Table 5: Percentage of GP patients reporting dementia or Alzheimer’s in North & West Herefordshire and Dementia prevalence in comparison to England

Lower 99.8% Similar Higher 99.8% Quintiles: Low High Not applicable

Area name	% reporting	Dementia prevalence	comparison to England
England	0.5	0.8	
North & West Herefordshire	1.7	1.1	Significantly higher than
Kington Medical Practice	0.6	1.9	Significantly higher than
Ryeland Surgery	3.9	1.0	Significantly higher than
Tenbury Surgery	0.8	1.1	Significantly higher than
The Mortimer Medical Practice	1.0	0.8	No significant difference
Weobley & Staunton-on-Wye Surgeries	0	0.8	No significant difference

Source: [National General Practice Profiles](#) dataset, based on the GP Patient Survey and Quality and Outcomes Framework. Last accessed 12th March 2026

10. Wider determinants of health and wellbeing

Other factors can influence good or bad health, including the social, economic and environmental factors which shape people's lives. These factors are collectively described as the wider determinants of health ([Public Health England 2018](#)).

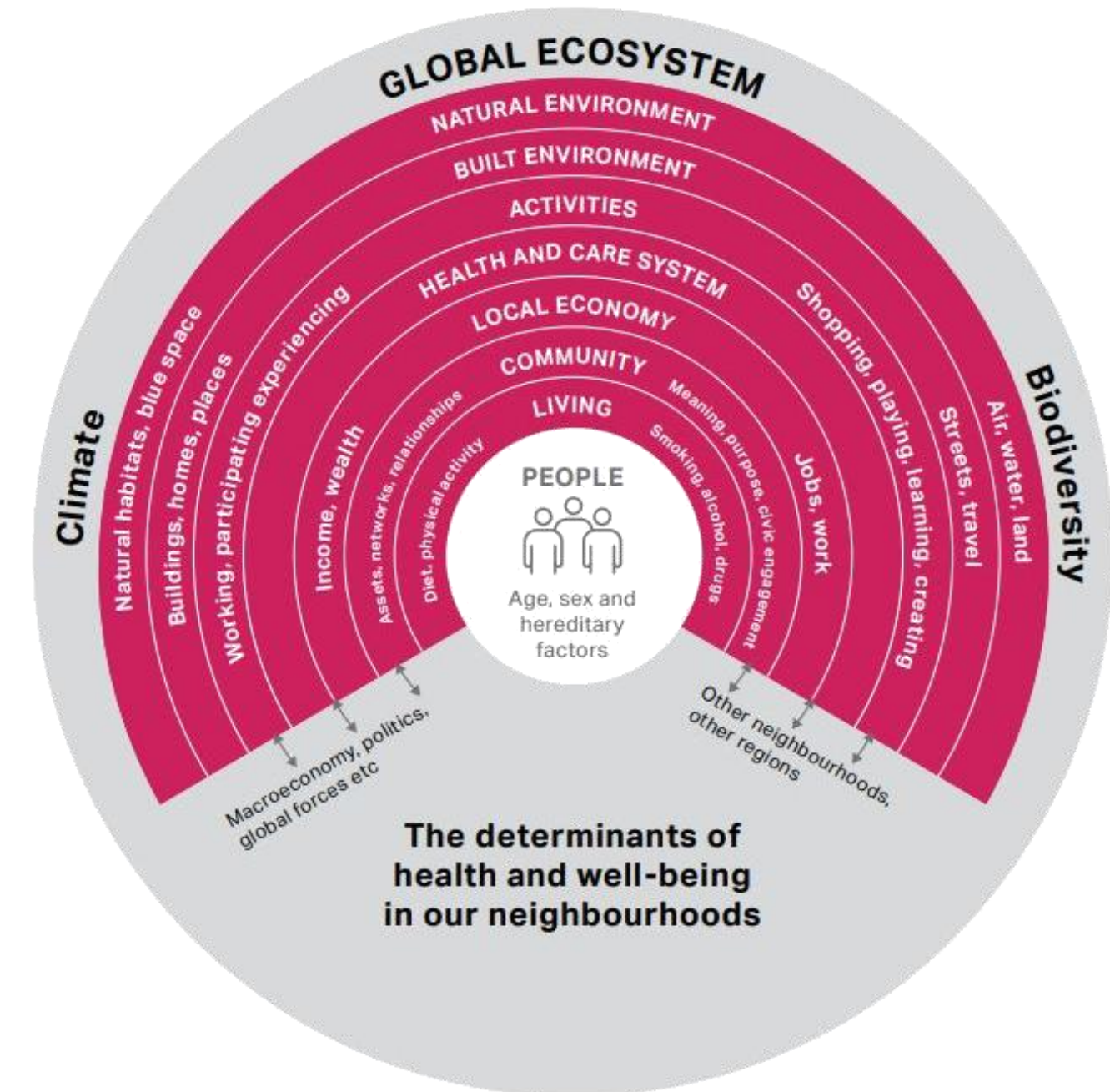
'Our health is a precious asset. Good health and wellbeing enable us to live happy, fulfilling lives and free us up to achieve our potential. Building a healthy society is like constructing a sturdy building. To succeed, we need all the right building blocks in place.'

'When we don't have what we need to heat our homes or buy healthy food, for example, and are constantly worrying about making ends meet, it can lead to chronic stress, poor health and lives being cut short.'

'But change is possible. By improving things like access to good-quality jobs, developing affordable homes, reducing poverty and making healthy food more accessible, we can... fix the gaps and build better health for all our communities.'

([The Health Foundation 2024](#))

Some of these wider factors and what they look like in North & West Herefordshire are considered on the following pages.



Source: [Future of London](#), adapted from Dahlgren and Whitehead (1991).

Environmental challenges

‘Evidence shows that a thriving, wildlife-rich environment benefits both physical and mental health. People with nature on their doorstep are more active, mentally resilient and have better all-round health’. ([The Wildlife Trusts](#))

Agriculture

Shaped by the natural environment, agriculture is a cornerstone of Herefordshire’s economy, heritage and communities. In the 2021 Census, **2,000 employed people** aged 16 and over living in the North & West **worked in agriculture, forestry and fishing**: 8% compared to 6% across Herefordshire and Tenbury and 1% for England as a whole.

Flooding

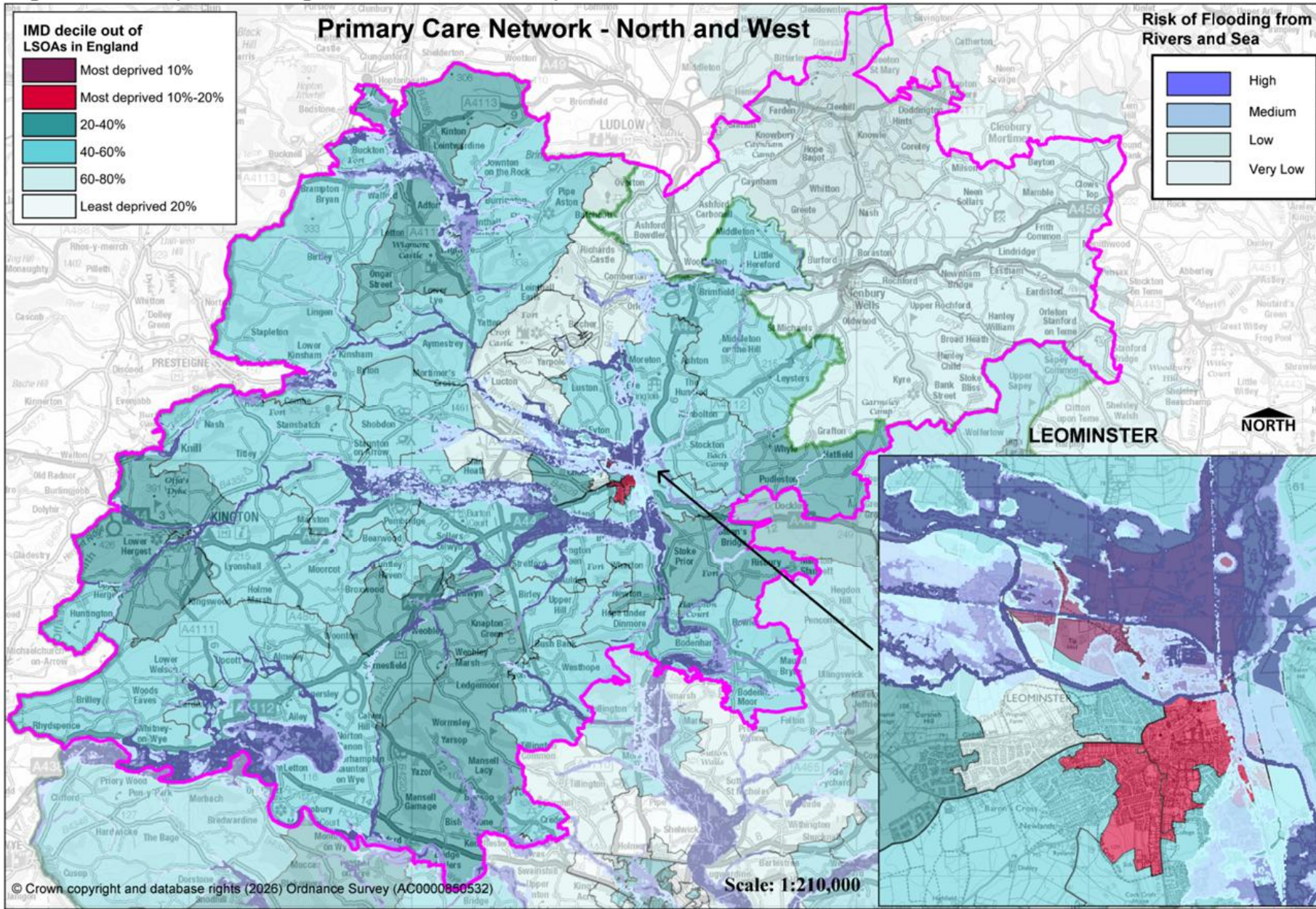
Much of Herefordshire is at risk of flooding and the threat of flooding can have a significant impact on the wellbeing of those affected, not just in terms of the physical dangers from flood waters, but in the trauma caused by damage to property and disruption to travel. Analysis to inform the Climate Change Adaptation Plan for Herefordshire 2023-2028 found that there had been 41 severe weather events in Herefordshire between 2008 and 2022, including 11 ‘highly significant’ floods.

Flooding can occur from surface water, or from seas and rivers (fluvial flooding). Surface water flooding is highly unpredictable, whereas fluvial flooding can be modelled based on the topography of an area and climate analysis. The map on the right shows those areas of the North & West that are at risk of fluvial flooding from the River’s Arrow, Lugg, Teme, and Wye, with the different colours representing areas at high, medium and low risk.

Leominster is the main urban centre for the North & West and had the highest concentration of housing at risk of flooding. The northern part of the town is most at risk of fluvial flooding from the river Lugg, including the most deprived area of

Ridgemoor. Some more rural areas are also at higher risk, including parts of Bodenham, Eardisley, Leintwardine and Whitney-on-Wye.

Figure 9: Map detailing flood risk and deprivation across North & West Herefordshire



Data source: [Risk of flooding from Seas and Rivers DEFRA](#) and [Indices of deprivation 2025](#)

Access to the natural environment

‘Evidence shows that a thriving, wildlife-rich environment benefits both physical and mental health. People with nature on their doorstep are more active, mentally resilient and have better all-round health’. ([The Wildlife Trusts](#))

Although the North & West PCN area does not include either of Herefordshire’s two National Landscapes (Wye Valley and Malvern Hills), it does contain the county’s only Country Park (Queenswood) and part of the Forestry Commission managed Mortimer Forest. Bodenham Lakes Nature Reserve is also one of numerous protected areas accessible to the public.

However, the **many benefits of the natural environment are under threat**. As well as risks from climate change, widespread declines in biodiversity were recognised in the council’s declaration of a Climate and Ecological Emergency in 2019.

Pollution means that the ecological health of the entire catchment of our two biggest rivers (the Wye and its tributary the Lugg) has been downgraded to ‘poor’ (‘unfavourable-declining’) by Natural England. This is mainly attributable to nutrient run-off from intensive poultry farms and discharges of raw sewage.

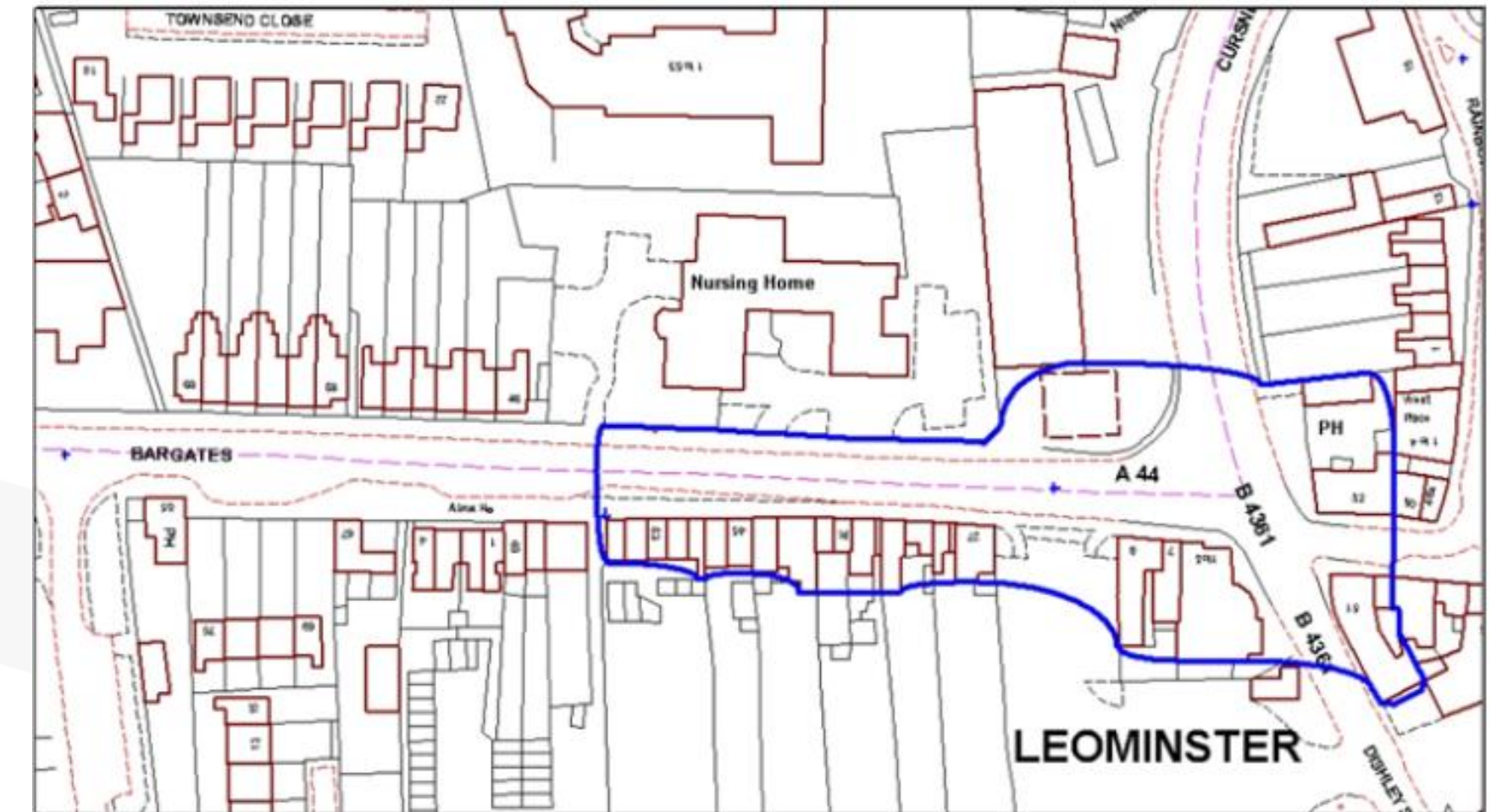
Since the Lugg flows through the North & West, much of the area is part of its catchment. A pioneering integrated constructed wetland project at Luston, in the North & West area, is attempting to mitigate local river pollution.

Outdoor living environment

The outdoor living environment domain of the Indices of Deprivation measures relative deprivation in terms of noise pollution, air quality and road safety. No areas of North & West were amongst the most deprived in England in 2025, but three were amongst the 20% most deprived in Herefordshire: ‘Leominster Grange’, and the rural areas of ‘Knillshall’ and ‘Shobbridge’.

Air quality problems in Herefordshire are mainly related to traffic. Leominster - Grange (see figure ten) contains one of the county’s two air quality management areas. An area encompassing the junction between the A44 (Bargates) and B4361 (Dishley Street/Cursneh Road), which includes 20 houses, has higher nitrogen dioxide levels than the Government threshold. Source: [Air quality management areas - Herefordshire Council](#).

Figure 10: Street map of the air quality management area of Leominster Grange



Data source: [Air quality Management Areas](#). Defra. Last Accessed 13 May 2026

Transport: geography and infrastructure

Good transport options and infrastructure can enable exercise, employment and road safety.’ ([The Health Foundation](#), May 2024). The rural nature of Herefordshire limits the availability of good transport options in the county.

The main towns and villages of the North & West area are connected by single-carriageway A roads, including the county’s only trunk road (A49), which runs north to south past Leominster. Leominster has one of only four rail stations in the county; other public transport options are limited – the scattered nature of the population makes commercially sustainable bus provision problematic ([Herefordshire Local Transport Plan 2016-2031 Strategy](#)).

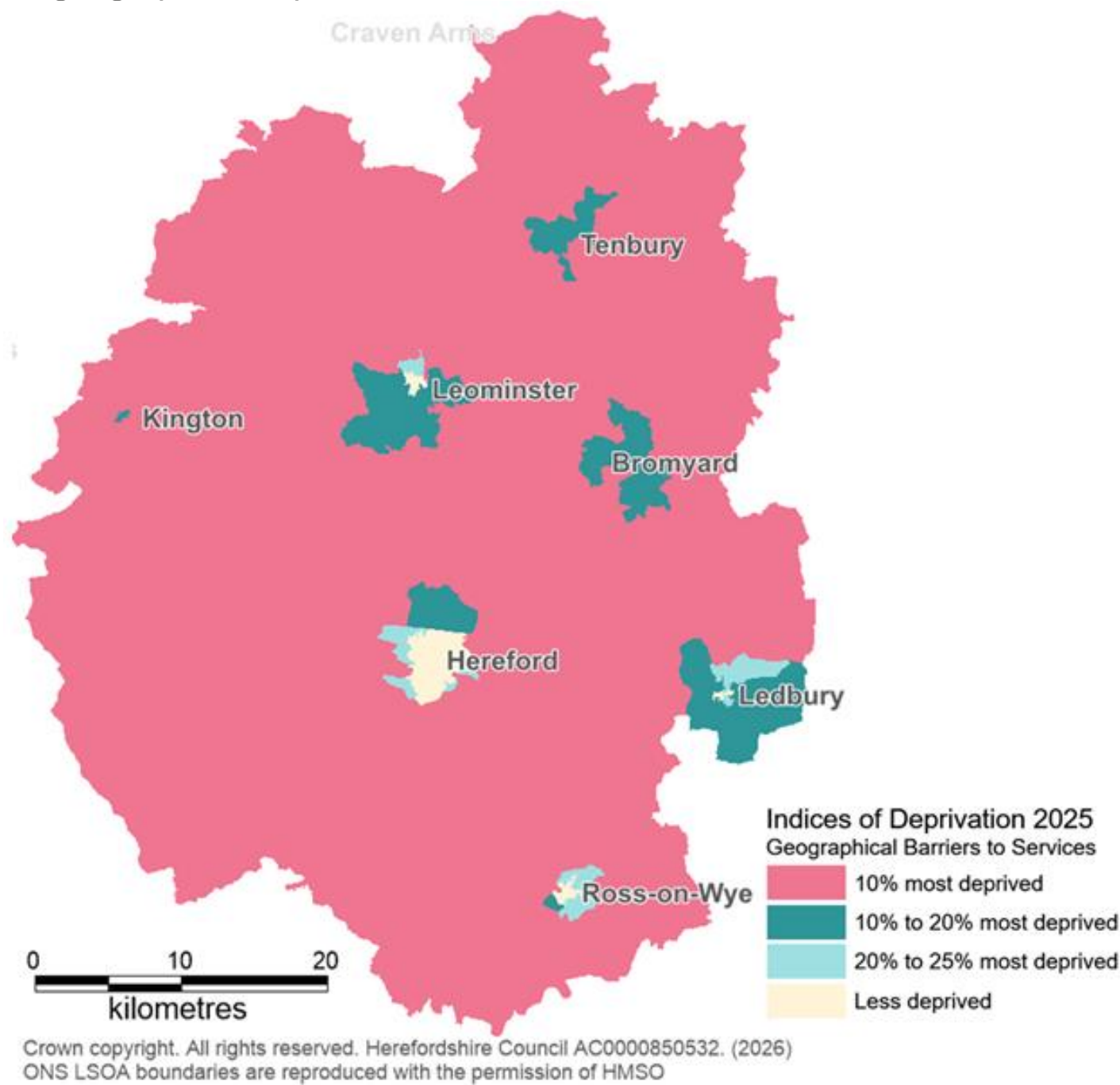
Geographical barriers to services deprivation

Geographical barriers to services were the most widespread type of deprivation affecting the whole of Herefordshire and Tenbury (see map in figure eleven), and North & West was no exception. **81 of Herefordshire’s 116 LSOAs were amongst the 25% most deprived in England** in 2025; with 54 amongst the 10% most deprived. Only the three Leominster town areas of ‘Grange’, ‘Gateway’ and ‘Meadows, Rugg’ were not. Of the ten Tenbury LSOAs, eight were among the 10% most deprived in England and two among the 20% most deprived on this domain (West and Burford Boraston).

In a local context, **six of the eleven** 10% most deprived areas of the county were in North & West:

- Aymestrey Horseshoe (2nd)
- Greater Docklow (3rd)
- Knillshall (4th)
- Tollbridge (5th)
- Greater Foxley (7th)
- Middleton (10th)

Figure 11: LSOA map of Herefordshire showing the most deprived areas in England for geographical deprivation



Data source: [Indices of deprivation 2025](#). Last accessed 12 May 2025.

Due to the distances and lack of public transport, there is a heavy reliance on car travel across the county. The 2021 Census recorded that 24% of working adults in Herefordshire and Tenbury travelled over ten kilometres to get to work, compared to 19% across England, with 59% of workers commuting by car, compared to 35% across England.

Unsurprisingly, the North & West area had similar patterns. 30% of working adults travelled over 10km to get to work. Car ownership was a necessity, 60% commuted to work by car and only 11% of households did not own at least one.

Car availability

Car availability in the North & West was similar to the county, as is to be expected for the most rural area of the county, with around 39% of households owning one car, 33% owning two cars, and 17% owning three cars.

Rural areas were more likely to have a car than urban areas with only 5% of households not owning a car in rural Kington compared to 21% in Leominster town. Notably, more households in Leominster Grange did not own a car whilst households in more rural areas such as Baldwin and Cleobury Neen Sollars in Tenbury had two or more cars.

Travel to work

Similar to the county, most working residents travelled to work by car, van or motorbike (60%).

Those not travelling to work by car either utilised public transport (0.9%), walked/cycled (10%) or worked from home (29%). Residents were more likely to walk, cycle or use public transport to get to work in urban areas which aligns with the broader county. Notably, more residents in Leominster Grange used public transport to get to work.

Transport: travel

Residents were more likely to work from home in rural areas, with notably more residents working from home in Cleobury Neen Sollars in Tenbury.

Future transport plan

The need to improve local transport opportunities is a priority for [Herefordshire Council's Local Transport Plan](#), with plans to develop the transport infrastructure in place until 2031. Leominster is one area set to receive improvements to transport support as housing expands in the area. A development of a core network of bus services aims to connect the core market towns with Hereford City is a priority to maintain access via public transport.



Housing

A county’s housing stock has implications for how people are living and fuel poverty (discussed on page 40). The nature of the housing stock in Herefordshire means that homes are less likely to be well-insulated or connected to the gas network, making them difficult to heat which results in poorer energy efficiency scores and colder homes. This can be problematic since our homes can influence both our physical and mental health. Good housing should be affordable to all, decent quality, and secure and stable.’ ([The Health Foundation](#), May 2024)

Housing tenure

Similar to the county, **over two thirds** of households in the North & West owned their own homes (69%) in **2021**, with almost half owning them outright (47%). The exception to this was Leominster town, where although the majority were homeowners (58%), a higher-than-average proportion rented (42% vs 31% in the North & West) with notably higher rates of social renting in Leominster Ridgemoor and higher rates of private renting in Grange.

Stock condition: Cold homes

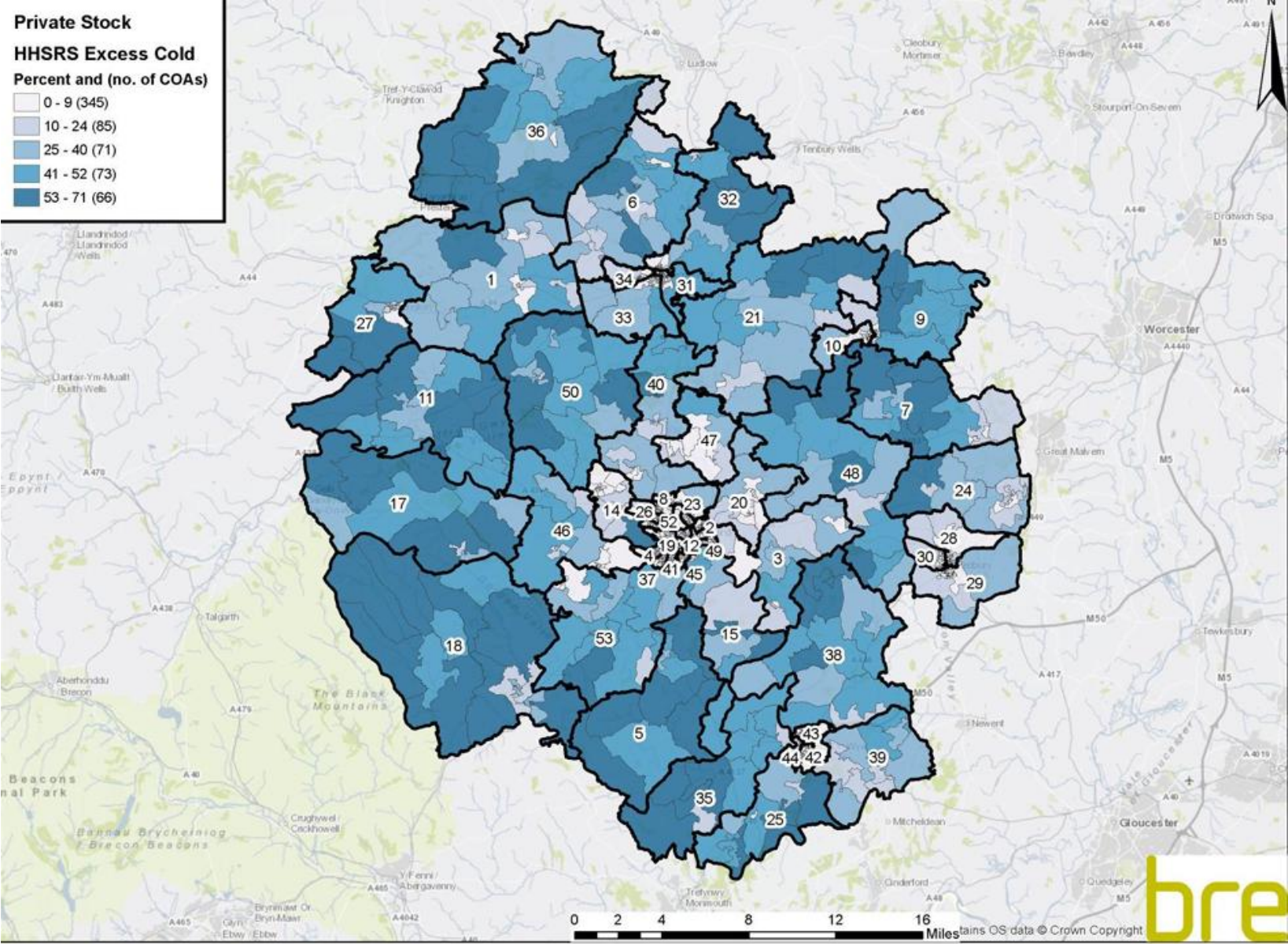
In 2019, **BRE** surveyed the housing conditions across Herefordshire, finding:

- High proportions of detached houses (40%) compared to England (23%)
- More homes built pre-1900 (39%) compared to England (8%)
- Lower households using mains gas (69%) compared to England (87%)
- High proportion of dwellings perform worse for excess cold hazards (17%) compared to England (3%)

The North & West had the **second worst** score for all hazards (35%) and excess cold (27%). The map in figure 12 shows the excess cold hazards for private stock across the county, with rural areas in the North & West having higher excess cold hazards, such as Mortimer, which ranked second of all localities for excess cold

hazards (36%) in owner occupied housing and Weobley which ranked second for private rented housing (34%).

Figure 12: Ward map showing the excess cold risk across Herefordshire’s private stock, ward boundaries may overlap different LSOA boundaries.



Data source: [BRE housing survey 2019](#). Understanding Herefordshire. Last Accessed 12 May 2026

Stock Condition: Falls

The 2019 BRE survey identified North & West Herefordshire as ranking **joint first** (11%) with South & West Herefordshire for fall Hazards across Herefordshire's private stock.

At the locality level, Kington had the **worst risk** for fall Hazards in private stock of all localities at 12%, closely followed by Mortimer and Weobley at 11% who also shared scores with Bromyard and Golden Valley.

The ward map in figure 13 reflects these findings, showing higher levels of fall Hazards across the more rural areas of the North & West such as Mortimer.

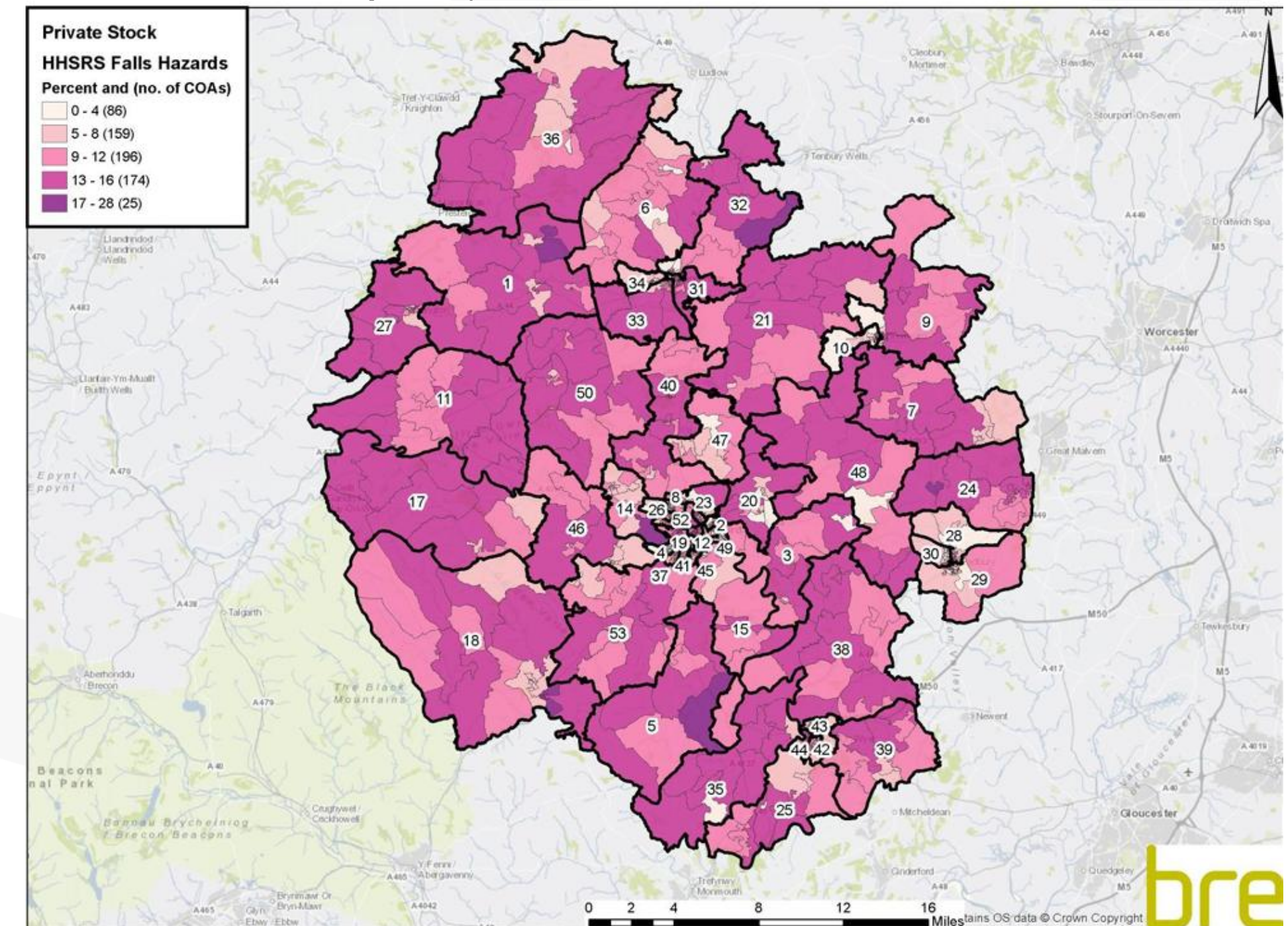
Central heating

From the [2021 census](#), most of the North & West had similar levels of central heating to the county, where 98% of households had central heating and 2% did not.

Moderately less households relied on mains gas (37%) compared to the county (52%) and nationally (74%), and moderately more households relied on oil (25%) compared to the county (16%) and nationally (4%).

Notably more households in Leominster Meadows Rugg, Leominster Grange and Leintadmore had electric only heating sources, whilst notably more households in Leominster Ridgemoor had no central heating.

Figure 13: Ward map showing the fall hazard risk across Herefordshire's private stock, ward boundaries may overlap different LSOA boundaries



Data source: [BRE housing survey 2019](#). Understanding Herefordshire. Last Accessed 12 May 2026

Indoor living environment

Indoor living environment was one of the key areas where Herefordshire and Tenbury were more deprived compared to England as a whole. Poor housing conditions such as homes not meeting the Decent Homes Standard, low Energy Performance Certificate (EPC) ratings, and a lack of adequate outdoor space contribute significantly to this deprivation. Across Herefordshire, **one-third** of LSOAs fell within the 10% most deprived in England for indoor living environment, 14 of which were in the North & West.

Locally, 23 areas fall within the 20% most deprived in Herefordshire, of which:

- **Nine** were in the rural areas of the North & West: Middleton, Greater Docklow, Knilshall, Eardishill, Berrington, Tin Hill, Tollbridge, Aymestrey Horseshoe and Greater Foxley.
- Greater Foxley, Aymestrey Horseshoe, Tollbridge, Tin Hill and Berrington were in the 10% most deprived areas.

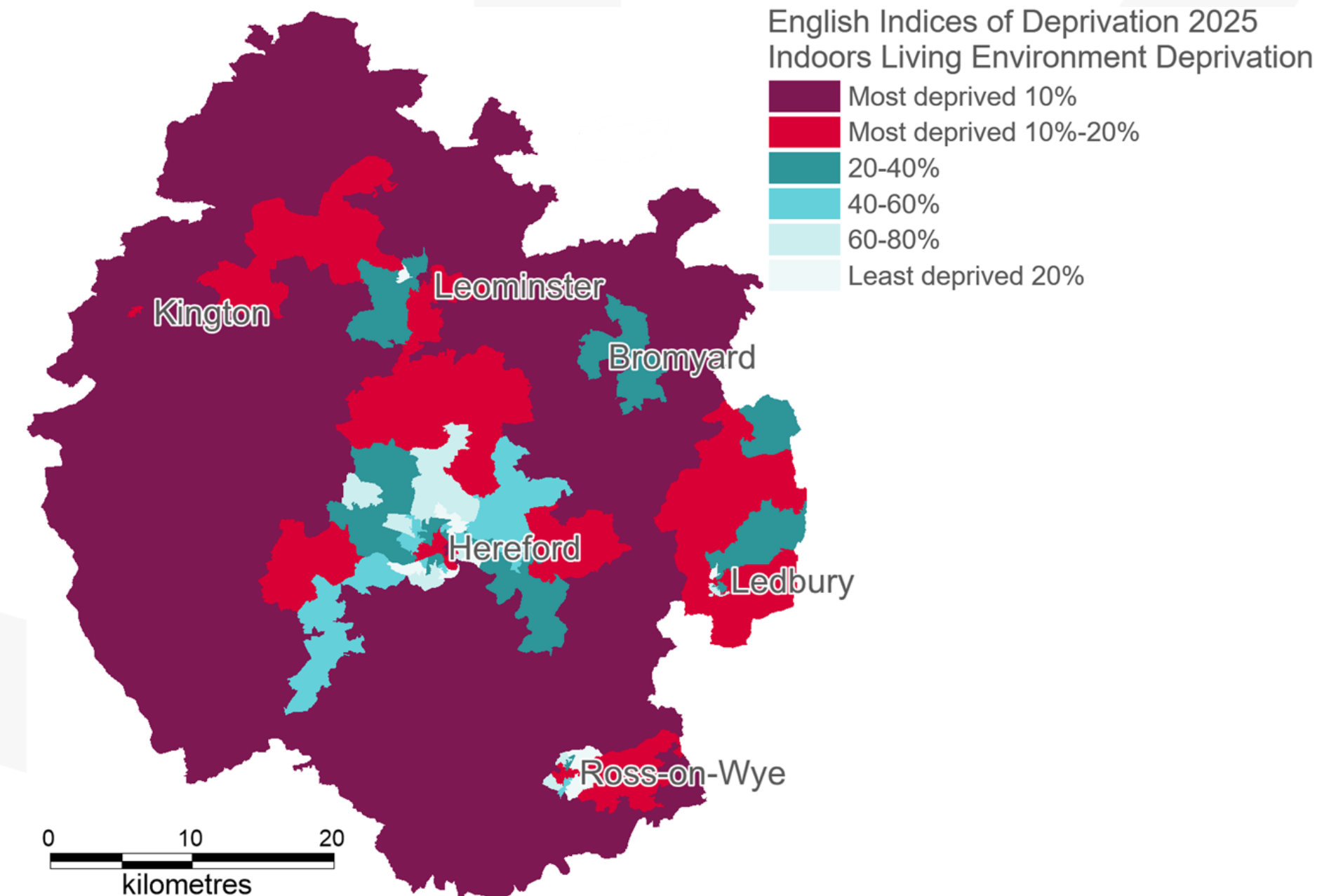
Eight of the ten Tenbury locality LSOAs also fell within the 20% most deprived in England, with Lindridge, Baldwin, Stoke St Milborough Henley, Ashfords Cayman, Knowle Greete, Doddington Hopton Wafes and Cleobury Neen Sollars falling in the 10% most deprived in England.

Housing affordability and deprivation

Herefordshire is generally less deprived in terms of wider barriers, including housing affordability, which is one of the indicators that make up this sub-domain.

Within the North & West PCN area, **only Kington Central** and **Kington Doughnut** fell among the locally deprived areas for this measure.

Figure 14: Map showing the most deprived areas in England on the Indoor Living Environment for Herefordshire LSOAs (excluding Tenbury)



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ONS LSOA boundaries are reproduced with the permission of HMSO

Data source: [Indices of deprivation 2025](#). Last accessed 12 May 2025.

Education and skills

As noted in the [2024 JSNA](#), ‘Good education and skills provide a strong foundation for good health and a decent quality of life.’ ([The Health Foundation](#), May 2024). Below county level, the most useful information about education and skills for both children and adults come from the 2025 Indices of Deprivation combined with detail from the 2021 Census.

Children and young people’s education and skills

Eight Herefordshire LSOAs in the North & West and **the West LSOA in Tenbury** were amongst the 20% most deprived in England in terms of CYP education and skills (see map), which takes account of educational attainment and absence levels.

Leominster’s Ridgemoor, Grange, Gateway and Baron’s Cross were the only LSOAs in the North & West to fall amongst the 10% most deprived locally on this domain. The remaining four LSOAs of Hopebodenham, Leominster Meadows Rugg, Kington Doughnut and Kington Central fell amongst the 20% most deprived locally.

Adult skills and qualifications

This domain considers entry to higher education as well as qualifications and English language proficiency (for those for whom English is not their first language).

Unlike for CYP education, only **two areas** of North & West were amongst the 20% most deprived in England in terms of adult skills in 2025: Leominster’s Ridgemoor and Grange. Locally, five areas in the North & West were amongst the 20% most deprived in Herefordshire: Kington Central, Gateway, Baron’s Cross, Grange and Ridgemoor, with the latter two being amongst the 10% most deprived.

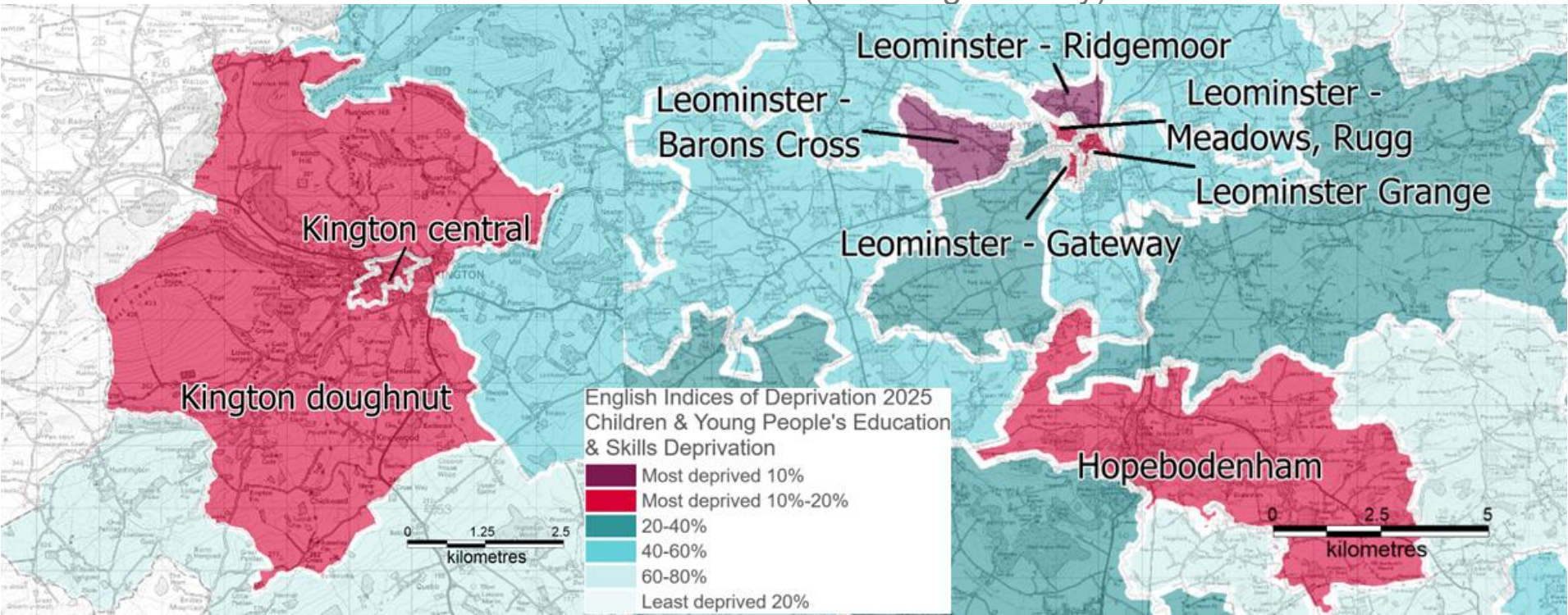
From the [2021 Census](#), residents aged 16 and over in the North & West had similar levels of qualifications to the county:

- **18%** have no qualifications

- **10%** have level 1 qualifications
- **15%** have level 2 qualifications
- **17%** have level 3 qualifications
- **32%** have level 4 or higher qualifications
- **6%** have an apprenticeship

Notably, there were higher rates of apprenticeships in Leominster Buckfield and higher rates of level 1-4 qualifications in LSOAs across Tenbury (i.e., Baldwin, Lindridge and Cleobury Neen Sollars). Notably less residents had level 2 qualifications in Leominster Grange.

Figure 15: LSOA Map showing national deprivation for Children and Young People’s Education and Skills in North & West Herefordshire (excluding Tenbury)



Data source: [Indices of deprivation 2025](#). Last accessed 12 May 2025.

Economy

Our economy is the backbone of the county and sadly, Herefordshire has consistently fallen behind national rates. Earnings and employment rates do not follow national trends to industries due the structure of our economy. With reduced productivity compared to nationally, we have lower wages and different employment activities. Despite this, economic activity is increasing.

Industry of employment

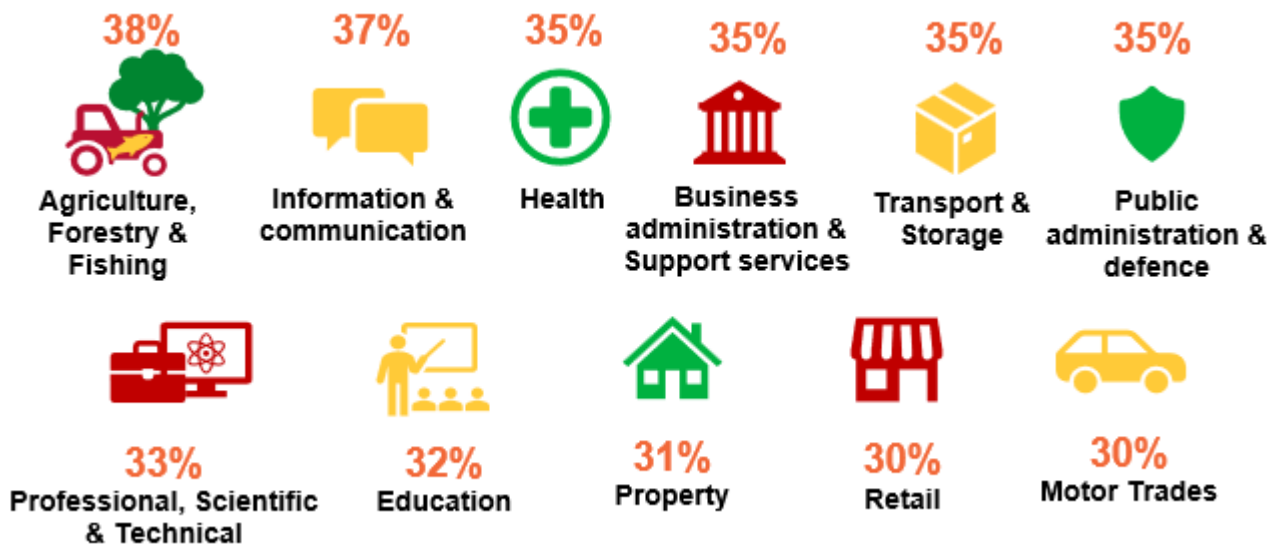
In 2025, **3,385** (32%) of the 10,740 business enterprises across Herefordshire were in the North & West PCN area (excluding Tenbury).

Similar to nationally, most Herefordshire businesses were in the private sector (97%) and were micro-sized enterprises with less than ten employees (87%). However, the distribution of businesses between industrial sectors is significantly different to nationally, most noticeably with an over-representation of businesses in the agriculture, forestry and fishing sector (30% of Herefordshire businesses compared to only 4% in England).

Agriculture, forestry and fishing represented a quarter of all businesses (845) in the North & West, the highest proportion (38%) of any Herefordshire PCN area.



Other business sectors with the highest proportions in the North & West were:



The differing distribution of businesses across industrial sectors in each PCN area has implications for productivity, jobs, earnings and skills.

Contribution to Herefordshire's economy

The Gross Value Added (GVA) represents the value generated from economic outputs of goods and services in an area per year. In 2023, Herefordshire's GVA per capita was £4.9 million which consistently lags behind the rest of the country with England's GVA being £2.1 billion. There is no up-to-date data available at LSOA or PCN area level.

Per head, Herefordshire was significantly lower (£25,947) than England (£36,103).

Employment type

Similar to the county, most working aged residents in the North & West were in full-time employment (66%) with over a third in part-time employment (34%). Notably more residents worked part-time and less worked full-time in Doddington Hopton Wafes (Tenbury).

People in work

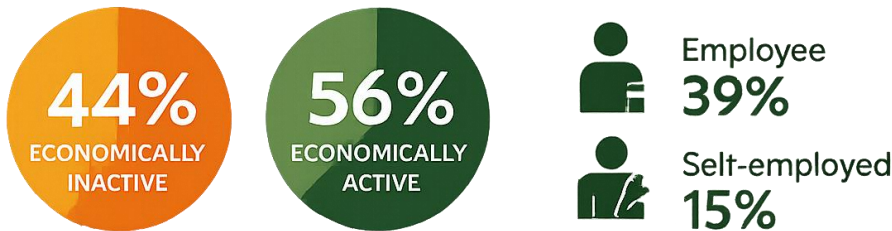
‘Rewarding and fulfilling work supports good physical and mental wellbeing. It fairly rewards peoples’ efforts, enables them to earn a decent living wage and provides opportunity for personal development and financial security.’ (JHWBS)

Economic activity

The economic activity rate is a measure of the proportion of people either in work or available for work.

Herefordshire’s economic activity profile differs from England’s: [2021 Census data](#) showed that **58%** of residents aged over 16 were economically active, compared to 61% nationally, driven by the greater proportion of people in retirement (29% compared to 22%), reflecting the older age structure of the county’s population.

The North & West area had similar economic activities to the county, with 56% of the 44,880 residents aged 16+ being economically active in 2021. Notable exceptions to this included Greater Docklow and Aymestrey Horseshoe which had more residents who were self-employed.

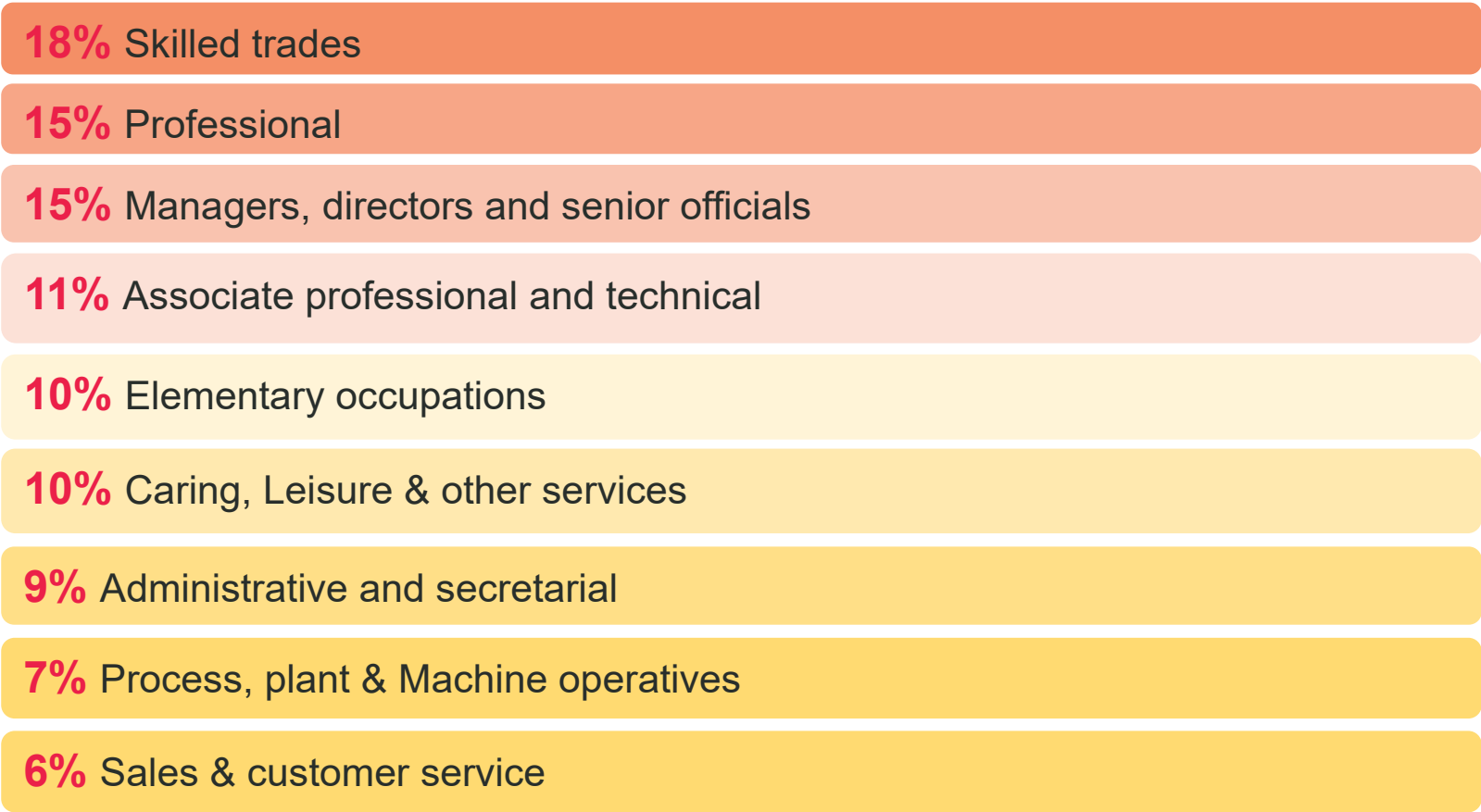


Hours worked

Similar to the county, most residents (50%) aged 16+ in full time work, worked 31 to 48 hours per week, with 16% working 49+ hours per week. For part-time work, most residents (22%) worked 16-30 hours per week, with 12% working 15 hours or less.

Occupation

The proportion of residents working in specified occupations in the North & West was similar to the county:



Notable exceptions included higher proportions of residents in:

- Associate professional and technical, and administrative and secretarial roles in Leominster Buckfield and Doddington Hopton Wafes.
- Skilled trades in Doddington Hopton Wafes.

People not in Work

‘Unemployment has consistently been found to have a negative impact on a range of health outcomes, including mental health issues such as depression, anxiety and levels of self-esteem.’ ([The Health Foundation](#), July 2024).

Employment deprivation

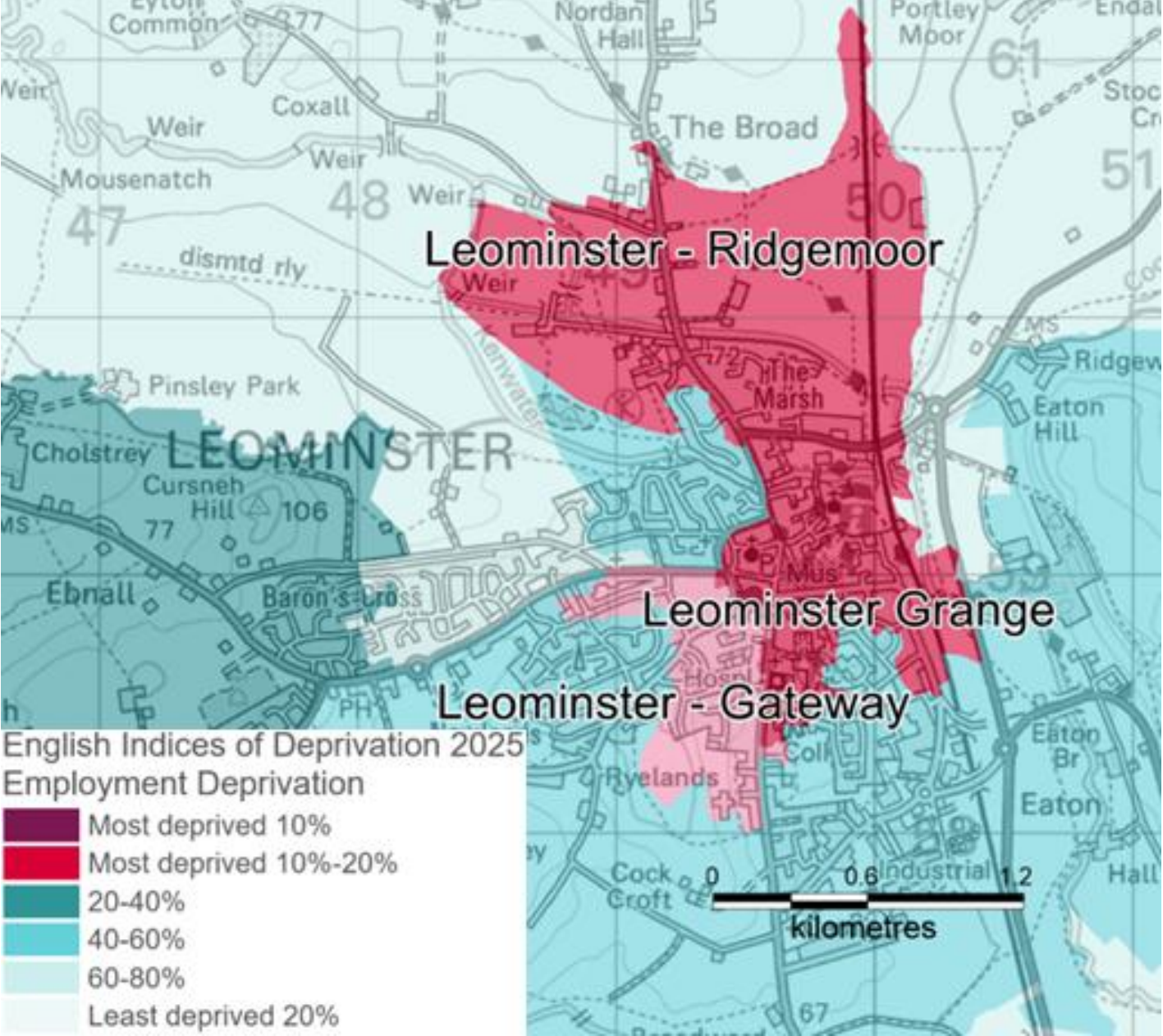
Employment deprivation measures the proportion of the working aged population (16-64 years) who would like to work but are unable to do so due to unemployment, sickness or disability, or caring responsibilities. Overall, Herefordshire is relatively less deprived of employment across all the local authorities in England, less than a tenth of LSOAs in the county fall in the 20% most deprived.

Leominster’s Ridgemoor and Grange fall in the 10% most deprived in England on this domain, whilst Gateway falls in the 20% most deprived in England.

Five of Herefordshire’s 23 most employment-deprived LSOAs were located within the North & West PCN area. These included:

- Ridgemoor, Grange and Gateway – 10% most employment deprived locally and most deprived for health and disability.
- Leominster Barons Cross and Kington Central – 20% most deprived locally, Only Baron’s Cross is deprived for health and disability.

Figure 16: LSOA map showing the areas in Leominster that were the most deprived in England on the employment domain



Source: [Indices of deprivation 2025](#). Last accessed 12 May 2026.

People who are unemployed but looking for work

Unemployment rates are calculated from the economically active population aged 16 and over. Whilst not available at PCN level, they can be calculated for counties where the [Office for National Statistics](#) recommends using its model-based estimates.

Herefordshire unemployment rates are low, but in increasing

The model-based unemployment rate for October 2024 – September 2025 was **4.1%** in Herefordshire, equating to 4,100 working aged people 16+. Whilst lower than England (4.3%), this rate had increased more than nationally and regionally from the previous period.

Out of work benefit claimant count is the best proxy for exploring unemployment at the PCN level. These numbers increased dramatically across Herefordshire peaking in May 2020 and have not returned to pre-COVID-19 levels despite falling.

In December 2025 there were around **2,690** claimants, **29% more** than in February 2020.

645 working aged people (16-64 years) were **claiming out of work-related benefits in the North & West** in December 2025. This was highest in the Leominster East Ward (4.8%) which is consistently amongst the highest in the county and well above Herefordshire's average of 2.5%. Claimant counts are highest in areas of high deprivation.

People not working due to ill-health and disability

Economic inactivity due to ill health is at an all-time high nationally due to [declining population health, increasing mental health](#) and economic pressures.

In Herefordshire, **a third** of working age residents who were economically inactive, were economically inactive due to disability and ill-health in July 2025; **1,405** of these were in the North & West.

Notably, in the 2021 census, more residents reported being long-term sick or disabled in Leominster's Grange and Ridgemoor, with the latter also reporting notably higher rates of residents looking after the home or family. People who suffer with ill health may seek support through benefits such as PIP (discussed on page 20).

Money and Resources

‘Secure financial circumstances lead to better material conditions, including adequate food and heating and reduce the likelihood of stress. Income also provides the resources to have a healthy diet and can provide the impetus to give up health-harming behaviours.’ [\(JHWBS\)](#)

Income Deprivation

Herefordshire overall is less income-deprived than the average local authority district in England; however, when focusing on children aged 0–15 living in income deprived families, it is more deprived than the average. Compared to England, **three LSOAs** fall among the 20% most deprived in the North & West: Leominster’s Ridgemoor, Grange and Gateway. Ridgemoor falls in the 10% most deprived areas in England.

Compared to Herefordshire, **five of the 20% most income-deprived LSOAs** were within the North & west, mostly congregated in Leominster. These areas experience deprivation across both the children’s (IDACI) and older people’s (IDAOP) income-related sub-domains:

- 1,500 children aged 0–15 lived in income-deprived households in Ridgemoor, Gateway, Grange, Barons Cross and Kington Central.
- 3,490 residents aged 60+ also lived in income-deprived households in these areas (excluding Barons Cross).

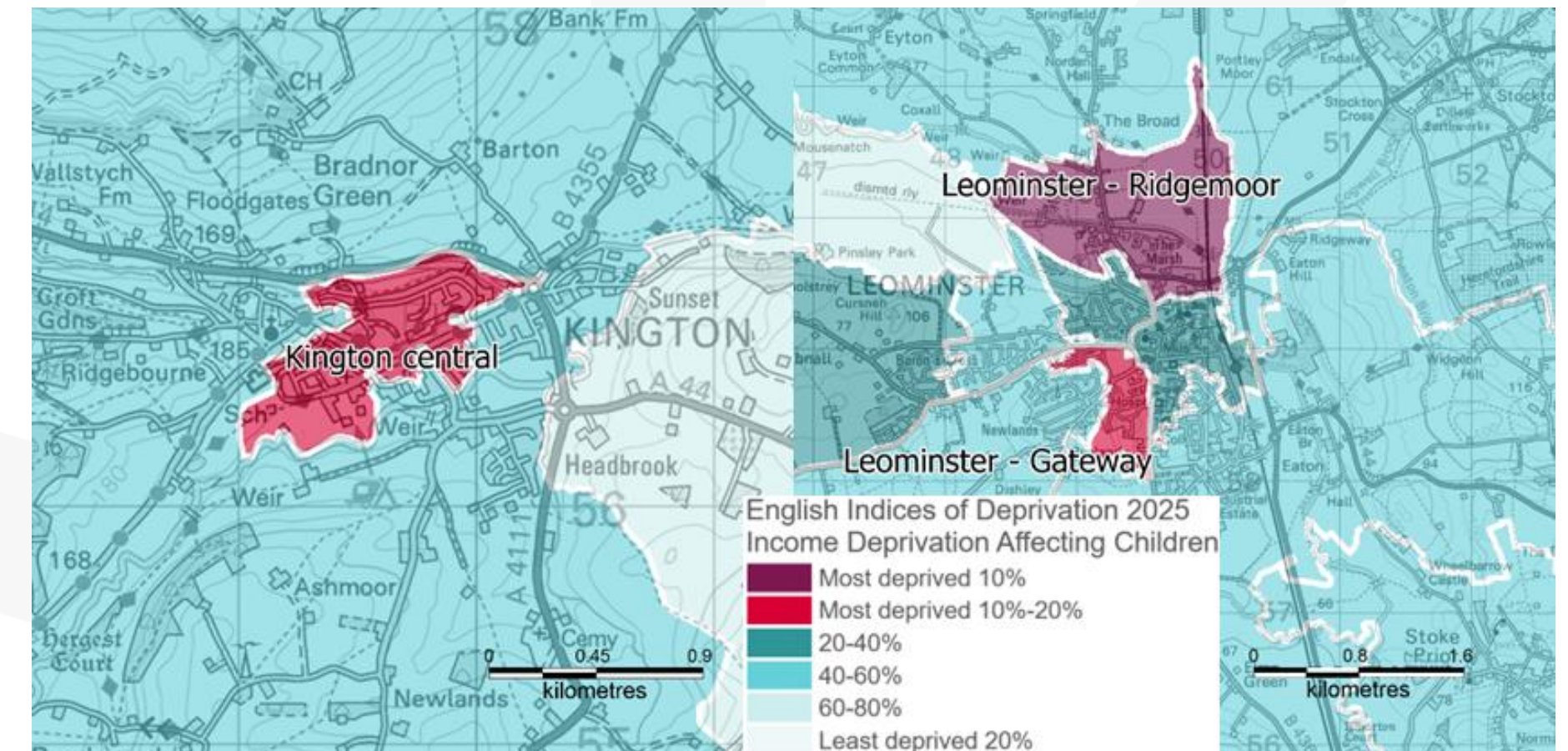
Universal Credit

Universal Credit is the main benefit available for those on low incomes or who are out of work, covering living, housing, and child costs.

In the North & West, **3,901 people claimed universal credit** in November 2025. The count reflects an increase from previous months and aligns with the national trend of universal credit claimants increasing month-on-month.

Leominster had the highest proportions of residents seeking universal credit with the three **most deprived areas** having the highest counts: Ridgemoor at 359, Grange at 352, and Gateway at 291. Mortimer typically had the lowest proportions of residents seeking universal credit.

Figure 17: LSOA Maps showing the most deprived areas in England for income deprivation affecting children in the North and West (excluding Tenbury)



Data source: [Indices of deprivation 2025](#). Last accessed 12 May 2026.

Housing Benefits

Housing benefit was the main benefit available for those on low incomes or who were out of work to help people to pay their rent. It is [being replaced by Universal credit](#) so new claims are only given to specific groups i.e. if you are state pension age or in supported or temporary housing.

There were **3,922 claimants** across Herefordshire and Tenbury in August 2025, **1,088** were in the North & West. As with Universal credit claimants, there is a clear increase in housing benefit claimants in the more deprived areas such as Leominster's Ridgemoor (77) and Grange (112).

Pension credit

Pension credit is a means-tested benefit that provides help with living or housing costs for people who are over state pension age and are on a low income. The number of claimants is dependent on the demographic profile of an area.

In November 2025, there were **3,879 claimants** across Herefordshire, **1,032** of which were in the North & West. The ward with the highest number of claimants in the county was Leominster East (179), of which Leominster Grange is part of.

Housing Stock: Low-income households and Excess cold

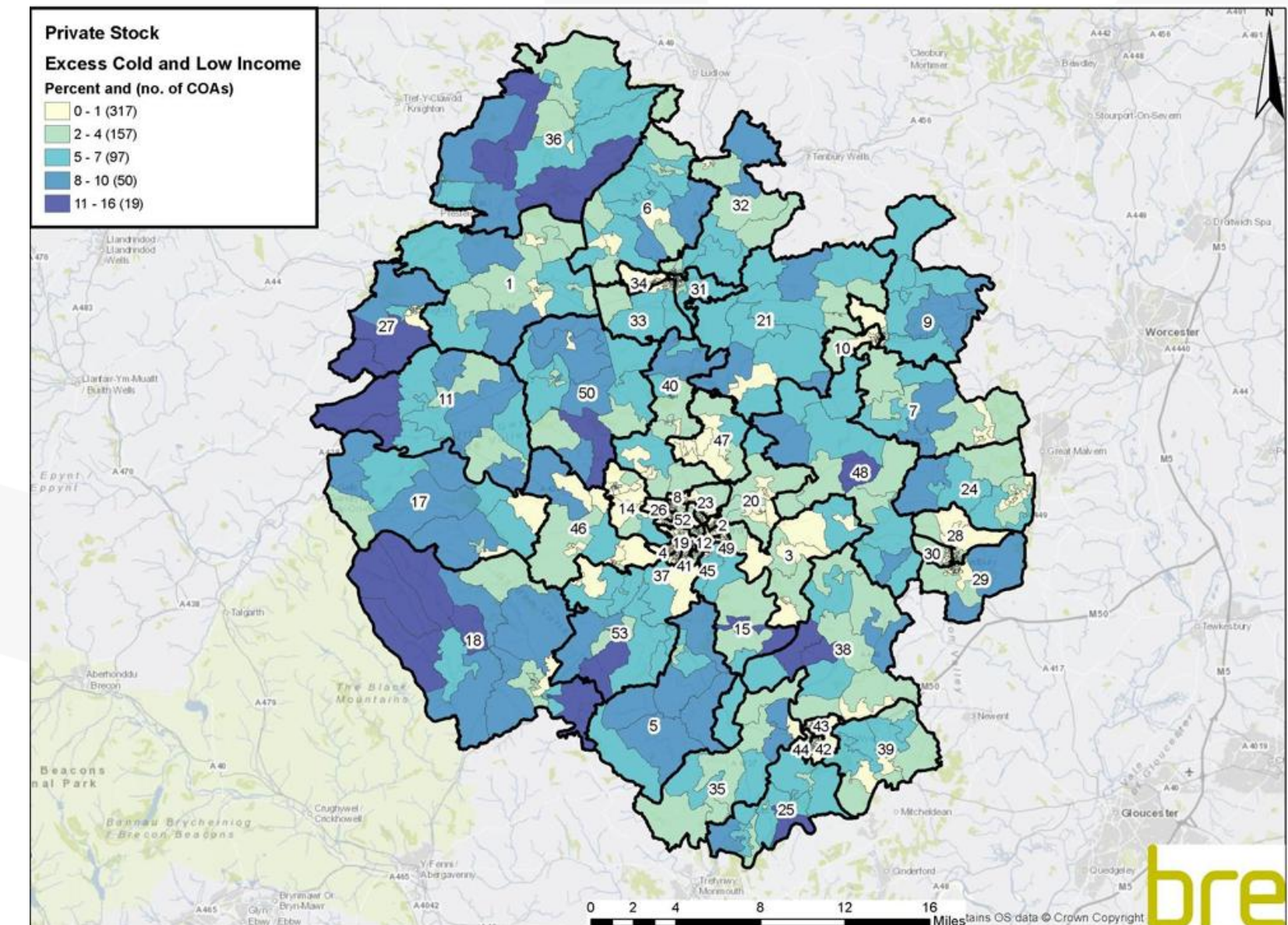
The [2019 BRE housing stock survey](#) of Herefordshire identified that the North & West PCN area was the second worst for low-income households for total (34%) and private stock (19%), with Hereford City coming first (33% and 23% respectively).

At the locality level, Leominster came first for of all localities for low-income households for both total (34%) and private stock (27%), with Hereford City coming second.

Despite such high ratings from Leominster, the North & West PCN area also has two localities with the lowest percentage of low-income families. For total stock, Mortimer scored the lowest of all localities at 15%. For Private stock, Mortimer and Weobley scored the lowest of all localities at 14%, alongside Golden Valley.

The map below shows the percentage of private stock with excess cold and low incomes across Herefordshire. Within the North & West, higher pockets of households with excess cold and low incomes tend to be in the most rural or the most deprived areas.

Figure 18: Ward map showing risk for excess cold and low-income households across Herefordshire's private stock. Ward boundaries may overlap different LSOA boundaries.



Data source: [BRE housing survey 2019](#). Understanding Herefordshire. Last Accessed 12 May 2026

Fuel poverty

Fuel poverty is where a household cannot afford central heating which increases their vulnerability for poorer health and wellbeing outcomes.

In 2024, the [Department for Energy Security and Net Zero](#) found that:

- **13%** of households experienced fuel poverty across the county
- **15%** of households experienced fuel poverty in the North & West

Fuel poverty varies across the PCN area, reflecting a clear rural-urban divide (see map). The highest **levels of fuel poverty were concentrated in the rural sub-localities** of Mortimer, Weobley and Kington (both town and rural) and the surrounding rural area of Leominster.

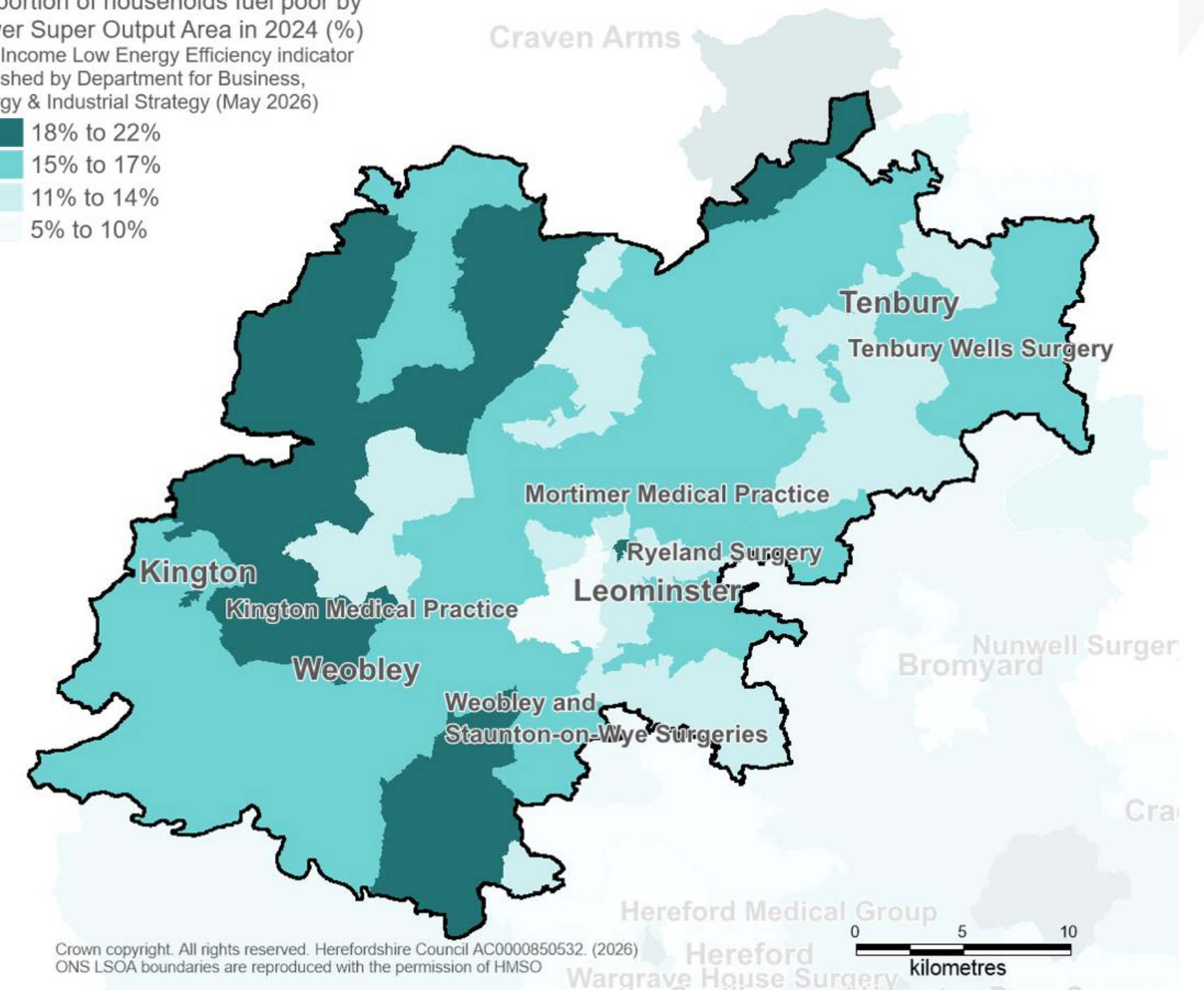
Greater Foxley (Weobley) and Aymestrey Horseshoe (Mortimer) stand out as having the highest fuel poverty rates in the county.

According to the Department for Energy Security and Net Zero, a household experiences fuel poverty when:

- They are living in a property with a fuel poverty energy efficiency rating of band D or below and,
- They are left with an income below the poverty line when spending the required amount of money to heat their home.

Figure 19: LSOA Map showing the percentage of households experiencing fuel poverty in North & West Herefordshire in 2024.

Proportion of households fuel poor by Lower Super Output Area in 2024 (%)
Low Income Low Energy Efficiency indicator published by Department for Business, Energy & Industrial Strategy (May 2026)



Data source: [Sub-regional fuel poverty data 2026 \(2024 data\)](#), Department for Energy Security and Net Zero.
Last accessed 01 June 2026.

Digital Exclusion

The proportion of adults in Herefordshire who do not use the internet has fallen in recent years, reflecting national trends. The 2023 Community Wellbeing Survey found that digital exclusion is driven more by lack of need, skills and affordability than by connectivity issues. Those most likely to be digitally excluded were people aged 55+, those with no formal qualifications and disabled people. Adults in the North & West were significantly less likely to feel positive about moving to online services than adults in Hereford City.

Two measures of digital exclusion risk at both national and local levels are available: The [Digital Exclusion Risk Index](#) (DERI) and the [Digital Exclusion Risk Atlas](#) (DERA).

DERI and DERA

The DERI assesses risk of digital exclusion using three domains:

- Broadband – availability and quality of broadband connectivity
- Demographics – characteristics associated with higher risk including older age and disability
- Deprivation – factors such as multiple deprivation, low qualifications and welfare dependency.

The DERA was developed to support access to digital health and care services, assessing risk on four domains: Digital access and capability, affordability and economic pressure, ability and skills, and agency, motivation and trust.

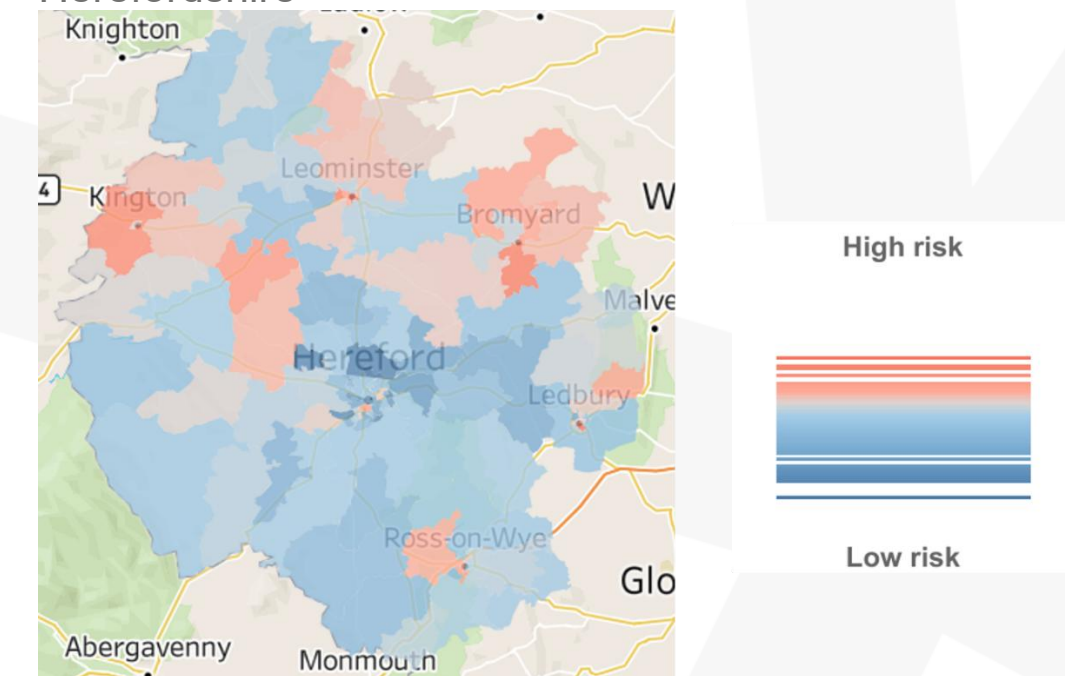
Both measures identified **Leominster Grange** as the **area at greatest risk of digital exclusion in Herefordshire**: DERI using local indicators and DERA using national indicators. The DERA ranked Leominster Grange 621 out of 33,755 LSOAs in England. Risks were linked to demographics and deprivation (in the DERI) and

digital access and capability, ability and skills, and agency, motivation and trust (in the DERA).

Other areas at risk included:

- Kington Doughnut, ranking 1,575th nationally on the DERA, with risk driven by digital access and capability and agency, motivation and trust – the two most common contributors to digital exclusion risk in Herefordshire.
- Leominster Buckfield, Kington Doughnut, Greater Weobley and Leominster Gateway were locally at risk on the DERI, due to demographics with the latter also at risk for deprivation alongside Leominster Ridgemoor.
- Tenbury, Stoke St Milborough, Doddington Hopton Wafes and Knowle Greete where at risk on the DERI for deprivation and demographics, with the DERA ranking West as the second most at risk area in the North & West PCN area and Tenbury the 5th.

Figure 20: LSOA Map showing risk of digital exclusion due to demographics in Herefordshire



Source: [DERI v2.1 | Tableau Public](#) Last accessed 16th March 2026

Family, friends and communities

‘Family, friends and communities are the cornerstone of our everyday lives and play an important role in shaping our health and wellbeing.’ ([The Health Foundation](#), May 2024). The 2023 Community Wellbeing Survey (CWS) provided insights into Herefordshire adults’ perceptions of community wellbeing and their quality of life, and how these have changed over time.

As noted in the [2024 JSNA](#), in common with the rest of Herefordshire, this area has strong, cohesive and resilient communities. However, there were concerns around feelings of safety after dark and pockets of crime in Leominster.

Community resilience

North & West adults had **similar levels of community belonging** to the county and were less likely to be dissatisfied with their area as a place to live, with **86% of adults being satisfied with their area**, a significant difference when compared to adults in Hereford City.

Despite this, North & West adults were significantly less likely (alongside Hereford City) to perceive that others from different backgrounds got along well in their area (80%) when compared to adults in East (89%) and South & West Herefordshire (88%).

North & West adults had similar levels of providing unpaid help as the county, with 41% providing unpaid help (40% county) and just over half not providing any unpaid help (53% in the North & West and the county). Those who had provided unpaid help were more likely to do so once a week (19% North & West and county) as opposed to once a month (10% North & West, 11% county).

Loneliness

As noted in the 2024 JSNA, the majority of adults said they had contact with family, friends or neighbours most days (57%), similar to the county.

However, **6%** of those who responded in the North & West area **reported feeling lonely often or all of the time**, similar to the county.



Community safety

‘The level of crime in an area can influence how safe people feel, which can in turn affect mental health – along with impacting participation in activities which are good for our health’ ([The Health Foundation](#), May 2024)

The 2023 Community Wellbeing Survey found that, unusually for a rural area, adults in the North & West were significantly less likely to feel safe, with **only 69% saying they felt safe outside** in their local area after dark. This was more in line with adults in Hereford City area (70%) than East and South & West (both >80%).

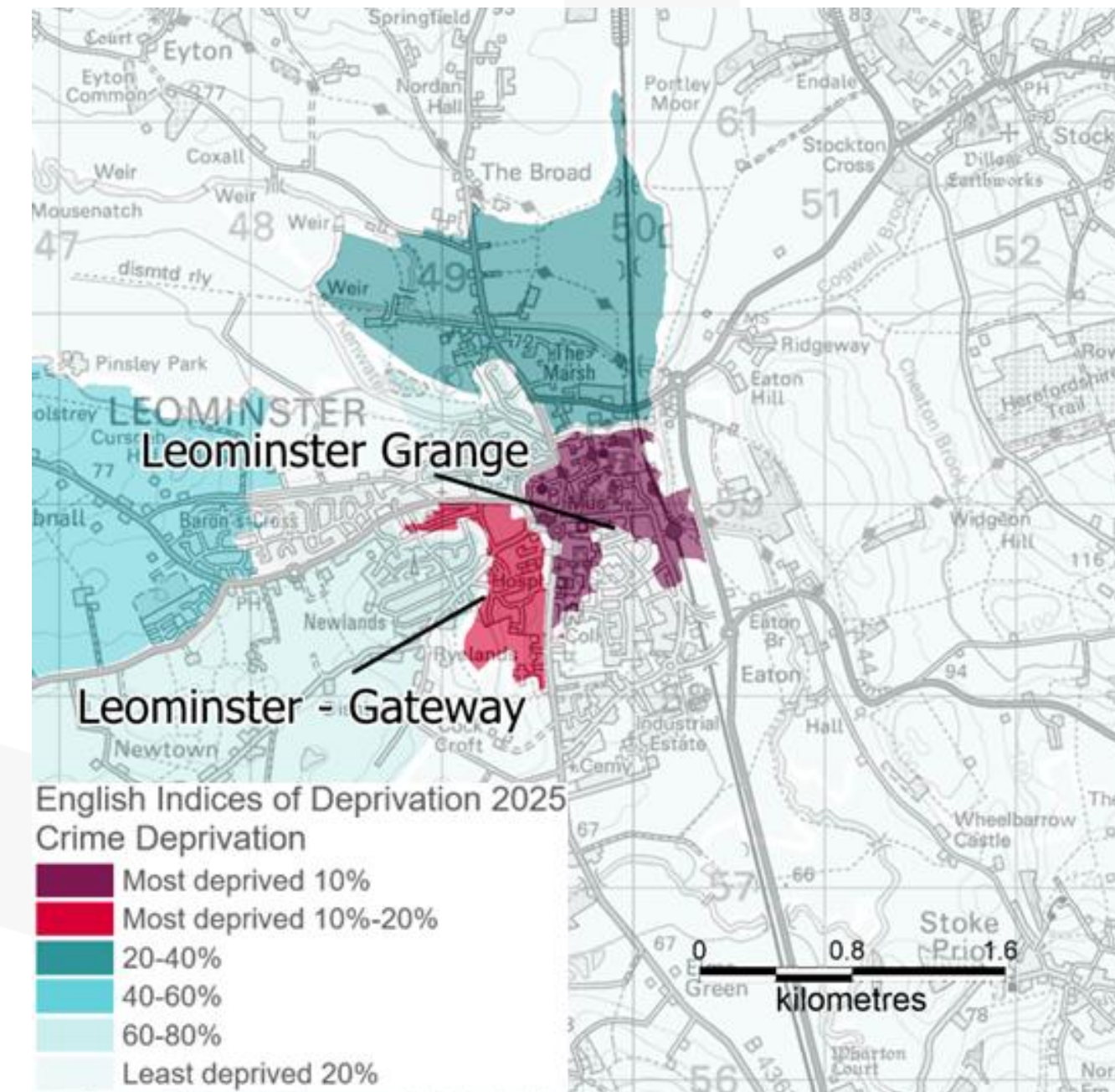
Crime deprivation

Crime is an important feature of deprivation that has major effects on individuals and communities. Overall, Herefordshire is less deprived than 86% of local authority districts in England for Crime deprivation and only 8% of Herefordshire’s LSOAs fall within the 20% most deprived in England. Leominster Gateway falls within the top 20% in England, whilst Leominster Grange falls within the top 10%.

Four LSOAs in the North & West PCN area were among the most 20% crime-deprived in Herefordshire:

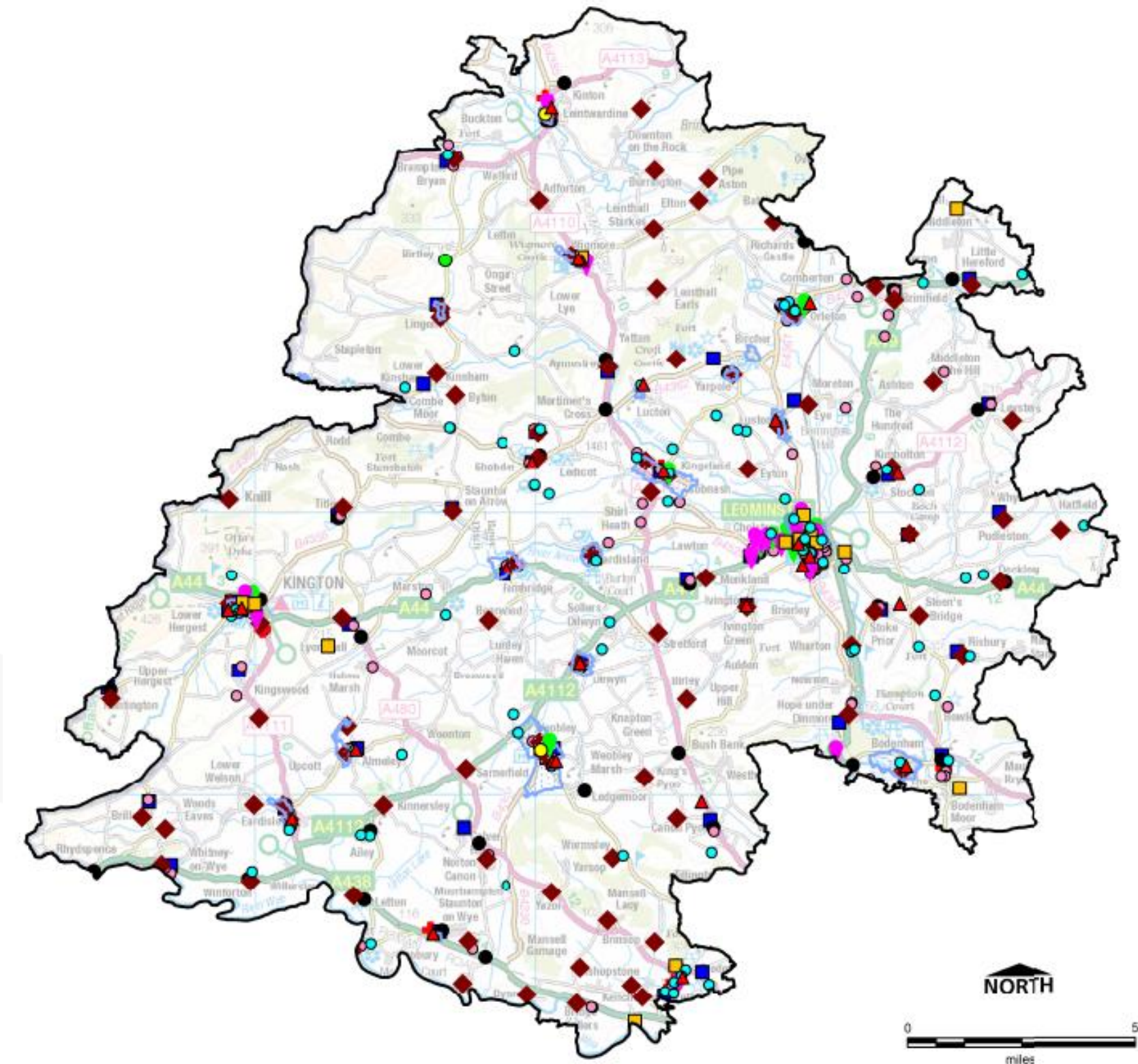
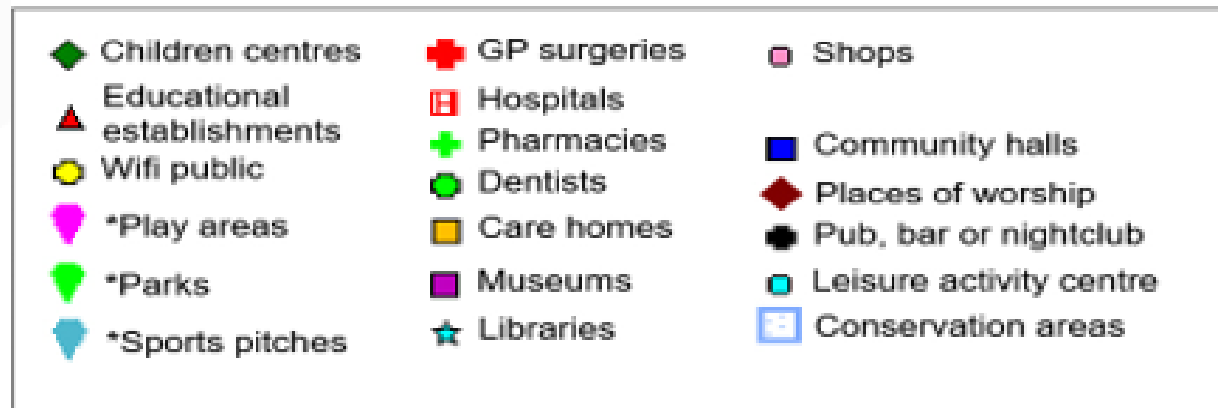
- Leominster Grange
- Leominster Gateway,
- Leominster Ridgemoor
- Kington Central

Figure 21: LSOA map showing the Leominster areas that are the most deprived in England for crime deprivation



Data source: [Indices of deprivation 2025](#). Last accessed 13 May 2026.

Community assets



11. Appendices

The JSNA is a continuous process of analysis and review to ensure that commissioning and service planning decisions are informed by the latest available evidence relevant to a particular decision.

Fingertips Public Health Profiles (fingertips.phe.org.uk/profiles)

These profiles provide collections of indicators covering a range of public health topics, organised into themes like mental health, obesity, healthy ageing etc. They have been developed to show local area data alongside relevant comparators as well as:

- Trends over time.
- Within county variation showing significant differences for **residents** of [middle super output areas](#) (MSOAs) and [wards](#) compared to the rest of the county and nationally, plus variation by index of multiple deprivation quintile for some indicators.

County-level benchmarking

[ONS Local](#): Office for National Statistics experimental tool enabling comparison of 70 local indicators, including disposable household income, further education and life satisfaction. Note this is mainly to compare Herefordshire to other parts of the UK.

[LG Inform](#): Local Government Association benchmarking tool allowing users to compare local authority areas and assess performance locally, regionally and nationally across a range of topics and indicators.

A growing number of self-serve tools are available to allow users to explore certain information: such as long-term trends, comparisons with other similar areas, or trying to better understand outcome variation within Herefordshire.

Local tools to analyse GP registered patients

Dashboards developed with Taurus Healthcare, designed primarily to help Primary Care Networks understand their local populations. Accessible on request from herefordshire.analytics@nhs.net. Including:

- Herefordshire inequalities dashboard: focusing on key indicators within the CORE20Plus5 measures (see p.8), such as Health Checks and other screening programme uptake, as well as prevalence of conditions including hypertension. Compare differences between IMD quintile and other characteristics.
- Herefordshire Population Health Management tool: segmentation of patients based on long-term conditions in each GP practice in Herefordshire. Data can be sliced by ethnicity and IMD.

Data profiles of residents of areas within Herefordshire

[Herefordshire area profiles](#): explore a wide range of census and deprivation statistics about the **resident population** of the county's 53 wards and the LSOAs within them (lower super output areas: statistical geographies of about 1,500 people)

Office for National Statistics 2021 Census tools:

- [2021 Census Maps](#): explore maps of key variables.
- [Profiler tool](#): build your own areas to extract data.



**Understanding
Herefordshire**
People and places

North and West Herefordshire Neighbourhood Profile Summary

Herefordshire Council Evidence and Insight Team
July 2026

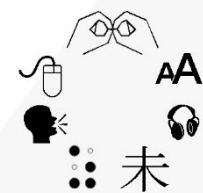
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Version 0.08



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If you need help to understand this document, or would like it in another format or language, please contact us on 01432 261944 or e-mail researchteam@herefordshire.gov.uk

1. Introduction

About the neighbourhood profiles

This profile aims to provide key insights into those living under the North and West Herefordshire Primary Care Network (PCN) area. *By highlighting key differences between localities and neighbourhoods within the area on a variety of topics such as population, health and wellbeing, mortality and the wider determinants of health, areas with high concentrations of deprivation and poorer outcomes can be identified. This can then inform effective commissioning and place-based, targeted planning.*

A rate that is relatively high or low in a local context may not have the same interpretation when compared elsewhere in the country. To remain focused on highlighting key differences across the PCN area, a statement about every dataset analysed is not provided.

Links to data sources used to create this neighbourhood profile are located throughout the document and key sources are provided in the appendix.

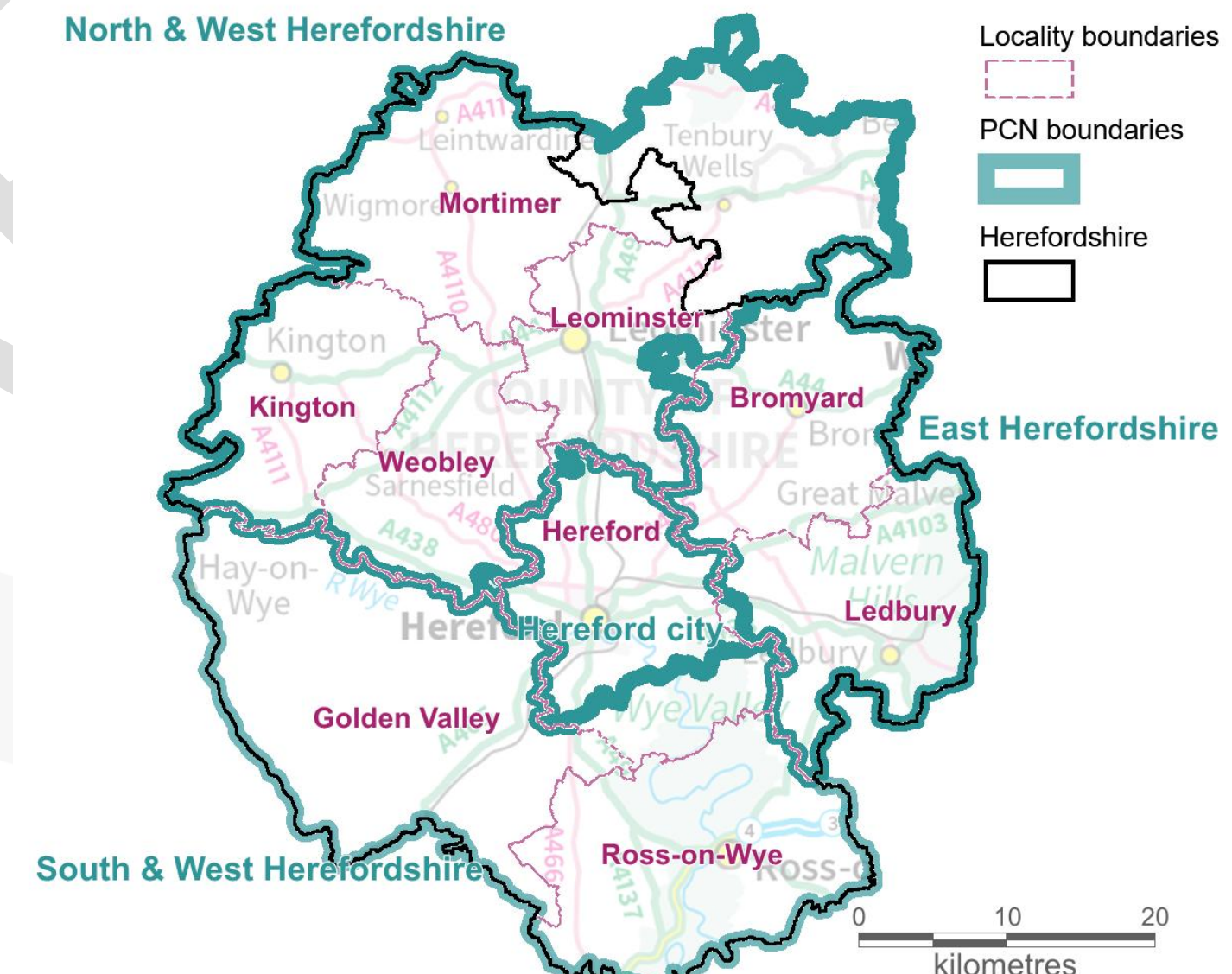
How have we defined a neighbourhood?

'Neighbourhoods' can be defined in different ways i.e. PCN, a Lower Super Output Areas (LSOA) or ward. In this profile, a 'neighbourhood' refers to localities within a PCN. This includes capturing data on the residents who live in each PCN and the patients who are registered with the General Practitioners (GPs) in the PCN.

Both are captured because the data between the two can differ. For example, most health statistics are based on patients who are registered with a GP surgery in the county, which may differ or not relate to their 'usual residence', where people are counted at their family home.

The boundaries used in this neighbourhood profile may differ to those used elsewhere. The North and West PCN boundary is represented below, complete with the localities situated within this PCN.

Figure 1: Map of Herefordshire showing PCN areas and locality boundaries



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2. North and West Herefordshire PCN Area: overview

The North and West Herefordshire PCN area covers the market towns of Leominster and Kington and the wholly rural localities of Mortimer and Weobley. It also includes the Worcestershire town of Tenbury, since Tenbury Wells Surgery is one of the five GP practices which work together as the North and West PCN. The others are the Herefordshire practices of Kington Medical Practice, Ryeland Surgery, Mortimer Medical Practice and Weobley and Staunton on Wye Surgeries.

With 12,000 residents, Leominster is Herefordshire's largest market town, and local services are concentrated here as well as in Tenbury (4,000 residents) and Kington (3,200). Ludlow and Presteigne in the bordering counties of Shropshire and Powys are also service centres for people who live in the area. Weobley, Eardisley, Pembridge and neighbouring villages make up Herefordshire's famous medieval 'black and white trail'.

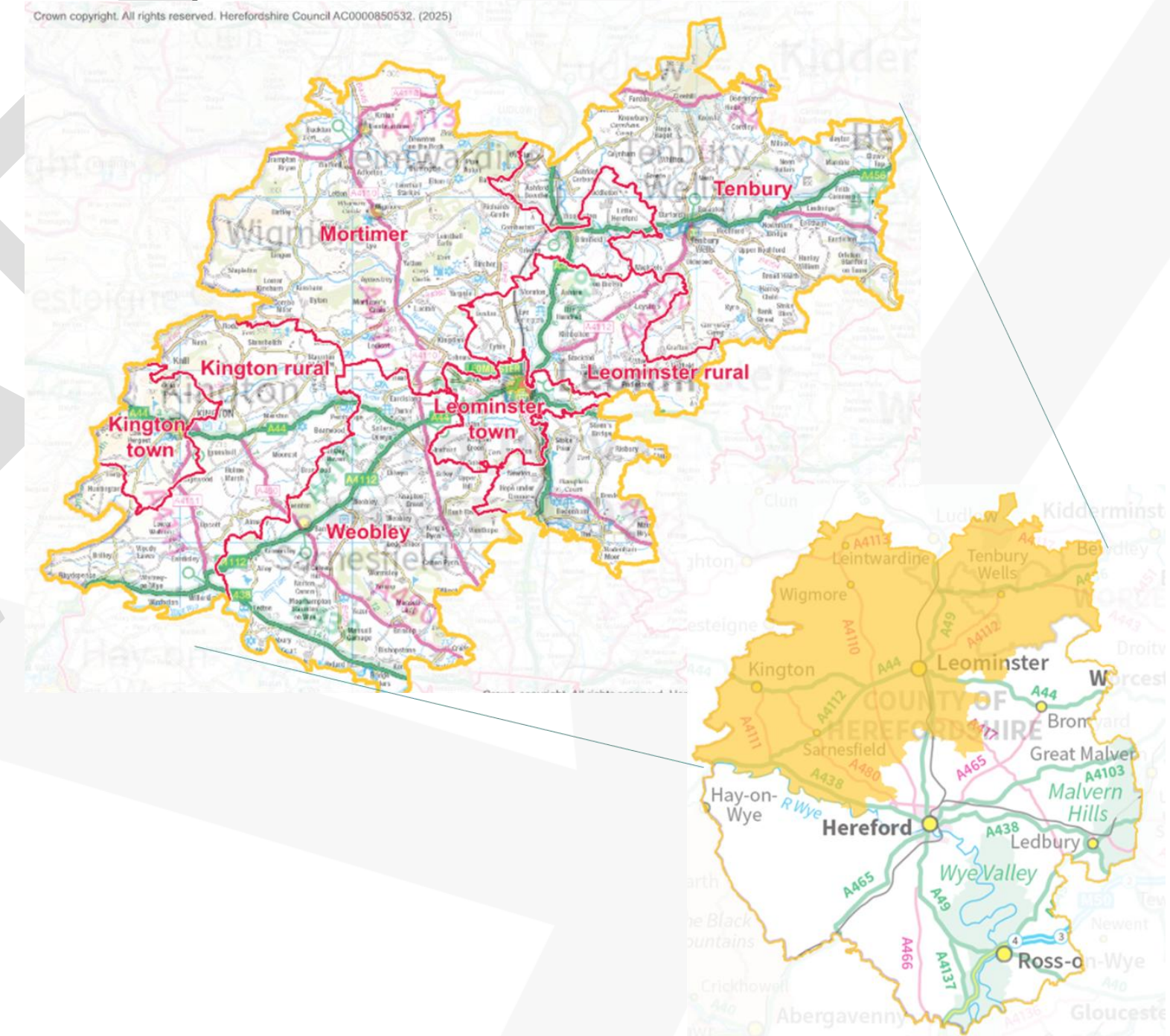
The North and West PCN area is the largest geographically, and is home to 26% of the county's population. There were 52,900 residents in 2024 and a total of 51,800 patients were registered with the five GP practices as of April 2025, although not all will live in the area (and some residents will be registered with other GPs).

North and West Herefordshire's landscape is characterised by rolling, often wooded, hills to the north, which give way to wider, intensively farmed river valleys as you travel west and to the south. The rivers Lugg and Arrow run through this part of Herefordshire, whilst the Teme flows through Tenbury Wells. The Lugg catchment is a Special Area of Conservation, and high phosphate levels in recent years put a hold on all new housing developments.

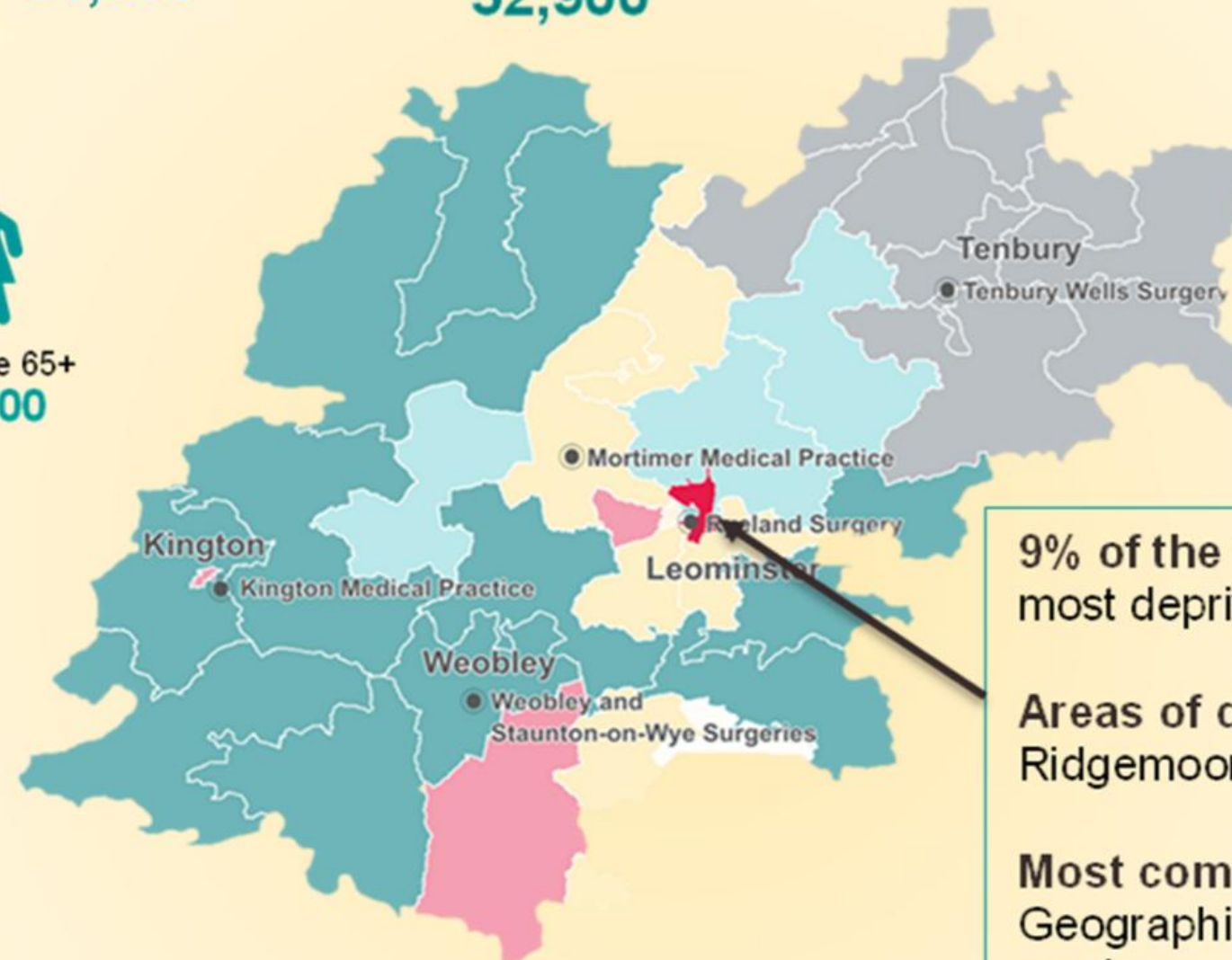
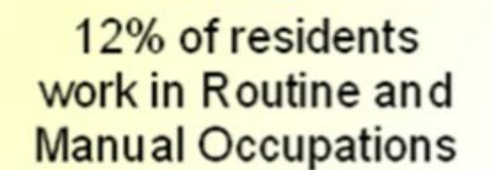
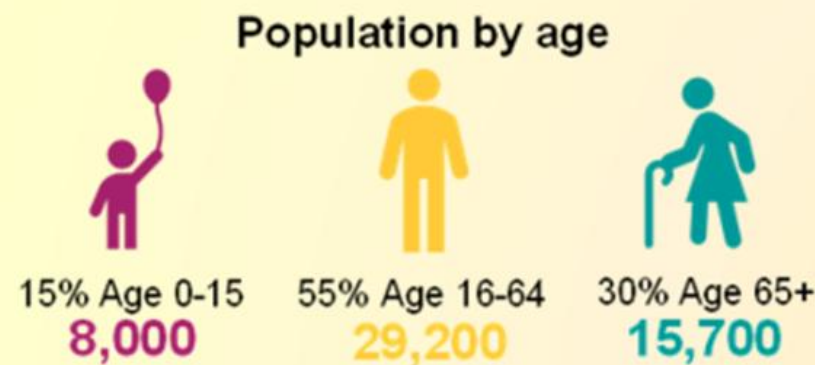
A note on Tenbury

As Tenbury lies outside Herefordshire, some datasets used throughout this profile are unavailable at locality level. Whilst Tenbury is included wherever possible, evidence is more comprehensive for the Herefordshire localities within the PCN.

Figure 2: Map of North and West Herefordshire, complete with localities in comparison to the county



PCN at a glance



9% of the population live in the 20% most deprived areas in England.

Areas of deprivation: Leominster Ridgemoor, Grange & Gateway

Most common deprivation is Geographical barriers to housing and services.



392 square miles



96% green space

Key geographical features:



Rivers Lugg & Arrow



Mortimer Forest



Bodenham Lakes Nature Reserve

Understanding North and West: insights for decision-makers

The North & West neighbourhood profile contains a wide range of information on the area's population, health and wellbeing, wider determinants of health and community characteristics. The insights below summarise the most important themes emerging from the profile. They are intended to help readers understand the story of the area and identify the factors most likely to influence future population wellbeing and demand for services.

Patterns of need, outcomes and service demand vary considerably across North & West Herefordshire. Understanding these local differences is essential for effective planning and commissioning. Note that the evidence available for Tenbury is more limited than for other parts of the PCN area because the locality sits outside Herefordshire administrative boundaries.

1. A predominantly rural and ageing area, with modest population growth concentrated in market towns such as Tenbury Wells and Leominster

North & West is the county's most rural area and in common with the rest of the county has an older population profile than England. Together, rurality, ageing and modest town-led growth provide the overall context for demand for and access to services.

- North and West has the lowest population density in Herefordshire, and 79% of its 53,000 residents live in rural areas.
- 31% of residents are aged 65 or over, compared with 27% in Herefordshire overall; the oldest age profiles are seen in Tenbury Wells and rural localities.
- The population grew by 2% over the last decade, mostly in the market towns with Tenbury Wells having the highest growth, followed by Leominster.

2. Leominster, Kington and the rural hinterland experience different forms of need

Around a quarter of North and West residents (12,000) live in Leominster which has a younger, more diverse age profile than surrounding rural areas. Whilst overall, multiple deprivation is generally low across the PCN, long-standing pockets are present in Kington and the three Leominster areas of Ridgemoor, Grange and Gateway. Deprivation in rural areas is more commonly associated with access to housing and services.

- Ridgemoor, Grange and Gateway are amongst the 20% most deprived neighbourhoods in England in terms of overall multiple deprivation; Ridgemoor is *the* most deprived area in Herefordshire and among the 10% most deprived nationally.
- Ridgemoor and Gateway have younger populations and higher levels of child and family need, whilst Grange has a larger working-age population, higher levels of private renting and different patterns of disadvantage – including a particularly high risk of digital exclusion due to skills.
- With 3,200 residents, Kington is the smallest and most remote of Herefordshire's five market towns. In common with the others, its town centre (Kington Central) is amongst the 20% most deprived areas of the county.
- In contrast, many rural areas experience place-based deprivation, particularly around housing, transport and access to services.

These patterns highlight three distinct experiences within the PCN: concentrated but not homogeneous deprivation in parts of Leominster, a more localised pocket of need in Kington, and widespread rural challenges relating to access, transport and services.

3. Overall, health outcomes are comparable to the county, but mask large inequalities within the area

Overall health outcomes across North and West are similar to or better than Herefordshire averages, reflecting relatively good health in many rural communities. However, areas of Leominster experience significantly poorer outcomes:

- Male life expectancy in South Leominster (Gateway and Grange) is almost four years lower than the county overall (75.6 years compared to 79.9).
- Mortality rates in the most deprived neighbourhoods are around 70% higher than in the least deprived areas, compared with around 40% across Herefordshire overall.
- Emergency hospital admissions are more common in Leominster Gateway, Ridgemoor, Grange and Kington Central, reflecting a wider geography of unmet need than deprivation measures alone might suggest.
- Long-term sickness, disability and Personal Independence Payment (PIP) claims are also concentrated in the most deprived neighbourhoods, with Ridgemoor having the highest number of PIP claimants.

4. Need among children, families and working-age adults is concentrated within the most deprived neighbourhoods, reflecting overlapping and intergenerational disadvantage

- Ten North and West areas - around one third of all those identified across Herefordshire - have significantly higher rates of need among children under five. The highest levels of need are in Leominster Ridgemoor, Grange and Gateway where multiple indicators are elevated including Children in Need, Early Help, Free School Meals and SEND.
- Overall SEND prevalence is highest in Leominster Ridgemoor and Greater Weobley.
- Economic activity rates are similar to the county overall but:
 - The rate of people claiming out of work benefits in Leominster East Ward is consistently among the highest in the county.

- Economic inactivity due to ill-health or disability is concentrated in the most deprived areas.

5. Housing and fuel poverty shape everyday living conditions

Several cross-cutting factors shape living conditions across North and West:

- Housing stock is more likely to be older, off the gas network and less energy efficient than nationally.
- Higher levels of excess cold hazards and some of the highest fuel poverty levels in the county
 - Clear rural-urban divide in fuel poverty across the area, with the highest levels of fuel poverty concentrated in the rural sub-localities of Mortimer, Weobley and Kington (both town and rural) and the surrounding rural area of Leominster.
 - Leominster Ridgemoor has higher rates of households with no central heating.

6. Along with the rest of Herefordshire, North and West has strong community cohesion but people are less likely to feel safe after dark, with crime an issue in areas of Leominster and Kington

Adults living in North & West Herefordshire are strongly attached to their local area, with the highest levels of satisfaction with their area as a place to live in the county. However, there are some challenges which signal areas for preventative and community-based action:

- Around one in five residents report feeling lonely some or all of the time.
- Feelings of safety after dark are significantly lower than the county average. Alongside Hereford City, North and West has significantly lower levels of feeling safe after dark (69%) than East and South and West (both <80%).
- Several neighbourhoods in both Leominster and Kington are amongst the most deprived in the county for crime, contributing to lower perceptions of safety than might typically be expected in an otherwise largely rural area.

Areas of deprivation

Health inequalities are unfair and avoidable differences in health outcomes caused by the differing conditions in which people grow, live, work and age. One important driver is living in areas of deprivation. The Indices of Deprivation measure small areas across seven domains - income, employment, education, health, crime, housing and services, and the living environment - to create the overall Index of Multiple Deprivation (IMD).

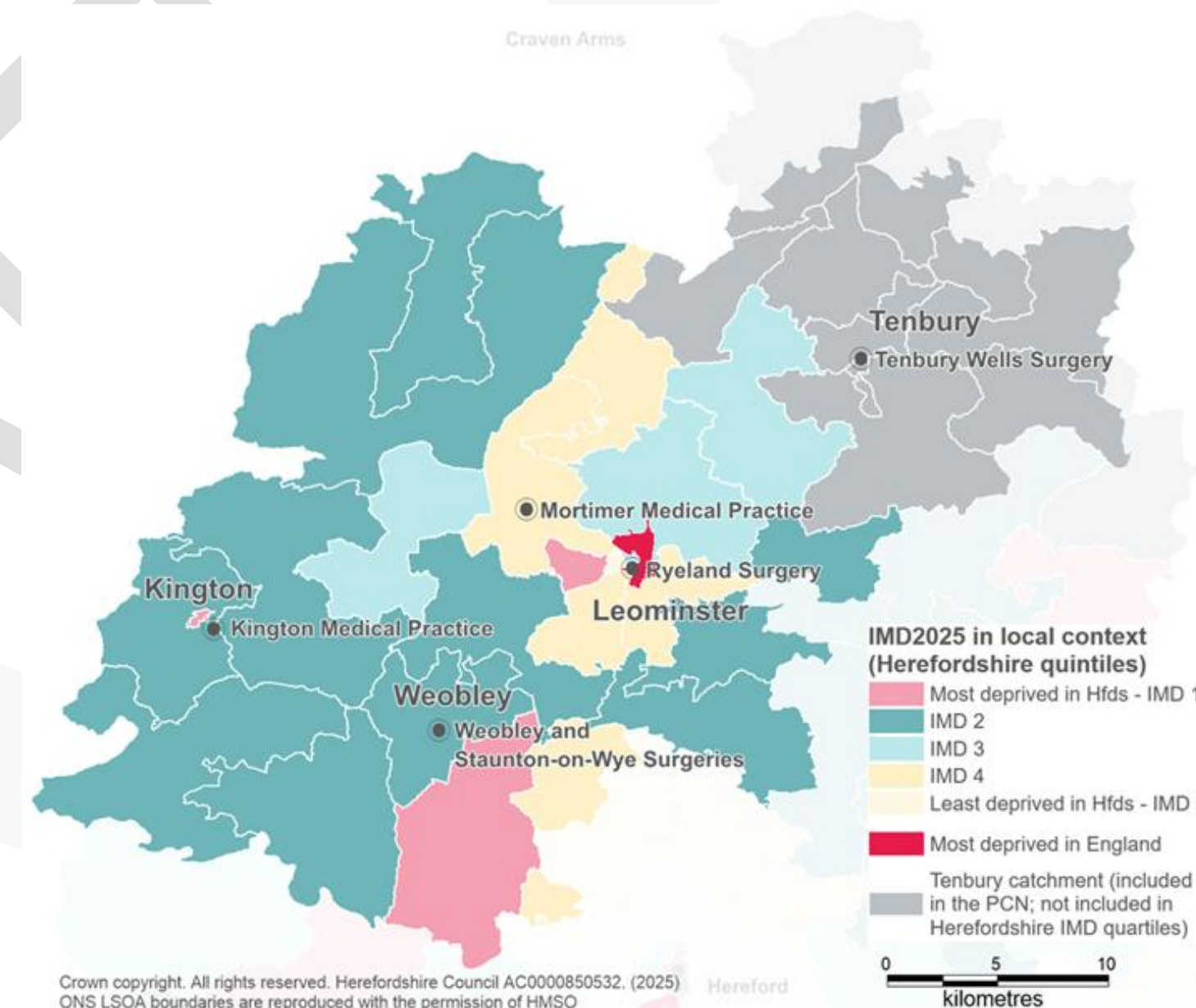
Overall, Herefordshire experiences average levels of multiple deprivation, but there are persistent pockets, mainly in the city and market towns. This includes Leominster's Ridgemoor, Grange and Gateway neighbourhoods, which were **three of only nine** county areas amongst the 20% most deprived in England in the 2025 IMD. Ridgemoor was *the* most deprived area of the county, and the only one amongst the 'top 10%' in England.

Three other areas of North & West were also amongst Herefordshire's 20% most deprived (IMD1): Leominster Barons Cross, Kington Central and Greater Foxley.

Individual types of deprivation are covered in relevant sections of this profile, but to summarise:

- Urban areas tend to be more deprived on the people-based measures of deprivation. In North & West, Leominster's Ridgemoor, Grange, Gateway and Barons Cross fall within the 20% most deprived in the county for income, employment, health and disability, education and skills and crime. Ridgemoor was the most deprived area of the county on income, employment and education and skills.
- Rural areas tend to be more likely to experience place-based deprivation; over half of the LSOAs in this PCN, inclusive of Tenbury, are amongst the 10% most deprived in England for geographical barriers to housing and services and the living environment. Lindridge and Baldrigde fall within the 10% most deprived for living environment and barriers to services, whilst Greater Docklow, Aymestrey Horseshoe, Tollbridge, Knillshall, Middleton, Greater Foxley, Tin Hill and Eardishill fall within the 20% most deprived in the county.

Figure 3: Map of overall local deprivation in 2025 across North and West Herefordshire



Deprivation scores for GP practices are included in OHID's [National General Practice Profiles on Fingertips](#).

Focus on areas of deprivation: Leominster Ridgemoor, Grange and Gateway

The adjoining neighbourhoods of Leominster Ridgemoor, Gateway and Grange constitute a concentrated cluster of deprivation within the North and West PCN. The 4,700 residents of these areas are some of the most likely in Herefordshire to experience multiple forms of deprivation, especially across people-based measures. However, because they live in a market town, they are comparatively less deprived in relation to geographical barriers to housing and access to services.

Leominster Ridgemoor ranks as the most deprived neighbourhood in the county, followed by Grange as the second, and Gateway as the seventh.

A **quarter** of North and West's residents live in Herefordshire's 10% most deprived neighbourhoods. Half (51%) of the residents of Ridgemoor live in income deprivation, as does over a third of residents of Gateway (40%) and Grange (36%). Almost all residents (95%) are registered with Ryeland's GP surgery.

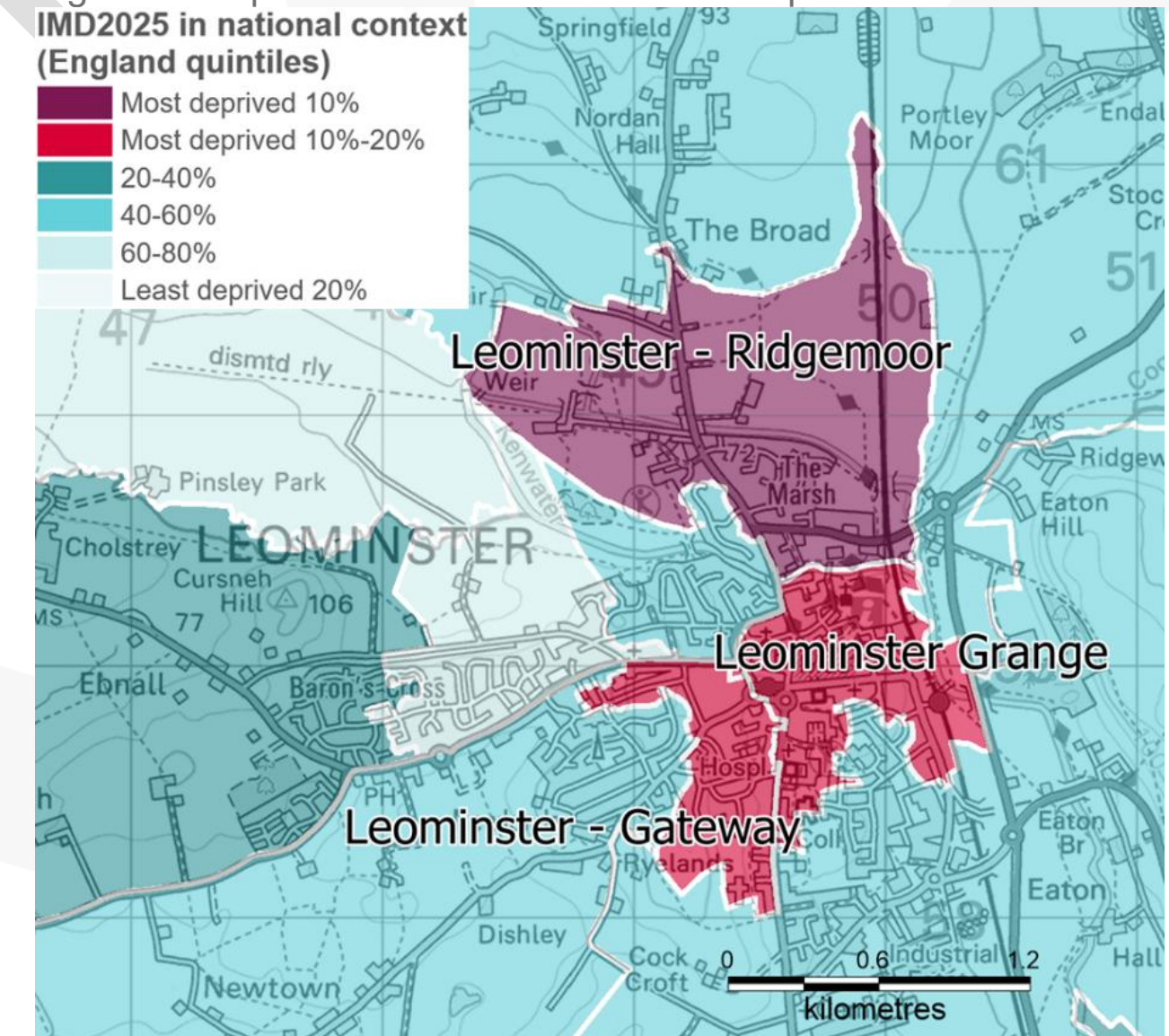
Ridgemoor and Gateway have relatively young populations, with notably high numbers of children and high proportions of lone parents. In contrast, Grange has a high proportion of working aged, particularly middle-aged residents.

Other observations include:

- Higher levels of people with a disability significant enough to need help with daily living that meets the threshold for benefits such as PIP, attendance allowance and disability living allowance.
- Higher levels of people with low income who meet the threshold for benefits such as housing, pension credit and universal credit.
- Higher levels of people who are unemployed and claiming out-of-work benefits, alongside high levels of people with no formal qualifications and high levels working in routine occupations.
- Higher levels of renting - particularly social renting in Ridgemoor and Gateway. Private renting is more common in Grange, where there are also a large number of houses of multiple occupation in comparison to the county.
- High rates of emergency hospital admissions
- High rates of under 5s identified as Children in Need, and of families needing Early Help intervention with Gateway and Grange having high rates of children under 5 eligible for Free School Meals.
- Ridgemoor has a high proportion of children and young people recorded as having special educational needs and disabilities (SEND)

- Grange is most at risk for digital exclusion with both Grange and Ridgemoor identified as being highest risk for 'digital deprivation', with Gateway seventh.

Figure 4: Map of Leominster's three most deprived areas
IMD2025 in national context (England quintiles)



Data source: [Indices of deprivation 2025](#)



**Understanding
Herefordshire**
People and places

South and West Herefordshire Neighbourhood Profile Summary

Herefordshire Council Evidence and Insight Team
July 2026

DRAFT

Version 0.04 - Short



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1. Introduction

About the neighbourhood profiles

This profile aims to provide key insights into those living under the South and West Herefordshire Primary Care Network (PCN) area. By highlighting key differences between localities and neighbourhoods within the area on a variety of topics such as population, health and wellbeing, mortality and the wider determinants of health, areas with high concentrations of deprivation and poorer outcomes can be identified. This can then inform effective commissioning and place-based, targeted planning.

A rate that is relatively high or low in a local context may not have the same interpretation when compared elsewhere in the country. To remain focused on highlighting key differences across the PCN area, a statement about every dataset analysed is not provided.

Links to data sources used to create this neighbourhood profile are located throughout the document and key sources are provided in the appendix. For a full list of sources that have informed these key findings and further explanatory notes, please see the glossary of information.

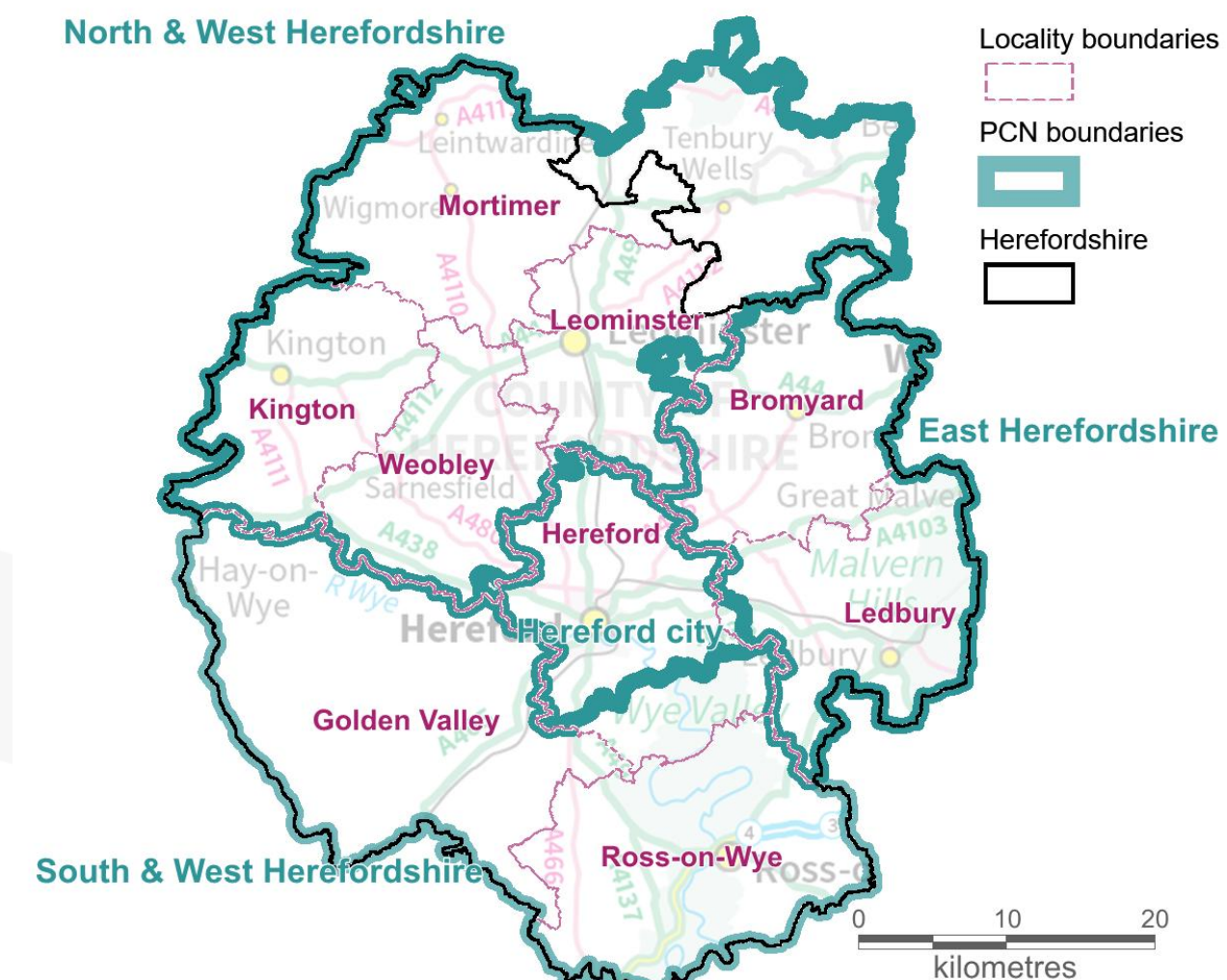
How have we defined a neighbourhood?

‘Neighbourhoods’ can be defined in different ways i.e. PCN, a Lower Super Output Areas (LSOA) or ward. In this profile, a ‘neighbourhood’ refers to localities within a PCN. This includes capturing data on the residents who live in each PCN area and the patients who are registered with the General Practitioners (GPs) in the PCN.

Both are captured because the data between the two can differ. For example, most health statistics are based on patients who are registered with a GP surgery in the county, which may differ or not relate to their ‘usual residence’, where people are counted at their family home.

The boundaries used in this neighbourhood profile may differ to those used elsewhere. The South and West PCN boundary is represented below, complete with the localities situated within this area.

Figure 1: Boundary map of Herefordshire showing PCN and locality boundaries



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2. South and West Herefordshire PCN Area: overview

The South and West Herefordshire PCN area encompasses the two distinct localities of Ross (town and rural) and the rural locality of Golden Valley. As a result, the area combines one of Herefordshire's best-connected locations with some of its least accessible communities.

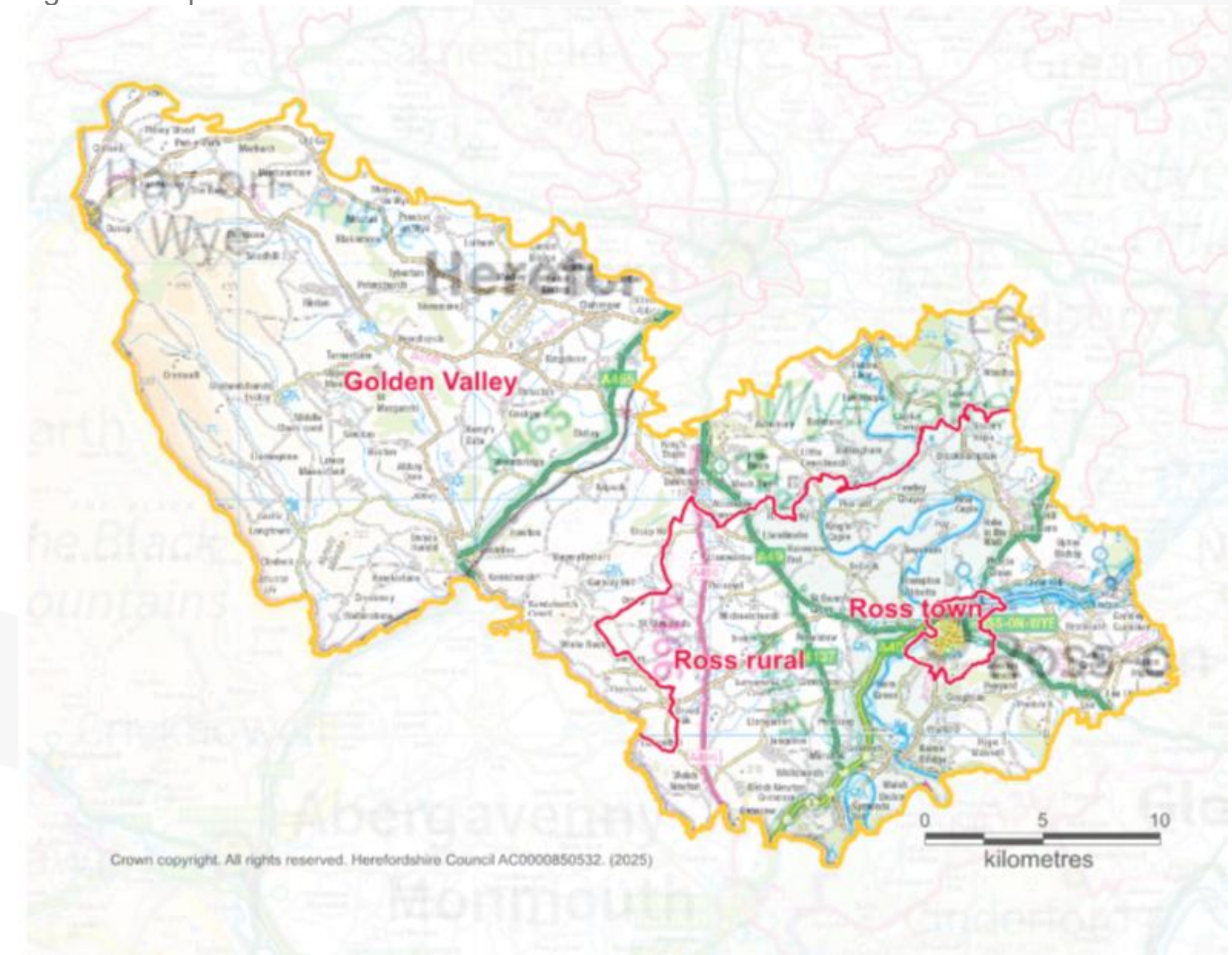
Six GP practices make up the South and West Herefordshire PCN: Alton Street Surgery, Fownhope Medical Centre, Golden Valley Practice, Much Birch Surgery, Pendeen Surgery and The Surgery Kingstone.

There were 41,700 residents in 2024 and a total of 43,900 patients were registered across the six GP practices as of April 2025, although not all will live in the area (and some residents will be registered with other GPs). The PCN area is home to 21% of the county's population.

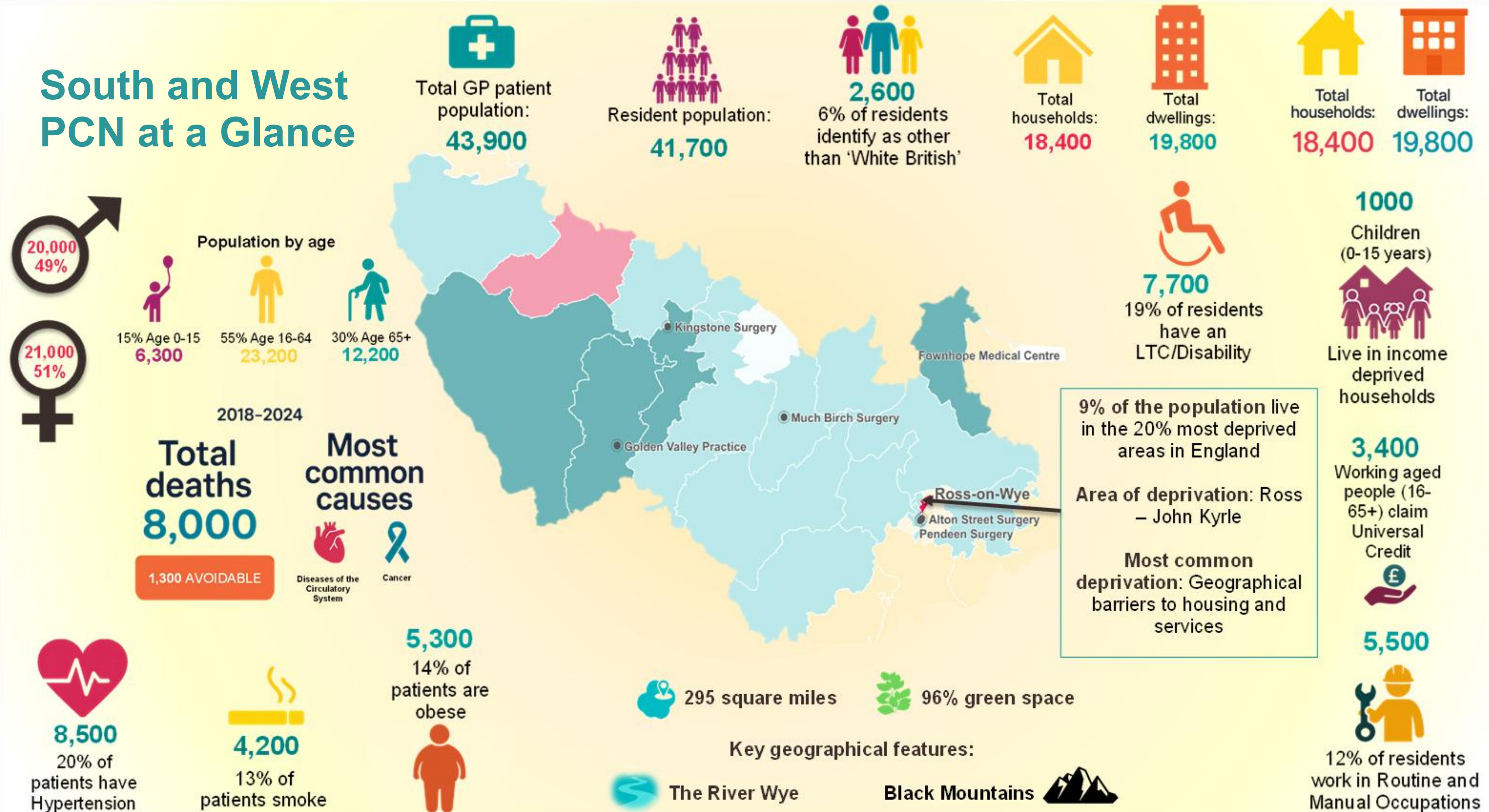
With 11,400 residents, Ross-on-Wye is Herefordshire's second largest market town, and local services are concentrated here. Located at the intersection of the M50 and A40, it is the only part of Herefordshire with direct access to the motorway network and acts as a key service hub for much of the surrounding area.

South and West Herefordshire's landscape is characterised by high moorlands in the Black Mountains to the west, which move into intensively farmed land and pastures as you travel south and east into the Golden Valley locality. Unlike Ross-on-Wye and its surrounding hinterland, Golden Valley is physically distinct and characterised by dispersed villages, hamlets and isolated dwellings linked primarily by a network of minor roads. Moving further East towards Ross-on-Wye, the landscape changes to narrow and meandering floodplains and undulating farmlands, stopping at the Forest of Dean, south of Ross-on-Wye, where the South and West Herefordshire Boundary ends. South and West contains one of Herefordshire's two areas of outstanding natural beauty which much of the Ross-on-Wye locality falls within. The river Wye also runs through the northern boundary of the Golden Valley locality, before leaving the county south of Ross-on-Wye town. The River Wye is a Site of Special Scientific Interest.

Figure 2: Map of South and West Herefordshire and the localities within it



South and West PCN at a Glance



Understanding South and West: insights for decision-makers

The South & West neighbourhood profile contains a wide range of information on the area's population, health and wellbeing, wider determinants of health and community characteristics. The insights below summarise the most important themes emerging from the profile. They are intended to help readers understand the story of the area and identify the factors most likely to influence future population wellbeing and demand for services.

1. One area, three realities: a well-connected market town, its rural hinterland and some of the county's most remote places

Home to 43,200 residents in 2024, South and West Herefordshire is the most geographically diverse of the county's four PCN areas. It contains one of the best-connected places and some of its least accessible communities. More than two-thirds of residents (68%) live in sparsely populated rural areas.

Sitting at the intersection of the M50 and A40, Ross-on-Wye is the only part of Herefordshire with direct access to the motorway network. As the county's second largest market town (11,400 residents), it is the principal service hub for much of the area, particularly its rural hinterland.

In contrast, and not directly connected to Ross by an A road, the Golden Valley locality is physically distinct. Extending some 20-25 miles westwards to the Black Mountains on the Welsh border, it is characterised by dispersed villages, hamlets and isolated dwellings reliant on a network of minor roads.

These differences in geography and connectivity are a defining feature of the area and help shape residents' experiences of everyday life.

2. A growing population with changing need

South & West experienced the fastest population growth of any Herefordshire PCN over the last decade, with much of this associated with housing development in and around Ross-on-Wye. Future growth is expected to continue, with almost a third of the county's outstanding housing commitments located within the area. Notably, around half of these future commitments are within the Golden Valley locality.

At the same time, the area's population profile has become older, with residents aged 65 and over accounting for most of the increase over the last decade. Together, these trends are likely to influence future demand for housing, health and care services.

3. Different forms of inequality: urban deprivation in Ross contrasts with access barriers for rural communities

Ross-on-Wye contains the area's most concentrated pockets of socioeconomic deprivation, particularly Ross—John Kyrle, where poorer outcomes are seen across health, employment, education, skills and crime.

In contrast, many of the more dispersed rural communities experience some of the highest levels of deprivation in Herefordshire relating to access to housing and services.

A different pattern is seen in larger villages such as Kingstone and Clehonger, which have younger population profiles and higher levels of need among children and families than are typically seen elsewhere in the PCN.

Together, these contrasting patterns highlight that need presents in different ways across South & West and is not always captured by overall measures of deprivation.

4. Housing stands out as a significant challenge

Despite high levels of home ownership, South & West has some of the poorest housing condition indicators in Herefordshire. The area has the county's highest levels of overall housing hazards, with excess cold representing a particular concern, alongside joint-highest levels of falls hazards.

Housing challenges affect both urban and rural communities. However, lower access to mains gas, greater reliance on oil heating, higher levels of fuel poverty and relatively high deprivation related to indoor living environments are particularly evident in some rural parts of the area, especially Golden Valley.

5. Good overall health outcomes and variations in health need

South & West performs well across a range of health indicators, with lower smoking prevalence, lower obesity levels and lower rates of avoidable mortality than Herefordshire overall. Life expectancy is generally comparable with, or better than, county averages.

However, these positive outcomes are not experienced equally across the area. Ross—John Kyrle – South & West's most deprived area - experiences some of the greatest health inequalities, with higher rates of emergency hospital admissions and disability-related benefit claims. It is the only area in South & West ranked amongst the 20% most deprived nationally for health and disability.

Long-term conditions are common amongst PCN patients and diagnosed prevalence of several important conditions, including diabetes, hypertension and heart failure, has increased in recent years. Together with demographic change, this is likely to influence future demand for health and care services.

6. Strong social connections and environmental assets are important local strengths

South & West benefits from strong social connections and community cohesion. Overall satisfaction with the area as a place to live is high. Residents are significantly more likely than the county overall to volunteer, have regular contact with family, friends and neighbours, feel that people from different backgrounds get on well together and to feel safe in their local area.

These social strengths sit alongside an exceptional natural environment, including the Wye Valley National Landscape and Black Mountains, which are defining features of the area. However, many of these environmental assets face increasing pressures from climate change and ecological decline, particularly within the River Wye catchment.

At the same time, some residents experience digital exclusion. Parts of the Golden Valley are the most at risk in Herefordshire in relation to broadband connectivity. In contrast, higher risks in parts of Ross town are associated more closely with demographic and socioeconomic factors.

Areas of deprivation

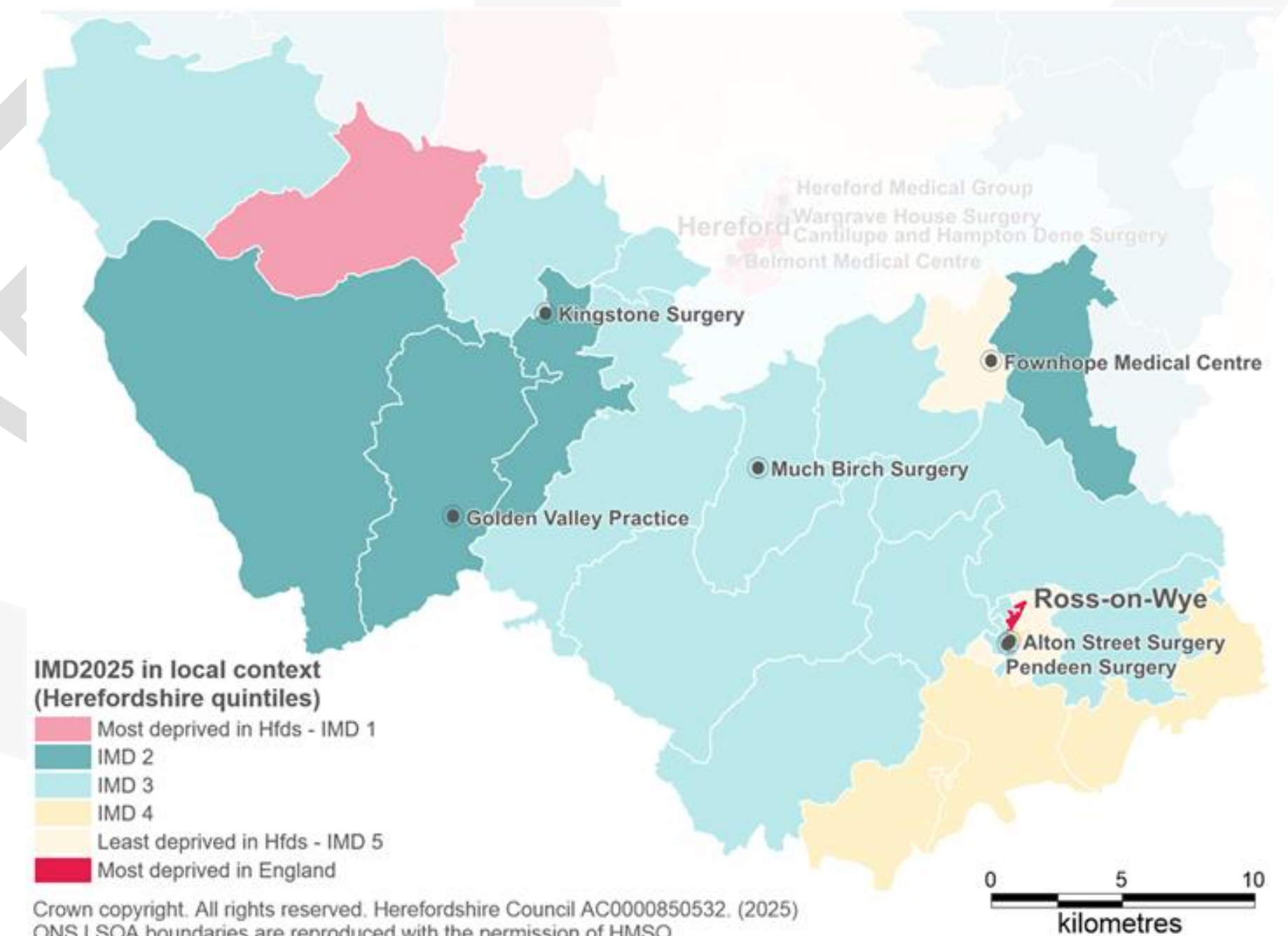
Health inequalities are unfair and avoidable differences in health outcomes caused by the differing conditions in which people grow, live, work and age. One important driver is living in areas of deprivation. The Indices of Deprivation measure small areas across seven domains - income, employment, education, health, crime, housing and services, and the living environment - to create the overall Index of Multiple Deprivation (IMD).

Overall, Herefordshire experiences average levels of multiple deprivation, but pockets persist, mainly in the city and market towns. This includes Ross - John Kyrle which falls within the 20% most deprived in England in the [2025 IMD](#) and within the 10% most deprived locally, sitting as the 8th most deprived area in Herefordshire.

Individual types of deprivation are covered in relevant sections of this profile, but to summarise:

- Urban areas tend to be more deprived on the people-based measures of deprivation. In South & West, Ross - John Kyrle falls within the 10% most deprived in the county for income, employment, health and disability, education, skills and training, and crime.
- Rural areas tend to be more likely to experience place-based deprivation; **five LSOAs** in this PCN area are amongst the 10% most deprived in Herefordshire for geographical barriers to housing and services (Black Mountains, Welsh Corner and Garwaywood) and indoor living environment (Black Mountains, Loughpool and Greater Walford).
- Arthur's Stone and Hole in the Wall fall in the 20% most deprived for geographical barriers to housing and services, whilst Garwaywood, Hole in the Wall, Symonds Yat, Dulas Brook and Arthur's stone fall in the 20% most deprived for indoor living environment.

Figure 3: Map of overall local deprivation in 2025 across South and West Herefordshire



Focus on area of deprivation: Ross - John Kyrle

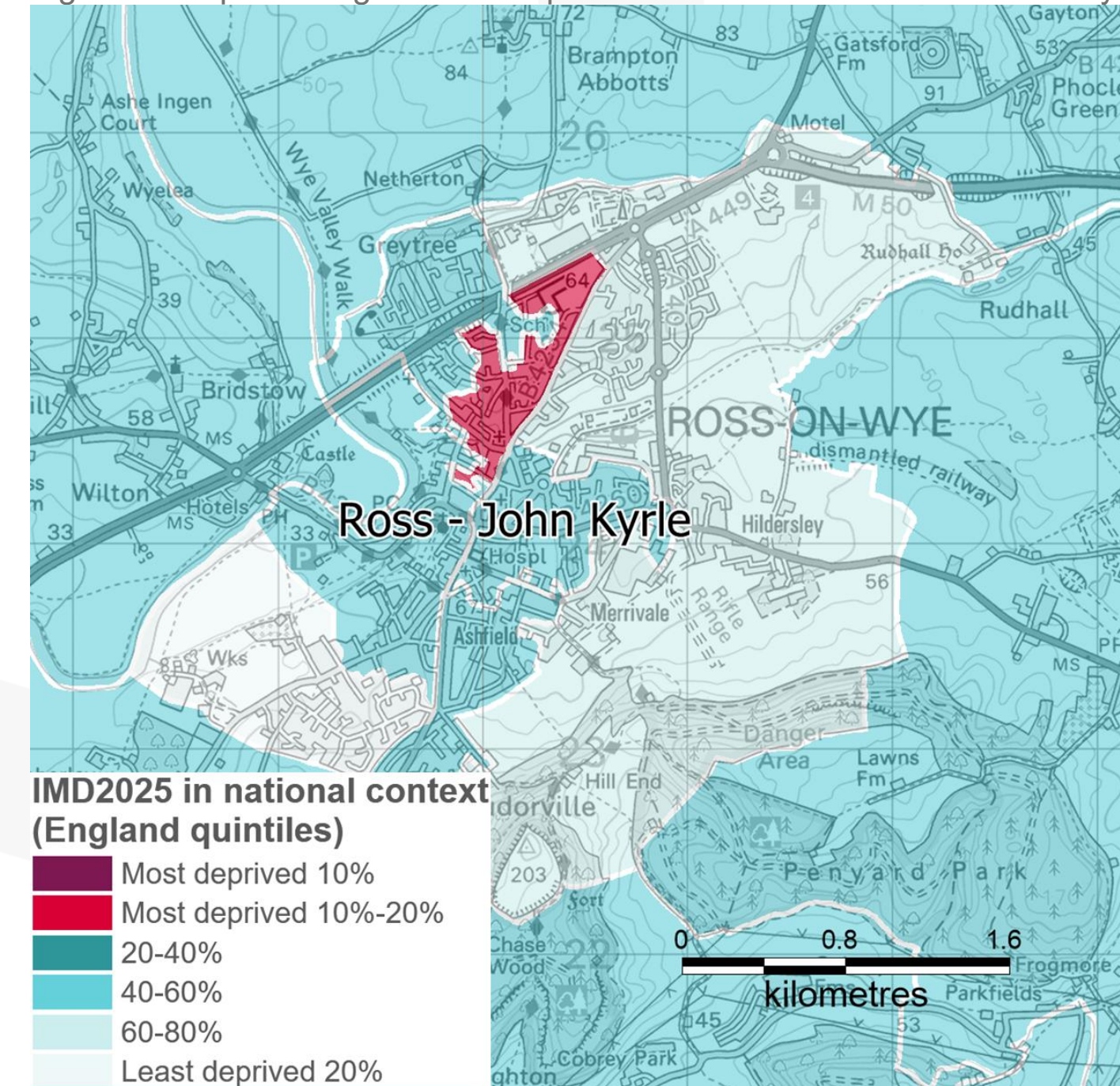
One LSOA in South and West is amongst the nine areas of Herefordshire which fall within the 20% most deprived in England. Ross – John Kyrle is persistently amongst the most deprived areas of the county, being the 8th most deprived area in the 2025 IMD.

The John Kyrle area shows higher levels of deprivation in people-based measures, but lower levels of deprivation in relation to housing access, services, and the living environment. **Around a third** of 1,500 residents across this neighbourhood experience income deprivation; 48% of children under 15 and 22% of older people live in an income deprived household. Most residents are registered at either Pendeen Surgery or Alton Street Surgery.

Other observations include:

- The only LSOA in South and West to be amongst the 10% most deprived on children and young people's education and and adult skills and qualifications
- High emergency hospital admissions for all-cause and respiratory admissions
- Higher rates of under 5's receiving free school meals
- Higher rates of social renting
- Higher proportions of residents in elementary occupations
- Higher rates of unemployment
- High rates of residents claiming Universal credit, housing benefits, and Personal Independence Payments
- High risk for deprivation-related digital exclusion.

Figure 4: Map showing national deprivation levels across Ross - John Kyrle



Data source: [Indices of deprivation 2025](#)



**Understanding
Herefordshire**
People and places

East Herefordshire Neighbourhood Profile Summary

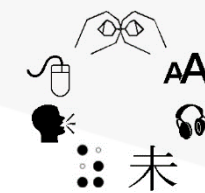
Herefordshire Council Evidence and Insight Team
July 2026

DRAFT

Version 0.03

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1. Introduction

About the neighbourhood profiles

This profile aims to provide key insights into those living under the East Herefordshire Primary Care Network (PCN) area. By highlighting key differences between localities and neighbourhoods within the area on a variety of topics such as population, health and wellbeing, mortality and the wider determinants of health, areas with high concentrations of deprivation and poorer outcomes can be identified. This can then inform effective commissioning and place-based, targeted planning.

A rate that is relatively high or low in a local context may not have the same interpretation when compared elsewhere in the country. To remain focused on highlighting key differences across the PCN area, a statement about every dataset analysed is not provided.

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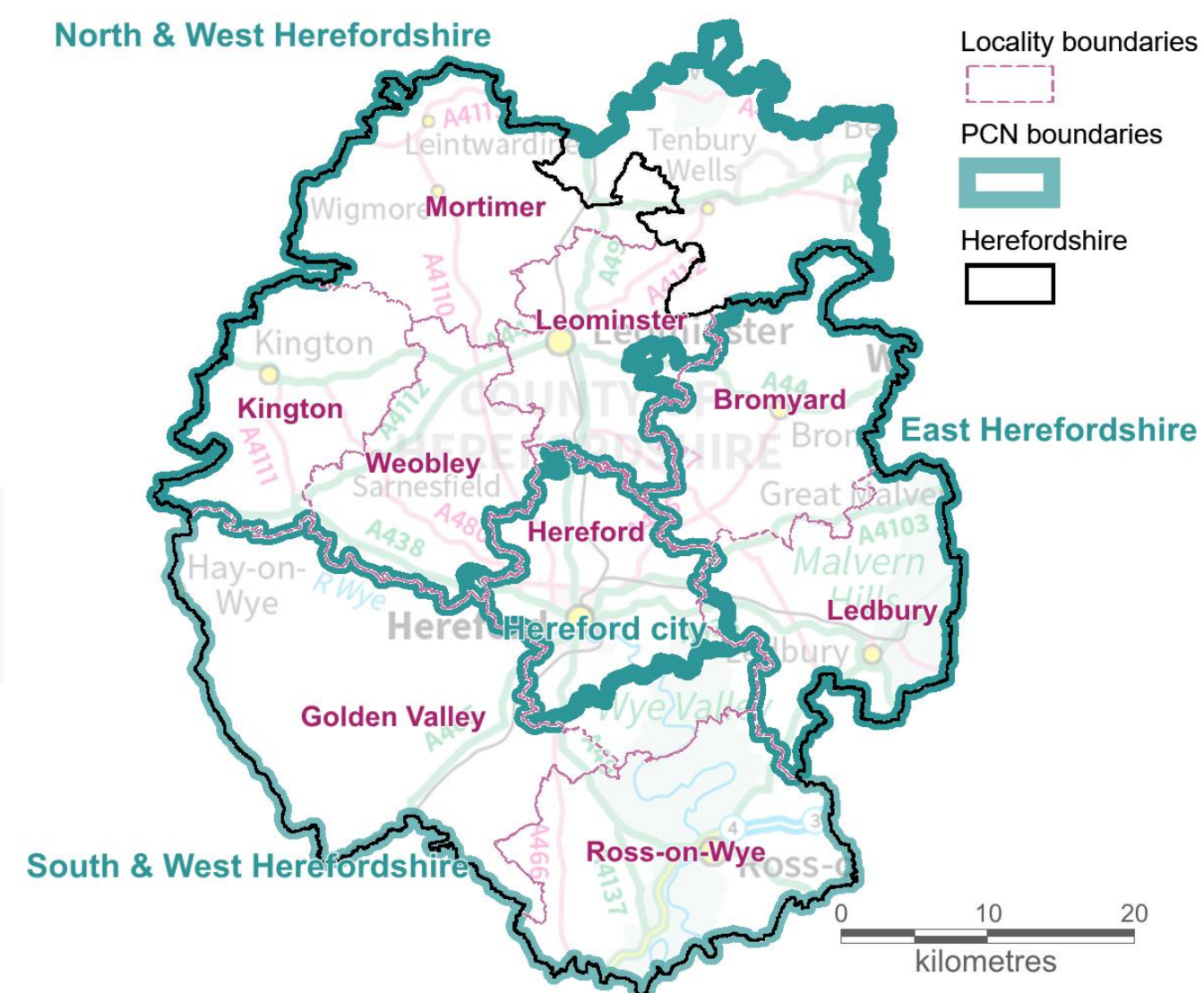
How have we defined a neighbourhood?

'Neighbourhoods' can be defined in different ways i.e. PCN, a Lower Super Output Areas (LSOA) or ward. In this profile, a 'neighbourhood' refers to localities within a PCN area. This includes capturing data on the residents who live in each PCN area and the patients who are registered with the General Practitioners (GPs) that form the PCN.

Both are captured because the data between the two can differ. For example, most health statistics are based on patients who are registered with a GP surgery in the county, which may differ or not relate to their 'usual residence', where people are counted at their family home.

The boundaries used in this neighbourhood profile may differ to those used elsewhere. The East PCN boundary is represented below, complete with the localities situated within this area.

Figure 1: Boundary map of Herefordshire showing PCN and locality boundaries



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2. East Herefordshire PCN Area: overview

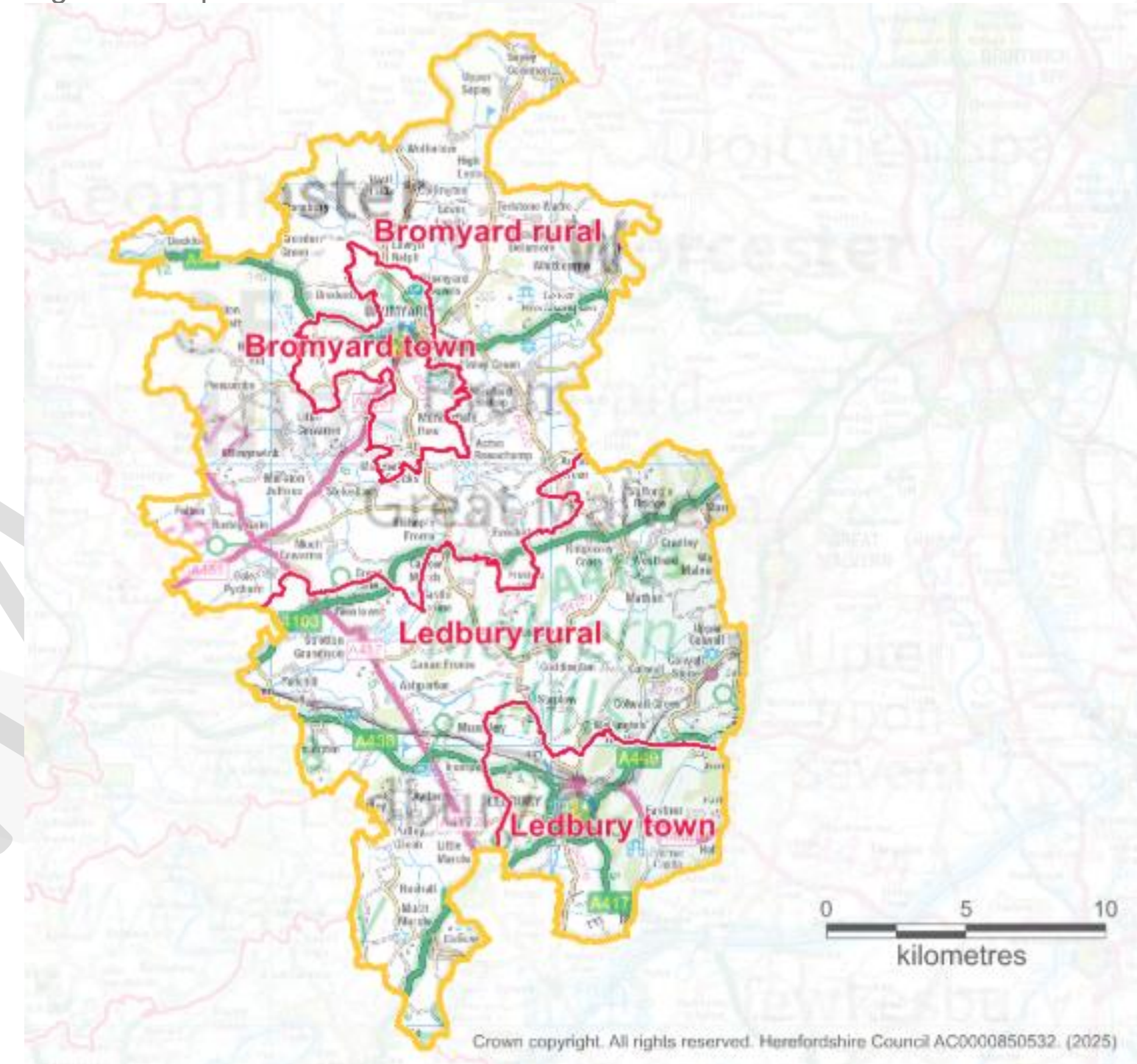
The East Herefordshire PCN area covers 169 square miles of the county bordering Worcestershire and Gloucestershire to the east and south. It encompasses the market towns of Bromyard and Ledbury and their rural hinterlands. Four GP practices comprise the East Herefordshire PCN: Colwall Surgery, Cradley Surgery, Ledbury Health Partnership and Nunwell Surgery.

There were 30,100 residents in 2024 and a total of 29,100 patients were registered with the four GP practices as of April 2025, although not all will live in the area (and some residents will be registered with other GPs).

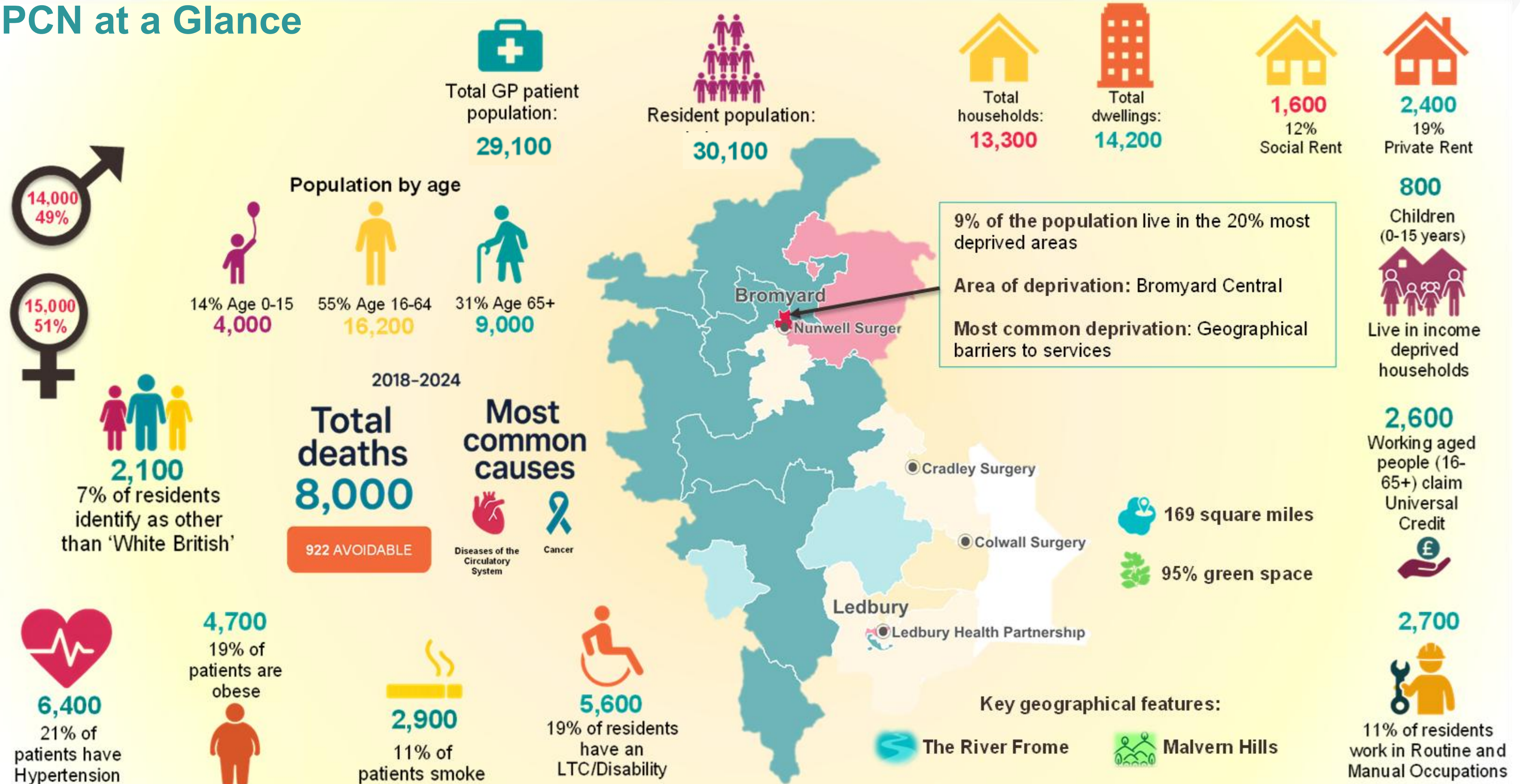
With 9,800 residents, Ledbury is Herefordshire's third largest market town (behind Leominster and Ross) and, with 4,800, Bromyard is the fourth. Colwall and Cradley are two of the county's largest villages. The area is relatively well-connected by road and rail to Hereford and the wider national network, and close to the larger service and cultural hubs of Malvern and Worcester.

The Malvern Hills National Landscape is one of East Herefordshire's most distinctive landscape features, forming much of the area's south-eastern boundary with Worcestershire. Its dramatic ridgeline, traditional orchards, ancient woodlands, commons and farmland create a varied and nationally important landscape that supports wildlife, recreation and wellbeing. The area is valued for its natural beauty, cultural heritage and tranquillity, contributing significantly to East Herefordshire's identity and visitor appeal. In the north of the area, the Bromyard Downs provide an important local landscape feature, while the area's network of river valleys, including the Frome and Lodon, help shape its distinctive agricultural landscape.

Figure 2: Map of North and West Herefordshire PCN area and its localities



PCN at a Glance



Understanding East: insights for decision-makers

The East neighbourhood profile contains a wide range of information on the area's population, health and wellbeing, wider determinants of health and community characteristics. The insights below summarise the most important themes emerging from the profile. They are intended to help readers understand the story of the area and identify the factors most likely to influence future population wellbeing and demand for services.

1. A largely rural area anchored around two very different market towns

East Herefordshire contains two of the county's five market towns, Ledbury and Bromyard, which together are home to almost half of the area's 30,100 residents. Ledbury is the larger of the two, with 9,800 residents in 2024 (33%) compared to Bromyard's 4,800 (16%). Whilst they differ in size and patterns of need, each plays an important role as a service hub for its surrounding rural communities.

The area's geography is equally varied. The Malvern Hills National Landscape forms much of the area's south-eastern boundary with Worcestershire, near the large villages of Colwall and Cradley. In contrast, the Bromyard Downs and wider farming landscape contribute to a more dispersed and rural character in the north of the PCN area.

2. Strong connections and generally positive outcomes

East Herefordshire generally experiences favourable health and wellbeing outcomes, with relatively few deprived communities compared with some other parts of the county.

Adults are more likely to report good health here than in either North and West or Hereford City PCN areas. Life expectancy is equal to or better than the county overall, with particularly good outcomes in the Ledbury and Fownhope, Tarrington and Marcle areas. Overall mortality and avoidable mortality rates are lower than the county average, as are rates of smoking and obesity.

Several A roads connect the area with nearby towns and the M50, which together with rail stations at Ledbury and Colwall (two of only four in the county) gives residents particularly good access to employment, education and services compared with much of the rest of Herefordshire. Around 31% of workers travel more than 10 kilometres to work compared with 24% for the county overall, reflecting access to employment opportunities beyond the immediate area.

3. An ageing population is reshaping future needs

Despite significant housing development, overall population growth in East Herefordshire has been relatively modest at around 3% over the past decade. Demographic change has instead been driven increasingly by an ageing population. This is reflected in the fact that population growth has been greater in Bromyard than Ledbury despite a greater increase in housing development around Ledbury.

All areas of East Herefordshire have seen an increase in older residents alongside declines in working-age populations, and in children and young people in most. The population aged 65 and over grew by 46% in Bromyard Rural and 29% in Ledbury Rural. One in six households across the area consists of an older person aged over 65 living alone, highlighting the importance of preventing isolation and supporting independent living.

4. Significant inequalities are hidden within generally positive outcomes

Although East Herefordshire generally experiences good outcomes, a small number of communities experience deprivation and poorer outcomes. Bromyard Central is one of the nine Herefordshire areas amongst the 20% most deprived in England, and is the only area in East Herefordshire among the county's most deprived for health and disability. Ledbury Central and Bromyard Downs are also among the 20% most deprived areas in Herefordshire.

Bromyard Central and Ledbury Central experience higher rates of emergency hospital admissions for all causes, and cardiovascular disease specifically. Both, along with Ledbury Ring Road and Greater Mathon, also experience higher levels of need amongst young children and families, suggesting greater demand for early support and intervention services.

Area-wide averages can therefore mask important differences between communities, with some areas experiencing distinct patterns of need that are not fully explained by multiple deprivation alone.

5. Strong communities and quality of life are key local strengths

East Herefordshire benefits from strong community networks, high levels of resident satisfaction and a strong sense of belonging. These strengths provide an important foundation for health, wellbeing and resilience.

- 90% of adults are satisfied with their local area as a place to live, the highest level among Herefordshire's four PCN areas.
- People are more likely to feel a sense of belonging (88%) compared to those living in Hereford City (80%).
- Almost 90% believe people from different backgrounds get on well together.
- People are more likely to provide unpaid help to others: 46% of adults compared to only a third in Hereford City.
- Around 80% of residents feel safe in their area after dark, the highest proportion in the county.
- East is the only one of Herefordshire's 4 PCN areas where no areas are amongst the 20% highest in England for deprivation related to crime – although Bromyard and Ledbury Central are among the 20% most deprived in Herefordshire.

Areas of deprivation

Health inequalities are unfair and avoidable differences in health outcomes caused by the differing conditions in which people grow, live, work and age. One important driver is living in areas of deprivation. The Indices of Deprivation measure small areas across seven domains - income, employment, education, health, crime, housing and services, and the living environment - to create the overall Index of Multiple Deprivation (IMD).

Overall, Herefordshire experiences average levels of multiple deprivation, but pockets persist, mainly in the city and market towns. The East Herefordshire PCN area has a mixed picture of deprivation, with eight of the area's 19 LSOAs being amongst the 50% least deprived in England, one (Ledbury – New Mills) is amongst the 20% least deprived. Only Bromyard Central was amongst the 20% most deprived LSOAs in England in the [2025 IMD](#).

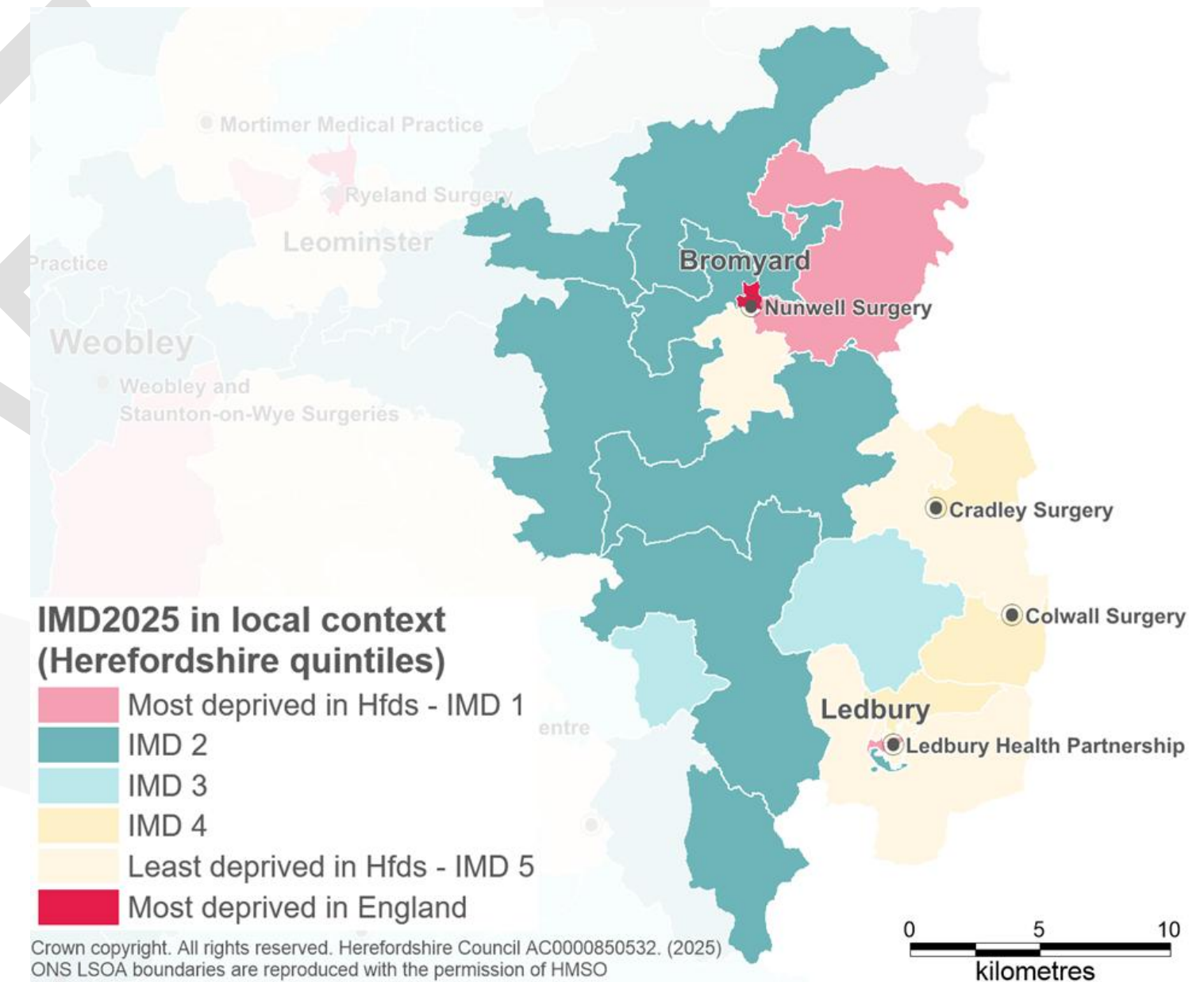
In a local context, Bromyard Central is one of the 10% most deprived areas in Herefordshire, whilst Ledbury Central and Bromyard Downs are among the 20% most deprived.

Individual types of deprivation are covered in relevant sections of this profile, but to summarise:

- Bromyard Central is among the 10% most deprived areas in the county for income and employment, as well as in the adult skills and outdoor living environment sub-domains. The area also falls within the 20% most deprived for health and disability, crime, and education (children and young people).
- Other parts of the market towns also experience people-based deprivation. Ledbury Central, Ledbury Ring Road, and Bromyard Rural fall within the 20% most deprived locally for income, education, and employment. Ledbury Central also falls within the 20% most deprived for the crime domain.
- Rural areas in the East PCN area tend to experience more place-based deprivation. Burley Gate, Trumpet, The Slip, Frome's Hill, Bredensapey, and

Bromyard Downs all fall within the 20% most deprived in Herefordshire for the Barriers to Housing and Services and Indoor Living Environment domains.

Figure 3: Map of overall local deprivation in 2025 across East Herefordshire



Data source: [Indices of deprivation 2025](#). Deprivation scores for GP practices are included in OHID's [National General Practice Profiles on Fingertips](#).

Focus on areas of deprivation: Bromyard Central

Bromyard Central is the most deprived area in East Herefordshire PCN area according to the Index of Multiple Deprivation 2025. This means that the 1,700 people living in this area are relatively more likely to experience multiple forms of deprivation, especially across people-based deprivation measures including income, employment, education, health and disability and crime.

Bromyard central is one of the nine areas of Herefordshire that fall within the 20% most deprived in England (also known as the NHS Core20 areas). It is the only area of East to do so, and is amongst the 10% most deprived areas of the county.

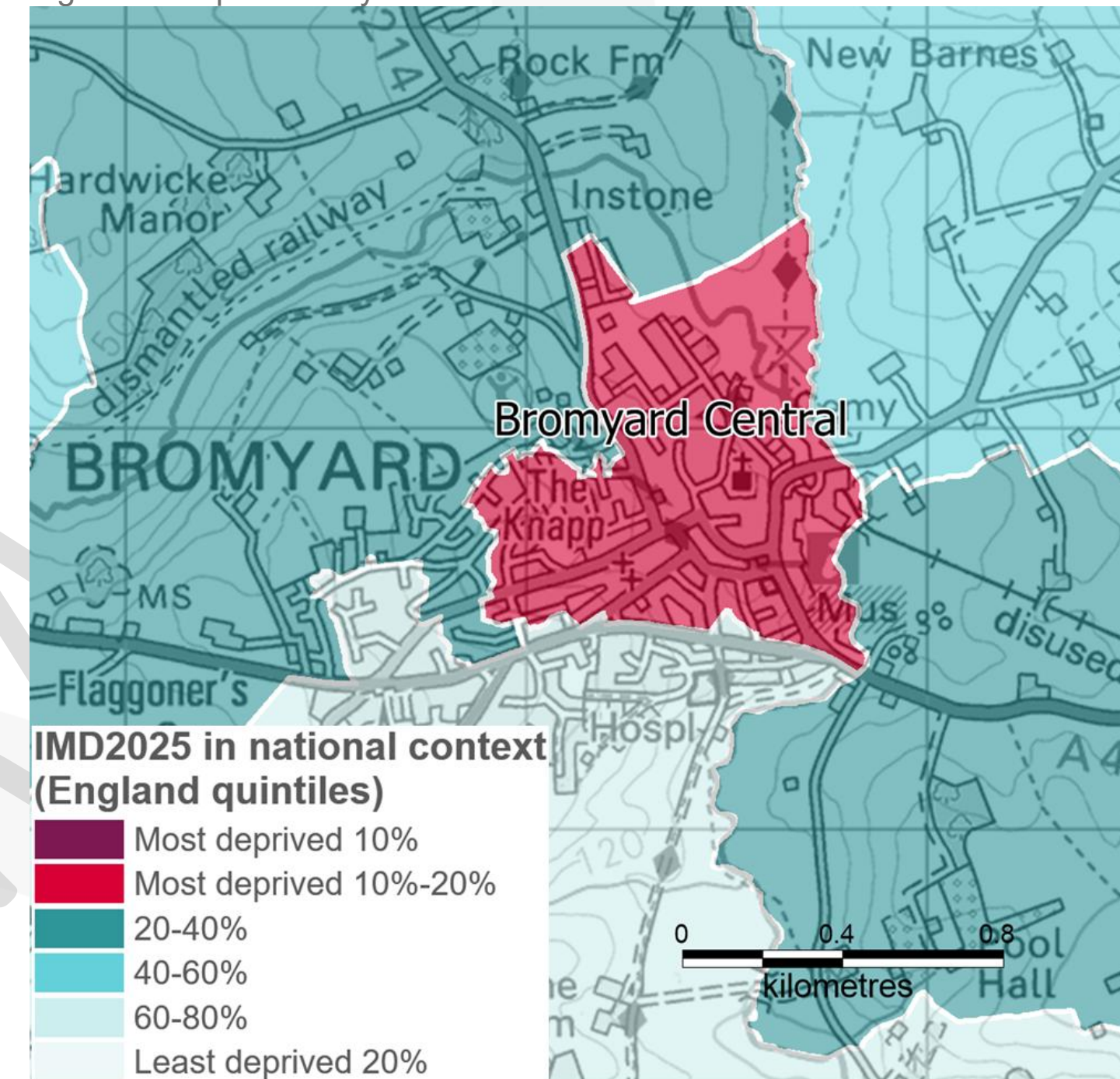
The area has a broadly similar age profile to the county overall, with 15% aged under 16, 60% aged 16 to 64 and 26% aged 65 and over. Almost all residents who are registered with a GP are registered with Nunwell Surgery.

Just over a **third** of the 1,700 residents (36%) experience income deprivation; in particular 51% of children under 15 and 38% of older people live in an income deprived household.

Other observations include:

- High deprivation on the placed-based measure of outdoor living environment.
- Higher rates of residents with no religion
- Higher rates of residents who are legally married but are separated
- Notably higher rates of disability
- High benefit claimants for disability-related benefits (Disability Living Allowance and Personal Independence Payments)
- Higher rates of emergency hospital admissions for all causes, and particularly cardiovascular disease
- Higher levels of need amongst young children (under 5) and their families, particularly for social care, Early Help and special educational need and disability.

Figure 4: Map of Bromyard Central



Data source: [Indices of deprivation 2025](#)



Title: Work Programme 2026-27

Meeting: Health, Care and Wellbeing Scrutiny Committee

Meeting date: Monday 27 July 2026

Report by: Statutory Scrutiny Officer

Classification

Open

Report purpose

The report:

- Provides the committee with a draft work programme for the committee, for approval.
- Provides the committee with a copy of the council's forward plan of key decisions to assist the committee in deciding its programme of work.
- Lists the recommendations made by the committee since January 2025, and any responses to these recommendations.

Background

1. 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.

Meeting objectives

2. To agree the committee's work programme.
3. To note the work programmes of Herefordshire Council's other scrutiny committees.

Report information

4. The most recent work programme was published July 2026 and is attached as Appendix 1.
5. Attached as Appendix 2 to this report is the council's most recently published forward plan of key decisions.

6. Appendix 3 is a list of all recommendations made by the committee in 2025 and 2026.

Consultees

7. 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.

Appendices

Appendix 1 – Scrutiny Work Programme July 2026

Appendix 2 – Herefordshire Council Forward Plan 10 July 2026

Appendix 3 – Recommendations made by Health, Care and Wellbeing Scrutiny Committee in 2025 and 2026

Background papers and resources

None



APPENDIX 1

SCRUTINY WORK PROGRAMME

July 2026 – March 2027

Below are the work programmes of Herefordshire Council's five scrutiny committees and their six task and finish groups.

Work programmes are subject to change, with revised programmes agreed at the end of formal committee meetings.

Please note that no meetings will be scheduled after March 2027 until after the 2027 Council elections have concluded.

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Children and Young People Scrutiny Committee

Committee work programme

Committee Meeting

22 July 2026 **report deadline 14 July 2026** **pre meeting lines of enquiry planning 17 July 2026**

Topic and Objectives	Evidence required	Attendees*
Families First Programme - Scrutinise changes to services and the support offer for families as part of the Families First reforms. - Scrutinise early outcomes from the implementation of service changes.	Officer report	Dawn Knight, Service Manager Early Help - Lindsay MacHardy, Public Health Principal <i>Core members of the steering group</i>
Early Help Task and Finish Group Review group findings and recommendations	Final group report	Chair, Children and Young People Scrutiny Committee
Work programme Review work programme	Draft work programme	Statutory Scrutiny Officer

Committee Meeting

6 October 2026 **report deadline 28 September 2026** **pre meeting lines of enquiry planning 2 October 2026**

Topic and Objectives	Evidence required	Attendees*
Alternative provision - Review of capital programme relating to alternative provision - Overview of existing provision	Officer report	Liz Farr - Louise Tanner, Head of Learning and Achievement - Hilary Jones, Head of Additional Needs - Jane Morse - Commissioning

Topic and Objectives	Evidence required	Attendees*
Youth Strategy	Draft strategy	- Tina Russell - Hereford Rural Media - Will Lindsey HVOSS - Lindsay McHardy
Work programme Review work programme	Draft work programme	Statutory Scrutiny Officer

Topics for possible future scrutiny

- Included in the programme
- Participation strategy
- Housing
- School place planning
- Fostering (generally)
- Welfare and Education Bill (ref to SEND reforms)

Early help task and finish group

Terms of reference

Background

Herefordshire's Early Help offer includes both universal and targeted services aimed at supporting children, young people, and families before statutory intervention is required. The offer includes:

- **Universal services:** Provided largely through Talk Community, voluntary and community organisations, schools, health, and public health-funded initiatives.
- **Targeted early help:** Led by the Early Help team within Children's Services, working directly with families who require structured support.

Key developments in this area in recent years include:

- Integration of Early Help into wider Children's Services through locality models.
- Introduction of Families First and Lead Practitioner roles.
- Recruitment of two new children's-focused community development workers within Talk Community.
- Partnership commissioning (such as with the PCC) to support local early intervention initiatives.

To build on these developments, work is underway to identify and address weaknesses in current practice, including:

- Persistent confusion around distinctions between universal and targeted Early Help.
- Limited public visibility of the Early Help offer and recent developments.
- Variability in provision and access across different localities.
- Pressure on schools to deliver Early Help without sufficient funding or infrastructure.
- Need for improved coordination between statutory and non-statutory partners.

Purpose

The group therefore aims to provide a constructive and collaborative space to:

- Recognise strengths in current Early Help provision.
- Identify good practice across different communities.
- Highlight gaps or inconsistencies in provision and the work in place to address them.

Scope of Inquiry:

In recognition of the broad and varied nature of early help available in Herefordshire, the group intends to carry out two distinct but closely interdependent streams of work:

- **Targeted Early Help and Families First**
 - Understanding the Families First implementation.
 - Exploring the role of lead practitioners.
 - Clarifying the role of schools and multi-agency collaboration.
- **Community and Universal Offer**
 - Mapping and showcasing local Early Help initiatives.
 - Exploring partnerships with Talk Community hubs, voluntary groups, parish and town councils.
 - Engagement around youth activities, access barriers (transport), and local innovation.

Work Programme

The group will determine its programme of work to meet the above objectives. This programme will include:

- Local Appreciative Inquiry events in Hereford City Ross, and Leominster, supported by Talk Community and Children's Services.
- Case studies
- Meeting with families and professionals, individually and in focus groups

Work programme

Targeted early help and Families First

- Recognise strengths in current Early Help provision.
- Identify good practice across different communities.
- Highlight gaps or inconsistencies in provision and the work in place to address them.

Guide:

Not completed and overdue	Partially completed and overdue	On track	Completed
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Objective	Evidence required	Responsible officer	Date
Understand targeted early help - rationale and performance	• Overview of programme briefing note ○ Thresholds of need ○ Current performance management ○ Current programme of activity	Simon Cann	November 2025
Overview of current Families First programme and targeted early help	• Meeting with service managers ○ Victoria Leader ○ Dawn Knight	Simon Cann	15 Dec 2026, 3pm
Update on implementation of Families First programme and targeted early help	• Meeting with service managers ○ Dawn Knight	Simon Cann	14 or 19 May 2026
Support for young carers, no wrong door	• Meeting with young carers ○ Jane Marshall – South – Ross and VL, John Burgess, Susan Brace, Niall Crawford	Simon Cann	2 Mar 2026, 3pm
Appraise locality-based targeted early help	• Meeting with a locality team ○ Victoria Roe – North ○ Jane Marshall – South – Ross ○ Chantelle Bennett – Central	Simon Cann	16 Jan 2025, 3pm

Objective	Evidence required	Responsible officer	Date
	Tracey Spencer – Central		
Working with schools	- Meeting with schools - Neil Crawford	Simon Cann	21 Jan 2026, 3pm
Commissioned targeted early help services	- Meeting with Venture – commissioned service - Hilary Thomas hilary.thomas@vennture.org	Simon Cann	27 Feb 2026, 1pm

Community and Universal Offer

- Mapping and showcasing local Early Help initiatives.
- Exploring partnerships with Talk Community hubs, voluntary groups, parish and town councils.
- Engagement around youth activities, access barriers (transport), and local innovation.

Topic	Evidence required	Responsible officer	Date
Overview of local early help initiatives	Early help marketplace – Ross-on-Wye	Danial Webb	13 Oct 2025
Overview of local early help initiatives	Early help marketplace - Hereford	Danial Webb	17 Nov 2025
Overview of local early help initiatives	Early help marketplace - Leominster	Danial Webb	3 Dec 2025
Understand how midwives support young parents to be.	- Meeting with midwives - Emily Strange (named safeguarding midwife) - Sian Jenkins (community Midwife manager)	Simon Cann	20 Mar 2026
The role of school nurses	- Meeting with school nurses - emma.dewar@wvt.nhs.uk - Wendy.Long@wvt.nhs.uk - Nikki.Lawley@wvt.nhs.uk	Simon Cann	8 May 2026
The role of health visitors	- Meeting with health visitors - Lyndsay McHardy, Julia Stephens -0-19 Strat.	Simon Cann	17 Mar 2026

Topic	Evidence required	Responsible officer	Date
	○ Hannah Bannister-White ● “Best Start in Life” strategy		
Youth clubs overview	● Overview of youth and sports clubs in Herefordshire ● Visit to youth club ● Meeting with youth club attendees ● HVOSS Will Lindesay	Simon Cann	9 April 2026
Talk Community and co-ordination of support for universal community services	● Overview community support carried out by Talk Community. ● Nikki Stroud, Emily Lowe, Michelle Trussler, Abigail Allcock	Simon Cann	21 April 2026

Report to Cabinet

Topic	Evidence required	Responsible officer	Date
Draft final report	Learning from above meetings		July 26
Agree final report	Draft report	Task and Finish Group	22 July 26
Present to Cabinet	Final report	Toni Fagan	July 26

Connected Communities Scrutiny Committee

Committee work programme

Committee Meeting

7 July 2026 **report deadline 29 June 2026** pre meeting lines of enquiry planning 2 July 2026

Topic and Objectives	Evidence required	Attendees*
Year of delivery – capital projects - Mid-year review of capital projects taking place in 2026. - Scrutinise project budgets.	- Council capital programme - Individual programme progress reports - Capital delivery programme	Service Director, Economy and Growth - Director of Resources
Work programme Review work programme	Draft work programme	Statutory Scrutiny Officer

Committee Meeting

20 July 2026 **report deadline 10 July 2026** pre meeting lines of enquiry planning 16 July 2026

Topic and Objectives	Evidence required	Attendees*
Hereford Bypass Phase One – full business case Scrutinise the full business case to ensure it provides Cabinet with sufficient information to make an informed decision on Hereford Bypass Phase One, having regard to the assessment criteria.	- Hereford Bypass Phase One full business case. - Assessment criteria for the full business case.	Delivery Director, Infrastructure Representative AECOM Expert Witness Bypass Phase One Project Manager
Public participation in planning task and finish group Verbal update from the group chair	Verbal update	None

Topic and Objectives	Evidence required	Attendees*
Work programme Review work programme	Draft work programme	Statutory Scrutiny Officer

Committee Meeting

22 September 2026 **report deadline 14 September 2026** pre meeting lines of enquiry planning TBC 2026

Topic and Objectives	Evidence required	Attendees*
UK Shared Prosperity Fund - Review of projects funded - Examine future funding opportunities	TBC	Service Director, Economy and Growth
Public participation in planning task and finish group - Review final report - Agree report recommendations	Final report	Statutory Scrutiny Officer
Work programme Review work programme	Draft work programme	Statutory Scrutiny Officer

Committee Meeting

27 January 2027 **report deadline 19 January 2027** pre meeting lines of enquiry planning TBC

Topic and Objectives	Evidence required	Attendees*
Year of delivery – capital projects End of year review of capital projects taking place in 2026.	- Council capital programme - Individual programme progress reports	To be determined

*The Corporate Director, Economy and Environment, Cabinet Member, Economy and Growth, Cabinet Member, Community Services and Assets, Cabinet Member, Roads and Regulatory Services, and Cabinet Member, Transport and Infrastructure, all have a standing invitation to the meeting.

Placemaking and Public Participation task and finish group

Terms of reference

Background

Herefordshire is entering a significant period of growth and change. Delivering new housing, infrastructure, and services must strengthen local communities and reflect the county's distinctive rural character.

Research shows that while public involvement in planning is vital, engagement often remains procedural rather than meaningful. Many residents feel disconnected from decision-making, uncertain about how to participate, or unconvinced that their input makes a difference.

The Planning and Compulsory Purchase Act 2004 requires every local planning authority such as Herefordshire to publish a Statement of Community Involvement. The Levelling-up and Regeneration Act 2023 and resultant secondary legislation is likely to place greater emphasis on this statement with a proposed requirement for a local planning authority Community Involvement Scheme. This provides a timely opportunity to modernise Herefordshire's existing Statement of Community Involvement (January 2022), ensuring it reflects Herefordshire Council's 2024–2028 priorities for economic growth and community development.

This task and finish group will explore how Herefordshire can plan with its communities, ensuring that growth, infrastructure and environment evolve together in a fair, transparent, and creative way. It will then make recommendations to underpin the Council's new statutory engagement framework.

The aim is to move beyond statutory minimum consultation and create a culture in which residents look forward to new development as something they have helped to shape. Growth with, not to, communities.

Purpose

To identify and recommend practical, evidence-based measures for making community engagement in planning and placemaking more inclusive, accessible, and effective across Herefordshire. The group will:

- Examine best practice and innovative approaches to public participation.
- Advise on the update and replacement of the Statement of Community Involvement (2022) with a new Community Involvement Scheme (2026).
- Ensure that community voice and cultural engagement sit at the heart of the county's future planning system.

Objectives

- To understand current legislation and good practice in community involvement and evaluate how residents currently engage with planning in Herefordshire and identify barriers to participation.
- Review and learn from good practice in community engagement in other local authorities and with housing providers.
- Inform and help draft the replacement of the Statement of Community Involvement (2022) with a new Community Involvement Scheme (2026)
- Make recommendations to the Connected Communities Scrutiny Committee and Cabinet to deliver the above.

Scope

The task and finish group will focus on how communities are involved in shaping growth, not on what is built or where sites are allocated. It will not duplicate the work of the Housing Development Working Group or the technical drafting of the Local Plan.

Membership and Governance

- 5–7 elected members of Herefordshire Council (no Cabinet members).
- Up to two co-opted members with relevant expertise or community experience.
- Supported by officers from Democratic Services, Economy and Environment, and Communications.
- Reports through the Connected Communities Scrutiny Committee, which will submit recommendations to Cabinet for formal response.

Expected Outputs

- A final report setting out
 - practical recommendations for improving public participation in planning and placemaking.
 - A proposed structure and content outline for Herefordshire's new Community Involvement Scheme (2026), replacing the 2022 Statement.
 - Case studies and prototypes demonstrating innovative engagement methods suitable for rural and market-town contexts.

Success Measures

- At least five examples of national or local best practice reviewed.
- Two or more new engagement methods agreed or trialled.
- Clear, costed recommendations adopted within the 2026 Community Involvement Scheme.
- Cabinet adoption of group recommendations into council policy.

WORK PROGRAMME

Guide:

Not completed and overdue	Partially completed and overdue	On track	Completed
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Objective To understand current legislation and good practice in community involvement and evaluate how residents currently engage with planning in Herefordshire and identify barriers to participation.

Objectives	Evidence required	Responsible officer	Date
Understand current legislation and good practice in community involvement	- Overview of The Planning and Compulsory Purchase Act 2004 - Overview of The Levelling-up and Regeneration Act 2023 - Good practice guidance		November 2025
Evaluate how residents currently engage with planning in Herefordshire.	- Herefordshire Council Statement of Community Involvement. - Interviews with housing associations and council planning officers.		November 2025
Identify current barriers to participation.	Interviews with housing association, community groups and council planning officers.		November 2025
GROUP MEETING		Henry Merricks Murgatroyd	November 2025

Objective Review and learn from good practice in community engagement in other local authorities and with housing providers.

Objectives	Evidence required	Responsible officer	Date
Examine requirements for new Community Involvement Scheme	Draft regulation and statutory guidance		December 2025

Objectives	Evidence required	Responsible officer	Date
Identify good practice in other local authorities	- Literature review - Site visit (if useful)		January 2026
Identify creative engagement methods.	Desktop search ideas such as including digital tools, easy-read and visual materials, short videos, and cultural or media partnerships.		January 2026
GROUP MEETING			February 2025

Objective Inform and help draft the replacement of the Statement of Community Involvement (2022) with a new Community Involvement Scheme.

This section of the work of the task and finish group is paused due to legislative changes that will replace the Community Involvement Scheme.

Objectives	Evidence required	Responsible officer	Date
Work with officers to set new parameters and scope for the Community Involvement Scheme	Draft Community Involvement Scheme	TBA	March 2026
Ensure inclusivity by improving reach to rural residents, younger people, working families, and under-represented communities.	Draft Community Involvement Scheme	TBA	April 2026
Recommend resourcing and governance arrangements to support sustained, meaningful participation.	- Meeting with planning officers in a 'good' local planning authority - Draft recommendations		May 2026
GROUP MEETING			May 2026

Objective Make recommendations to the Connected Communities Scrutiny Committee and Cabinet

Objectives	Evidence required	Responsible officer	Date
Draft report to committee	Draft report		September 2026
Draft report and recommendations to Cabinet (if required)	Final report		October 2026

Environment and Sustainability Scrutiny Committee

Committee work programme

Committee Meeting

21 September 2026 **report deadline 11 September 2026** pre meeting lines of enquiry planning 17 September 2026

Topic and Objectives	Evidence required	Attendees*
Transformation of the economy and environment directorate - Understand the transformed leadership structure and how it is performing currently, in particular where responsibility for delivering on the council's environmental priorities and targets, including net zero. - Has embedding a commercial mindset impacted on the delivery of these environmental priorities and targets. - Has transformation impacted on the overall resource dedicated to the environmental side of the directorate. - Explore the case for a more distinct operational area for environmental matters under the Corporate Director.	- Officer report - List of environmental projects currently undertaken by Herefordshire Council.	John Hobbs, Corporate Director Environment and Economy
Buses and passenger services task and finish group - To receive the final report from the group and consider their recommendations, including testing the evidence on which they are based. - To agree a set of recommendations to go forward from the committee to the executive.	Final report	Cllr Justine Peberdy, Chair - buses and passenger services task and finish group
Flooding spotlight review – terms of reference To agree the terms of reference for a proposed spotlight review to scrutinise flood risk management and flood emergency responses.	Spotlight review terms of reference	Statutory Scrutiny Officer

*The Corporate Director, Economy and Environment and Cabinet Member, Environment, both have a standing invitation to the meeting.

Committee Meeting2 December 2026 **report deadline 24 November 2026** pre meeting lines of enquiry planning 27 November 2026

Topic and Objectives	Evidence required	Attendees*
Rail Strategy Objectives to be agreed.	Evidence to be agreed	- John Hobbs - Ffion Horton - Roger Allonby - David Land
Herefordshire Council Carbon Management Plan - Objectives to be agreed. - Council-installed solar panels	- Carbon Management Plan - Cabinet paper (if available)	- Richard Vaughan - Daniel Lenain

Prospective spotlight review

March 2027

Topic and Objectives	Evidence required	Attendees*
Flooding and flood risk management Terms of reference to be agreed.	Evidence to be agreed	- John Hobbs - Other TBC

Bus and passenger services task and finish group

Work programme

Guide:

Not completed and overdue	Partially completed and overdue	On track	Completed
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Objective	Activity or information needed	Carried out by	Timeline
Initial review meeting		Task and Finish Group	July 2025
Create a central information repository	Setup Teams library and chat space	Simon Cann, Danial Webb	September 2025
Review Herefordshire Council's current powers and responsibilities.	Compile and provide overview of - Existing legislation in England and Wales - Local Transport Act 2008 - Transport Act 2000 - Bus Service Act 2017 - Bus Services (No. 2) Bill - Public Service Vehicle Regulations. Overview of who is responsible for local transport in England (Commons library) - Any allied statutory guidance - Bus operator legislation and guidance. - How these apply in Herefordshire.	Simon Cann, David Land, Craig Lewis, Natalie Amos, task and finish group	Sep-Oct 2025

Objective	Activity or information needed	Carried out by	Timeline
Review current passenger transport operations in Herefordshire and how they meet current and future need.	• Previous council bus service reviews (c. 2019) • For both commercial and community operators ○ Routes and frequency ○ Passenger numbers ○ Subsidy • Home to school transport ○ Current services provided ○ Current providers • SEND transport • Adult Social Care Passenger transport	Simon Cann, David Land, Craig Lewis, Natalie Amos	Sep-Oct 2025
Current local authority and regional funding	2025-2026 and medium-term funding • subsidised routes • community transport • other transport funding provided by the local authority	Simon Cann, David Land, Craig Lewis, Natalie Amos	Sep-Oct 2025
Review Meeting		Task and Finish Group	21 October 2025
Overview of current BSIP funding	Summary of • National Bus Strategy • Herefordshire Bus Service Improvement Plan 2024 Briefing on • Allocation of the £3.2m BSIP grant (2025–26) (£1.3m capital, £1.9m revenue) e.g., shelters, passenger experience, supported services • Progress in delivering funded projects and services • Their contribution to improved services Site visit to any BSIP-related capital project	Simon Cann, David Land, Craig Lewis, Natalie Amos	Nov-Dec 2025
Assess Enhanced Partnership performance	• Understand how the current enhanced partnership timetabling meets the objectives of the partnership.	Simon Cann, David Land, Craig Lewis,	Nov-Dec 2025

Objective	Activity or information needed	Carried out by	Timeline
	Identify ways to apply learning from the group to new ways of meeting the objectives of the enhanced partnership.	Natalie Amos, task and finish group	
Combining bus services with other transport services	Desktop research - Current rail services and how they align with bus services Group meeting - Network Rail or other responsible authority	Simon Cann, David Land, Craig Lewis, Natalie Amos	Nov-Dec 2025
Explore cross-border and cross-county transport	Map and list of current cross-border services to include - Frequency - Operator - Funding (if applicable) Examples from other local authorities - See previous work looking at other local authorities - Identify opportunities for any cross-border service support	Simon Cann, David Land, Craig Lewis, Natalie Amos	Nov-Dec 2025
Review Meeting		Task and Finish Group	11 December 2025
Community Transport	Site visits to community transport providers. Attendance at bus service forum. Overview brief of Services in Herefordshire, to include: - Current services, routes and frequencies - Cost - Funding	Simon Cann, David Land, Craig Lewis, Natalie Amos	Jan-Mar 2026
Home to school and other resident transport	Overview brief of home to school services in Herefordshire, to include: - Current services, routes and frequencies - Cost and funding	Simon Cann, David Land, Craig Lewis, Natalie Amos	March 2026

Objective	Activity or information needed	Carried out by	Timeline
	Meeting with Home to school co-ordinator Meeting with Transformation team		
Review Meeting		Task and Finish Group	26 March 2026
Examine how other rural local authorities provide sustainable services.	Internet research – what do they do in other rural local authorities? Suggested workstreams: • Demand Responsive transport ○ YorBus, CallConnect ○ Worcestershire on Demand Worcestershire County Council ○ The Robin (your bookable bus) Gloucestershire County Council • Use of powers of funding ○ Use of enhanced partnerships – Oxfordshire, Cornwall ○ Branding • Integrating transport and social care ○ Community transport ○ The role of third sector organisations Site Visit • Shropshire DRT – Shrewsbury • Social care focused visit	Simon Cann, David Land, Craig Lewis, Natalie Amos	June 2026
Bus franchising	Overview of Bus Services Bill Overview of approach taken by other local authorities Meeting with consultants or another local authority • What are the barriers to franchising in rural areas? • Is this an opportunity for Herefordshire to pursue? • Are there partnership opportunities with other local authorities?	Simon Cann, David Land, Craig Lewis, Natalie Amos	June 2026
Review Meeting		Task and Finish Group	June/July 2026

Objective	Activity or information needed	Carried out by	Timeline
Draft report and recommendations	• Draft final report • Draft recommendations	Simon Cann, David Land, Craig Lewis, Natalie Amos	September 2026
Present report to Environment and Sustainability Scrutiny Committee		Task and Finish Group	September 2026

Health Care and Wellbeing Scrutiny Committee

Committee work programme

Committee Meeting

27 July 2026 **report deadline 17 July 2026** pre meeting lines of enquiry planning 23 July 2026

Topic and Objectives	Evidence required	Attendees*
Joint Strategic Needs Assessment Review work to develop a new joint strategic needs assessment for Herefordshire.	Joint Strategic Needs Assessment	Zoe Clifford, Director of Public Health Charlotte Worthy, Lead Public Health Intelligence Analyst
Adult Mental Health Acute Inpatient and Rehabilitation Services an update on the progress of the Adult Mental Health Rehabilitation Redesign and Acute Inpatient Improvement Programme	Update report	Herefordshire And Worcestershire Health and Care NHS Trust
Adult Social Care budget outturn - Scrutinise financial outturn against budget - Scrutinise performance against the performance management framework	Quarterly budget outturn and performance monitoring	Hilary Hall, Corporate Director, Community Wellbeing
Work programme Review work programme	Draft work programme	Statutory Scrutiny Officer

Committee Meeting

14 September 2026 **report deadline 4 September 2026** pre meeting lines of enquiry planning 10 September 2026

Topic and Objectives	Evidence required	Attendees*
Right Care Right Place Update on work to deliver acute community mental health support in Herefordshire.	Evidence to be agreed	Gareth Morris, West Mercia Police Zoe Clifford, Director of Public Health
Meeting the demand for adult social care task and finish group Agree draft report and recommendations	Final task and finish group report	Chair, task and finish group
Adult Social Care budget outturn Scrutinise financial outturn against budget savings plans	Quarterly budget outturn and performance monitoring	Hilary Hall, Corporate Director, Community Wellbeing
Work programme Review work programme	Draft work programme	Statutory Scrutiny Officer

Committee Meeting

14 December 2026 **report deadline 4 December 2026** pre meeting lines of enquiry planning December 2026

Topic and Objectives	Evidence required	Attendees*
Shaping neighbourhood health - Analyse how the health partnership identifies health needs in communities. - Scrutinise provision of current and future neighbourhood health services.	2Neighbourhood health bid - Taurus Out of Hours GP service - Worcestershire Council papers	Zoe Clifford, Director of Public Health
Adult Social Care budget outturn Scrutinise financial outturn against budget savings plans	Quarterly budget outturn and performance monitoring	Hilary Hall, Corporate Director, Community Wellbeing
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.

Meeting the demand for adult social care task and finish group

Work programme

Guide:

Not completed and overdue	Partially completed and overdue	On track	Completed
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Objective To understand the extent of demand for adult social care services provided or commissioned in Herefordshire, and the likely change over time.

Objectives	Evidence required	Responsible officer	Date
Understand Herefordshire's demographics and future demographic change	Demographic information • <i>Understanding Herefordshire</i> demographic data • <i>Future population of Herefordshire</i> report • Joint Strategic Needs Assessment report	Charlotte Worthy/Herefordshire Research team	Dec 25-Jan 26
Understand the demand for adult social care in Herefordshire	• <i>Market Position Statement</i> • <i>Market Sustainability Plan</i> • Current rates of demand for adult social care ○ Type of demand (domiciliary, residential, nursing) ○ Duration ○ Change over time	Zakia Loughhead	Dec 25-Jan 26
Compare demographic change and demand for adult social care compared to other local authorities	• Desktop research comparison with 'statistical neighbours'	Danial Webb/Henry Merricks-Murgatroyd	Dec 25-Jan 26
GROUP MEETING		Henry Merricks-Murgatroyd	26 February 2026

Objective To explore the drivers of increased demand for adult social care, and the capacity of the local authority and other care providers to meet it.

Objectives	Evidence required	People to speak with	Date
Increased complexity of demand from an ageing population	Site visit – supported housing provider Site visit – third sector organisation working with older adults		Feb-Mar 26
The nature of funding for social care	Briefing on social care funding	Zakia Loughead ASC finance team	Feb-Mar 26
The size and structure of the social care market in Herefordshire	Overview of social care market Meeting with care providers	Zakia Loughead	Feb-Mar 26
Lack of housing growth, and flatlining tax base	Interview with Cabinet portfolio holders		Feb-Mar 26
GROUP MEETING		Henry Merricks-Murgatroyd	22 April 2026

Objective To identify strategies and work carried out by Herefordshire Council and partners such as housing associations and other organisations reduce demand for social care services, or to increase revenue to pay for services.

Objectives	Evidence required	People to speak with	Date
Assistive technology	Visit to Technology Enabled Care Services (TECS) Team	TBC	May-Jun 26
Community based universal and targeted services	Meeting with Talk Community Meeting with third sector organisation Meeting with other community team in another local authority	Emily Lowe – Talk Community	May-Jun 26

Objectives	Evidence required	People to speak with	Date
Market shaping and support	Meeting – service director Meeting – care providers' network	Commissioning	May-Jun 26
Supported living	Meeting – director for housing support Visit to supported housing	Hayley Crane A supported housing provider	May-Jun 26
In-house services and the role of Hoople	Case study – Essex Meeting with Hoople		May-Jun 26
GROUP MEETING		Henry Merricks-Murgatroyd	July 2026

Objective To make recommendations to the executive on steps that should be taken to reduce service demand and to increase revenue.

Objectives	Evidence required	People to speak with	Date
Write draft report and recommendations	Draft report and recommendations	Task and finish group	August 2026
Agree draft report and recommendations with committee	Draft report and recommendations	Task and finish group	September 2026

Scrutiny Management Board

Committee work programme

Committee Meeting

3 July 2026 **report deadline 25 June 2026** member briefing 22 June 2026 pre meeting lines of enquiry planning 30 June 2026

Topic and objective	Evidence required	Attendees
Adult Social Care - Scrutinise the recent CQC inspection report on adult social care. - Further scrutinise the council's budget and its plan for service transformation in light of budget pressures and the inspection findings.	- Herefordshire Council CQC local authority assessment - Herefordshire Council CQC improvement plan 2026-27 - Adult Social Care Demand Task and Finish Group interim report - Community Wellbeing 2026-27 budget position statement 2025-26 revenue outturn 2025-26 savings outturn 2025-26 capital outturn	Hilary Hall, Corporate Director Community Wellbeing Rachael Sanders, Director of Finance
Dedicated Schools Grant High Needs Block Management Plan Review the draft management plan	Management Plan	Rachael Sanders, Director of Finance Liz Farr, Service Director, Education
Work programme Review work programme	Draft work programme	Statutory Scrutiny Officer

Committee Meeting

September 2026 **report deadline TBC 2026** **member briefing TBC** **pre meeting lines of enquiry planning TBC**

Topic and objective	Evidence required	Attendees
Inequalities task and finish group final report Agree final report	Final report	Statutory Scrutiny Officer
Commercialisation task and finish group final report Agree final report	Final report	Statutory Scrutiny Officer
Annual review of effectiveness Agree final report	Scrutiny annual review	Statutory Scrutiny Officer
Hoople spotlight review terms of reference	Terms of reference	Statutory Scrutiny Officer
Work programme Review work programme	Draft work programme	Statutory Scrutiny Officer

Committee Meeting

1 December 2026 **report deadline 23 November 2026** **member briefing 24 November 2026** **pre meeting lines of enquiry planning 27 November 2026**

Topic and objective	Evidence required	Attendees
Work programme Review work programme	Draft work programme	Statutory Scrutiny Officer

Long list of potential topics

- Social Value in procurement
- Working with the voluntary sector and others to help deliver services
- Review of the workforce strategy
- Supplier risk management
- Emergency Planning
- Medium-Term Financial Strategy

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	Culture and 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
Councillor Dan Hurcomb	Local Engagement & Community Resilience

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.

Report title and purpose	Decision Maker and Due date	Lead officer and lead cabinet member	Directorate	Notice of decision first published / ID	Issue Type and exemptions
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FORWARD PLAN FOR 10 July 2026 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 and Non-Key decisions.

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
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Cabinet decisions by date (Key and Non-key listed)

Big Economic Plan Delivery Plan (previously known as the Big Economic Plan) To consider and approve the Big Economic Delivery Plan	Cabinet 30 July 2026	Cabinet member economy and growth Nadine Kinsey, Economic Development Manager nkinsey@herefordshire.gov.uk	Economy and Environment	3 July 2026	KEY Open
Children's Services Statutory Direction The Secretary of State issued Herefordshire Council with a statutory direction and appointed a Commissioner for Children's Services following the inadequate judgement of its children's services in July 22. Following the inspection of children's services in November 25 which saw a judgement of Good in all areas with Outstanding in leadership the commissioner has now completed their final report. That report makes a recommendation to the Secretary of State that the statutory direction is lifted.	Cabinet 30 July 2026	Cabinet member children and young people Diane Kennett, Executive Assistant To Management Board Diane.Kennett@herefordshire.gov.uk Tel: 01432 383744	Children and Young People	3 July 2026	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
Corporate Peer Challenge Progress Review To receive the report on the outcome of the Local Government Association Corporate Peer Challenge Progress Review, held on 28 May 2026, and to endorse the continued delivery of the council's action plan in response to the original recommendations.	Cabinet 30 July 2026	Cabinet member corporate strategy and budget Hilary Hall, Corporate Director Community Wellbeing, Caroline Marshall, Executive Support Officer Hilary.Hall@herefordshire.gov.uk, caroline.marshall3@herefordshire.gov.uk Tel: 01432 260249	Corporate Support Centre	3 July 2026	Non Key Open
CQC Assessment report and Improvement plan The purpose of this report is to present Cabinet with the outcome of the Care Quality Commission (CQC) Assessment and to approve Herefordshire's CQC Assurance improvement plan 2026-27	Cabinet 30 July 2026	Cabinet member adults, health and wellbeing Emma Evans, Head of Service Transformation & Improvement, Hilary Hall, Corporate Director Community Wellbeing Emma.Evans@herefordshire.gov.uk, Hilary.Hall@herefordshire.gov.uk Tel: 01432 260460,	Community Wellbeing	3 July 2026	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
Food Waste Collection Implementation To approve the implementation of the food waste collection scheme	Cabinet 30 July 2026	Cabinet member culture and Environment Sabrina Entwistle, Project Manager- Waster Services, Nicola Percival, Waste Services Manager sabrina.entwistle@herefordshire.gov.uk, npercival@herefordshire.gov.uk Tel: 01432 260991	Economy and Environment	3 July 2026	KEY Part exempt
Herefordshire County Business Improvement District (HCBID) - Second Term Ballot To agree to vote in favour of the Herefordshire County Business Improvement District (HCBID) for the second, five year term (2026 – 2031).	Cabinet 30 July 2026	Cabinet member economy and growth Nadine Kinsey, Economic Development Manager nkinsey@herefordshire.gov.uk	Economy and Environment	3 July 2026	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 Parking Strategy 2026 - 2041 (formerly non key) The purpose of this report is to seek Cabinet approval for the adoption of a new Parking Strategy for Herefordshire. This report presents the new Parking Strategy, which sets out the Council's long-term vision, principles and priorities for parking across Herefordshire. The strategy is intended to guide decision-making, investment, and operational practice for both on-street and off-street parking, ensuring that parking plays a supportive role within the wider transport network rather than operating in isolation. The strategy has been developed to align with the Local Transport Plan, the Council Plan and other relevant corporate and place-based priorities. It recognises the role parking plays in supporting town centres, tourism, freight and servicing, enabling access for disabled users and residents, and creating safe and attractive public spaces. It also reflects the increasing importance of integrating parking with sustainable travel choices, technological innovation, and efficient asset management.	Cabinet 30 July 2026	Cabinet member roads and regulatory services Ffion Horton, Transport Planning Services Manager ffion.horton@herefordshire.gov.uk	Economy and Environment	3 July 2026	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
Hereford Bypass Phase One – Assessment Report To seek approval from Cabinet to award the construction contract to the preferred bidder and authorise spending against the capital budget to construct Phase One of the Hereford Bypass.	Cabinet 10 September 2026	Cabinet member transport and infrastructure Scott Tompkins, Delivery Director - Infrastructure scott.tompkins@herefordshire.gov.uk	Economy and Environment	3 July 2026	KEY Open
Q1 Performance Report To review performance for Quarter 1 (Q1) 2026/27 and to report the performance position across the council for this period.	Cabinet 24 September 2026	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	3 July 2026	Non Key Open
To re-commission the home care framework in Herefordshire To approve the re-commissioning of the council's home care framework, called Services In Your Home (SIYH), in Herefordshire. The new SIYH framework needs to be operational by 1 May 2027.	Cabinet 24 September 2026	Cabinet member adults, health and wellbeing Sharon Amery, Senior Commissioning Officer sharon.amery2@herefordshire.gov.uk Tel: 01432 383734	Community Wellbeing	3 July 2026	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
Travel Plan Strategy The purpose of this report is to seek Cabinet approval for an updated Travel Plan process for Herefordshire. The updated approach sets out a clearer, more consistent and outcome-focused process for the development, implementation and monitoring of travel plans across new developments, existing organisations and key trip-generating sites.	Cabinet 24 September 2026	Cabinet member transport and infrastructure Ffion Horton, Transport Planning Services Manager ffion.horton@herefordshire.gov.uk	Economy and Environment	3 July 2026	KEY Open
Update on the Phase 2 Phosphate Mitigation Schemes To provide Cabinet with an update regarding the Phosphate Mitigation Wetland schemes	Cabinet 24 September 2026	Cabinet member culture and Environment Roger Allonby, Service Director Economy and Growth, Gemma Dando, Chief Operating Officer, Scott Tompkins, Delivery Director - Infrastructure, Susan White, Programme Manager Roger.Allonby@herefordshire.gov.uk, gemma.dando@herefordshire.gov.uk, scott.tompkins@herefordshire.gov.uk, Susan.White2@herefordshire.gov.uk Tel: 01432 260330, , Tel: 01432 260070	Economy and Environment	3 July 2026	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
Recommissioning of Drugs & Alcohol Recovery Services To obtain approval to recommission drug and alcohol recovery services in Herefordshire for an initial five-year period (2028–2033), with the option to extend the contract by a further two years. (2033–2035).	Cabinet 17 December 2026	Cabinet member adults, health and wellbeing Natalie Johnson-Stanley, Public Health Lead - Substance Misuse / Tobacco Natalie.Johnson-Stanley@herefordshire.gov.uk Tel: 01432 383230	Community Wellbeing	3 July 2026	KEY Open
Cabinet Member Decisions (Key and Non Key decisions)					
Portfolio: adults, health and wellbeing					
To extend the council's current commissioned home care framework To approve an extension to the council's current commissioned home care framework for up to six months from 31 October 2026 to 30 April 2027.	Cabinet member adults, health and wellbeing 28 July 2026	Cabinet member adults, health and wellbeing Helen Davies, Commissioning Manager helen.davies3@herefordshire.gov.uk	Community Wellbeing	3 July 2026	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
Domestic Abuse Commissioning - 2026 To approve the recommissioning of domestic abuse services, via a competitive tendering process, commencing.	Cabinet member adults, health and wellbeing 31 July 2026	Cabinet member adults, health and wellbeing Wendy Dyer, Commissioning Officer Communities Wendy.Dyer@herefordshire.gov.uk Tel: 01432 261673	Community Wellbeing	3 July 2026	KEY Open
Herefordshire Care Home Partnerships Framework To approve the procurement of a new multi provider partnership framework for the provision of care home placements and related services. The Council is looking to formalise partnership arrangements for a minimum of 500-550 placements across all providers. Estimated value of up to £320m across the framework term (maximum of 8 years).	Cabinet member adults, health and wellbeing Before 31 July 2026	Cabinet member adults, health and wellbeing Ros Murphy, Commissioning Manager, Community Wellbeing ros.murphy@herefordshire.gov.uk	Community Wellbeing	3 July 2026	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
Procurement of Sensory Impairment Service To approve the re-procurement of the Sensory Impairment Service for Herefordshire	Cabinet member adults, health and wellbeing 14 August 2026	Cabinet member adults, health and wellbeing John Burgess, Senior Commissioning Officer John.Burgess3@herefordshire.gov.uk	Community Wellbeing	3 July 2026	KEY Open
Herefordshire Adult Social Care Prevention Strategy The purpose of the report is to approve the 2026-2036 Herefordshire Adult Social Care Prevention Strategy	Cabinet member adults, health and wellbeing 30 November 2026	Cabinet member adults, health and wellbeing David Collyer, Acting Consultant in Public Health: General Practitioner david.collyer2@herefordshire.gov.uk	Community Wellbeing	3 July 2026	KEY Open
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
Recommissioning of Children's Rights & Advocacy and Independent Visitors Services To approve the decision to recommissioning of Children's Rights & Advocacy and Independent Visitors Services	Cabinet member children and young people Before 31 July 2026	Cabinet member children and young people Ellie Jenkins, Commissioning Officer, All Age Mental Health / Wellbeing, Karen Stanton, Corporate Grant Lead - Corporate Support ellie.jenkins@herefordshire.gov.uk, kstanton@herefordshire.gov.uk Tel: 01432 260463	Children and Young People	3 July 2026	KEY Open
Portfolio: community services and assets					
Establish a new Alternative Provision Centre capital spend To approve the spend of the capital allocation to establish a new Alternative Provision Centre	Cabinet member community services and assets 30 July 2026	Cabinet member community services and assets Quentin Mee, Head of Educational Development Quentin.Mee@herefordshire.gov.uk	Children and Young People	3 July 2026	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
Relocation of Herefordshire Pupil Referral Units Capital Spend To approve the spend of the capital allocation to relocate Herefordshire Pupil Referral Units onto a single site.	Cabinet member community services and assets 30 July 2026	Cabinet member community services and assets Quentin Mee, Head of Educational Development Quentin.Mee@herefordshire.gov.uk	Children and Young People	3 July 2026	KEY Open
High Needs Provision Capital Grant spend To approve the spend of the High Needs Provision Capital Grant to extend our inclusion offer in mainstream schools and increase places for children with Special Educational Needs and Disabilities (SEND)	Cabinet member community services and assets 31 July 2026	Cabinet member community services and assets Quentin Mee, Head of Educational Development Quentin.Mee@herefordshire.gov.uk	Children and Young People	3 July 2026	KEY Open
Portfolio: economy and growth					
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
Adoption of Herefordshire Local Nature Recovery Strategy To formally adopt the Herefordshire Local Nature Recovery Strategy and accept associated government grant for delivery.	Cabinet member culture and Environment 14 August 2026	Cabinet member culture and Environment Mandy Neill, Senior Landscape Officer, Richard Vaughan, Sustainability and Climate Change Manager mandy.neill@herefordshire.gov.uk, Richard.Vaughan@herefordshire.gov.uk Tel: 01432 260192	Economy and Environment	3 July 2026	KEY Open
Portfolio: finance and corporate services					
Public Notices To approve a contract via a direct award process for the placing of public notices in newspapers circulating within Herefordshire.	Cabinet member finance and corporate services 29 July 2026	Cabinet member finance and corporate services Ed Bradford, Major Contracts Programme Director Edward.Bradford@herefordshire.gov.uk Tel: 01432 260786	Economy and Environment	3 July 2026	KEY Open
Portfolio: local engagement and community resilience					

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
Portfolio: roads and regulatory services					
National Parking Platform (NPP) To agree to join the NPP to provide multiple options of cashless parking providers for all council pay and display car parks and on-street.	Cabinet member roads and regulatory services Before 27 July 2026	Cabinet member roads and regulatory services Michael Barnes, Parking Services Manager michael.barnes@herefordshire.gov.uk	Economy and Environment	3 July 2026	KEY Open
Portfolio: transport and infrastructure					
Active Travel Capital Fund 2026/27 This report is to confirm the work that will be delivered with the Active Travel Capital Fund that Herefordshire Council have received for 2026/27 financial year	Cabinet member transport and infrastructure 17 July 2026	Cabinet member transport and infrastructure Ffion Horton, Transport Planning Services Manager ffion.horton@herefordshire.gov.uk	Economy and Environment	3 July 2026	Non Key Open



APPENDIX 3

Recommendations made by Health, Care and Wellbeing Scrutiny Committee in 2025 and 2026

Monday 27 January 2025			
Dental services in Herefordshire			
No.	Recommendation	Accepted/Rejected	Response
1	That Herefordshire Council work with governing bodies of schools to encourage those not participating in the Time to Smile scheme to do so.	Accepted	Item was raised when presenting sign up of Herefordshire's Supervised Toothbrushing Scheme, it was noted that some schools in more deprived areas are not taking part in the initiative. The board suggested working with governing bodies of schools to encourage those not participating in the Supervised Toothbrushing Scheme.

Monday 17 February 2025			
Supported housing for working age adults with additional needs			
No.	Recommendation	Accepted/Rejected	Response
1	That Herefordshire Council brings forward an Accommodation with Care Strategy to aid the reduction in cost pressures in the Health and Wellbeing Directorate.	Accepted	ASC and Housing are currently working on a number of strategies looking at accommodation needs especially for the vulnerable client cohorts.

Monday 31 March 2025			
Health and Wellbeing Strategy			
No.	Recommendation	Accepted/Rejected	Response
1	That Herefordshire Council 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.	Accepted	Accepted The Herefordshire Council Plan 2024-2028, was approved in May 2024 and sets out four priorities for the council: people, place, growth and transformation. The Delivery Plan 2025-2026 outlines how the council's priorities and objectives will be achieved and what will be delivered in the next 12 months. The Delivery Plan is reviewed annually and progress is reported on a regular basis. Public Health leads on key deliverables within the plan, particularly in relation to the 'people' priority and reports on these quarterly.

			The Herefordshire Joint Local Health and Wellbeing Strategy 2023-33 sets out the vision of achieving 'Good health and wellbeing for everyone'. This is supported by four ambitions. Herefordshire Council demonstrates in the Delivery Plan how the work public health undertakes relates to the strategic vision and four ambitions of the Health and Wellbeing Strategy with the following examples: [see further document] The Health and Wellbeing Strategy identifies two core priorities: • Best Start in Life: ensuring every child has the best start in life. • Good Mental Health: promoting good mental health across the lifetime. Detailed implementation plans relating to these two core priorities are being taken forward by the public health team with wider partnership organisations enabling a whole system approach to achieving positive outcomes for our population. Herefordshire Council demonstrates through the Council Delivery Plan how the work of Public Health contributes to the delivery of the Health and Wellbeing Strategy vision and ambitions. Achieving these ambitions requires the collective effort of all partner organisations across our system. The Health and Wellbeing Board recognises the vital contributions that all member organisations make to improving the health and wellbeing of Herefordshire residents.
Community Activity - Day Provision			
No.	Recommendation	Accepted/Rejected	Response
1	That Herefordshire Council organises a briefing for councillors on the community activity services available in Herefordshire.	Accepted	Agreed

Monday 19 May 2025			
Adult Mental Health Inpatient and Rehabilitation Services Redesign			
No.	Recommendation	Accepted/Rejected	Response
1	That the Herefordshire and Worcestershire Health and Care NHS Trust should set out the pros and cons of each of the three redesign options against the six "and we" criteria in the NHS Commissioner Guidance for adult mental health rehabilitation inpatient services.	Accepted	The Herefordshire and Worcestershire Health and Care Trust agree with the recommendation, this will be evidenced and fully described within the options appraisal process, in addition this will form part of the pre-consultation business case as part of the NHSE Major Change Process.

Monday 11 February 2026**Herefordshire and Worcestershire Health and Care NHS Trust Strategy**

No.	Recommendation	Accepted/Rejected	Response
1	That the Trust provides the committee with an annual update of its strategic priorities, including: • Workforce capacity • Recruitment and retention • Training compliance • Staff survey results • Freedom to speak up activity With any actions taken where performance was identified as requiring improvement.	Accepted	The Trust will attend scrutiny to present its annual report at a mutually convenient time.
2	Provide the committee with the findings of the national workforce survey when available, with detail pertaining to Herefordshire where possible.	Accepted	The Trust will attend scrutiny to present its annual report at a mutually convenient time.

Monday 27 April 2026**Carers' Partnership Board Annual Report 2025**

No.	Recommendation	Accepted/Rejected	Response
1	To support the introduction of a carers' card for all carers.	Partially Accepted	Members of the Carers Partnership Board have considered different approaches to the introduction of a carers' identification card. At the most recent Partnership Board meeting, it was agreed that, rather than developing a Herefordshire-specific carers' ID card, the focus should be on supporting the introduction and promotion of the nationally recognised Carers Card UK scheme. The Carers Card UK scheme provides a form of identification for carers and includes access to a range of discounts across national retailers. There is a small cost associated with the card (£8.00 for a two-year period). In addition to promoting the national offer, there is an opportunity to explore how local businesses and organisations within Herefordshire could be encouraged to recognise the card and offer local discounts and benefits.

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