GETTING IT RIGHT FIRST TIME

Mental Health Rehabilitation

GIRFT Programme National Specialty Report

By Dr Sridevi Kalidindi CBE
GIRFT National Clinical Lead for Mental Health Rehabilitation

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Foreword from Professor Tim Briggs and Professor Tim Kendall

We are delighted to recommend this Getting It Right First Time review of mental health rehabilitation, led by Dr Sridevi Kalidindi CBE.

When we were developing the GIRFT programme for mental health, we were keen to take a focused look at rehabilitation. A good rehabilitation service should be timely and close to home, taking a whole-system and holistic approach to support the needs and aspirations of an individual to help them live as independently as possible.

There are some great services out there, with dedicated staff taking a hopeful yet trauma informed approach, responding to the complex needs of service users and connecting with the local health and social care system. But we know there is a lot of variation and too many people find themselves in restrictive care, far from home and the communities that can best support them in living meaningful, engaged lives.

We know that tackling this variation is not easy work, but it can be done with the right dedicated, multidisciplinary team that is well connected to other community services, has the support of senior leaders, and involves service users in designing support that meet their needs and those of communities.

This GIRFT report comes at a time when the NHS Long Term Plan is driving huge changes across mental health services. This includes ring-fenced local investment worth at least £2.3 billion a year in real terms by 2023/24 to provide high quality, evidence-based mental health services to an additional two million people. There is a focus on providing care closer to home - by 2023/24 there will be almost £1 billion extra a year available for community services for adults and older adults, which explicitly includes investing in expanding dedicated community rehabilitation functions. The shift to Integrated Care Systems (ICS) and new NHS-led provider collaborative models also add to the opportunities to embed a place-based, multidisciplinary approach to rehabilitation.

We are confident that lessons from GIRFT, along with Long Term Plan "early implementer" sites and input from wider experts and service users, will enable us to guide and support local systems to deliver better rehabilitation care.

The time is right for transformation: the Long Term Plan sets the direction and this report provides wide-ranging advice on how to implement change. We hope that all those involved in delivering rehabilitation services will work shoulder to shoulder to drive improvements, so that everyone who needs it can receive the right care, close to home.

Professor Tim Briggs *CBE*

GIRFT programme Chair and National Director of Clinical Improvement for the NHS

Professor Tim Briggs is a consultant orthopaedic surgeon at the Royal National Orthopaedic Hospital NHS Trust, where he is also Director of Strategy and External Affairs. He led the first review of orthopaedic surgery that became the pilot for the GIRFT programme, which he now chairs. Professor Briggs is also National Director of Clinical Improvement for the NHS.

Professor Tim Kendall

National Clinical Director for Mental Health for the NHS

Professor Tim Kendall is National Clinical Director for Mental Health for the NHS. He is also Director of the National Collaborating Centre at Royal College of Psychiatrists and University College London (UCL) where he is visiting professor. He is a consultant psychiatrist for homeless people in Sheffield.

Introduction from Dr Sridevi Kalidindi

It has been an incredible privilege to be the clinical lead for the mental health rehabilitation Getting It Right First Time (GIRFT) workstream. I have spent over 14 years as a consultant rehabilitation psychiatrist, alongside dedicated multidisciplinary colleagues, patients and carers, developing a whole system rehabilitation pathway and services locally; both inpatient and community. This has enabled care close to home and ongoing community rehabilitation, facilitating people using rehabilitation services, to achieve greater independence and live more fulfilling lives, on their terms. This approach has also improved the use of health and social care resources. My team went from having around 40 people placed in inpatient rehabilitation settings outside of our locality, to three, developing significant community assets including supported housing, with commissioners, to facilitate this shift. There have been many successes for those using our services, with many having their own front door and flat after many years in hospitals and/or care home settings.

Most of my 14 years have also been spent in various roles on the Royal College of Psychiatrists' Rehabilitation and Social Psychiatry Faculty Executive, including as chair from 2013-2017. As a result, I have understood the impact that the lack of national policy and direction in rehabilitation has had on local rehabilitation services around the country, and the wider mental health service landscape. This impact includes the significantly detrimental effect on patients and their families, as well as staff when trying to support and treat people with complex needs without the necessary specialist services in place (both inpatient and community).

I have also seen what incredible outcomes, and improved patient and family experiences, are possible around the country, where there are good local rehabilitation services and pathways. This has been in those areas where there is a clinical champion, along with other key stakeholders (such as operational leaders and commissioners), who understand the evidence base. These staff have the skills, leadership and passion to work with, and advocate for, this often-neglected patient cohort. Essentially these good working relationships allow innovation, and improved collaborative working across boundaries, to happen. However, when there are changes in key personnel, the whole ecosystem can collapse. This happens time and again when people come into roles who do not understand, do not have the expertise, or who do not see the value of rehabilitation. Sometimes this is due to their holding a view of rehabilitation which is not modern rehabilitation, as I or most other rehabilitation specialists would see it. For those patients at the more complex end of the spectrum, it can take some years to move through to the most independent setting possible for them, as shown by the evidence base, and this is an important understanding for staff to have, while still always holding hope and remaining positive and proactive in the rehabilitation journey. Having national guidance for rehabilitation services for the first time, from key organisations such as NHSEI, GIRFT, CQC and NICE, which essentially supports the longstanding RCPsych position, should significantly improve the issue of unwarranted variation.

There have been many consultants with whom I have spoken over the years whose teams and wards are closed; the whole rehabilitation team and expertise disbanded. Then after a few years, when significant amounts of money had been spent on a small number of patients in placements outside of the local care system, a local rehabilitation unit and/or a Community Rehabilitation Team (CRT) would be redeveloped. This waxing and waning across the country has not best served patients or the local mental health systems. If savings had to be made, rehabilitation wards were sometimes the short-term fix.

The degree of disinvestment in local rehabilitation in some parts of the country has resulted in a threat to the existence of rehabilitation trainee posts for specialist trained doctors who wish to become rehabilitation specialists, or trainees having to compete for the only rehabilitation trainee post. We do not know currently how many rehabilitation consultants (with the training) there are in the country. This workforce issue is important to address. Occupational therapy colleagues also receive specific training in mental health rehabilitation and the skills are applicable across services.

In some areas, good intensive supported housing offers have been developed, with circumscribed community rehabilitation clinical care. This community model, strengthening the community offer, supports the aim of the least restrictive solutions of being close to home. This is essential to reduce the reliance on inpatient rehabilitation. There are many successes – however, there is learning here too in what does not work or increases risk. We have heard concerns from colleagues on deep dives, and during discussion of this report, that the necessity of local community rehabilitation services and rehabilitation inpatient beds is sometimes not recognised by all involved in planning services locally. Nationally, the need for the right number of local inpatient beds is recognised, based on local need, including via National Institute for Health and Care Excellence (NICE) guidance for people with complex psychosis. The NICE guidance provides a much needed and insightful position and recommendations to embed into services.

The Care Quality Commission (CQC) published its State of Care report after inspecting all mental health services, including rehabilitation inpatient units in England.[1] This report specifically highlighted the issue of the significant and worrying use of out of provider placements (OPP) for patients needing inpatient rehabilitation care. Around two-thirds of the £550 million per year to be spent on inpatient rehabilitation was spent on OPPs. OPPs are defined in the report as any inpatient rehabilitation placements that are in another provider other than the person's local NHS provider, including independent sector providers. GIRFT findings show that around £280 million is currently spent annually on OPPs inpatient rehabilitation. This is money that could be spent on local inpatient and community rehabilitation services, with better outcomes and greater value, as shown by the recently published NICE Rehabilitation Guidance.

The CQC found that many of the placements did not know who the home/placing teams or CCGs were for the patients in their care. This speaks to a level of dislocation. The CQC survey also found that many staff were not skilled in rehabilitation. This led to patients being maintained effectively, but not being successfully treated to step back to local care or step-down into community care. Evidence showed the cost of rehabilitation in OPPs costs around 65% more than local placements, mainly due to longer lengths of stay and variable quality. This was not caused by the patients placed out of area being more complex or more difficult to treat.[2]

Mental health rehabilitation supports and treats people at the most complex and severe end of the spectrum, with most having a primary diagnosis of psychosis, often alongside other comorbid mental health conditions and physical health conditions. However other groups, in particular women (mainly) who have received a diagnosis of emotionally unstable personality disorder usually due to being subjected to complex trauma, have also often been sent out of area to services described as 'locked rehabilitation' and claiming to offer specialist personality disorder treatment. While mental health rehabilitation services are focused on supporting recovery and fostering independence for people with serious mental illness and are not diagnostic specific, we have identified that in many cases patients are being cared for in a rehabilitation service, but the service is not well placed to meet their needs and is being utilised in the absence of more tailored, trauma informed support for people in their community. This report outlines an approach for this cohort of patients too, based on good practice.

Reflecting on the GIRFT process to date, rehabilitation data started at a low baseline, with many trusts having only a part of the rehabilitation whole system/pathway in place. Thus, there was a significant ask for additional data to tie together the whole rehabilitation piece and needs across the system. There were several trusts who had already been working on improving rehabilitation pathways where the data was better. Surfacing unmet need will be important going forward in waiting times on acute wards, in out of provider placements and in readmissions after a rehabilitation inpatient stay or repeated acute inpatient admissions. This is in the form of local rehabilitation data dashboards and improving the regular automated data requests via NHS Digital and the Mental Health Services Data Set (MHSDS).

At the time of writing, we have visited 42 out of 53 mental health trusts. I have been struck by the dedication, the thinking and planning of staff – the clinicians, operational staff, commissioners, and others who work for this patient group. There was real willingness to be open minded about the data being presented and benchmarked positions being discussed to improve, as well as celebrate when doing well. There has been much good practice, which we will be showcasing in this report and on our resource webpage. The people involved must be heartily congratulated for this. It is clear from a financial perspective that local rehabilitation care, with a pathway weighted to community care, releases significant funds to be better used on less restrictive care, with better patient experience and outcomes.

With all guidance pulling in the same direction - NICE guidance, CQC, the NHS Long Term Plan, together with money for community rehabilitation and GIRFT - there is an incredible opportunity to develop local rehabilitation services which meet the needs of local people in a timely manner, and have improved patient, family and staff experience and outcomes, providing true value all-round. Lastly, embedding continuous quality improvement is essential and, while there will rightly be ongoing changes as local needs and surrounding service provision shift over time, we must never go back to a situation where local responsibility is not taken for this cohort of people.

[1] *Care Quality Commission (2017) The state of care in mental health services 2014-2017. CQC. www.cqc.org.uk/publications/major-report/state-care-mental-health-services-2014-2017*

[2] *Killaspy, H. and Meier, R. (2010) A Fair Deal for Mental Health Rehabilitation Services. The Psychiatrist, 34: 265-267.*

I extend my heartfelt thanks to every person who has been and is involved in working towards good local mental health rehabilitation pathways for people. Keep up the great work and use this opportunity to build on it, with and for those we serve – patients and their families.

Getting it right first time for people with mental health rehabilitation needs benefits all involved.

Dr Sridevi Kalidindi *CBE*

Dr Kalidindi is a consultant rehabilitation psychiatrist at the South London & Maudsley NHS Foundation Trust and Chair of the Association of Mental Health Providers.She is a former Chair of the Rehabilitation & Social Psychiatry Faculty at the Royal College of Psychiatrists, a former national advisor for the development of the National Collaborating Centre for Mental Health (NCCMH) guidelines for community psychiatry and co-developed NICE guidance on rehabilitation.

Dr Kalidindi is a visiting senior clinical lecturer at the Institute of Psychiatry, Psychology and Neuroscience and has authored and co-authored numerous key policy documents and research papers. She was awarded 2017 Psychiatrist of the Year by the Royal College of Psychiatrists and remains a spokesperson for the college, strongly advocating for good mental health services for the population.

She was honoured with a CBE in 2019 for services to rehabilitation psychiatry.

Statement of support

The Royal College of Psychiatrists

We very much welcome this report on an issue that is crucial to securing the best outcomes for people with mental illness. Rehabilitation has for too long been overlooked when it comes to prioritising attention and resources but through the implementation of the recommendations and advice in this report, there is a real opportunity to drive progress.

A lack of adequate rehabilitation care locally means far too many people are still sent out of area for treatment, with the consequential negative impacts flowing from that, whether it be the outcome for the patient or the waste of resources. As this report reflects, by local services having end-to-end rehabilitation services in place that meets people's needs, many of these out of area placements could be avoided. A lack of evidence and information has previously been cited as a reason for a lack of progress in this area. However, now with the guidance produced by NICE and the data available to benchmark and improve rehabilitation services, there is an obligation on local areas to put in place better care.

We, as the Royal College of Psychiatry, will do all we can to support the implementation of this report, in particular by supporting regional rehabilitation quality networks to facilitate the changes, learning and support between teams and trusts within each region.

Dr Adrian James

President, The Royal College of Psychiatrists

Executive summary

The opportunity

The opportunity afforded to get it right first time for people who will benefit from mental health rehabilitation services has never been stronger or more compelling.

Policy, practice, and finances are aligned in a way that has not happened for decades.

The NHS Long Term Plan[3] incorporates community rehabilitation as a core part of the Community Mental Health Framework[4], with significant funds assigned to the development of dedicated functions, services and teams, in all trusts by March 2024.

National Institute for Health and Care Excellence (NICE) guidance for the cohort of people who require rehabilitation and who have complex psychosis was published in August 2020.

Why action is needed now

The Care Quality Commission (CQC) has two reports (information requests relating to 2017 and 2019), highlighting the need for local rehabilitation whole system pathways to be in place. This was a solution to the concerns about people being sent out of area for inpatient rehabilitation care, away from family, local care teams and communities they were familiar with. At times, this can be for many years, with no clear plans of when or how they may be discharged and return home. Lack of sufficient skills in staff in some hospitals serving mainly those in out of provider placements (OPPs) has also become apparent, resulting in maintaining people in placements, rather than their active rehabilitation and recovery. Out of provider placements are defined in the report as any inpatient rehabilitation placements that are in another provider other than the person's local NHS provider, including independent sector providers. There have been significant safeguarding incidents linked to people being in closed-care systems a long way from home and family, with insufficient oversight (e.g. Winterbourne View Hospital, Whorlton Hall Hospital, and Yew Trees Cygnet) leading to calls to prioritise and invest in community options for people.

The unwarranted variation between trusts includes:

- the numbers of people who are in OPPs, with a range of 0 to 114, with some trusts keeping all of their patients 'in-sight and in-mind';
- the amount spent per 100,000 population on rehabilitation services per annum, varying between £141,000 to £5.2m;
- the mean lengths of stay (LoS) in inpatient high dependency rehabilitation units (HDU), varying between 50 to 1,567 days.

The variation in local supported housing and dedicated clinical community rehabilitation services impacts on the number of admissions and LoS in acute inpatients and rehabilitation inpatients and on numbers of people in OPPs, both health and social care. There is considerable variation in the number of admissions to acute physical health hospitals too.

What is clear is that by linking data and clinical and operational oversight across the whole rehabilitation pathway, the needs of this cohort of patients can be better served with more efficient, better quality, episodes of care supported.

Working in collaboration can transform services and bring people closer to home

Many trusts, with their rehabilitation clinicians and operational staff working collaboratively with their commissioners, housing and Voluntary Community and Social Enterprise (VCSE) partners, patients, and carers, are realising the improved quality of care and financial benefits possible with local delivery of rehabilitation services for their population. Success is about the wider team that is created through such collaboration and the focus on this cohort of people with complex needs to good effect. A key aspect of managing the interfaces well, so that patient journeys are smooth, is streamlining budgetary interfaces in order that patients can be in the least restrictive, usually lower cost, placement at every point. The innovation and dedication seen is impressive.

However, no one size fits all. Using the existing evidence base and best practice from around the country and indeed internationally, it is clear that a whole system approach to rehabilitation, and specifically local rehabilitation, provides the best chance of getting it right for this cohort. The cohort of people requiring rehabilitation services are amongst the most resource intensive of our patients. Thus, by getting it right for this group, this impacts positively on the rest of the mental

[3] *NHS England NHS Improvement (2019) The NHS Long Term Plan. NHS England NHS Improvement. www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf*

[4] *NHS England NHS Improvement (2019) The community mental health framework for adults and older adults. NHS England NHS Improvement. www.england.nhs.uk/publication/the-community-mental-health-framework-for-adults-and-older-adults/*

health and care system too. The broader shift towards Integrated Care Systems (ICS) and the new NHS-led provider collaborative models is an excellent opportunity to embed this whole system approach, where people can access a robust rehabilitation offer that is both flexible in response to their needs and available locally.

Examples of positive local innovation

Local solutions involve harnessing data and using it to make the case for setting up multidisciplinary, multi-agency, community rehabilitation services alongside rehabilitation inpatients and supported housing solutions based on local need. Data has been used to track improvements and identify the improvements to be made. This involved working in close collaboration and in alliance with relevant stakeholders across the pathway. Other innovation has included cross-trust working, bringing strength in numbers and combined resources together, funnelled through intelligent, clinically led, single points of access. This led to significant reductions in OPPs, associated reduction in costs and an increase in quality of care and improved clinical outcomes and patient experience.

Some steps such as clear protocols around procurement of OPPs when necessary and using purchasing power across several trusts have yielded relatively quick wins. This also enabled a more thoughtful and planned approach which has brought people, even when in an OPP, far closer to home. The crucial role VCSE partners play in this ecosystem cannot be overestimated. Their recovery focused, person-centred, strength-based approach can contribute towards outcomes for people that exceed all expectations; ultimately helping people back into lives they enjoy with meaning and structure.

People with personality disorder / complex emotional needs following trauma

Some cohorts have specific, different/additional needs, alongside the usual care provided by the rehabilitation pathway. This includes people with a primary diagnosis of severe emotionally unstable personality disorder (EUPD), or complex emotional needs usually following trauma, who are best served by a pathway and services, where they have access to specific evidence-based treatment, such as Dialectical Behaviour Therapy (DBT) or Mentalization-based Therapy (MBT), with a team trained and able to deploy this approach consistently. Repeated and extreme self-harm is a prominent presentation in this patient cohort.

This is different from the approach and interventions needed for most of the rehabilitation patients who have a primary diagnosis of psychosis. These individuals are often resistant to treatment and with a need for significant support around their activities of daily living, and concomitant management of their health and safety for which they require 24-hour staffed settings in their journey at times. Of course, those with this latter presentation have often experienced trauma also and to this end all rehabilitation services should be trauma informed.

Recommendations

Based on the evidence, best practice, and findings from the deep dive meetings with trusts and key stakeholders, the recommendations fall into five broad themes:

1. Improving the use of data to drive services, patient pathways, community rehabilitation and supported housing.
2. Developing NHS-led provider collaboratives and integrated rehabilitation systems.
3. Data-driven continuous quality improvement (QI).
4. Standardisation of local procurement processes and protocols.
5. Ensuring the right workforce with the right training, and hence skill set, can support improved patient care, treatment, and outcomes.

There are potentially quick wins for trusts in streamlining and standardising any existing OPP contracts and joining up with other regional trusts. This is a powerful lever for buying power and increasing influence with and oversight of those providing the inpatient rehabilitation OPP beds.

NHS Long Term Plan

This report is intended to support existing mental health priorities identified in the NHS Long Term Plan. The report recommendations assist delivery of the Community Health Framework, by recommending a rehabilitation dashboard to monitor patient flows across the rehabilitation pathway. We also offer recommendations to address OPPs for rehabilitation. This extends the existing focus on acute out of area placements within the Long Term Plan and compliments existing community mental health goals.

Improving the use of data to drive services and continuous quality improvement

By improving the use of data and developing local rehabilitation dashboards which look across the whole rehabilitation system at the need, the access and waits, the LoS in different parts of the system, the outcomes, patient experience, and the effectiveness and efficiency of the whole system, blocks can be identified and improved. The right timely access to inpatient rehabilitation from skilled practitioners who will support recovery and greater social inclusion will pay dividends. This includes access from early intervention in psychosis services into rehabilitation services, and from acute inpatient wards to rehabilitation, and then again into the community rehabilitation settings. Efficiencies realised can be reinvested to further improve the rehabilitation offer and outcomes, and then to support the rest of the mental health system too - in particular, strengthening community options. Reducing and stopping reliance on spot purchased placements outside of an individual's local network of care is a main priority of this work. Quality of data will also improve as this iterative work continues. Using the data for ongoing quality improvement work will be essential and embed ways of working.

Patient pathways

By standardising the different rehabilitation services and patient pathways, using evidence-based and best practice frameworks, improvements across the system are possible. This is not to bring rigidity but to provide a guide of tried, tested and evidence-based rehabilitation known to work well. Innovation and iterative improvements will be welcomed and expected. With learning from one another being a new normal, rehabilitation services are supported to network better with one another, both regionally and nationally.

Community rehabilitation and supported housing

The investment from the Long Term Plan supports the development of community rehabilitation services or improvement where they already exist. Close collaboration with VCSE, housing and local authority (LA) commissioner colleagues is imperative for the best patient outcomes and sustainable community living. The right complement of supported housing and care packages, using a flexible model from 24-hour staffed to those with floating support, is integral to facilitating ongoing rehabilitation and flow through the system. Some areas have used partnerships with housing colleagues to move people directly to their own flats and scale the support up and down, which also works well for some. The evidence and role of housing is clear in the prevention of acute admissions, reducing delayed transfers of care from hospital into the community, reduction of OPPs, and reduction in tenancy breakdown.[5, 6]

The choice for patients as to whether they are aiming for their own flat, or somewhere where there is more communal living, is important to build into the system as well.

Developing collaborative and integrated rehabilitation systems

The opportunity for NHS-led provider collaboratives is an exciting one. This is with a clinically led single point of access, bringing clarity and ease to the process for all. The NHS-led provider collaborative model supports the recommendations above by enabling clinical, provider level focus on the whole population, enabling a focus on people receiving care out of area. In addition, the model supports savings on inappropriate out of area care to be reinvested into community provision, and a drive to improve quality assurance of the care people are receiving. Local commissioners and providers should explore the potential of their existing NHS-led provider collaboratives to commission the mental health rehabilitation pathway.

[5] *Centre for Mental Health (2016) More than shelter. Centre for mental health. www.centreformentalhealth.org.uk/more-than-shelter*

[6] *NICE (2020) Rehabilitation for adults with complex psychosis. NICE. www.nice.org.uk/guidance/ng181.*

NHS providers are encouraged to explore the potential of the NHS-led provider collaborative model in this regard, learning from the integrated approach to providing and commissioning the adult secure pathway for example. We are aware of some of the local systems who are already operating their NHS-led provider collaborative across the mental health rehabilitation pathway. This creates the opportunity to purchase the services locally to better meet the needs of their population.

ICSs bring the opportunity to also align and improve reasonable adjustments for access to physical healthcare too. This can support better health outcomes for patients and less usage of urgent and emergency care, particularly addressing smoking cessation and obesity levels and all the non-communicable long-term conditions that they lead to.

Workforce and training

For all of this to come to realisation, the right numbers of workforce are required, and they need to have the right skills to provide rehabilitation. To this end, clarifying and developing training is essential. The use of digital technology will be an important component of how we deliver services and interventions, and this should be embraced and further understood and developed, while also addressing the issue of digital exclusion.

Prevention

One key element that must be addressed is how we prevent people becoming unwell as much as possible in the first place. Public mental health[7] has an important role to play. Preventing adverse childhood experiences is essential as they increase the risk of psychosis and other mental disorders. For this, a whole system, societal perspective is needed. By tackling inequalities, the damage to our citizens will be reduced and the cost of their health and social care usage, as well as the personal cost to themselves and their families, will also be reduced.

Co-production

Co-production is key to developing and improving mental health rehabilitation services. To genuinely co-produce services, commissioners should develop and implement local plans in collaboration with people with experience, service providers and partner agencies.[8]

This report, including the recommendations, has had input from experts with experience of rehabilitation services including: the carers of those who have used or still use rehabilitation services; clinicians of all disciplines across rehabilitation (including their representative Royal Colleges or member organisations) and beyond; all relevant stakeholders including across NHS England and NHS Improvement departments; NHS Digital, NHS X; the national GP Clinical Commissioning Group (CCG) commissioning lead; Association of Directors of Adult Social Services; NHS Confederation; CQC; Health Education England (HEE); VCSE colleagues; Department of Health and Social Care (DHSC); and the Department for Housing, Communities and Local Government.

The resounding feedback has been that this is a much needed, long overdue, welcomed report. More importantly, this report is an important call to support and guide the national improvement and up-levelling of all rehabilitation services, locally across the country. This is the time to get it right first time for people who will benefit from rehabilitation services, as well as their carers, and the staff and local health and care systems across the whole country,

[7] *Joint Commissioning Panel for Mental Health jcpmh-publicmentalhealth-guide.pdf https://mentalhealthpartnerships.com/publisher/joint-commissioning-panel-for-mental-health/*

[8] *Royal College of Psychiatry (2019) New tools to tackle inequalities in mental health care by involving patients in service design. www.rcpsych.ac.uk/news-and-features/latest-news/detail/2019/05/09/new-tools-to-tackle-inequalities-in-mental-health-care-by-involving-patients-in-service-design*

Recommendations

Using data to support improvement

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
1.1 All mental health trusts, health commissioners and social care commissioners should work together to provide all aspects of rehabilitation services. They should develop and use a local rehabilitation data dashboard. Data should be used for improvement, not performance, using a QI approach.	**a** Mental health trusts to work with their local IT team and Chief Clinical Information Officer to: • establish and maintain robust systems for measuring rehabilitation data; • ensure the local data dashboard includes timely analysis where there is variance, alongside an explanation and contingent actions if necessary; • commit to recording and reporting outcomes consistently for all patients; • measure outcomes using the RCPsych Rehabilitation Faculty Outcomes Framework and locally relevant outcome data. This should cover economic wellbeing and opportunities to work; • ensure all protected characteristics are measured (e.g. ethnicity, gender) to understand and better tackle inequalities; • routinely collect and flow all data to the MHSDS in line with the Information Standard notice as mandated in the NHS standard contract.	Mental health trusts, health commissioners and social care commissioners.	Quarterly reports will be in place, and seen in board to floor reports by commissioners, STPs/ICS boards, mental health trust boards, and operational and clinical staff responsible for rehabilitation services. Additionally, those running acute and community mental health services, given the interface with rehabilitation.	For immediate progress upon publication. Ready to go live October 2022 with a quarterly or monthly rehabilitation data dashboard.
	b Ensure supported housing leaders have access to and contribute to the rehabilitation system data. Data to be integrated between different sectors, with shared outcomes and data for measurement.	Supported housing providers and VCSE sector to be included. This needs to be supported with the additional resource to facilitate such data collection, which will then be the source of improvement work.	Quarterly reports will be in place, and seen in board to floor reports by commissioners, STPs/ICS boards, mental health trust boards, and operational and clinical staff responsible for rehabilitation services. Additionally, those running acute and community mental health services, given the interface with rehabilitation.	For immediate progress upon publication. Ready to go live October 2022 with a quarterly or monthly rehabilitation data dashboard.

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
1.2 All mental health trusts, health commissioners and social care commissioners, as well as housing partners, should robustly record and monitor all OPPs and report this on a minimum quarterly basis.	**a** Confirm a local definition of OPPs and track numbers in advance of the NHS England and NHS Improvement developed definition being agreed in 2022.	Mental health trusts, health commissioners and social care commissioners, as well as housing partners.	Data available to all who need to know and act on reducing OPPs.	For immediate progress upon publication. Rehabilitation OPPs report quarterly, commencing as soon as practical after publication.
	b Include reasons for the placement needing to be OPP and, in line with NICE guidance, write to the patient and family including the timeframe as to when they will return to local services.	Mental health trusts, health commissioners and social care commissioners, as well as housing partners.	Data available to all who need to know and act on reducing OPPs.	For immediate progress upon publication. Rehabilitation OPPs report quarterly, commencing as soon as practical after publication.
	c Data on placements should identify if any groups are particularly over-represented in OPPs, including protected characteristics.	Mental health trusts, health commissioners and social care commissioners, as well as housing partners.	Data available to all who need to know and act on reducing OPPs.	For immediate progress upon publication. Rehabilitation OPPs report quarterly, commencing as soon as practical after publication.
	d Data should be reported to and discussed at trust boards, with any relevant issues identified then raised with health commissioners, LAs and ICSs if appropriate on a minimum quarterly basis.	Mental health trusts, health commissioners and social care commissioners, as well as housing partners.	Data available to all who need to know and act on reducing OPPs.	For immediate progress upon publication. Rehabilitation OPPs report quarterly, commencing as soon as practical after publication.
	e Ensure any issues identified are acted on.	Mental health trusts, health commissioners and social care commissioners, as well as housing partners.	Data available to all who need to know and act on reducing OPPs.	For immediate progress upon publication. Rehabilitation OPPs report quarterly, commencing as soon as practical after publication.
	f Data should be reported both for inpatient and community supported housing OPPs.	Mental health trusts, health commissioners and social care commissioners, as well as housing partners.	Data available to all who need to know and act on reducing OPPs.	For immediate progress upon publication. Rehabilitation OPPs report quarterly, commencing as soon as practical after publication.
	g Where there is a provider collaborative approach the definition of OPP may be different, recognising there may be a number of providers working together to deliver a seamless pathway of care. Here, it is key to ensure that connections with the LA of origin are maintained as well as the family and local care team connection.	Mental health trusts, health commissioners and social care commissioners, as well as housing partners.	Data available to all who need to know and act on reducing OPPs.	For immediate progress upon publication. Rehabilitation OPPs report quarterly, commencing as soon as practical after publication.

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
1.2 (continued)	**h** Local systems should continue to monitor Out of Provider Placements (OPPs) for people with rehabilitation needs to highlight gaps in local service provision and to identify health commissioner spend that could be reinvested locally to address people's needs close to home and in the least restrictive environment. NHS England and NHS Improvement should use this information to develop a set of metrics that can be applied consistently between areas which will help drive this reinvestment in local rehabilitation pathways, allow for benchmarking, and demonstrate progress towards delivering high quality local services which support people with rehabilitation needs in the least restrictive setting.	Mental health trusts, health commissioners and social care commissioners, as well as housing partners.	Data available to all who need to know and act on reducing OPPs.	For progress by April 2022, with national data collection considered thereafter.
1.3 All trusts, health commissioners and LAs should ensure timely access to rehabilitation services and introduce local 'access and wait times' data to optimise and monitor. This should include rehabilitation services accessing evidence-based interventions and services, in line with relevant NICE guidance.	**a** Identification of all people who meet the criteria for rehabilitation services, including people with complex psychosis as set out in recent 2020 NICE guidance. Be inclusive by default and monitor their wait times into rehabilitation services (inpatient and community).	Mental health trusts in-reach.	Measure flow in rehabilitation pathways and understand when people's pathways and use of resource can be improved.	Commence as soon as possible and be in place within six months of publication.
	b Time to access of rehabilitation evidence-based interventions to be measured, reported on, monitored and minimised.	Monitoring by commissioners locally.	Measure flow in rehabilitation pathways and understand when people's pathways and use of resource can be improved.	Commence as soon as possible and be in place within six months of publication.
	c Provide in-reach into acute inpatient units to identify those who meet the criteria for rehabilitation.	Form part of the NHSBN national annual collection.	Measure flow in rehabilitation pathways and understand when people's pathways and use of resource can be improved.	Commence as soon as possible and be in place within six months of publication.
	d Include appropriate access to supported accommodation or specialist placements.	In time, collect and report centrally via NHS Digital.	Measure flow in rehabilitation pathways and understand when people's pathways and use of resource can be improved.	Commence as soon as possible and be in place within six months of publication.

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
1.3 (continued)	**e** Monitor and report on patients coming from early intervention in psychosis services into rehabilitation services, particularly optimising early intervention for rehabilitation. Around 15% of early intervention in psychosis patients should be expected to come into rehabilitation services.		Measure flow in rehabilitation pathways and understand when people's pathways and use of resource can be improved.	Commence as soon as possible and be in place within six months of publication.
1.4 Coding - rehabilitation care should be coded consistently and accurately.	**a** GIRFT team to develop MHSDS and SNOMED with NHS Digital. This is pre-existing development work.	Mental health trusts, health and social care commissioners across the whole system (once developed by the GIRFT team with NHS Digital and other stakeholders).	Data will be available that is correctly coded. It will be used from 'floor-to-board' to ensure services meet needs and there is continuous improvement. Also personalised care should be implemented as much as possible.	For immediate progress upon publication. Finalise by October 2022.
	b Ensure this includes psychiatric and physical health comorbidities.	Mental health trusts, health and social care commissioners across the whole system (once developed by the GIRFT team with NHS Digital and other stakeholders).	Data will be available that is correctly coded. It will be used from 'floor-to-board' to ensure services meet needs and there is continuous improvement. Also personalised care should be implemented as much as possible.	For immediate progress upon publication. Finalise by October 2022.
	c Include PCSP, SP and PHB coding, with input from the NHS England and NHS Improvement Personalised Care Group.	Mental health trusts, health and social care commissioners across the whole system (once developed by the GIRFT team with NHS Digital and other stakeholders).	Data will be available that is correctly coded. It will be used from 'floor-to-board' to ensure services meet needs and there is continuous improvement. Also personalised care should be implemented as much as possible.	For immediate progress upon publication. Finalise by October 2022.
1.5 A rehabilitation lead clinical information officer to support the rehabilitation data dashboard and the improvement of data quality across the trust and the rehabilitation pathway.	**a** This should have at least one Whole Time Equivalent (session) of time attached.	Trust board	Role will be appointed.	Within 12 months of publication.

Patient pathways

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
2. Trusts, health commissioners and social care commissioners should develop whole system rehabilitation pathways, using a local needs assessment and based on NICE guidance and NHS England and NHS Improvement policy and guidance relating to community mental health transformation as part of the NHS Long Term Plan.	**a** Health and social care commissioners, along with trusts, to undertake a needs assessment and formulate plans around a whole system rehabilitation service offer, including inpatient, community, and specific clinical support into supported housing and early identification of rehabilitation needs.	Health commissioners and social care commissioners, in close collaboration with providers. GIRFT/NHS England and NHS Improvement to track this.	Able to see local rehabilitation needs assessments and subsequent development plans.	All trusts to commence with immediate effect and complete before April 2024.
	b Ensure that the numbers of patients coming through to services tallies with the identified need, including those coming from early intervention for psychosis services, where timely access to rehabilitation services can positively impact on their trajectory.	Health commissioners and social care commissioners, in close collaboration with providers. GIRFT/NHS England and NHS Improvement to track this.	Able to see local rehabilitation needs assessments and subsequent development plans.	All trusts to commence with immediate effect and complete before April 2024.
	c Ensure patients and carers are included in the development of rehabilitation services.	Health commissioners and social care commissioners, in close collaboration with providers. GIRFT/NHS England and NHS Improvement to track this.	Able to see local rehabilitation needs assessments and subsequent development plans.	All trusts to commence with immediate effect and complete before April 2024.
	d Trusts to undertake a gap analysis based on the 2020 NICE guidance best practice.	Health commissioners and social care commissioners, in close collaboration with providers. GIRFT/NHS England and NHS Improvement to track this.	Able to see local rehabilitation needs assessments and subsequent development plans.	All trusts to commence with immediate effect and complete before April 2024.
	e Trusts to work with system partners – including health commissioners and social care commissioners, VCSE, housing partners and care providers, to develop a plan or a whole system rehabilitation pathway. Sufficient operational support and proper funding of the support element in housing is necessary for success.	Health commissioners and social care commissioners, in close collaboration with providers. GIRFT/NHS England and NHS Improvement to track this.	Able to see local rehabilitation needs assessments and subsequent development plans.	All trusts to commence with immediate effect and complete before April 2024.
	f Good practice around agreeing responsible commissioner and care of homeless people should be developed.	Health commissioners and social care commissioners, in close collaboration with providers. GIRFT/NHS England and NHS Improvement to track this.	Able to see local rehabilitation needs assessments and subsequent development plans.	All trusts to commence with immediate effect and complete before April 2024.

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
2. (continued)	**g** Commissioning to ensure local care, and length of stay (LoS) to be monitored to facilitate least restrictive options.	Health commissioners and social care commissioners, in close collaboration with providers. GIRFT/NHS England and NHS Improvement to track this.	Able to see local rehabilitation needs assessments and subsequent development plans.	All trusts commence with immediate effect and complete before April 2024.
3. All trusts, health commissioners and LAs should develop robust systems to bring patients treated out of area back to their local area.	**a** A senior named placements co-ordinator, as part of the CRT, to review and plan the person's move back to local care, and in the community wherever possible. Need to have or be directly linked with commissioning powers under the Care Act (e.g. social worker involved in reviews), or Mental Health Act Section 117, Continuing Care, or the Children and Family Act 2014 (up to 25 years old). Education, health and social care to support planning or work directly with commissioners to bring the person back into local care.	Provider trusts, through their CRT.	OPPs numbers reduced. Sustained local community living for more of those previously in OPPs.	All trusts commence with immediate effect and complete before April 2024.
	b All systems are expected to develop a PHB offer for those eligible and use PCSP to ensure care is aligned to people's own identified health and wellbeing outcomes.	Health commissioners and LAs.	OPPs numbers reduced. Sustained local community living for more of those previously in OPPs.	All trusts commence with immediate effect and complete before April 2024.
	c Develop an adequate complement of supported housing of different levels of support and expertise (using the NHS Digital accepted terminology).	GIRFT/NHS England and NHS Improvement to monitor this centrally.	OPPs numbers reduced. Sustained local community living for more of those previously in OPPs.	All trusts commence with immediate effect and complete before April 2024.
	d Should OPPs be deemed necessary, the national procurement framework should be used, with clear oversight and monitoring systems in place and arrangements to ensure care is appropriate to the person's needs, with contracts to work towards discharge back to the person's local team.	Health commissioners	OPPs numbers reduced. Sustained local community living for more of those previously in OPPs.	All trusts commence with immediate effect and complete before April 2024.

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
3. (continued)	**e** Consider whether mental health rehabilitation could be explicitly included for support from the Better Care Fund 2021/22, in order to develop local community mental health rehabilitation pathways and repatriate people back to their funding LA.	Social care commissioners	OPPs numbers reduced. Sustained local community living for more of those previously in OPPs.	All trusts commence with immediate effect and complete before April 2024.
4.1 Trusts and health commissioners should develop standardised care pathways and service frameworks in line with NHS Digital definitions from the service framework of community rehabilitation teams and typology of different inpatient rehabilitation services from RCPsych Rehab Faculty. Provider collaboratives will come into play.	**a** Trusts to use these definitions to develop a whole system rehabilitation pathway.	Health commissioners and social care commissioners. RCPsych, involving all relevant stakeholders for multidisciplinary representation.	Definitions will show in the rehabilitation data dashboard and in provision of services. Nationally agreed standardised framework development will be completed by RCPsych and all other relevant stakeholders, and then implemented by all.	For immediate progress upon publication. 100% of trusts to have fully developed local rehabilitation services by March 2024.
	b Co-develop service frameworks covering inpatient rehabilitation units and CRTs. Coverage of inpatient rehabilitation units would be similar to that of the Secure Care Programme. The frameworks would be developed with multidisciplinary input, and in co-ordination with developing guidance products from NHS England and NHS Improvement related to provider collaboratives and the Long Term Plan.	Health commissioners and social care commissioners. RCPsych, involving all relevant stakeholders for multidisciplinary representation.	Definitions will show in the rehabilitation data dashboard and in provision of services. Nationally agreed standardised framework development will be completed by RCPsych and all other relevant stakeholders, and then implemented by all.	For immediate progress upon publication. 100% of trusts to have fully developed local rehabilitation services by March 2024.
	c Include advice on staffing complement.	Health commissioners and social care commissioners. RCPsych, involving all relevant stakeholders for multidisciplinary representation.	Definitions will show in the rehabilitation data dashboard and in provision of services. Nationally agreed standardised framework development will be completed by RCPsych and all other relevant stakeholders, and then implemented by all.	For immediate progress upon publication. 100% of trusts to have fully developed local rehabilitation services by March 2024.
	d Ensure that PCSP and PHB are included to reflect legislation (Section 117).	Health commissioners and social care commissioners. RCPsych, involving all relevant stakeholders for multidisciplinary representation.	Definitions will show in the rehabilitation data dashboard and in provision of services. Nationally agreed standardised framework development will be completed by RCPsych and all other relevant stakeholders, and then implemented by all.	For immediate progress upon publication. 100% of trusts to have fully developed local rehabilitation services by March 2024.

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
4.2 NHS-led provider collaborative programmes to consider provider collaborative model for whole care pathway for people with complex emotional needs.	**a** The provider collaborative programme to develop clear outcomes to be delivered by a Complex Emotional Needs/EUPD, provider collaborative model.	NHS-led provider collaborative	There will be clear outcomes delivered by the complex emotional needs/EUPD PC model. They will be within their own specialist pathway in line with NICE guidance on personality disorders: borderline and antisocial.*	Within two years of publication.

* *NICE (2015) NICE guidance on personality disorders: borderline and antisocial https://www.nice.org.uk/guidance/qs88. https://pathways.nice.org.uk/pathways/personality-disorders*

Community rehabilitation and supported housing

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
5. Trusts, health commissioners and LAs should ensure that a dedicated community mental health rehabilitation service/team is developed across all health commissioners/LAs.	**a** Trusts to develop a robust system to ensure oversight of community provision for those in placements or with complex care packages.	Health commissioners and social care commissioners.	Rehabilitation data dashboard incorporates key community rehabilitation data variables.	Within two years of publication. All trusts by March 2024.
	b All trusts or health commissioners should have a dedicated community mental health rehabilitation service/team which should be NICE guidance concordant for the cohort of people with complex psychosis.	Mental health trusts.	All trusts have a specialist dedicated community mental health rehabilitation service/team.	Within two years of publication. All trusts by March 2024.
	c Trusts to follow the standards outlined in the CCQI AIMS-Rehab Community Teams (currently being piloted). Include MDT – as per NICE guidance.* Caseload numbers to be outlined. Interface with Community Mental Health Framework to be considered.	CQC and AIMS-Rehab.	CQC and AIMS-Rehab to work towards inspecting/ assessing community rehabilitation services regularly to ensure they meet the required standards, including for quality.	Within two years of publication. All trusts by March 2024.
	d Ensure LA secondment of staff into this team, who can operate the Care Act collaboratively. An integrated team, and jointly set up, to run the responsibility for rehabilitation.	Health commissioners and social care commissioners.		Within two years of publication. All trusts by March 2024.
6. All trusts should work with their local partners to proactively improve provision of different levels of supported housing in their area, aligned to the local level of need, using a flexible model.	**a** Urgently improve the availability and provision of specialist supported housing in each area, proportionate to the local need.	DHSC and MHCLG.	Access and wait times for housing for those in the rehabilitation pathway will be reasonable and the capacity and flow will be good.	Within two years of publication, contingent on adequate funding.
	b LAs, health commissioners and provider trusts to use the needs assessment to develop a housing strategy over each ICS/STP. This should be an integrated commissioning strategy.	ICS/STP - with statutory responsibility at health and social care commissioner level.	Access and wait times for housing for those in the rehabilitation pathway will be reasonable and the capacity and flow will be good.	Within two years of publication, contingent on adequate funding.

* *https://www.nice.org.uk/guidance/ng181*

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
6. (continued)	**c** LA supported housing framework (including outcomes) to be developed for different types of rehabilitation supported housing with health partners, in which the needs of mental health are understood and met.	NHS Confederation Mental Health Network's Mental Health and Housing Forum.	Access and wait times for housing for those in the rehabilitation pathway, will be reasonable and the capacity and flow will be good.	Within two years of publication, contingent on adequate funding.
	d Ensure strategic optimisation of funding for supported housing e.g. such as Greater London Authority grants which can be accessed by housing providers for capital funds; housing associations have access to specific capital grants for specialist supported housing and can also adapt existing housing too to meet needs. The Care and Support Specialist Housing Fund (CASSH funding) should also be looked into.	DHSC and MHCLG.	Access and wait times for housing for those in the rehabilitation pathway, will be reasonable and the capacity and flow will be good.	Within two years of publication, contingent on adequate funding.
	e Follow MHCLG supported housing national expectations. This reiterates the need for local needs mapping and also provision to an agreed standard.	ICS/STP - with statutory responsibility at health and social care commissioner level.	Access and wait times for housing for those in the rehabilitation pathway, will be reasonable and the capacity and flow will be good.	Within two years of publication, contingent on adequate funding.

Developing collaborative and integrated rehabilitation systems

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
7. Develop and optimise partnership working to improve patient and system outcomes and value. **7.1** All trusts and health commissioners should develop Local Provider Collaboratives (LPC) when commissioning services. These may extend to include supported housing and other VCSE care provision.	**a** Giving due regard to the approach of and opportunities provided via the national NHS England and NHS Improvement Provider Collaboratives in Mental Health Programme, systems should be clear for all relevant stakeholders, including patients and carers, to work collaboratively and, where possible, in an integrated manner, to provide local rehabilitation and recovery services.	Provider trusts.	Patients kept in area, in the community as much as is possible.	Within two years of publication.
	b Use the needs assessment to understand whether a provider collaborative between mental health trusts would benefit a local system. This can help support rehabilitation services to be commissioned and provided, within their local areas.	Health commissioners.	Patients kept in area, in the community as much as is possible.	Within two years of publication.
	c Health commissioners to consider delegated budgets, with clear risk sharing should demand increase. Financial efficiencies to be kept by the collaboratives to develop local rehabilitation pathways, strengthening community provision especially.	Commissioners and providers of health, social care and housing, patients and families together	Patients kept in area, in the community as much as is possible.	Within two years of publication.
	d Consider provider collaborations across the whole pathway, including housing and VCSE providers.	Commissioners and providers of health, social care and housing, patients and families together	Patients kept in area, in the community as much as is possible.	Within two years of publication.

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
7.2 All trusts and health commissioners should create systems to provide an integrated model of physical and mental health care, ensuring the physical healthcare of those in rehabilitation services is prioritised and effective arrangements for access to physical health referrals are in place. This includes reasonable adjustments to facilitate access and care.	**a** Record mortality data per mental health trust routinely and centrally. Rehabilitation patients should be included as a key cohort within overall local plans (at primary care or ICS level) to improve the physical health care of people with SMI, both in the community as well as in inpatient settings.	Mental health trusts, rehabilitation teams, NHS Digital. Mental health trusts and GPs as part of the Quality and Outcomes Framework and LTC work. ICS leaders and secondary care acute care trusts CEOs and medical and nursing directors.	Over time, premature mortality rates due to physical health long term conditions will be reduced. Measures of usage of inpatient acute care for those with SMI. Reduce uptake of physical healthcare upstream is improved.	Within two years of publication.
	b All patients should have: • a GP (including inpatients - an SLA may be needed by the trust for inpatients); • a shared care arrangement in place; • physical health checks and screening; • tailored plans for smoking cessation for those with SMI and to reduce obesity, are likely to be the most effective way of reducing long term conditions. The 2020 NICE Mental Health Rehabilitation guidance, including the four-week comprehensive assessment, should be used to ensure all is covered. It is important to track: • physical health commissioning for quality and innovation (CQUIN) data in rehabilitation teams; • that shared care is signed up to and what this looks like in the new Community Mental Health Frameworks; • rehabilitation patients using acute physical healthcare beds.	Mental health trusts, rehabilitation teams, NHS Digital. Mental health trusts and GPs as part of the Quality and Outcomes Framework and LTC work. ICS leaders and secondary care acute care trusts CEOs and medical and nursing directors.	Over time, premature mortality rates due to physical health long term conditions will be reduced. Measures of usage of inpatient acute care for those with SMI. Reduce uptake of physical healthcare upstream is improved.	Within two years of publication.

Data driven continuous QI

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
8. All trusts, health commissioners and social care commissioners should invest in developing a skilled and competent MDT workforce within their mental health rehabilitation systems, particularly as part of local ICS community mental health transformation plans.	**a** Routinely consider skill mix in any workforce reviews or developments.	Providers.	Improved skills of staff and teams, leading to improved care, treatment and outcomes, as measured on the local rehabilitation data dashboard.	Within two years of publication.
	b HEE, alongside a whole system approach and with all relevant other stakeholders, to continue to consider the training needs of the MDT workforce to provide best practice, skills and competencies needed and applied in context into mental health rehabilitation.	HEE, alongside all relevant stakeholders across the system.	Improved skills of staff and teams, leading to improved care, treatment and outcomes, as measured on the local rehabilitation data dashboard.	Within two years of publication.
	c Consideration given to resourcing HEE to develop the articulation of these competencies more formally, harnessing this in an overarching framework, across the whole system.	HEE, alongside all relevant stakeholders across the system.	Improved skills of staff and teams, leading to improved care, treatment and outcomes, as measured on the local rehabilitation data dashboard.	Within two years of publication.
	d Assess existing guidance so as not to replicate some of the core training that some specialties, particularly occupational therapy and psychiatry, already incorporate.	HEE, alongside all relevant stakeholders across the system.	Improved skills of staff and teams, leading to improved care, treatment and outcomes, as measured on the local rehabilitation data dashboard.	Within two years of publication.
	e Ensure staff wellbeing is a core part of the regular reviews with a clear implementation plan.	Providers.	Improved skills of staff and teams, leading to improved care, treatment and outcomes, as measured on the local rehabilitation data dashboard.	Within two years of publication.
	f Ensure inequalities monitoring of patient experience, outcomes and staff progression is undertaken and reviewed. Ensure the incorporation of training and actions to address inequalities are embedded in rehabilitation services.	Providers.	Improved skills of staff and teams, leading to improved care, treatment and outcomes, as measured on the local rehabilitation data dashboard.	Within two years of publication.
	g Education providers to develop rehabilitation training to be delivered to staff.	HEE and education providers.	Improved skills of staff and teams, leading to improved care, treatment and outcomes, as measured on the local rehabilitation data dashboard.	Within two years of publication.

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
8. (continued)	**h** Support and train patients and carers to access and use digital support, care and treatment.	Providers.	Improved skills of staff and teams, leading to improved care, treatment and outcomes, as measured on the local rehabilitation data dashboard.	Within two years of publication.
	i All staff to have training on access and funding for housing and housing-related issues.	Providers.	Improved skills of staff and teams, leading to improved care, treatment and outcomes, as measured on the local rehabilitation data dashboard.	Within two years of publication.
9. All trusts, health commissioners and LAs housing providers should use data informed continuous QI approaches across the whole system of mental health rehabilitation.	**a** All rehabilitation pathways should demonstrate use of routine clinical data to drive QI programmes. The expertise should be at the trust and provider collaborative level.	Provider trusts and provider collaboratives.	QI initiatives in place and continuous improvement being seen across rehabilitation services in key areas.	Within 12 months of publication.
	b Trusts to work with RCPsych AIMS-Rehab to inform and support local rehabilitation QI programmes. This could include using tools such as Quality Indicator for Rehabilitative Care [QuIRC]/(QuIRC-SA)	Provider trusts and provider collaboratives.	Routine quality network meetings, with data being discussed and good practice shared.	Within 12 months of publication.
	c Regional quality networks should be established. Include LA and supported housing and care staff and partners. This may be through the RCPsych regional College Engagement Networks.	Provider trusts and provider collaboratives.	A learning and mutually supportive environment developed in each region.	Within 12 months of publication.
10. Trusts and other service providers should utilise digital technology in developing and delivering rehabilitation services.	**a** All rehabilitation units/services to invest in and improve digital technology to ensure good communication and to facilitate frequent clinical reviews.	Provider trusts and providers of other services.	Improved use of technology, facilitating clinical reviews and staff with the skills to support patients to access digital support care and treatment. Reduced levels of digital exclusion.	Within 12 months of publication.
	b Staff skills and competencies to reflect supporting and training patients and carers to access and use digital support, care and treatment. To include social prescribing and enable digital access.	Local digital transformation opportunities.	Improved use of technology, facilitating clinical reviews and staff with the skills to support patients to access digital support care and treatment. Reduced levels of digital exclusion.	With immediate effect. To be in place within two years of publication.

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
10. (continued)	**c** Consider the issue of digital exclusion and how to overcome this.	Local digital transformation opportunities.	Improved use of technology, facilitating clinical reviews and staff with the skills to support patients to access digital support care and treatment. Reduced levels of digital exclusion.	Within 12 months of publication.

Standardisation of procurement processes and protocols

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
11. Standardise and systemise processes and protocols around procurement.	**a** Use trusted providers, fewer and as close to home as possible, while still optimising care and outcomes. The national OPPs framework to be used and this to be updated to reflect current best practice annually.	Whoever is placing, monitoring and paying for placements.	There will be fewer providers and people will be placed near their homes while retaining quality. All providers of OPPs will use the standardised framework which gives greater consistency of quality of care and reporting back to the placing authorities.	Within two years of publication.
	b Standards around specialist rehabilitation staff training need to be incorporated into standardised OPP contracts.	Provider trusts, and health and social care commissioners.	There will be fewer providers and people will be placed near their homes while retaining quality. All providers of OPPs will use the standardised framework which gives greater consistency of quality of care and reporting back to the placing authorities.	With immediate effect. To be in place within two years of publication.

Litigation

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
12. Reduce litigation costs by application of the GIRFT programme's five-point plan.	**a** Clinicians and trust management to assess their litigation claims covered under Clinical Negligence Scheme for Trust (CNST) notified to the trust over the last five years.	Clinicians and trust management	Findings will be shared with staff and staff will be cognisance of issues around litigation and ways to reduce the risk.	Within six months of publication.
	b Clinicians and trust management to discuss with the legal department or claims handler the claims submitted to NHS Resolution to confirm correct coding to that department. Inform NHS Resolution of any claims which are not coded correctly to the appropriate specialty via CNST.Helpline@resolution.nhs.uk	Clinicians and trust management	Findings will be shared with staff and staff will be cognisance of issues around litigation and ways to reduce the risk.	Upon completion of **a**.
	c Once claims have been verified clinicians and trust management to further review claims in detail including expert witness statements, panel firm reports and counsel advice as well as medical records to determine where patient care or documentation could be improved. If the legal department or claims handler needs additional assistance with this, each trusts panel firm should be able to provide support.	Clinicians and trust management	Findings will be shared with staff and staff will be cognisance of issues around litigation and ways to reduce the risk.	Upon completion of **b**.
	d Claims should be triangulated with learning themes from complaints, inquests and SI/ PSI and where a claim has not already been reviewed as SI/PSI we would recommend that this is carried out to ensure no opportunity for learning is missed. The findings from this learning should be shared with all staff in a structured format at departmental/directorate meetings (including MDT meetings, morbidity and mortality meetings where appropriate).	Clinicians and trust management	Findings will be shared with staff and staff will be cognisance of issues around litigation and ways to reduce the risk.	Upon completion of **c**.
	e GIRFT clinical leads and regional teams to share with trusts examples of good practice where it would be of benefit.	GIRFT Clinical Leads	Findings will be shared with staff and staff will be cognisance of issues around litigation and ways to reduce the risk.	For continual action throughout GIRFT programme.

Mental health rehabilitation today

Mental health rehabilitation encompasses the community and inpatient treatment and rehabilitation of individuals with severe mental illness. Mental health rehabilitation in the UK began in its original form and developed into a clinical specialty when the asylums closed in the late 1960s, with the Faculty of Rehabilitation and Social Psychiatry forming in 2009 at the Royal College of Psychiatrists (RCPsych). Following this in 2010, specialist training in general psychiatry with endorsement in rehabilitation psychiatry began.

The decision to close asylums was in response to research highlighting the negative impact of institutionalisation on those with mental illness.[9] There was also, in the latter parts of the movement, a political and financial position taken by those in power leading to the eventual closure of all asylums in favour of community care. However, the investment in community care for this population was poorer than anticipated, with significant variation in the care delivered. Mental health rehabilitation care in many areas is outstanding, with staff, patients, carers and the wider network of services working closely together in a 'triangle of care' to achieve positive outcomes. This deserves to be recognised and celebrated. However, even today, there are significant variations in service quality as measured through CQC ratings - see **Figure 1**.

Around 100,000 people live in mental health supported accommodation in England of varying types, with significant associated costs.[10] The amount and quality of ongoing mental health rehabilitation within supported accommodation is highly variable, as evidenced by the significant variation in LoS and levels of recovery-based practice.[11] Good practice exists where there is a whole system approach and pathway of mental health rehabilitation, with supported accommodation providers and clinicians working well together towards rehabilitation and, wherever possible, greater levels of independence and social inclusion[12], as evidenced by the services visited on deep dives. However, where there is a lack of ongoing mental health rehabilitation and recovery, a somewhat 'virtual asylum' has been established across numerous hospitals, care homes and supported accommodation settings. Many people who could benefit from mental health rehabilitation do not receive it and are effectively 'stuck' in longer term settings, both in inpatient (for example, 'locked' rehabilitation) and community based supported accommodation services, such as 24-hour residential care. The GIRFT programme, alongside the NHS Long Term Plan[13], looks to support all areas to develop and provide good local mental health rehabilitation services to address this unmet need.

[9] *Wing, J.K. and Brown, G.W. (1970) Institutionalism and Schizophrenia: a comparative study of three mental hospitals, 1960-1968. Cambridge University Press.*

[10] *Killaspy, H. and Priebe, S. (2020) Research into mental health supported accommodation – desperately needed but challenging to deliver. The British Journal of Psychiatry.*

[11] *Killaspy, H., Priebe, S., King, M. et al. (2019) Supported accommodation for people with mental health problems: The QuEST research programme with feasibility RCT. NIHR Journals Library.*

[12] *Joint Commissioning Panel for Mental Health (2015) Practical Mental Health Commissioning: Guidance for commissioning public mental health services. Joint Commissioning Panel for Mental Health.*

[13] *NHS England and NHS Improvement Long Term Plan (2019)*

CASE STUDY

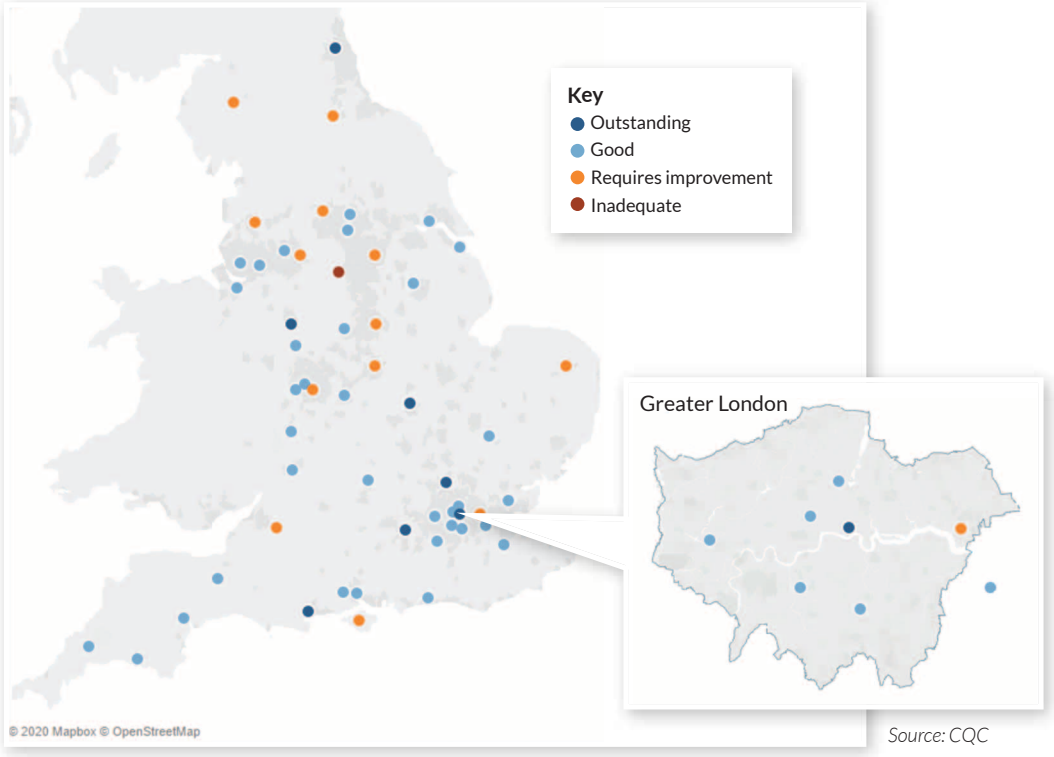
David Shiers, expert carer and retired GP, talks about his daughter's care and the need to strongly advocate for her to remain close to home for rehabilitation care.

"Mary developed schizophrenia at the age of 16, changing her from a normal schoolgirl into a terrified young woman, unable to think, communicate or take part in life. Despite initial appointments in children's clinics, her illness became worse, support at home became unsustainable, and she was admitted first to an acute adult ward and then to a rehabilitation unit in the local asylum. She spent nearly three years in hospital. A lack of suitable community-based rehabilitation meant she could not leave this inappropriate setting. The local health authority located five community rehabilitation services, but all were more than 50 miles away from home. Following further strong advocacy and support from her excellent psychiatrists, the local health and social care services eventually commissioned a local community rehabilitation service. Mary was at last able to move into a modern home in the real world - her own room, her own pictures, and her own music. Within weeks, Mary began to improve and to rediscover her identity. Most of all she liked being with other young people. She took part in activities that focused on her strengths, not her weaknesses. She tentatively explored her new surroundings, went to a local college, went shopping, went swimming. She began to enjoy family activities.

"Now in her 40s, Mary still requires much support for daily activities and to manage a mixture of mental and physical disorders and treatments. Nevertheless, she is settled and happy in an excellent local residential care home. She lives for today, takes pride in her appearance and loves shopping. Her world revolves around the town she grew up in and where all her family live. We're so proud she has come through.

"But why in 2021, over 20 years on, are people like Mary still struggling to find appropriate local rehabilitation services? Unlike Mary, many have no-one to advocate for them. Nor does everyone have a psychiatrist or mental health practitioner prepared to fight for the commissioning of appropriate services or to stop displacing people from their local communities, families, and friends. In challenging commissioners to end this practice, the new NICE guidelines on rehabilitation are welcome, as is the GIRFT mental health rehabilitation programme. Indeed, they are overdue for families like mine. Hopefully receiving a decent local rehabilitation service will no longer be down to luck."

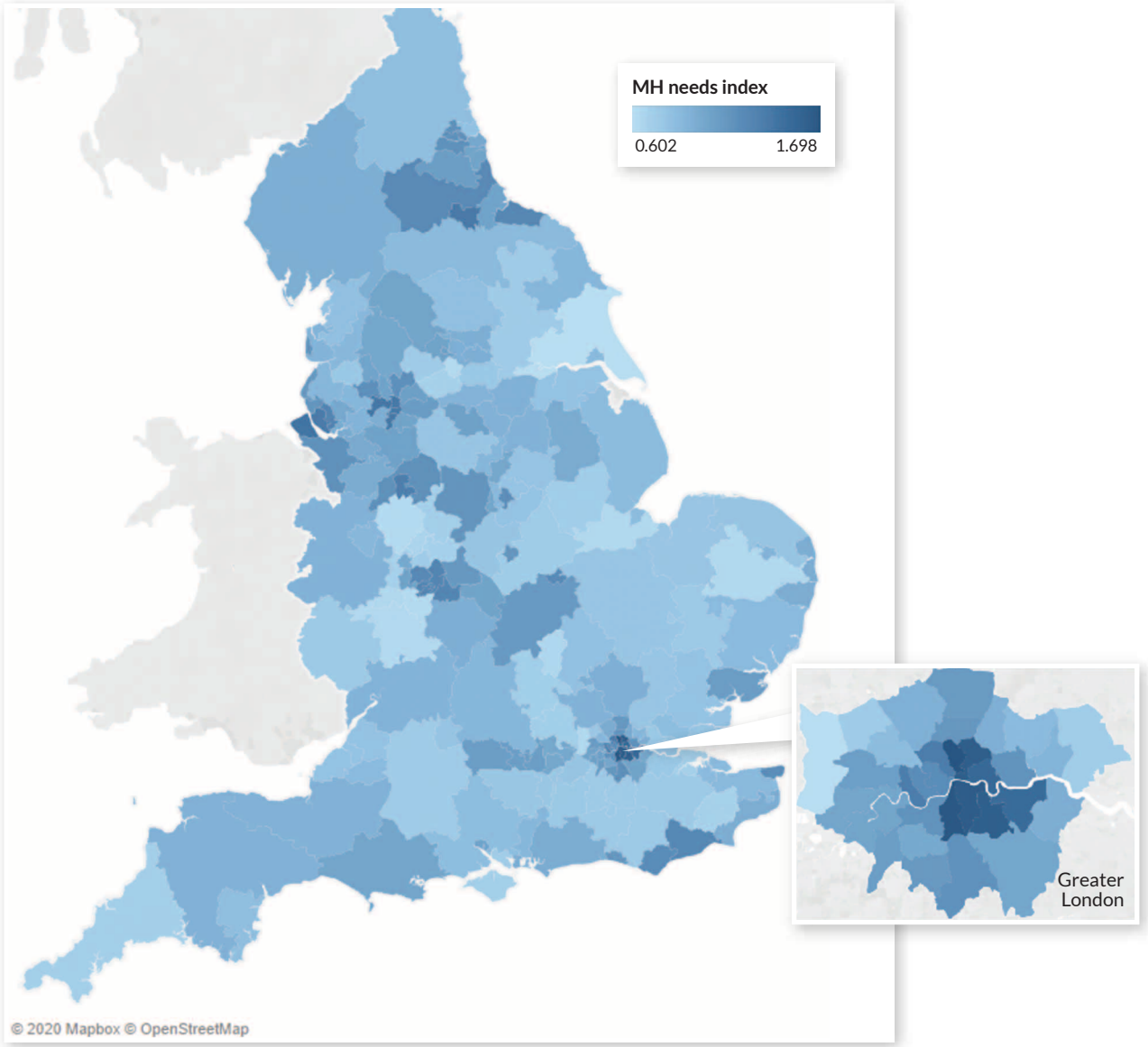
Figure 1: Map of CQC ratings - July 2020



Source: CQC

As seen in **Figure 1**, there is huge variation in social deprivation across England. This means mental health service demand also varies widely within and between providers. A thorough understanding of patient demand is necessary to appropriately plan services. It should be noted that the Person-based Resource Allocation for Mental Health (PRAMH) statistical method was used to produce the Mental Health Needs Index.[14]

Figure 2: Mental health needs index by CCG



Source: NHS England and NHS Improvement Five Year Forward View

Public Health England's Mental Health and Wellbeing Joint Strategic Needs Assessment (JSNA) knowledge guide provides an overview of what to consider when thinking about local mental health needs. Additionally, the Advancing Mental Health Equality resource supports commissioners and providers in efforts to tackle mental health inequalities in local areas. Patient outcomes and mental health rehabilitation are significantly improved when the community mental health rehabilitation functions are within a team that care co-ordinates.[15] People with especially complex mental health needs cannot be adequately supported by general adult mental health services.

[14] *Sutton, M., Kristensen, S.R., Lau, Y.S. et al (2012) Developing the mental health funding formula for allocations to general. Department of Health. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213333/ACRA201218A-Developing-the-Mental-Health-Funding-Formula-For-Allocations-to-General-Practices.pdf*

[15] *Lavelle, E., Ijaz, A., Killaspy, H. et al. (2011) Mental Health Rehabilitation and Recovery Services in Ireland: a multicentre study of current service provision, characteristics of service users and outcomes for those with and without access to these services. Mental Health Commission of Ireland.*

What is mental health rehabilitation?

Modern mental health rehabilitation is:

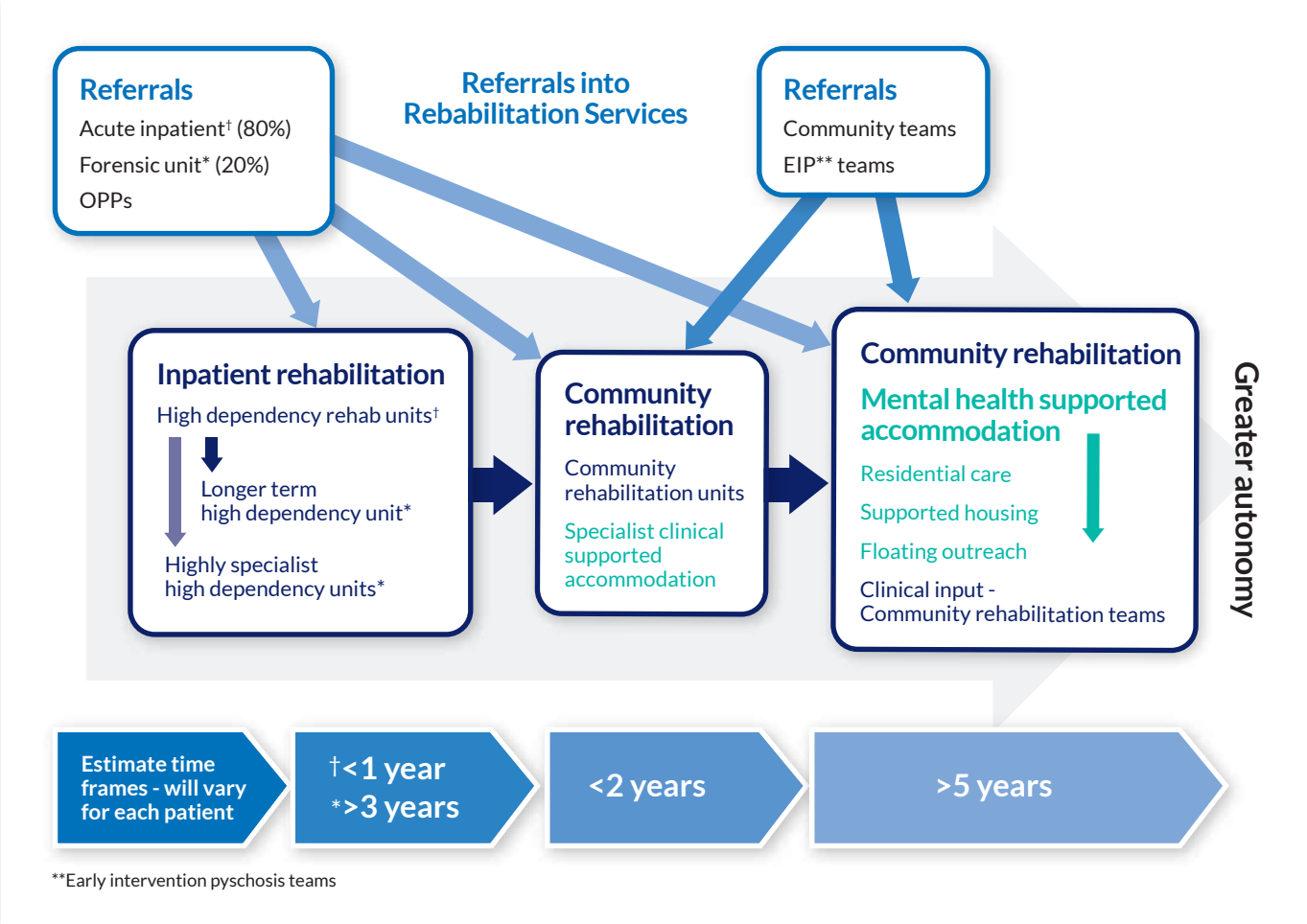
"A whole system approach to recovery from mental ill health which maximises an individual's quality of life and social inclusion by encouraging their skills, promoting independence and autonomy in order to give them hope for the future and which leads to successful community living through appropriate support."[16]

There are three main elements that together facilitate rehabilitation:

1. Help the person to build on their capabilities.
2. Modify the environment to increase support and enable function.
3. Encourage societal change to decrease stigma and discrimination.

The key aspect of the whole system mental health rehabilitation definition is the need for individual components and providers that make up the mental health system to work collaboratively to support recovery. There is an emphasis on enabling an individual's function, with services maintaining therapeutic optimism. This means that services should aim for recovery when supporting individuals, especially when other parts of the system and the patient and their family/carers may feel disillusioned and stuck.[17] Pathways and referrals should include people from the community who are able to remain in the community, with access to early community rehabilitation interventions – see **Figure 3** illustrating mental health rehabilitation services and pathways.[18]

Figure 3: Mental health rehabilitation services and pathways



Source: Joint Commissioning Panel for Mental Health

[16] *Killaspy, H., Harden, C., Holloway, F., King, M. (2005) What do mental health rehabilitation services do and what are they for? A national survey in England. Journal of Mental Health, 14(2): 157-165. www.tandfonline.com/doi/abs/10.1080/09638230500060144*

[17] *Killaspy, H. (2019) Contemporary mental health rehabilitation. Epidemiology and Psychiatric Services, 28(1): 1-3. https://doi.org/10.1017/S2045796018000318*

[18] *Joint Commissioning Panel for Mental Health (2016) Guidance for commissioners of rehabilitation services for people with complex mental health needs. JCPMH. www.jcpmh.info/good-services/rehabilitation-services/*

NICE clinical guidance[19] recommends rehabilitation services for people with complex psychosis should:

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

It should be noted that the recommendations in this report aim to reduce unwarranted variation across rehabilitation pathways, and broadly align with recent NICE rehabilitation guidance published in August 2020.

Patient outcomes and mental health rehabilitation are significantly improved when the community mental health rehabilitation functions are within a team that care co-ordinates. However, as seen in **Table 1**, 46.4% of mental health providers in England did not have separate community mental health rehabilitation provision in 2018/19. In these trusts, generic psychiatric teams were often in place. Given that users of these services have complex psychosis, this suggests that many people do not have access to the specialist mental health rehabilitation services they need, either locally or elsewhere.[20] With the Community Mental Health Framework[21] being developed around the country, with a focus on those needing rehabilitation as a core component of its work, it is essential that there is dedicated provision with the right mix of skills, not necessarily being a specific team.

Table 1: Types of rehabilitation community teams

	N
Providers with community rehabilitation team (recent definition*)	16.1% (9/56)
Providers with community rehabilitation team (older definition**)	30.4% (17/56)
Providers with generic CMHT supporting rehabilitation patients	7.1% (4/56)
No identified community rehabilitation provision	46.4% (26/56)

*Recent definition **Older definition
NB if provider provides more than 1 community service the more comprehensive type was selected

Source: NHSBN and GIRFT 2018/19; Community Mental Health Teams (CMHTs)

[19] *www.nice.org.uk/guidance/ng181*
[20] *www.nice.org.uk/guidance/ng181*
[21] *NHS England and NHS Improvement Community Mental Health Framework (2019)*

Why is mental health rehabilitation needed and who needs these services?

People with especially complex mental health needs are, for the most part, not adequately supported by general adult mental health services. This is because their needs require specialist assessment and treatment, as well as a whole team approach, where all service users are held in mind by the team as a whole. The longer-term mental health rehabilitation approach and continuity of care is also a central tenet of effective care and improved outcomes. With a specialist multidisciplinary team (MDT) who treat, manage, and address the complex issues that arise, while always maintaining hope, patients will be able to thrive and have their needs effectively met.

We do not promote exclusion criteria for rehabilitation services based on diagnosis but do recognise that they are predominantly received by those with psychosis. Over 80% of people who are referred for mental health rehabilitation have a primary diagnosis of schizophrenia, schizoaffective disorder or other psychosis, with approximately 8% diagnosed with bipolar affective disorder, and the remaining 12% with other diagnoses.[22] Approximately two-thirds are men. Although people who need mental health rehabilitation have varied primary diagnoses, a common feature is the complex problems they experience.

For those with complex psychosis, NICE guidance recommends offering rehabilitation to individuals with one or more of the following:[23]

- treatment-resistant symptoms – for people with a primary diagnosis of psychosis, this may include 'positive' symptoms such as delusions and hallucinations and/or severe 'negative' symptoms that lead to problems with motivation. Approximately 15-20% of those presenting to early intervention psychosis teams require rehabilitation services in the longer-term due to the severity of their functional impairment and symptoms;[24, 25]
- specific cognitive impairments associated with severe psychosis that have a negative impact on the person's organisational and social skills;
- coexisting mental health problems, such as severe anxiety, depressive or obsessive-compulsive symptoms, or substance misuse;
- physical health problems, such as diabetes, cardiovascular disease or pulmonary conditions;
- pre-existing neurodevelopmental disorders, for example autism spectrum disorder or attention deficit hyperactivity disorder, which may result in differences in presentation, treatment and outcomes;
- pre-existing co-morbid diagnosis of emotionally unstable personality disorder.

These challenges can have a severely negative impact on activities of daily living, including social, interpersonal, and occupational functioning. The person may also present with behaviour that is challenging for others, preferring not to engage with existing services, and may pose a risk to themselves or others. As a result, it is often difficult for people to be discharged from acute mental health inpatient care back into the community. Mental health rehabilitation is essential to address these complex issues. For the majority of people, mental health rehabilitation, when well-provided and executed, leads to successful and sustained discharge from hospital and a meaningful, rewarding community life.[26]

Those with mental health rehabilitation needs will benefit from support from specialist staff. Mental health rehabilitation services need to wrap around the person to aid recovery – either with specialist staff feeding into mental health rehabilitation settings or using their expertise alongside other services. Mental health rehabilitation services, for the most part, support people with a primary diagnosis of psychosis, alongside complex needs. When there are significant comorbid conditions such as EUPD or substance misuse, it is imperative that mental health rehabilitation staff are skilled up to support and treat those other components of care and have clear support from more specialised staff as needed. Similarly, when people with specific co-morbidities (such as EUPD, autism spectrum disorder) require a community placement, it is imperative that staff with rehabilitation skills are involved in helping to identify the most appropriate setting that can respond therapeutically to these additional needs. When people with a primary diagnosis of EUPD require placements, staff with rehabilitation skills will need to support the person to find the most appropriate placement for their needs and ensure that effective care plans are in place.

[22] *Killaspy, H., Marston, L., Omar, R, et al. (2013) Service Quality and Clinical Outcomes: An Example from Mental Health Rehabilitation Services in England. British Journal of Psychiatry, 202: 28-34.*

[23] *www.nice.org.uk/guidance/ng181*

[24] *Craig, T., Garety, P., Power, P. et al (2004) The Lambeth Early Onset (LEO) Team: randomised controlled trial of the effectiveness of specialised care for early psychosis. BMJ, 329: 1067-71. doi:10.1136/bmj.38246.594873.7C.*

[25] *Morgan, C., Lappin, J., Heslin, M., Donoghue, K., Lomas, B., Reininghaus, U., et al (2014) Reappraising the long- term course and outcome of psychotic disorders: the AESOP-10 study. Psychological Medicine, 44: 2713-6. doi: 10.1017/S0033291714000282.*

[26] *www.nice.org.uk/guidance/ng181*

A trauma-informed ethos and approach should be at the core of mental health rehabilitation services. We know many people who experience mental health needs will have experienced trauma in their life and will benefit from a trauma informed approach to their care and support. However, the purpose of rehabilitation should be clear in supporting anyone using rehabilitation services and in the mainstay, for those with a primary diagnosis of a psychotic condition and complex needs.

Through our analysis, we have identified the term 'rehabilitation' is used to describe a variety of inpatient services, many of which do not provide the traditional rehabilitation function. There exists inpatient provision specifically aimed at supporting people with complex emotional needs, a primary diagnosis of severe EUPD and a primary diagnosis of severe EUPD – several whom will have a history of trauma and may well have received a variety of diagnoses. This is described by commissioners as 'rehabilitation' in the absence of a specific term to describe the service type. We do not recommend continuing to describe this care and support as 'rehabilitation'.

While outside of the scope of this report, we do recommend a care pathway focused on people with complex emotional needs separate to the rehabilitation pathway. We support the current scoping work being undertaken through the NHS-led provider collaboratives programme to consider a provider collaborative model for the whole care pathway for people with complex emotional needs (both specialised and secondary care) and consider this to be the most appropriate way forward to better meet the needs of this client group.

NICE guidance[27] recommends a local rehabilitation service needs-assessment to support organising the rehabilitation pathway. This should include the number of people with complex psychosis who:

- are currently placed out of area for rehabilitation;
- have recurrent admissions or extended stays (for example, longer than 60 days) in acute inpatient units and psychiatric intensive care units, either locally or out of area;
- live in highly supported (24-hour staffed) accommodation;
- are receiving care from forensic services but will need to continue their rehabilitation locally when risks or behaviours that challenge have been sufficiently addressed (for example, fire setting, physical or sexual aggression);
- are receiving care from early intervention for psychosis services and developing problems that are likely to require mental health rehabilitation services now or in the near future;
- are physically frail and may need specialist support in their accommodation;
- are young adults moving from children and young people's mental health services to adult mental health services.

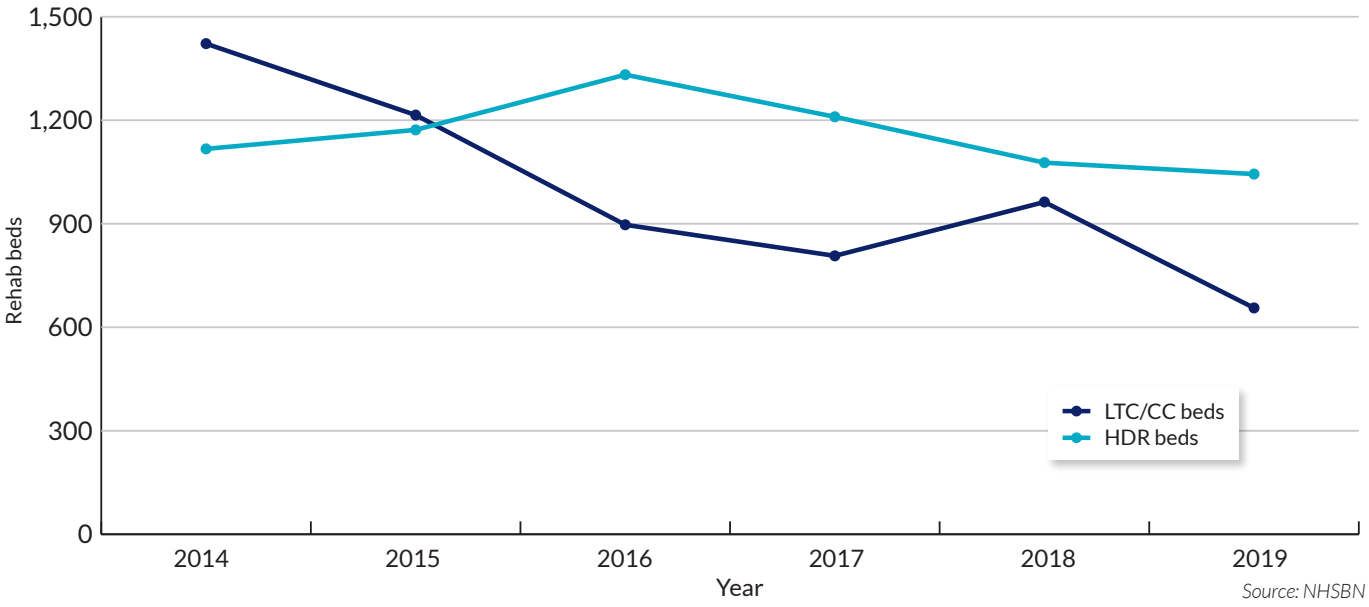
There is demand for rehabilitation care, with investment in local mental health rehabilitation pathways and a sustainable cost-effective approach. NHS Benchmarking Network (NHSBN) data of adult acute inpatient services found 14.3% of discharges during 2018/19 had a LoS of 60 days or more with an estimated cost of £550 million nationally. During the same period, 8% of discharges had a LoS of 90 days or more with an estimated cost of £400 million nationally. A proportion of the patients with these longer LoS on acute psychiatric wards will need and benefit from rehabilitation services. There is an opportunity to identify this cohort of people as early as possible in their acute admission and once appropriate, to transfer them into a rehabilitation service, either inpatient or community. The longer term approach and continuity of care is a central tenet of effective mental health rehabilitation care and outcomes. This is enabled by a specialist MDT in place who can treat, manage, and contain the complexity of the issues that arise, while always maintaining hope.

[27] *www.nice.org.uk/guidance/ng181*

Where is mental health rehabilitation now?

Over the five years between 2014 to 2019 in England, according to NHSBN annual data collections, the number of NHS mental health rehabilitation beds reduced by 33% from 2,539 in 2014 to 1,700 in 2019 – see **Figure 4**. The majority of the reduction was within Longer Term Care/Continuing Care Unit (LTC/CCU) mental health rehabilitation services, with a 54% reduction from 1,422 in 2014 to 656 in 2019. High Dependency Rehabilitation (HDR) beds reduced by 6.5% from 1,117 in 2014 to 1,044 in 2019. It is unclear and not possible to ascertain at a national level where those people who were previously in mental health rehabilitation beds were placed subsequently. **Figure 4** illustrates this downward trend in rehabilitation inpatient bed numbers, showing the reduction per 100K registered population (18-64).

Figure 4: Mental health rehabilitation NHS inpatient beds



Source: NHSBN

Many beds have been provided within the independent sector, at times, at a greater cost to both the NHS and the patient. The cost is mostly from longer LoS[28], but also partly due to patients often being located long distances from their own homes, causing isolation from family, friends, their own communities, and local community care teams. The NICE guidance[29] is clear that every time a person is placed out of area, commissioners/leaders making that decision must provide an explanation in writing to the person (and their family or carers, as appropriate):

- why they have been placed out of area;
- the steps that will be taken so they can return to their local area;
- how their family or carers will be helped to keep in contact;
- the advocacy support available to help them.

There may be some instances where the patient or person would like to be placed out of area to leave the place they associated with their difficulties. This should be facilitated and would not be deemed an inappropriate OPP. Ultimately, investment in local rehabilitation pathways is cost effective from an economic perspective and in terms of the experience and life trajectories of the patients and families, who are impacted.

From the Getting It Right First Time (GIRFT) supplementary questionnaire data, in 2018/19, the total spend on rehabilitation inpatient care in the NHS was estimated at £279m, with approximately £281m spent on rehabilitation OPP. This illustrates an approximate 50:50 split between OPPs and NHS inpatient costs in rehabilitation. There is wide provider variation in the number of OPP, with the actual number of OPPs in England at 1,847 in 2018/19, with the average per 100K registered population at 5.5 (0 minimum per provider and 100K weighted population and 26.4 per provider and 100K weighted population).

[28] *www.nice.org.uk/guidance/ng181*

[29] *www.nice.org.uk/guidance/ng181*

OPPs are not supported by NICE clinical guidance[30], recommending these placements to only be used when a local placement funding panel has confirmed that the person's care cannot be locally provided. Additionally, the placements should be limited to people with particularly complex needs, including:

- people with psychosis and brain injury, or psychosis and autism spectrum disorder, who need treatment in a highly specialist rehabilitation unit;
- people who have a clear clinical or legal requirement to receive treatment outside their home area.

There has been increased awareness of the need to reform mental health rehabilitation services from its unsustainable current national form. This is particularly pertinent as an inadequately functioning rehabilitation system can often result in acute OPP overspill, as well as mental health rehabilitation OPPs. In 2017, NHS England and NHS Improvement committed to ending the use of out of area placements (OAPs) for adults and older adults requiring non-specialist acute inpatient mental health care by 2021. Some OAPs are allowed where there are established pathways and continuity of care.[31] The NHS Long Term Plan Implementation Framework also highlights a plan to treat people needing rehabilitation locally. This is further supported by the CQC information request in 2019 concerned with the high number of beds in mental health rehabilitation wards situated a long way from the patient's home. Covering 85-90% of all rehabilitation wards in England, the report analysis found patients were much more likely to be on a ward located in a different area to the health commissioners funding the placement, with 78% of patients placed out of area in an independent sector bed.[32]

Furthermore, the 2019 NHS Mental Health Implementation Plan[33] (see **Table 2**) includes community mental health rehabilitation services within the total funding of an additional £975 million per year by 2023/24 to improve the community care of those with severe mental illnesses. All Sustainability and Transformation Partnerships (STPs)/ICSs will be investing local and new national funding to improve their community mental health rehabilitation services from 2021/22 onwards as part of implementing these NHS Long Term Plan ambitions.

Table 2: National funding profile

Funding Type (£ Million – Cash prices)		Baseline	Year 1	Year 2	Year 3	*Year 4*	*Year 5*
		2018/19	2019/20	2020/21	2021/22	*2022/23*	*2023/24*
Early Intervention in Psychosis*	Central / Transformation	0	0	0	*Funding for each of these commitments is included in 'Adult Mental Health (SMI) Community Care Total' from 2021/22 onwards*		
	CCG baselines	12	18	52			
	Total	12	18	52			
Individual Placement and Support*	Central / Transformation	13	30	23			
	CCG baselines	0	0	0			
	Total	13	30	23			
Physical Health Checks for people with Severe Mental Illnesses*	Central / Transformation	0	0	0			
	CCG baselines	2	51	79			
	Total	2	51	79			
New integrated community models for adults with SMI (including care for people with eating disorders, mental health rehabilitation needs and a 'personality disorder' diagnosis)*	Central / Transformation	0	31	52			
	CCG baselines	0	33	135			
	Total	0	65	187			
Adult Severe Mental Illnesses (SMI) Community Care Total	Central / Transformation	13	61	75	147	*370*	*456*
	CCG baselines	14	103	265	279	*326*	*519*
	Total	27	165	341	426	*696*	*975*

Source: NHS Mental Health Implementation Plan 2019/20-2023-24

[30] *www.nice.org.uk/guidance/ng181*

[31] *NHS Digital (2020) Out of Area Placements (OAPs). NHS Digital. https://digital.nhs.uk/data-and-information/clinical-audits-and-registries/out-of-area-placements-oaps*

[32] *Care Quality Commission (CQC) (2020) Mental Health Rehabilitation Inpatient Services: results from the 2019 information request. CQC. www.cqc.org.uk/sites/default/files/20201016_MH-rehab_report.pdf*

[33] *NHS England NHS Improvement (2019) NHS Mental Health Implementation Plan 2019/20-2023/24 www.longtermplan.nhs.uk/wp-content/uploads/2019/07/nhs-mental-health-implementation-plan-2019-20-2023-24.pdf*

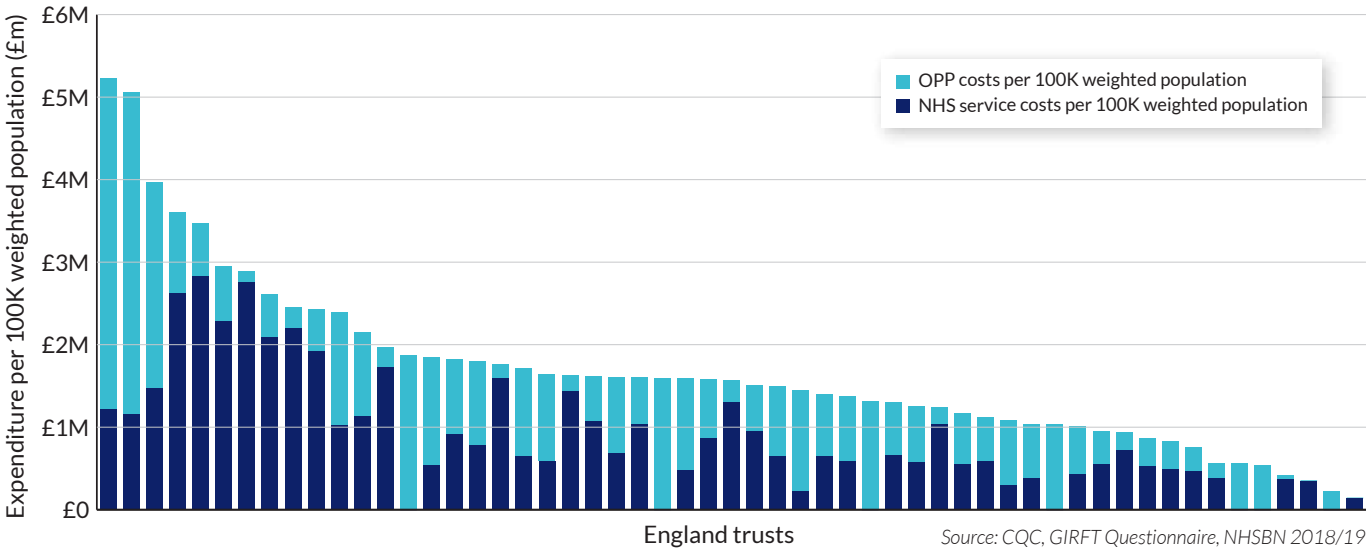
The nationally benchmarked data within this report has highlighted enormous variability, and differing levels of maturity within rehabilitation services, as well as service outcomes. The GIRFT process has supported the opportunity for reducing unwarranted variation across rehabilitation services through good practice learning. The data within this report will support those trusts and ICSs who have themselves focused on the improvement of data across a system, for the benefit of patients and the system.

Using data to support improvement

Using data to embed a continuous QI approach

Individuals in need of rehabilitation services, while relatively low in number, are a very high cost to the mental health system.

Figure 5: Rehabilitation expenditure (£m) per 100K weighted population



Source: CQC, GIRFT Questionnaire, NHSBN 2018/19

Figure 5 presents provider-level rehabilitation expenditure split by NHS/OPP per 100K weighted population across England. The 100K weighted population uses the Office for National Statistics (ONS) registered population for the core CCG areas which is then multiplied by the Mental Health Needs Index to obtain the weighting.

Figure 5 also illustrates there is significant provider variation in rehabilitation expenditure per 100K weighted population in England trusts and private provision together per year, ranging between over £5m to under £200K. There is significant provider variation in rehabilitation expenditure ranging between over £1.5m to £31m and the provider median is £8.7m. Of note, from the CQC findings, only 3.8% of OPPs were in other NHS provider beds (seven mental health trusts provide OPPs, with 2/3 being provided by one trust) and the rest of OPPs were provided for the independent health sector.

The CQC outlined that the OPP costs were greater within the independent sector when compared with the NHS, which was driven by longer LoS.[34] **Figure 5** of the national weighted population highlights areas where there is minimal investment in this population. There is significant variation across England in mental health rehabilitation provision, between the NHS and the independent sector. Generally, where NHS trusts and health commissioners have not invested in local mental health rehabilitation services to meet local need, the spend in mental health rehabilitation OPPs is high. Additionally, there is a hidden cost of people needing mental health rehabilitation sitting in other parts of the mental health system.

Therefore, despite the high economic per patient cost of this population through OPPs, there is a relatively low level of investment in this group.

[34] *Care Quality Commission (CQC): https://www.cqc.org.uk/sites/default/files/20180301_mh_rehabilitation_briefing.pdf*

Table 3: CCG mental health service investment

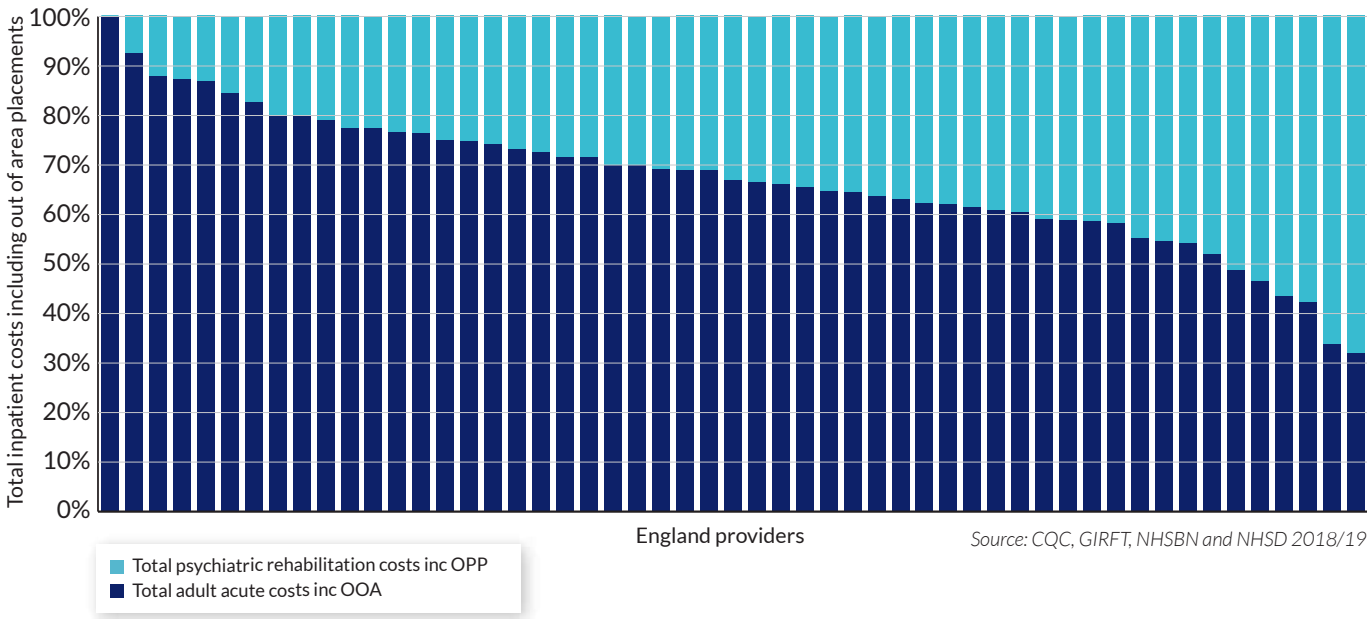
10 CCGs with highest MH funding per 100K weighted population	
CCG	**Expenditure per 100K weighted population**
NHS HAMBLETON, RICHMONDSHIRE AND WHITBY CCG	£26,737,545
NHS HEREFORDSHIRE CCG	£26,289,988
NHS NORTHUMBERLAND CCG	£25,878,421
NHS STAFFORD AND SURROUNDS CCG	£25,789,808
NHS RUSHCLIFFE CCG	£25,485,501
NHS SURREY HEATH CCG	£25,072,558
NHS CANNOCK CHASE CCG	£24,987,634
NHS DONCASTER CCG	£24,980,577
NHS SOUTH WARWICKSHIRE CCG	£24,522,514
NHS SOUTH TEES CCG	£23,941,136

10 CCGs with lowest MH funding per 100K weighted population	
CCG	**Expenditure per 100K weighted population**
NHS BRENT CCG	£10,792,321
NHS NEWHAM CCG	£11,134,110
NHS BRADFORD CITY CCG	£11,331,609
NHS WALTHAM FOREST CCG	£11,416,484
NHS MEDWAY CCG	£11,951,987
NHS SOUTHWARK CCG	£12,842,475
NHS CROYDON CCG	£12,933,413
NHS OXFORDSHIRE CCG	£13,104,153
NHS LAMBETH CCG	£13,151,216
NHS SOUTH SEFTON CCG	£13,420,269

Source: NHS Mental Health Dashboard 2020

The range in CCG mental health service investment (see **Table 3**) is from approximately £11m in Brent CCG to £27m in Hambleton, Richmondshire and Whitby CCG per 100K weighted population. The actual CCG average mental health service investment is just over £55 million, with approximately £18m per 100K weighted population. It should be noted that the PRAMH statistical method was again used to calculate these costings. Therefore, the expenditure per 100K population was adjusted to incorporate the Mental Health Needs Index and other key factors. Additionally, there is a relatively low level of NHS mental health rehabilitation funding compared to adult acute services in many parts of the country; it is the unwarranted variation, not necessarily based on local need that is striking. **Figure 6** highlights the differences in inpatient care (including OPPs) within adult acute and mental health rehabilitation service provision.

Figure 6: Balance of financial investment - inpatient care



Source: CQC, GIRFT, NHSBN and NHSD 2018/19

The cost of mental health rehabilitation inpatient care in the NHS represents 33% when compared with adult mental health acute inpatient costs. An estimated 50% of the mental health rehabilitation expenditure is spent on OPPs, compared with an estimated 10% of the adult mental health acute expenditure being spent on OPPs. **Appendix 1** (page 121) illustrates the balance of financial investment in inpatient care. It is interesting to note **Table 4** illustrating the relationship between adult acute out of area costs and rehabilitation OPP costs.

Table 4: Adult acute costs compared to mental health rehabilitation costs

Placement	Expenditure	Source
NHS adult acute inpatient*	£1,017m	NHSBN
NHS mental health rehabilitation inpatient	£279m	NHSBN/GIRFT
Adult acute OAP	£113m	NHS Digital
Psychiatric rehabilitation OPP	£281m	GIRFT/CQC
Total acute inpatients cost	**£1,130m per year**	
Total mental health rehabilitation inpatient costs	**£560m per year (55% of the spend on adult acute inpatients)**	

*Two adult acute providers were unable to provide NHS costs and are therefore excluded from the above, so the adult acute costs are likely to be an underestimate.
Source: NHSBN, GIRFT, NHS Digital, CQC

There is an opportunity (and expectation) for health commissioners and mental health trusts, as they develop plans to bring people back to local mental health rehabilitation services, to reinvest the money from OPPs into the local mental health rehabilitation patient pathways. Where possible community mental health rehabilitation provision should be created and/or strengthened, along with local mental health rehabilitation inpatient beds where needed too. Over time, as the local mental health rehabilitation system and pathway matures and develops, with greater needs-based supported housing alongside the clinical community rehabilitation offer, it may be that the weighting of community mental health rehabilitation should further increase. This is compared to more static or reducing inpatient mental health rehabilitation.

It should be noted that data should be used to understand the over-representation of detention of certain groups, and potentially explore how personalised approaches can address barriers. This links to the work the NHS England and NHS Improvement Personalised Care Group are undertaking with the Race Equality Foundation to demonstrate how the targeted use of personal health budgets (PHB) can support delivery of mental health rehabilitation. This aims to address subjective social, cultural, and spiritual experiences and beliefs of people from Black, Asian, and Minority Ethnic (BAME) communities.[35]

CASE STUDY

Personalised Health Budgets

Barnet, Enfield and Haringey NHS Foundation Trust

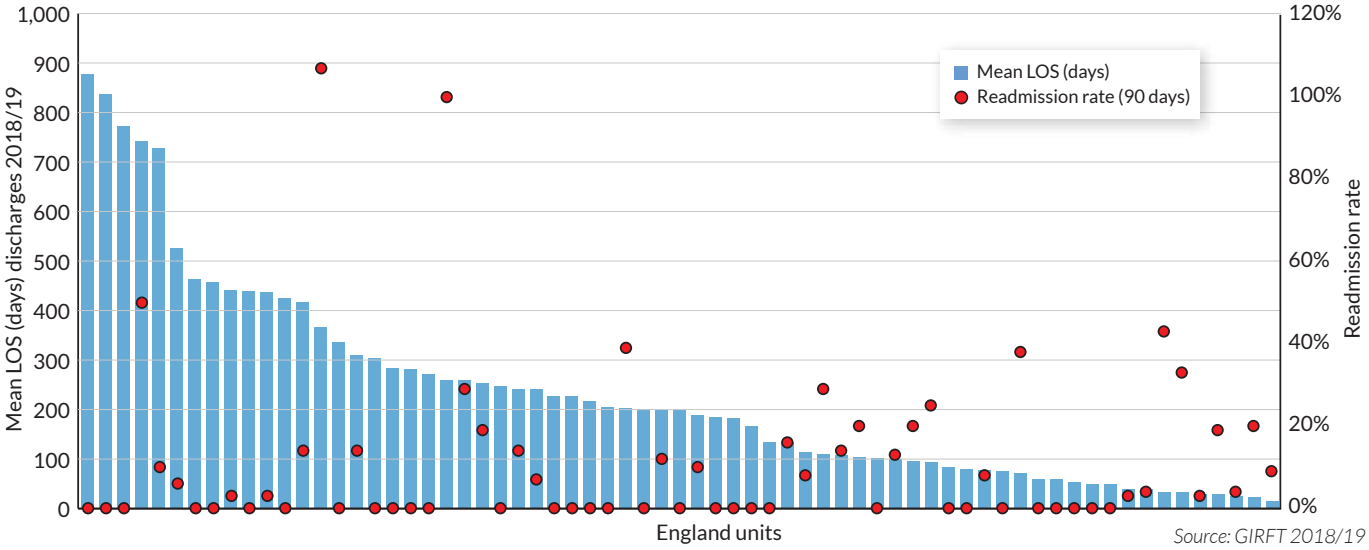
In agreement with local CCGs, the trust uses a Care Act Assessment to determine Personalised Health Budget needs. The borough has a Recovery Assessment Scale (RAS) tool which identifies the indicative budget, and although this is the main driver, the health risk is also incorporated. The indicative budget then goes for approval by social care managers to create a support plan. This plan then goes to panel, made up of social authority and CCG management, for further approval. In order to determine who commissions what, Enfield also has a joint tool which assists them in determining what percentage is paid by the CCG and what percentage is paid by social care.

We found that the issue of lack of investment within mental health rehabilitation services in local NHS systems often leads to the needs of individuals being displaced to an OPP. Therefore, it is vital that data is obtained to understand how services are functioning. However, mental health rehabilitation data is currently not collected in one location. This causes difficulty in understanding the effectiveness of services, both across the system and within mental health rehabilitation services. The poor data reporting causes challenges in tracking data across the system to ensure mental health rehabilitation services are used optimally. This is further exacerbated by the lack of an OPP definition, hence the commitment to develop this nationally by April 2022.

Consequently, there is a human and financial cost associated with data not being appropriately collated, shared and then acted on for continuous improvement. One such example of the poor data reporting and tracking across the system, is demonstrated in **Figure 7**. The aim of this chart is to show the relationship between LoS and re-admission rates into acute psychiatric beds, following an episode of treatment on a Community Rehabilitation Unit (CRU) within 90 days. However, there is no clear trend between LoS and re-admission across CRUs within England units. While LoS has been measured, it is not linked up to readmission rates. This means that an individual's care is not being tracked end-to-end. Therefore, there are unknown parts of the system. CRUs can be highly effective in reducing subsequent readmissions into acute psychiatric inpatient units when the right community support is in place and is meeting the needs of the patients. However, as most CRUs currently do not track their readmissions, there is not an effective feedback loop to understand how successful the goal of supporting greater sustained community living has been. In addition, it is challenging to learn whether it was a 'too early discharge' or an issue with the support in the community that led to the person being readmitted. Therefore, there is no clear mechanism to learn and continuously improve the quality of care, patient experience, and outcomes.

[35] *NHS England NHS Improvement (2010) COVID-19: Guidance on the legal rights to have personal health budgets and personal wheelchair budgets. NHS England NHS Improvement. www.england.nhs.uk/publication/guidance-on-the-legal-rights-to-have-personal-health-budgets-and-personal-wheelchair-budgets/*

Figure 7: CRU - mean LoS and readmission rate within 90 days



Source: GIRFT 2018/19

Often on our deep dives, clinical teams reflected that they had limited sight of this data prior to the meeting and had little input into reviewing/assuring the data. This not only reduces oversight and understanding of their own services, but it also reduces their ability to take actions to improve outcomes, as well as accountability.

Mental health rehabilitation services require in-depth data analysis, which this report has undertaken. However, this needs to be followed up by service development and local understanding of pathways to ensure real change happens. We recommend all mental health trusts develop and use local mental health rehabilitation data dashboards. The tracking of key data will routinely include health economics for the pathways of this group of people. We suggest cost effectiveness data should be collected in all health commissioned and LA areas, and for each ICS to have agreed metrics. An outline of useful data variables is in the GIRFT deep dive packs and the GIRFT webpage has an outline of these key variables for a local whole system mental health rehabilitation service. GIRFT are creating a short list of key service metrics with standards of achievement to be monitored on an ongoing basis.

The exhaustive list of data variables used in the GIRFT supplemental questionnaire can be found on the GIRFT website at ***https://www.gettingitrightfirsttime.co.uk/medical-specialties/mental-health/***

To ensure transparency and a joined-up system, certain aspects of the mental health rehabilitation dashboard will be shared at different levels of delivery and management of the service and trust. For example, the clinical team will have a dashboard which includes a checklist of Key Performance Indicators (KPIs) – such as, patient safety, the use of red to green, patient outcomes and experience, staff wellbeing and other good practice to be in place for all teams. There will be high level national standardisation of data for mental health rehabilitation inpatient teams as well as community. While this is being set up via NHS Digital and NHS England and NHS Improvement, a core local mental health rehabilitation data set should be collected by all mental health trusts. This will include process and outcome measures, across the mental health rehabilitation patient pathway, for decisions to be made about improvements, performance, quality, safety, staffing, service development and optimisation of the whole system supporting patients with serious mental illness (SMI).

It should be noted that the mental health rehabilitation patient pathway includes the RCPsych Faculty of Rehabilitation and Social Psychiatry definitions of the different types of inpatient rehabilitation units and supported accommodation provided by LAs, housing associations, and the third sector, with clinical input from Community Rehabilitation Teams (CRT). It is essential to work closely then with LAs and providers of housing and, more widely, other VCSE provision in the rehabilitation pathway to collate relevant agreed data. All partners in the rehabilitation pathway must also be resourced to facilitate such data collection and also the ability to use it in improvement work.

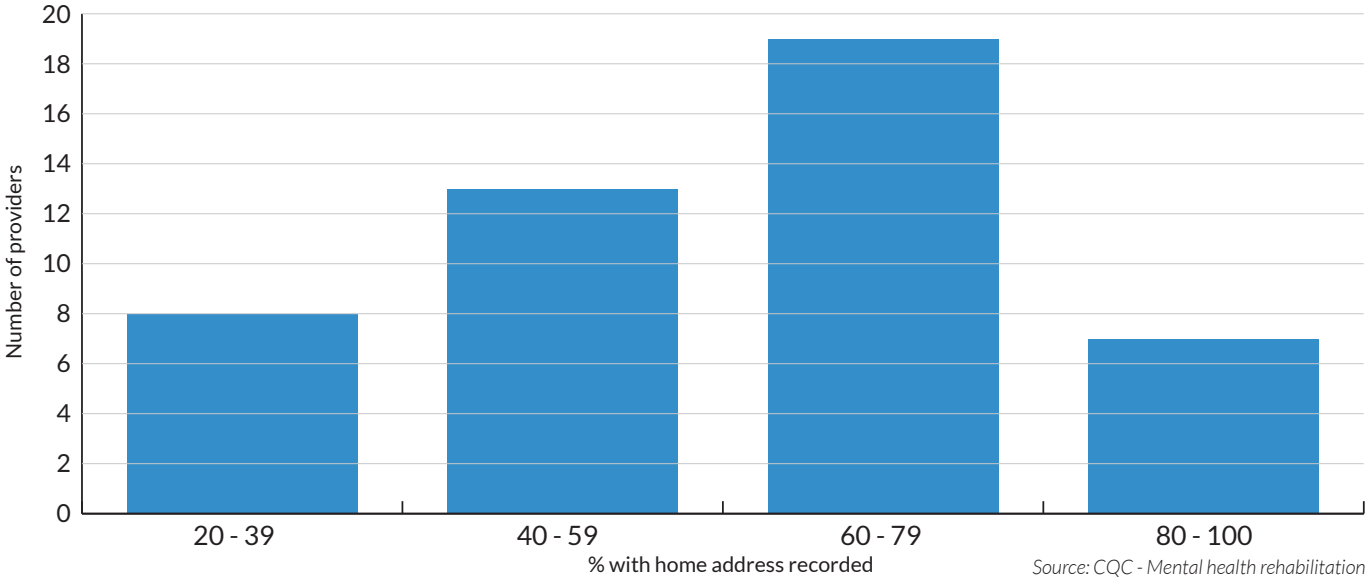
It is important the trusts are data literate, and own and engage with their data. We recommend CRTs to 'own' their own data, working with IT and analysts to ensure it is collected and reviewed in ways that are helpful to the team and their patients. Teams should receive data every quarter (at a minimum), and track performance over time to improve outcome measures – for example, LoS and readmission rates. (see **recommendation 1.1**, page 53).

Using data to monitor provider placements

As previously mentioned, OPP does not have an agreed national definition, causing challenges in measuring data across the system. During 2021/22, NHS England and NHS Improvement will work to co-produce a standard definition, but at present the differences in local definitions means there are differences in how classifications are agreed. As a result of the lack of an agreed definition, and also due to different groups such as the health commissioner, social care commissioner or the trust holding different parts of the information, regular data collection and interpretation is impacted. **Figure 8** shows data from the 2019 CQC survey, highlighting that only seven trusts (14.9%) providing rehabilitation inpatient care had 80% or more of their OPP's home address recorded. So, in essence, the lack of knowledge/recording of the patient's home address implies a level of disconnection in the delivery of care.

There is a significantly low proportion of vital patient data recorded by independent inpatient rehabilitation providers. This poor data quality further illustrates the lack of communication with the placing trust/health commissioner. This disconnect between the rehabilitation inpatient provider and the home health commissioner and mental health trust placing team is problematic. It translates into a lack of clear clinical and potentially quality and governance oversight by the placing authorities. It also indicates the lack of clear care planning around the plans and timeframe to repatriate patients back to their home health commissioners and mental health trusts. Importantly, a subsequent question is raised around where the ultimate responsibility lies. There can be confusion and variation in process, as to who is responsible for monitoring an individual's progress and liaising with the OPP provider regarding timely discharge planning. Placing health commissioners take this on or delegate it to the mental health trusts they work with. With variations in functioning of teams and how they monitor flow of patients repatriated into local provision, it is important the system now agrees what the needs are for rehabilitation. Without a clearly defined local rehabilitation offer/service, individuals may end up stuck on inpatient wards, in revolving door readmissions, institutionalised, and in OPP for unnecessarily long periods of time. Without a clearly defined service, LoS may become extremely long, and readmissions can become very common.

Figure 8: Inpatient OPP - recording of home address



Source: CQC - Mental health rehabilitation inpatient services - 2019

OPPs for supported accommodation are also important to track. They result in particularly significant costs within residential care. However, the extent of the financial cost is not held centrally. The same issues around dislocation from family, friends and local communities, the potential for institutionalisation, greater challenge on monitoring quality and safety from a distance and monitoring progress and outcomes against care plans, including further stepping down to greater independence, as well as timely repatriation to local community services, may all be negatively impacted. Again, there is a need for local commissioners, mental health trusts and associated providers to take the responsibility and show the leadership required to ensure the right services, and the right provision of care, support, and treatment in the community, are in place and being monitored in terms of meeting the local needs of the population.

It is important to ensure those who place patients follow the NICE rehabilitation guidance[36], and write to the service user and, where appropriate, their family or informal carer. This should be a measured metric, to increase the transparency and accountability in the system to patients and their families.

Supported step-down care on discharge

Another important factor is to understand where people are sent following a period of inpatient rehabilitation. It would be hoped that the inpatient rehabilitation intervention would enable people to move to supported settings in the community which are more independent than if they did not receive inpatient rehabilitation. For example, it may be that some patients can be placed directly from an acute ward to a 24-hour registered residential care home. If there has been an inpatient rehabilitation intervention, the hope is that this will support some (but not all) people being discharged to more independent supported accommodation – for example, a 24-hour supported living placement. This is more independent, and generally less expensive, than residential care. Once in the community, further rehabilitation would be ongoing with clinical input from a CRT. Evidently, step-down in this way is dependent on the availability of the correct mixture and quantity of supported accommodation being available. Where it is not, working with social care commissioners, housing providers and providers of the care and support element into supported housing can aid the development of this provision, matching local supply with local need.

Discharge destinations (step-up/step-down) are an important aspect of monitoring the effectiveness of the rehabilitation patient pathway and it is important that accurate data is obtained on this transition. **Figure 9** illustrates the discharge destination in England for patients that are stepped up or down from HDU. Data highlights those stepped down:

- Shared Lives - 0.7%;
- Psychiatric Intensive Care Units (PICU) - 5.6%;
- Highly Specialist Inpatient Rehabilitation (HSIR) - 4%;
- LSU - 1.6%;
- Medium Secure Units (MSU) - 1.1%; and
- Prison - 0.4%.

The discharge destination in England for patients that are stepped up from CRU can be seen in **Figure 10**, and is as follows:

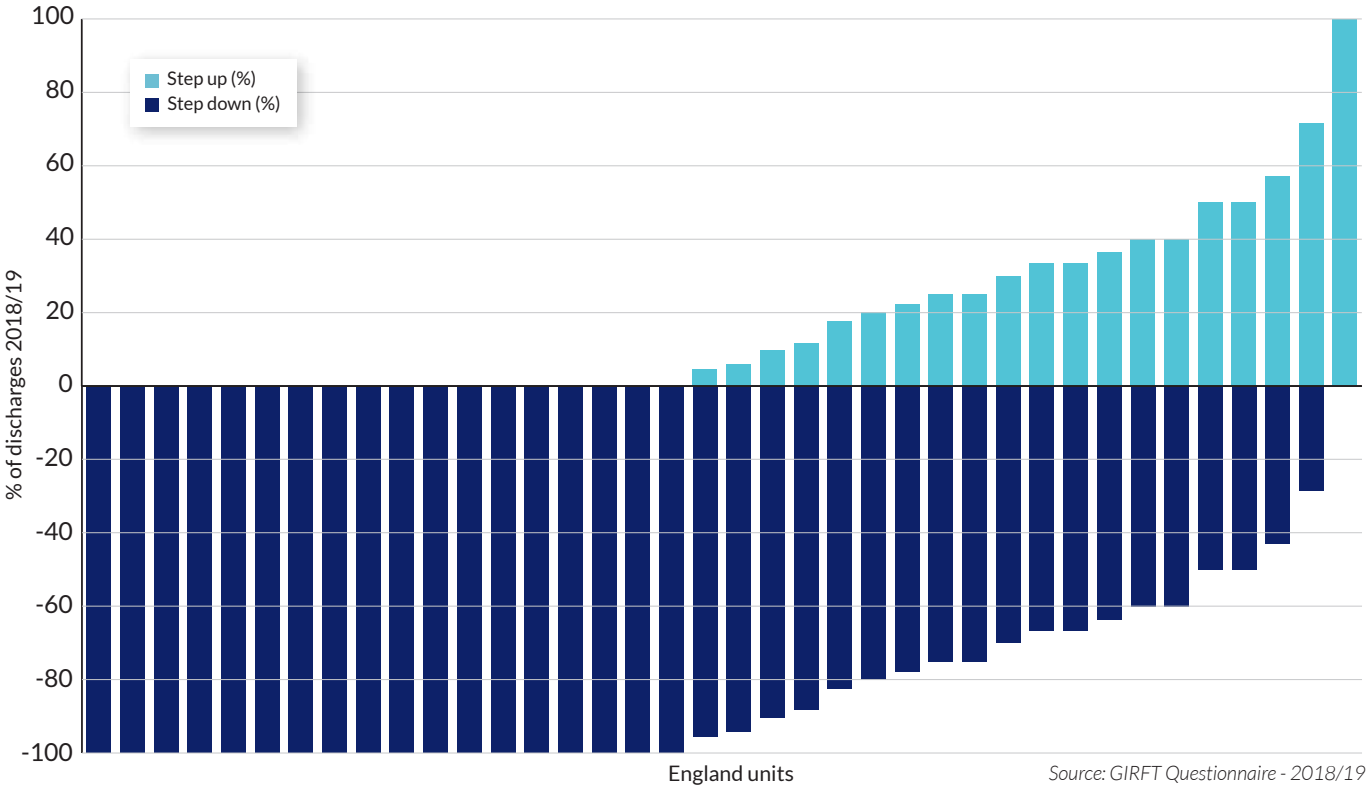
- HDUs - 2.0%;
- PICUs - 1.1%;
- LSUs - 0.5%;
- Longer Term High Dependency Units (LHDU) - 0.4%;
- MSUs -0.2%;
- HSIR - 0.1%.

A higher proportion of step-down is seen from CRUs.

Where there are step-ups in care, this does not necessarily indicate an unhelpful outcome, more an opportunity to learn about what may be missing from the local pathway. Also, where some rehabilitation inpatient units admit more people from forensic pathways, there may be a greater likelihood of more individuals requiring step-up from the rehabilitation inpatient unit. It is an opportunity to reflect, learn and further refine and develop the services, tailored to the local needs and pathways. Positive risk taking is to be supported. However, if many patients are stepping up instead of down, services may wish to reconsider the ward milieu and analyse which part of the care is leading to this outcome. It may be that the admissions criteria would benefit from a review, or that staff skills are not what they need to be, to support the patients being admitted or other issues. Rehabilitation inpatient admissions need to add value to the individual patient's journey and show a positive impact on the whole mental health system.

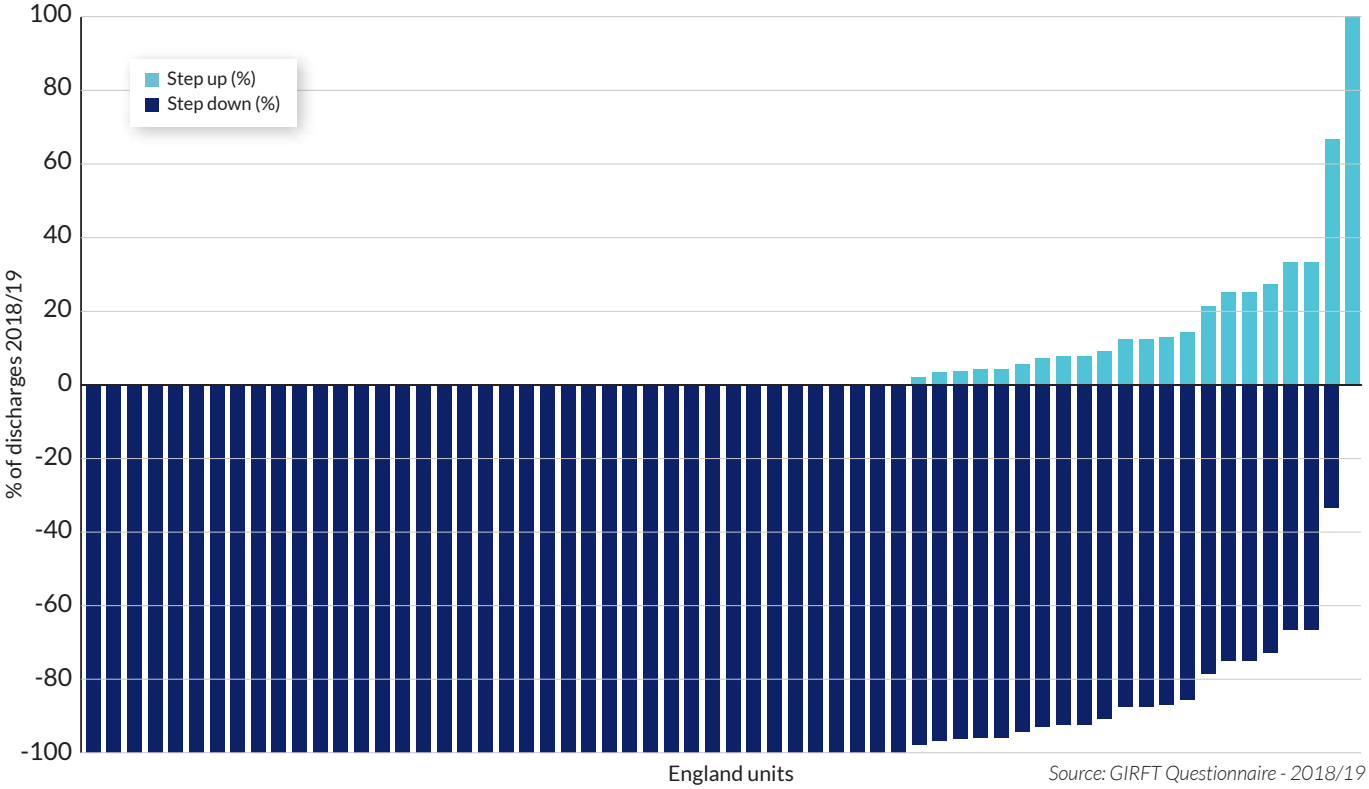
[36] *https://www.nice.org.uk/guidance/ng181*

Figure 9: HDU discharge destination, % step up/down



Source: GIRFT Questionnaire - 2018/19

Figure 10: CRU discharge destination, % step up/down

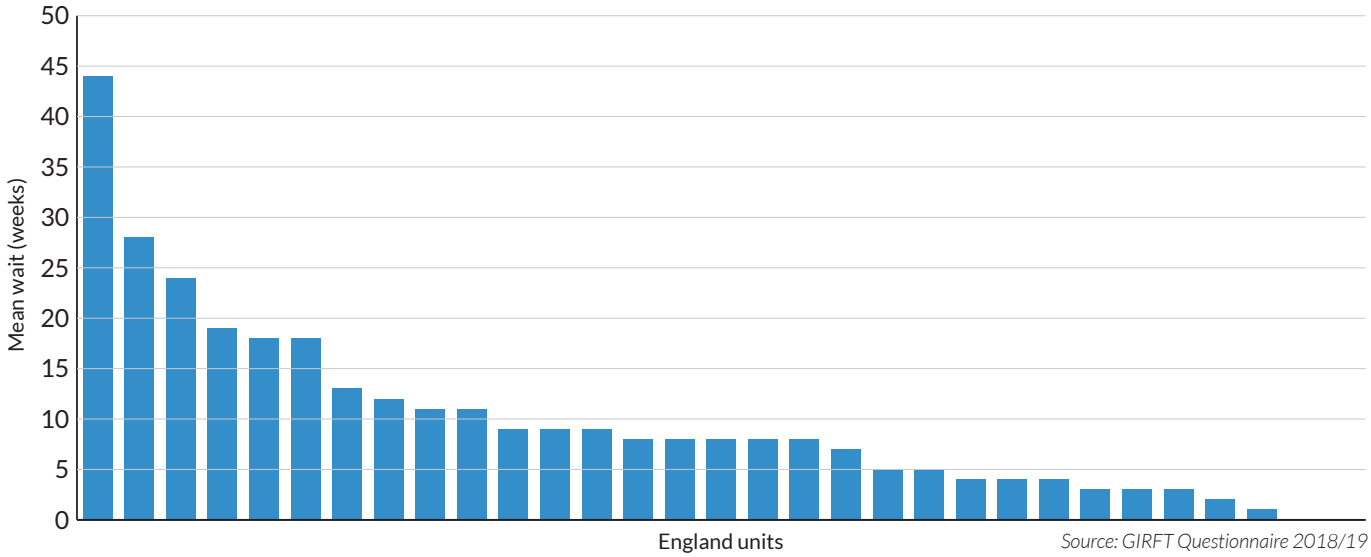


Source: GIRFT Questionnaire - 2018/19

Using data to optimise access and wait times

Currently service users who have been identified as needing mental health rehabilitation are often in other parts of the mental health system, as well as acute inpatient psychiatric beds – for example, PICUs and MSUs/LSUs. The waiting times for patients to access rehabilitation inpatient care can be a source of significant unwarranted variation. Expensive resources are still being used, as well as the patient not receiving the right care while receiving a less good patient experience. GIRFT data found 42% of acute inpatient services have a waiting list for HDU ranging from 1-48 weeks – however, the data quality was poor.

Figure 11: HDU waiting times for admission - 2018/19



Source: GIRFT Questionnaire 2018/19

As seen in **Figure 11**, the median HDU provider waiting time for admission is eight weeks with a range between 0 and 44 weeks. Data from NHSBN shows the average cost per adult acute occupied bed days (OBD) was £447, with a one-week wait costing £3,129, which means, for the average wait, a cost of £24.8K (8 weeks x £3.1K).

A thorough understanding of cost efficiencies is needed on what is being spent while the person is waiting elsewhere, and then also an understanding of spend per episode of mental health rehabilitation inpatient care. Additionally, information on whether Delayed Transfers of Care (DTOC) are due to lack of availability of suitable supported accommodation is important, and to also identify the gap – i.e. the financial cost of a patient waiting on an acute inpatient setting and understanding the opportunity to improve the inpatient mental health rehabilitation provision locally, based on need. There is also a need to understand and develop the supported and standard housing provision locally, working alongside commissioners - see **recommendations 5, 6, and 7**.

As mentioned, data collection on OPP is lacking. Locally defined out of area should be monitored, with regular quarterly (as a minimum) reporting. We will also review local definitions that are in use and consider options for a national definition, drawing on useful learning from NHS-led provider collaboratives. Our goal would be to provide systems with benchmarking information so they can compare OPP volumes in their system to others across the country. We expect this would help systems improve locally, and help GIRFT identify where it can support systems most effectively. Trusts and social care commissioners are recommended to work together locally to understand the numbers of patients who are out of responsible LA but within provider, as well as outside the provider trust. Trusts will receive central support also from GIRFT and NHS England and NHS Improvement to consider how to bring people back into local care and stop others needing to be sent out of area.

The definition of community out of area needs to be linked to each health commissioner and social care commissioner as it is at this level that the responsibility for local housing, care and support pathways lies. Inpatient mental health rehabilitation may be more nuanced in its out of area/OPP definition.

A proposed definition (with a local line of sight) is:

a) Out of responsible LA (out of area)

b) Out of local NHS provider trust area (OPP)

c) Out of local NHS provider trust, part of an agreed network of care (OPP+)

There is a need for monitoring of mental health rehabilitation OPPs, locally driven, with national oversight and support including sharing positive practice. This could begin with inpatients, then those in community supported accommodation settings (residential care, supported living). The aim is for this data collection to be tracking change over time, allowing for interventions to improve system working to be implemented early. It is also essential that the monies from OPPs are kept within the mental health rehabilitation pathway to improve the community and, where needed, the local inpatient offer.

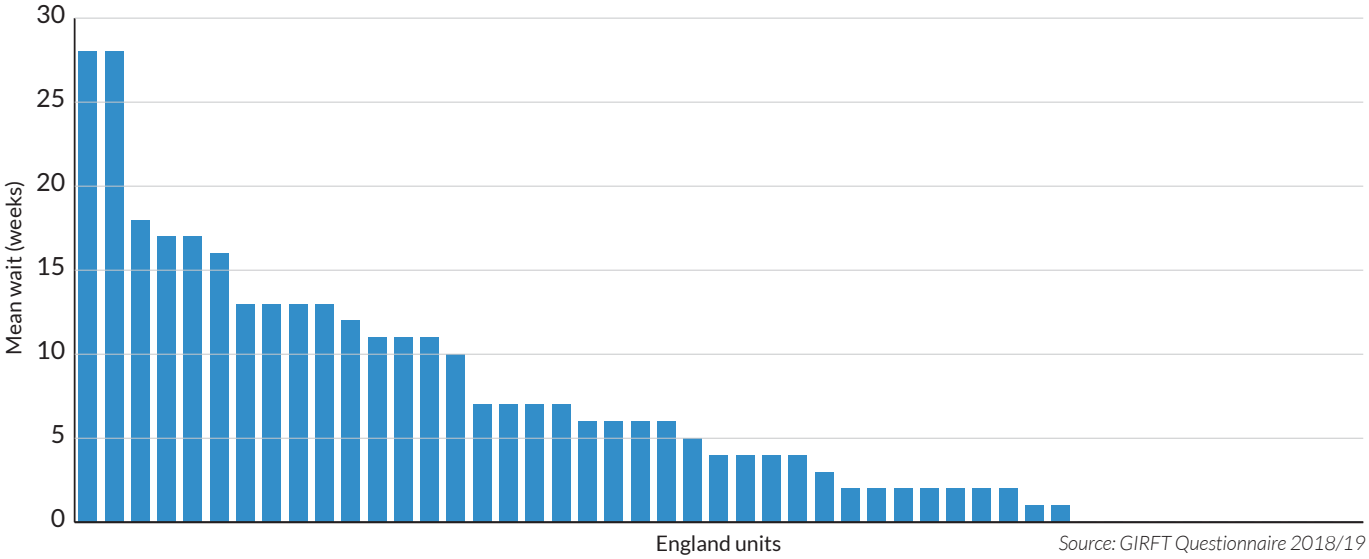
These monies form a part of the Mental Health Investment Standard and need to be tracked locally. Implementing NHS-led provider collaboratives across the rehabilitation pathway may be one way to enable this. Tracking the use of the NHS Long Term Plan transformation funds for community mental health rehabilitation locally is also an important central function. It is important to mention specific cohorts of people who end up in out of area/ OPPs care.

People with a primary diagnosis of EUPD are in placements at times, so it is important that clinical and accommodation staff with the right skill set, such as being DBT trained, work with this patient group. The mental health rehabilitation staff can adopt a consultancy or co-working model with this patient group, alongside the clinical team who are care co-ordinating and with responsible clinician involvement with the patients. Skilling up the community mental health rehabilitation team by specialist staff with skills in treating those with EUPD is important. Minimising changes and breaks in the continuity of staff working with this patient group is even more important to avoid breaking attachments which may lead to deterioration in mental health, behaviour, and function. Managing transitions well is even more paramount for those with a diagnosis of EUPD. Positive risk taking is important, with the least restrictive setting being used and patient being given as much choice as possible in accommodation and all other aspects of their care. The wider local need for specialist community care, support and treatment for those with EUPD is important to understand and ensure the right services are in place - see **recommendation 4.2**, page 75.

As part of the changing architecture of the NHS, we (NHS England and NHS Improvement) are exploring the opportunity for mental health provider collaboratives to work across the whole mental health pathway. We will learn from the NHS-led provider collaborative programme in specialised mental health, learning disability and autism services and its impact on reducing out of area care. We will consider how the provider collaborative model could support the ambitions to reduce inappropriate out of area care for people with rehabilitation needs and drive transformation and increased investment in community services for people with these needs.

Service users with complex needs are not receiving appropriate specialist rehabilitation care they require in a timely fashion. **Figure 12** illustrates the CRU waiting times for admission in 2018/19 and shows the median wait time as four weeks. NHSBN data shows the average cost per adult acute OBD was £447, with a one week wait costing £3,129. For CRU (range 0-28 weeks), provider range of costs are estimated as £0-£87,612, and for HDR (range 0-44 weeks), provider range of costs are estimated as £0-£137,676.

Figure 12: CRU waiting times for admissions 2018/19



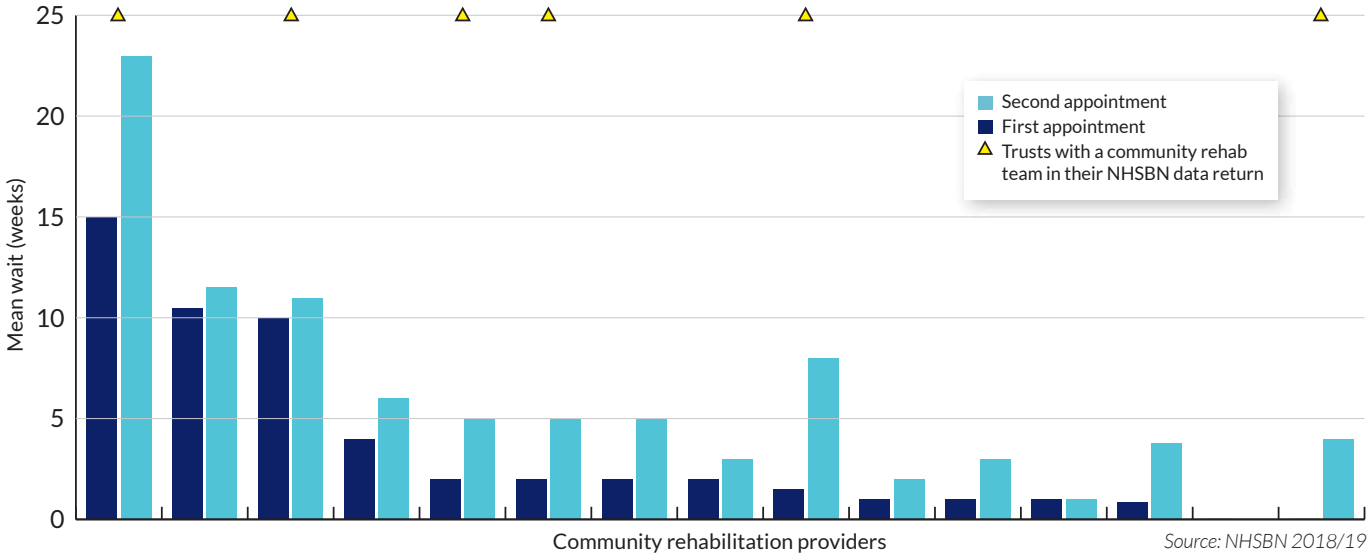
Source: GIRFT Questionnaire 2018/19

Longer waiting times inevitably impact on an individual's rehabilitation and recovery timeframe, and the ability to step into community services. Additionally, there is another cost to the system and other patients. If there are a number of people waiting for rehabilitation while placed in an acute inpatient bed, this causes a knock-on effect on acute pathway flow. As a result, there will be fewer beds available for those who need acute beds, and they may be placed in acute OPP.

A national survey of acute admissions undertaken as part of the Crisp report, also known as the Commission on Acute Adult Psychiatric Care, found that on average 16% of patients could have been treated in alternative settings, with rehabilitation services being named as one of the most common alternatives.[37] Additionally, on average 16% of patients per ward were identified as delayed discharges, due most commonly to issues with housing, particularly supported housing. This is the remit of CRTs and transferring service users to mental health rehabilitation services and community capacity/ resources.

Figure 13 illustrates the median waiting time for a first and a second appointment with a CRT. It shows that individuals often wait longer for their second appointment to receive this service. Data quality should be noted, with few providers providing data at a granular level. NHSBN data showed only 57% (15/26) of CRTs completed the wait times data collection in 2018/19.

Figure 13: Community Rehabilitation Teams: median waiting time for first appointment and second appointments



Source: NHSBN 2018/19

The cost data within the mental health system is hidden. This hampers optimal decision-making as unmet mental health rehabilitation need is not properly identified. Furthermore, the actual optimal number of rehabilitation inpatient beds and supported accommodation (effectively, beds in the community), and cost of clinical care in the community for rehabilitation patients, is not seen as a whole. Instead, the mental health rehabilitation need around the system is highlighted in a piecemeal way with non-joined up solutions being brought into play. It can be challenging then to identify the correct number of mental health rehabilitation inpatient beds and community supported housing to complement community clinical rehabilitation input (via a dedicated CRT or a generic team with a rehabilitation function). There is not a consistent understanding of who in acute inpatient beds may require mental health rehabilitation services instead. Additionally, it appears those with BAME backgrounds are often admitted onto locked challenging behaviour units, as opposed to more open settings. From recent NHSBN data it appears that there are issues with inequalities experienced by BAME service users in many areas of specialist mental health care. BAME service users are over-represented in service environments with most acuity and the highest degree of restriction. This is particularly evident in acute services, PICU, forensic care, and long-term rehabilitation services. However inequalities with reduced access exist in other services, such as substance misuse care and eating disorders.[38] Again, collating data as it pertains to those with protected characteristics is essential to understand and improve inequalities in healthcare, wherever they arise. Specifically, we are aware that more work assessing, and subsequently reducing, inequalities within mental health is necessary, including with respect to issues such as restrictive interventions, control and restraint, over-medication and polypharmacy. It is in this spirit that we have recommended data collection covering protected characteristics.

[37] *The Commission to review the provision of acute inpatient psychiatric care for adults (2015) Improving acute inpatient psychiatric care for adults in England. The Commission.*

[38] *Written communication from S Watkins, from 2020 NHS Benchmarking data.*

The GIRFT Mental Health Adult Crisis and Acute Care report[39] highlighted the use of restrictive practices and the variance across providers. Restrictive practice within mental health inpatient care should only be used as a last resort when the safety of patients and others cannot be guaranteed. The GIRFT Mental Health Adult Crisis and Acute Care report mentions concerns that there has been an increase in the use of restrictions as a COVID-19 response. For example, reduced visiting and reduced leave from acute inpatient units during full national lockdown were observed. Interestingly there are some inpatient units where restraints have reduced during lockdown due to access and support to exercise in the garden. We have also heard of service improvements with respect to restrictive practice in the secure mental health estate. Additional therapeutic activities have been introduced into a ward-based arrangement during lockdown in some services, for example. This resulted in a greater interaction with a number of patients who would usually not so easily partake in off-ward activities.

NICE guidance[40] suggests the lead commissioner works together with service providers to ensure that everyone with complex psychosis has access to rehabilitation services regardless of age, gender, ethnicity and other characteristics protected by the Equality Act 2010 and should actively monitor and report on access at least every six months. NICE also mentions that if any differences are found in rates of access for specific groups of people (for example, women or ethnic groups) compared with anticipated rates, these should be addressed, for example through:

- providing bespoke services for specific groups, such as women-only services;
- providing outreach into other services that work with under-served groups, or home visiting;
- providing tailored information and advocacy.

Data on pathway movement, including those with BAME backgrounds, is not currently collected. This is vital to review the level of need and resourcing, and to prevent institutionalisation in an inappropriate placement. While data has been included in this report, this is not routinely measured – instead, this data has been collected for the sole purpose of the report. It is important data is regularly collected to review need.

As highlighted in the GIRFT Mental Health Adult Crisis and Acute Care report, step-up should be as timely and local as feasible. Without timely support, patients, families, GPs, or other stakeholders (such as landlords) may be more reluctant for a step-down in the person's care. The understandable reticence is reduced when a rapid step-up in intensity is available, should it be needed as back up. Ultimately, rapid access, re-access and step-down also maximises the availability of existing resources and, in so doing, cuts waiting times for effective interventions. When working optimally, this is often referred to as 'easy in, easy out'.[41] As expected, waiting times lead to costs in acute care which are not currently measured.

This report focuses on patients who enter rehabilitation services; however, it is acknowledged that rehabilitation happens earlier and in many stages of a patient's journey with services. Patients can step out of rehabilitation services when ready, and ensuring sufficient MDT staff resource (occupational therapists and psychologists being a key component) with models where they work across services can make this possible.

We recommend the introduction of local 'access and wait times' data to optimise and monitor waiting times. Additionally, having this system in place allows for adherence to local and national waiting time standards. The service should review data at least annually, compare the data to local population statistics and address any access inequalities. This should include rehabilitation services having access to evidence-based interventions and services, in line with relevant NICE guidance. This recommendation will support better understanding of need, the development of the best complement of services for any locality, and inequalities in access to services being addressed - see **recommendation 1.3**, page 55.

Coding rehabilitation services

NHS Digital publishes monthly provider level recording levels as part of its data quality maturity index (DQMI). Primary and secondary diagnosis dates are core fields for the MHSDS which should be a driver to improve performance. Secondarily GIRFT has contributed to the NHS England and NHS Improvement annual bulletin (suggested changes to the MHSDS to NHS Digital) to improve the service types within the MHSDS, enabling more granular reporting of data items including diagnosis.

Table 5 illustrates primary diagnosis from the GIRFT data, showing a relatively high recording level when compared with the MHSDS which shows 33% at provider level for adults aged 18-65 in 2018/19.

[39] *GIRFT (2021) Mental Health - Adult Crisis and Acute Care GIRFT Programme National Specialty report*

[40] *https://www.nice.org.uk/guidance/ng181*

[41] *GIRFT (2021) Mental Health - Adult Crisis and Acute Care GIRFT Programme National Specialty report*

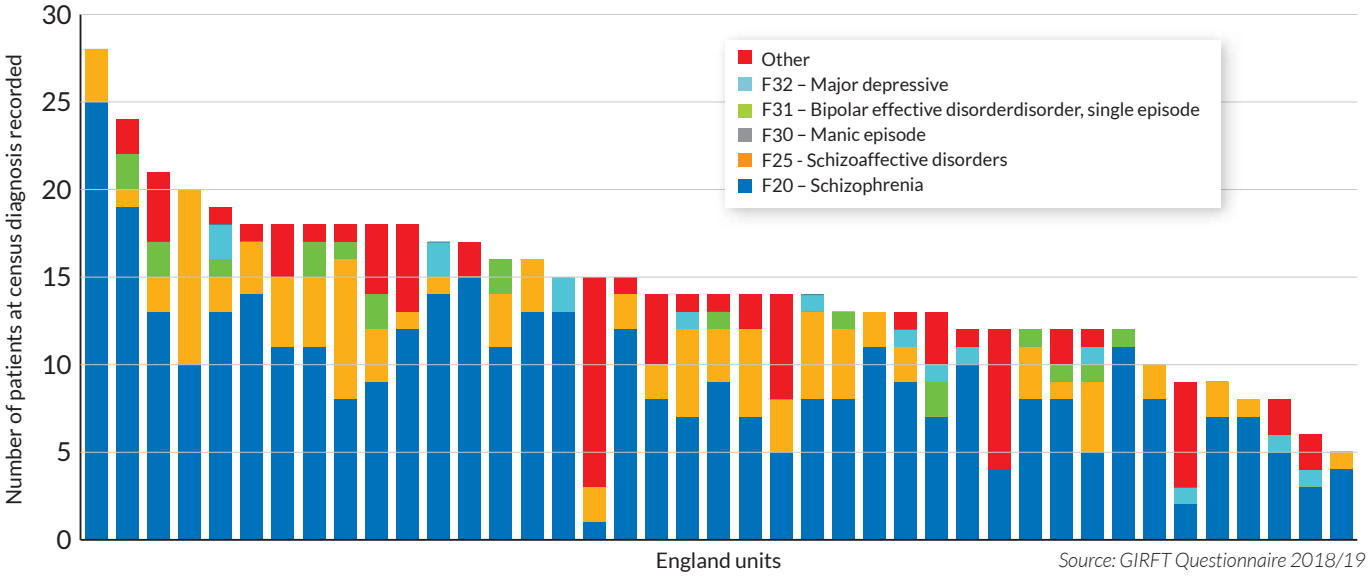
Table 5: Primary diagnosis % within HDU at census

Item	% (n)
HDU	42
100% or more	40.5% (17/42)
80% or more	78.6% (33/42)
Mean	87%
Median	93%

Source: GIRFT Questionnaire 2018/19

Figure 14 highlights the variation further, illustrating the proportion of patients with their diagnosis recorded across units in England. It is not possible to access the high level of diagnosis recording we achieved in our collection within the national datasets. A mean of 87% is a strong start point even with some providers having quite high levels of 'Other'.

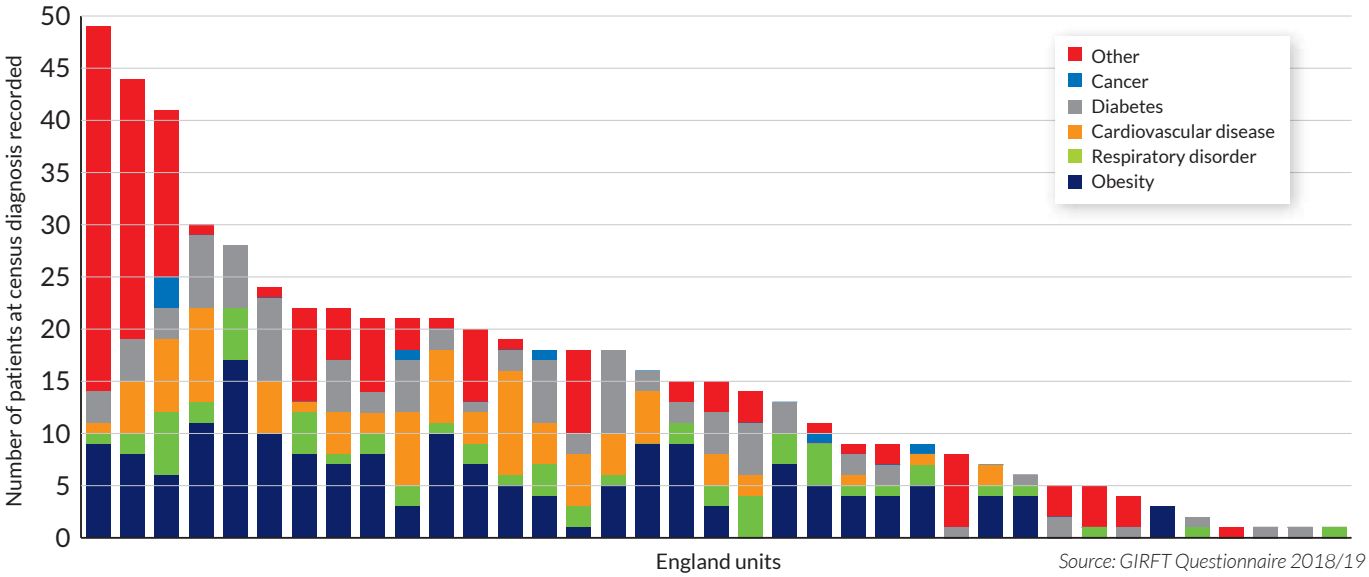
Figure 14: HDU - Primary diagnosis profile at census



Source: GIRFT Questionnaire 2018/19

Looking at the main physical health conditions which tend to be those responsible for premature mortality in this cohort of patients with SMI, the levels of obesity were striking – see **Figure 15**. There were a significant number of patients with a physical health diagnosis recorded as 'Other' across units in England. This demonstrates the wide range of physical health conditions this group suffer with and often it takes an admission to identify and treat these needs. It is an important opportunity, while patients are on the rehabilitation unit, to understand and optimise their physical health as well as their mental and social health.

Figure 15: HDU: Physical health diagnosis profile at census



Source: GIRFT Questionnaire 2018/19

Data quality issues are also seen when looking at the LoS for patients in accommodation settings, with only 26-35% of trusts nationally able to provide LoS for patients in supported accommodation settings. This provides a low baseline to enable a greater understanding of pathway movement and fails to understand the true needs of the individual. In addition, a low baseline of supported accommodation costs has been recorded, with only six to nine trusts providing data on the costs of aspects of their supported accommodation. This does not provide a full picture of the costings of services and what the need is going forward.

Without a comprehensive, granular, nuanced body of data, mental health rehabilitation services are unable to thoroughly assess services across and within trusts. Local knowledge should be segmented and combined with data enabling meaningful and tailored service planning.[42] Coding provides a rich picture of services, covering treatment, diagnosis, complications, comorbidities and outcomes. When accurately reported and analysed, coding offers benefits to rehabilitation services. It should be noted that the NHS Long Term Plan mandates all trusts to become compliant with the SNOMED-CT platform by 2020/21.[43]

Clusters are used as a currency to price mental health services, and the completeness and accuracy of clustering has been a concern.[44] For the GIRFT review, this has made understanding links between the quality and finances challenging. We expect patient level information on costs will provide valuable information needed to understand this, as patient-level costing information (PLICS) are expected to provide more robust data to better understand costs and their link to clinical outcomes.[45] PLICS were first introduced in the mental health sector for the financial year 2019/20.[46] PLICS are produced by identifying the resources used to provide care for an individual patient and calculating the expenditure on those resources based on actual costs from the provider.[47]

[42] *GIRFT (2021) Mental Health - Adult Crisis and Acute Care GIRFT Programme National Specialty report*

[43] *NHS England and NHS Improvement Long Term Plan (2019)*

[44] *NHS England NHS Improvement (2020) 2020/21 National Tariff Payment System Annex E: Technical guidance for mental health clusters. NHS England NHS Improvement. www.england.nhs.uk/wp-content/uploads/2021/02/20-21NT_Annex_E_Mental_health_clustering_tool.pdf*

[45] *NHS England NHS Improvement (2016) Patient-level costing: case for change https://webarchive.nationalarchives.gov.uk/20200501112705/https://improvement.nhs.uk/documents/36/CTP_PLICS_case_for_change.pdf*

[46] *NHS England NHS Improvement (2020) 2020 National Cost Collection guidance. Volume 5i: National Cost Collection – mental health. NHS England NHS Improvement. www.england.nhs.uk/wp-content/uploads/2020/10/2020-10-19-NCCG-Vol-5i-for-2020-Coll-Year.pdf*

[47] *https://www.gov.uk/government/statistics/mental-health-patient-level-activity-and-costing-2019-20*

A broader area in which improvements would further increase the worth of collected and reported data is data sharing. Increased sharing of and easier access to care records, for example, would make it easier to ensure that any co-occurring conditions are recognised and considered, regardless of which service a patient needs to access. This will make for a more cohesive treatment journey, especially for patients receiving care from multiple services, such as those with comorbidities. In addition, trusts and providers will be better equipped to assess local population health and plan services accordingly. It will also improve efficiency and provide better value by reducing duplication of assessments and tests. This area of work needs to include Personalised Care and Support Planning (PCSP), Social Prescribing (SP) and PHB coding, with input from the NHS England and NHS Improvement Personalised Care Group.

As previously mentioned, mental health rehabilitation services should own their own data dashboard. We recommend teams to work closely with coders. Mental health rehabilitation care should be coded consistently and accurately, with data quality to support accurate information for local use and also flowing to the MHSDS for national collation.

Much of the work to improve data collection and quality is pre-existing and GIRFT will continue to work closely with NHS Digital and other key interested parties. Most of the data is in principle already recorded but needs system collection - see **recommendation 1.4**, page 56.

Recommendations

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
1.1 All mental health trusts, health commissioners and social care commissioners should work together to provide all aspects of rehabilitation services. They should develop and use a local rehabilitation data dashboard. Data should be used for improvement, not performance, using a QI approach.	**a** Mental health trusts to work with their local IT team and Chief Clinical Information Officer to: • establish and maintain robust systems for measuring rehabilitation data; • ensure the local data dashboard includes timely analysis where there is variance, alongside an explanation and contingent actions if necessary; • commit to recording and reporting outcomes consistently for all patients; • measure outcomes using the RCPsych Rehabilitation Faculty Outcomes Framework and locally relevant outcome data. This should cover economic wellbeing and opportunities to work; • ensure all protected characteristics are measured (e.g. ethnicity, gender) to understand and better tackle inequalities; • routinely collect and flow all data to the MHSDS in line with the Information Standard notice as mandated in the NHS standard contract.	Mental health trusts, health commissioners and social care commissioners.	Quarterly reports will be in place, and seen in board to floor reports by commissioners, STPs/ICS boards, mental health trust boards, and operational and clinical staff responsible for rehabilitation services. Additionally, those running acute and community mental health services, given the interface with rehabilitation.	For immediate progress upon publication. Ready to go live October 2022 with a quarterly or monthly rehabilitation data dashboard.
	b Ensure supported housing leaders have access to and contribute to the rehabilitation system data. Data to be integrated between different sectors, with shared outcomes and data for measurement.	Supported housing providers and VCSE sector to be included. This needs to be supported with the additional resource to facilitate such data collection, which will then be the source of improvement work.	Quarterly reports will be in place, and seen in board to floor reports by commissioners, STPs/ICS boards, mental health trust boards, and operational and clinical staff responsible for rehabilitation services. Additionally, those running acute and community mental health services, given the interface with rehabilitation.	For immediate progress upon publication. Ready to go live October 2022 with a quarterly or monthly rehabilitation data dashboard.

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
1.2 All mental health trusts, health commissioners and social care commissioners, as well as housing partners, should robustly record and monitor all OPPs and report this on a minimum quarterly basis.	**a** Confirm a local definition of OPPs and track numbers in advance of the NHS England and NHS Improvement developed definition being agreed in 2022.	Mental health trusts, health commissioners and social care commissioners, as well as housing partners.	Data available to all who need to know and act on reducing OPPs.	For immediate progress upon publication. Rehabilitation OPPs report quarterly, commencing as soon as practical after publication.
	b Include reasons for the placement needing to be OPP and, in line with NICE guidance, write to the patient and family including the timeframe as to when they will return to local services.	Mental health trusts, health commissioners and social care commissioners, as well as housing partners.	Data available to all who need to know and act on reducing OPPs.	For immediate progress upon publication. Rehabilitation OPPs report quarterly, commencing as soon as practical after publication.
	c Data on placements should identify if any groups are particularly over-represented in OPPs, including protected characteristics.	Mental health trusts, health commissioners and social care commissioners, as well as housing partners.	Data available to all who need to know and act on reducing OPPs.	For immediate progress upon publication. Rehabilitation OPPs report quarterly, commencing as soon as practical after publication.
	d Data should be reported to and discussed at trust boards, with any relevant issues identified then raised with health commissioners, LAs and ICSs if appropriate on a minimum quarterly basis.	Mental health trusts, health commissioners and social care commissioners, as well as housing partners.	Data available to all who need to know and act on reducing OPPs.	For immediate progress upon publication. Rehabilitation OPPs report quarterly, commencing as soon as practical after publication.
	e Ensure any issues identified are acted on.	Mental health trusts, health commissioners and social care commissioners, as well as housing partners.	Data available to all who need to know and act on reducing OPPs.	For immediate progress upon publication. Rehabilitation OPPs report quarterly, commencing as soon as practical after publication.
	f Data should be reported both for inpatient and community supported housing OPPs.	Mental health trusts, health commissioners and social care commissioners, as well as housing partners.	Data available to all who need to know and act on reducing OPPs.	For immediate progress upon publication. Rehabilitation OPPs report quarterly, commencing as soon as practical after publication.
	g Where there is a provider collaborative approach the definition of OPP may be different, recognising there may be a number of providers working together to deliver a seamless pathway of care. Here, it is key to ensure that connections with the LA of origin are maintained as well as the family and local care team connection.	Mental health trusts, health commissioners and social care commissioners, as well as housing partners.	Data available to all who need to know and act on reducing OPPs.	For immediate progress upon publication. Rehabilitation OPPs report quarterly, commencing as soon as practical after publication.

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
1.2 (continued)	**h** Local systems should continue to monitor Out of Provider Placements (OPPs) for people with rehabilitation needs to highlight gaps in local service provision and to identify health commissioner spend that could be reinvested locally to address people's needs close to home and in the least restrictive environment. NHS England and NHS Improvement should use this information to develop a set of metrics that can be applied consistently between areas which will help drive this reinvestment in local rehabilitation pathways, allow for benchmarking, and demonstrate progress towards delivering high quality local services which support people with rehabilitation needs in the least restrictive setting.	Mental health trusts, health commissioners and social care commissioners, as well as housing partners.	Data available to all who need to know and act on reducing OPPs.	For progress by April 2022, with national data collection considered thereafter.
1.3 All trusts, health commissioners and LAs should ensure timely access to rehabilitation services and introduce local 'access and wait times' data to optimise and monitor. This should include rehabilitation services accessing evidence-based interventions and services, in line with relevant NICE guidance.	**a** Identification of all people who meet the criteria for rehabilitation services, including people with complex psychosis as set out in recent 2020 NICE guidance. Be inclusive by default and monitor their wait times into rehabilitation services (inpatient and community).	Mental health trusts in-reach.	Measure flow in rehabilitation pathways and understand when people's pathways and use of resource can be improved.	Commence as soon as possible and be in place within six months of publication.
	b Time to access of rehabilitation evidence-based interventions to be measured, reported on, monitored and minimised.	Monitoring by commissioners locally.	Measure flow in rehabilitation pathways and understand when people's pathways and use of resource can be improved.	Commence as soon as possible and be in place within six months of publication.
	c Provide in-reach into acute inpatient units to identify those who meet the criteria for rehabilitation.	Form part of the NHSBN national annual collection.	Measure flow in rehabilitation pathways and understand when people's pathways and use of resource can be improved.	Commence as soon as possible and be in place within six months of publication.
	d Include appropriate access to supported accommodation or specialist placements.	In time, collect and report centrally via NHS Digital.	Measure flow in rehabilitation pathways and understand when people's pathways and use of resource can be improved.	Commence as soon as possible and be in place within six months of publication.

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
1.3 (continued)	**e** Monitor and report on patients coming from early intervention in psychosis services into rehabilitation services, particularly optimising early intervention for rehabilitation. Around 15% of early intervention in psychosis patients should be expected to come into rehabilitation services.		Measure flow in rehabilitation pathways and understand when people's pathways and use of resource can be improved.	Commence as soon as possible and be in place within six months of publication.
1.4 Coding - rehabilitation care should be coded consistently and accurately.	**a** GIRFT team to develop MHSDS and SNOMED with NHS Digital. This is pre-existing development work.	Mental health trusts, health and social care commissioners across the whole system (once developed by the GIRFT team with NHS Digital and other stakeholders).	Data will be available that is correctly coded. It will be used from 'floor-to-board' to ensure services meet needs and there is continuous improvement. Also personalised care should be implemented as much as possible.	For immediate progress upon publication. Finalise by October 2022.
	b Ensure this includes psychiatric and physical health comorbidities.	Mental health trusts, health and social care commissioners across the whole system (once developed by the GIRFT team with NHS Digital and other stakeholders).	Data will be available that is correctly coded. It will be used from 'floor-to-board' to ensure services meet needs and there is continuous improvement. Also personalised care should be implemented as much as possible.	For immediate progress upon publication. Finalise by October 2022.
	c Include PCSP, SP and PHB coding, with input from the NHS England and NHS Improvement Personalised Care Group.	Mental health trusts, health and social care commissioners across the whole system (once developed by the GIRFT team with NHS Digital and other stakeholders).	Data will be available that is correctly coded. It will be used from 'floor-to-board' to ensure services meet needs and there is continuous improvement. Also personalised care should be implemented as much as possible.	For immediate progress upon publication. Finalise by October 2022.
1.5 A rehabilitation lead clinical information officer to support the rehabilitation data dashboard and the improvement of data quality across the trust and the rehabilitation pathway.	**a** This should have at least one Whole Time Equivalent (session) of time attached.	Trust board	Role will be appointed.	Within 12 months of publication.

Patient pathways

By identifying, quantifying, and understanding the local need for mental health rehabilitation services, it is possible to ensure the right provision and pathways can be put into place. This enables patients to access rehabilitation care in a timely manner, including those from early intervention psychosis services, which can positively impact on their life trajectories. When services can be responsive to local need in this manner, a reduction or avoidance of patients being sent to OPPs is possible, as well as the return to good local rehabilitation pathways of existing patients in OPPs.

Clear standardised frameworks and using standardised terminology for the different service provision are useful to facilitate best practice and evidence base being incorporated routinely. Benchmarking and learning from those teams is possible when a degree of standardisation is in place.

As we develop specialist pathways for particular cohorts of people, it is important that provider collaboratives work within their ICSs and ensure that the specialist components of the pathways (such as rehabilitation, EUPD, eating disorders) are linked with the rest of the mental health system within the region. This helps patients to flow between services seamlessly, ensuring integration and personalised care.

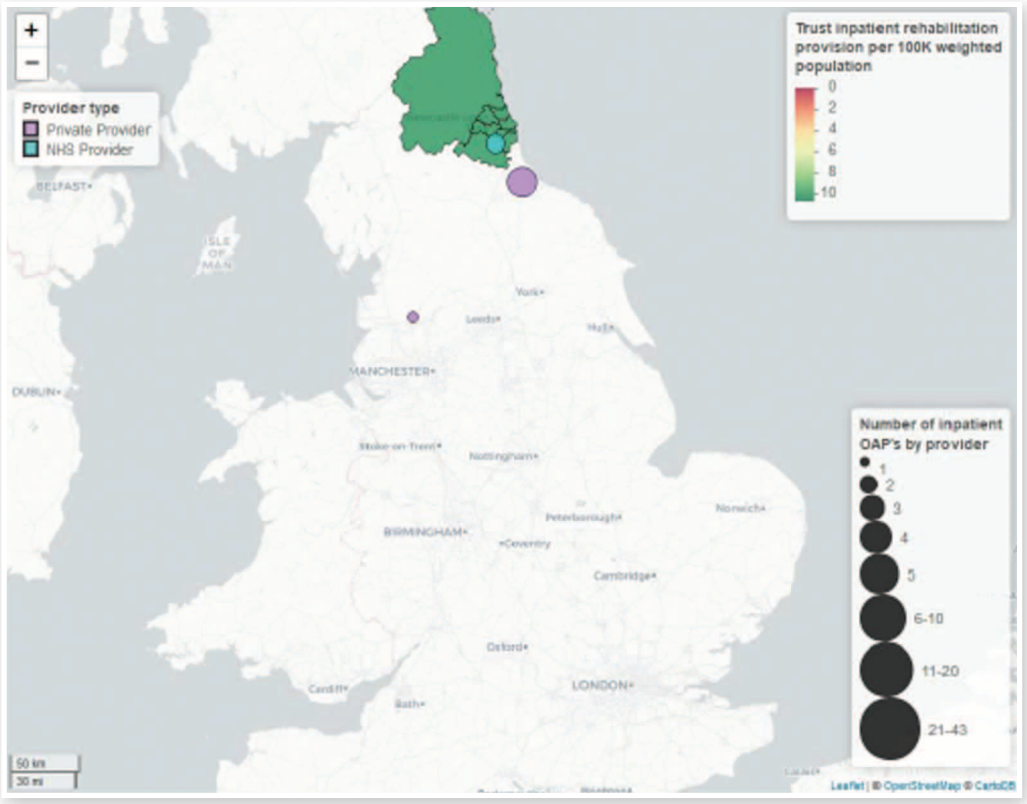
Developing local rehabilitation pathways

Nationally, there is significant variability in mental health rehabilitation care provision. At one end of the spectrum there is no mental health rehabilitation provided, while at the other there is a fully functioning mental health rehabilitation system – then, there is everything in-between. Even with mental health rehabilitation services where all parts of the system are in place, there are always areas to improve and to develop the next iteration of services which better match the needs of the patient group locally and best serve the broader mental health need and services.

People with especially complex mental health needs are not adequately supported by existing general mental health services since their needs require specialist assessment and treatment. The NHS Long Term Plan seeks to address this for community mental health services by significantly increasing funding, with new models able to provide a higher quality of services for people with severe mental health problems, including those with highly complex needs.

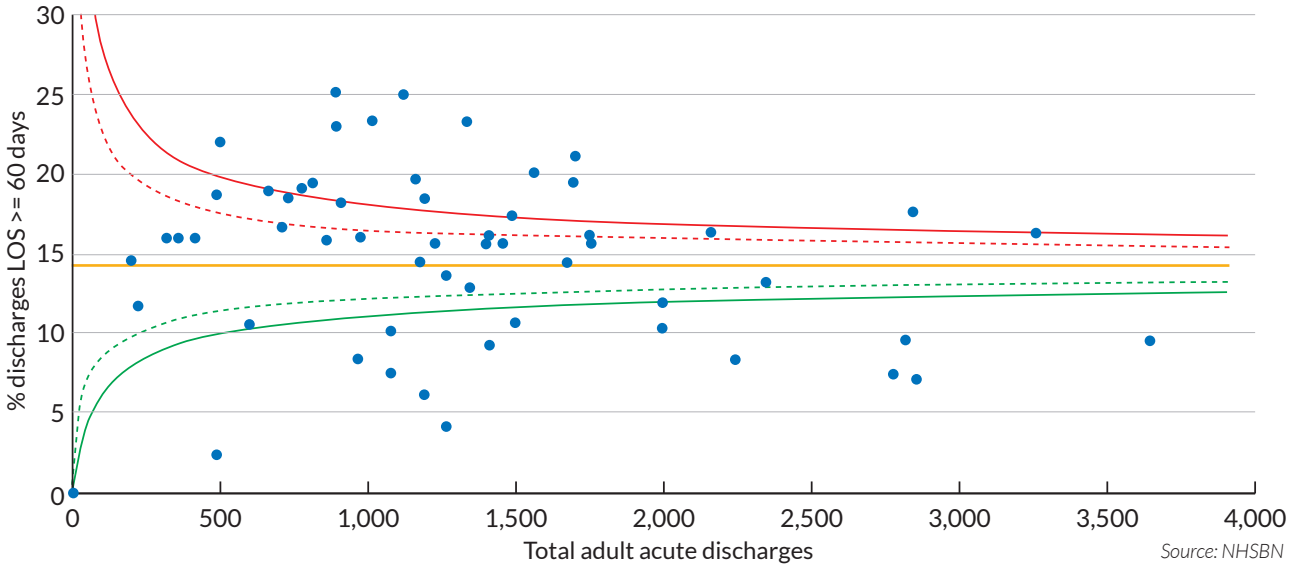
Figure 16 illustrates the potential impact of NHS inpatient rehabilitation provision (Northumberland, Tyne and Wear NHS Foundation Trust), showing that with a fully functioning whole system rehabilitation service, with well-staffed NHS provision, there are lower OPPs. In **Figure 17**, the proportion of adult acute discharges with a LoS >= 60 days (15.6%) is close to the national average. There will be a multitude of associated factors – however, there may be room to have a more proactive in-reach rehabilitation function or improved supported housing provision to speed up discharge for more acute inpatients. This trust is one of the largest in the country, covering a weighted population of nearly 1.5 million people aged 16 and over.

Figure 16: Core trust inpatient rehabilitation provision and CCG funded OPP by provider



Source: Source of numbers and location of inpatients in mental health rehabilitation from this trusts' postcodes: CQC - Mental health rehabilitation inpatient services – 2019

Figure 17: Proportion of adult acute mental health discharges with LOS => 60 days



Source: NHSBN

Funnel Plots

Funnel plots are a good way to identify and show variation. For example, **Figure 17** (above) shows the variation in the proportion of adult acute mental health discharges with LOS => 60 days in 2018/19.

How funnel plots work

The x-axis plots the volume metric (number of adult acute mental health discharges) and the y-axis plots the outcome metric (% discharges with LOS => 60 days). Each dot represents a specific provider. The mean value for the population (in this case 14%) is shown by the amber line.

The curves on either side show the likelihood of an outcome varying from the average due to chance alone:

- The inner curves (the dotted lines) show 2 standard deviations from the mean. 5% of values are likely to be beyond these curves due to chance.
- The outer curves (the solid lines) show 3 standard deviations from the mean. 0.3% of values are likely to be beyond these curves due to chance.

Accuracy and volume

When there is less volume (x-axis), the accuracy of calculating the variation due to chance is poorer, so the funnel curves are further from the average. When there is greater volume, the accuracy of calculating the variation due to chance is better, so the funnel curves are closer to the average.

Variation due to chance

Providers that sit outside these curves are the outliers. In **Figure 17**, the vast majority of providers have either higher or lower than expected rates.

Variation caused by other factors

All things being equal, funnel plots accurately show the variation from the average. However, **Figure 18** includes far more providers with outcome values above or below the outer ranges of the funnel than might be expected. This is called 'over-dispersion' and indicates that things are not necessarily equal—other factors may be influencing the data.

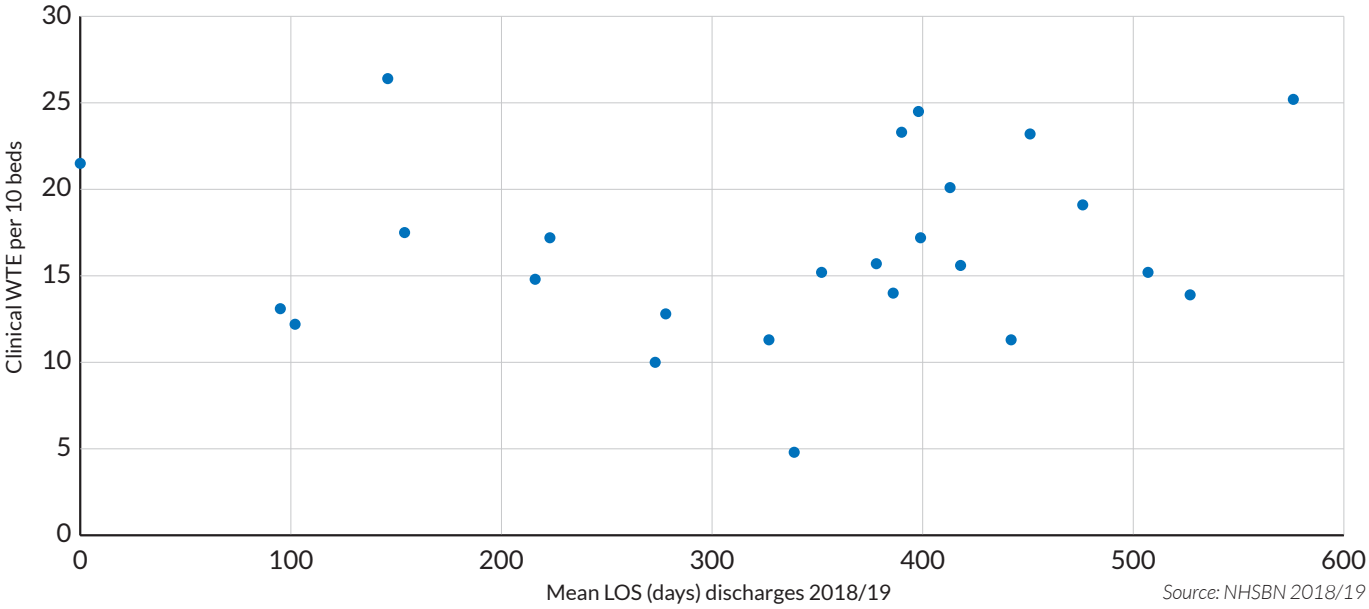
In this example, it could be due to vast discrepancies in the practices of different providers—with potential implications in terms of access, capacity, flow, and patient outcomes. There could also be discrepancies in how the data are recorded. Either way, the implication is of significant unwarranted variation, a factor not hinted at by the mean level.

In some trusts, around a quarter of all patients discharged within one year have spent > 60 days on the adult acute ward. It is likely that within that cohort of people there are individuals who have rehabilitation needs but are not able to access rehabilitation services due to inadequate provision and/or throughput due to reduced flow further along the pathway.

Of note, the GIRFT Adult Crisis and Acute Care[48] pathway work has shown that investing in and increasing generic community mental health team capacity and capability has a significant impact on reducing the numbers of people with LoS of 60+ days. They are not by any means all people needing rehabilitation, but some will be. It should also be noted that some trusts have developed good in-reach rehabilitation assessment and advice into the acute inpatient wards e.g. Cheshire and Wirral Partnership and the Complex Recovery Assessment and Consultation (CRAC) Team.

Another interesting finding in **Figure 18** shows the relationship between LoS and inpatient staffing. In part due to the relatively low numbers of complete returns, it was not possible to draw clear conclusions from the link between staffing levels and LoS on this occasion. However, a key point is that in the secure care pathway, NHSBN data showed that by having increased whole-time equivalent psychiatry, psychology and occupational therapy staffing on the ward, the LoS on LSU were significantly reduced by eight months on average. Analysis of 2016 NHSBN data within PICU showed a positive relationship between increased whole-time equivalent psychology and occupational therapy staffing on the ward, and shorter LoS. This was also shown in some subsequent years and highlights the important role specialist therapists play in supporting recovery – for example, in the use of specific psychological therapies, occupational therapists and art therapies.

Figure 18: HDR, mean LoS and inpatient staffing per bed



Source: NHSBN 2018/19

[48] *GIRFT (2021) Mental Health - Adult Crisis and Acute Care GIRFT Programme National Specialty report*

CASE STUDY

High Dependency Inpatient Rehabilitation

Cheshire and Wirral Partnership NHS Foundation Trust

Cheshire and Wirral Partnership's clinical leadership team formulated their time-limited, high dependency rehabilitation pathway and, steered by key guidance and policy, developed roles and responsibilities for each discipline in the care team in progressing patients through the pathway towards discharge from inpatient rehabilitation care.

The Complex Recovery Assessment and Consultation (CRAC) Team

The CRAC team works to improve safety, quality and to help address bed flow across the adult complex care pathway, by utilising expertise and specialist skills in complex care management. The aim is 'to ensure that no one receiving CRAC input loses one more day in the community than essential for the care and treatment, but that everyone needing an inpatient bed is placed in the best bed available for their needs that day'.

The High Dependency Rehabilitation Pathway

The pathway adopts the following phases:

1. Assessment phase

The access assessment includes a comprehensive bio-psychological history, formulation, Goal Attainment Scale (GAS) Rehabilitation goal setting, and input from the MDT (senior clinicians, nursing, occupational therapy, psychology), family and patient. An information pack is given to the patient and/or family. This assessment is completed by the CRAC Team.

2. Admission (within 72 hours)

The CRAC Team give a detailed handover to the receiving clinical team/gatekeeping assessor to key registered nurse or clinician lead. There is a senior clinician review and a physical health screening as per care notes. The nursing team perform an admission checklist and drug use screening. Occupational therapy have first contact and formulate the initial activity planner including gym and groups. Psychology also have an initial contact and explain their role.

3. Care Programme Approach (CPA) 1 – (at 4 weeks): Summary of Assessment

The team jointly review the GAS with the patient, set a tentative discharge date/destination, and complete HoNOS & DIALOG. Detailed input from across the MDT i.e. confirmation of diagnosis and medication planning, exploring goals of therapy, assessing daily living skills, create personalised activity planner.

4. CPA 2 (at 3 months): Treatment phase

A joint review of the GAS with the patient, review of tentative discharge data/destination, identification of specific actions arising from board rounds/ CPAs. Detailed input from across the MDT i.e. self-medication assessment, physical health assessment, side effect monitoring for medication, lifestyle interventions, and ongoing psychological interventions.

5. CPA 3 (at 6 months): Treatment phase ongoing

A further CPA is undertaken, similarly to CPA 2, and with sharing of intervention via peer supervision, relapse management plan development within the MDT, and completion of psychological report with formulation and intervention.

6. CPA 4 (at 9 months): Summary of treatment and discharge planning

Review of ongoing gatekeeping assessment, review GAS, plan discharge data/destination, formulate transition plans with MDT, and complete HoNOS & DIALOG. Create summary of diagnosis, treatment plan and physical health needs for discharge assessment, summary of physiological needs for future discharge planning, and consider referral to adult mental health services for continued psychological input.

7. Discharge CPA 5 (at 12 months):

A face-to-face handover with provider as part of the transition plan. Patient/carer/provider to be provided with a copy of the care plan/discharge plan/and relapse prevention plan. Gatekeeping access document is updated to give a comprehensive rehabilitation journey. Plans are shared with external support agencies.

8. Post 12 month admission

Establish rationale for delay – is there a need to assess/ explore further options? Is it an internal rehabilitation service delay or an external non-rehabilitation service delay? The team organise a peer review, including CCG and wider stakeholders.

The team's expectations throughout the pathway are that clear KPIs are set, there is a 4-weekly senior clinician review, weekly 1:1 with the key registered nurse, weekly 1:1 with a Community Support Worker (CSW), a copy of the care plan review is offered, there is monthly carer contact, and regular physical health screenings.

A recommendation to bridge the gap in current service variability would be for all trusts to undertake a needs assessment to formulate a clear plan of the additional resource required around a whole system rehabilitation service offer and put this forward for additional commissioning to health and social care commissioners. The offer needs to include inpatient and community, as well as specific clinical support required into supported housing in the form of CRT functions and early identification of rehabilitation needs.

A whole system rehabilitation service offer would encompass all the key components. For example, in-reach to acute wards, advice, and consultation to those with complex needs in other parts of the mental health system such as the community, as well as a local rehabilitation service (including inpatient and community). The initial decision making of all rehabilitation placement funding should be via funding panels, oversight of all people in rehabilitation placements clinically or through at least formal placement reviews. The core community element should be made up of the right type and number of supported accommodations, as well as staff with the right skill set in the accommodation and within the clinical MDTs to deliver necessary care and treatment. Plans can be put forward for funding from the NHS Long Term Plan and Community Mental Health Framework to health commissioners. This also includes ensuring sufficient consideration is given to the role and provision of services providing psychosocial support and vocational rehabilitation. Ensuring that these services are thoroughly accounted for within commissioning arrangements and that having genuine investment will be key to better outcomes for service users.

The offer will support reduction in acute admissions, reduction in 'long stays' on acute wards, and provide a streamlined pathway to community support, including supported housing and care packages. A reduction in, and stopping of, all inappropriate OPPs is also an essential component of the work of a CRT. It is also key to stop new people going into OPPs and bringing those already in OPPs back into local NHS inpatient rehabilitation provision and to supported accommodation. This is often a mixed economy of LA and private provision. This should use a census approach where everyone in a health/social care commissioner or trust funded placement is known about and their needs met, and onward moves planned with them and their families. This allows for stimulation of the market where there are gaps, and for efficiencies to be realised as people move to placements that are more independent.

CASE STUDY

Whole system local rehabilitation care pathways

Camden & Islington NHS Foundation Trust

Camden and Islington NHS Foundation Trust has managed to develop and sustain whole system local rehabilitation care pathways, i.e. inpatient and community rehabilitation units and community rehabilitation teams.

Key areas of development

In 2003, the trust developed a local rehabilitation pathway for people with complex psychosis, with a designated high dependency inpatient rehabilitation unit and community rehabilitation units for each borough. The following year an 'out of area reviewing officer' was appointed for each borough, identifying people who would move back into the local rehabilitation pathway. This generated financial flows which were reinvested in high quality, 24-hour supported accommodation, providing additional capacity, and better flow through the system, to repatriate people placed out of area.

In 2012, the trust successfully bid for health commissioner investment in local community rehabilitation teams to care co-ordinate over 200 people in 24-hour supported accommodation. The team also identified the need for a male only longer-term high dependency inpatient rehabilitation unit, due to an unmet need for men with complex psychosis and 'behaviours that challenge'. This was developed in partnership with North Central London ICS and the waiting list is actively managed from across the five boroughs. The unit has facilitated the return of 14 men who were placed out of area.

The trust said this success has relied upon:

- Strong leadership by local senior rehabilitation clinicians and service managers, to ensure the ongoing commitment of local health commissioners and trust executive to invest and support provision of local rehabilitation services.
- Building close working relationships with health commissioners, and having them on the local placement funding panels to understand the high levels of complexity in this service user group.
- Building close working relationships with local voluntary sector providers of supported accommodation, vocational services, and primary care.
- Collecting and collating outcome data to evidence this pathway as clinically effective, cost-efficient, and a better experience for service users.

We acknowledge that rehabilitation is broader than the specialist tertiary offers, and while the broader offer is not in scope for the purposes of this report, it is noteworthy that the Royal College of Occupational Therapists' 'Right to Rehabilitation' campaign outlines the benefit of occupational therapists leading and delivering rehabilitation alongside strong MDTs to improve inpatient flow. Expertise in rehabilitation can improve how services are structured, prioritised and resourced going forward.[49]

[49] *Royal College of Occupational Therapists (2020) Occupational Therapists Right to Rehabilitation. Royal College of Occupational Therapists.*

Recommendations

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
2. Trusts, health commissioners and social care commissioners should develop whole system rehabilitation pathways, using a local needs assessment and based on NICE guidance and NHS England and NHS Improvement policy and guidance relating to community mental health transformation as part of the NHS Long Term Plan.	**a** Health and social care commissioners, along with trusts, to undertake a needs assessment and formulate plans around a whole system rehabilitation service offer, including inpatient, community, and specific clinical support into supported housing and early identification of rehabilitation needs.	Health commissioners and social care commissioners, in close collaboration with providers. GIRFT/NHS England and NHS Improvement to track this.	Able to see local rehabilitation needs assessments and subsequent development plans.	All trusts to commence with immediate effect and complete before April 2024.
	b Ensure that the numbers of patients coming through to services tallies with the identified need, including those coming from early intervention for psychosis services, where timely access to rehabilitation services can positively impact on their trajectory.	Health commissioners and social care commissioners, in close collaboration with providers. GIRFT/NHS England and NHS Improvement to track this.	Able to see local rehabilitation needs assessments and subsequent development plans.	All trusts to commence with immediate effect and complete before April 2024.
	c Ensure patients and carers are included in the development of rehabilitation services.	Health commissioners and social care commissioners, in close collaboration with providers. GIRFT/NHS England and NHS Improvement to track this.	Able to see local rehabilitation needs assessments and subsequent development plans.	All trusts to commence with immediate effect and complete before April 2024.
	d Trusts to undertake a gap analysis based on the 2020 NICE guidance best practice.	Health commissioners and social care commissioners, in close collaboration with providers. GIRFT/NHS England and NHS Improvement to track this.	Able to see local rehabilitation needs assessments and subsequent development plans.	All trusts to commence with immediate effect and complete before April 2024.
	e Trusts to work with system partners – including health commissioners and social care commissioners, VCSE, housing partners and care providers, to develop a plan or a whole system rehabilitation pathway. Sufficient operational support and proper funding of the support element in housing is necessary for success.	Health commissioners and social care commissioners, in close collaboration with providers. GIRFT/NHS England and NHS Improvement to track this.	Able to see local rehabilitation needs assessments and subsequent development plans.	All trusts to commence with immediate effect and complete before April 2024.
	f Good practice around agreeing responsible commissioner and care of homeless people should be developed.	Health commissioners and social care commissioners, in close collaboration with providers. GIRFT/NHS England and NHS Improvement to track this.	Able to see local rehabilitation needs assessments and subsequent development plans.	All trusts to commence with immediate effect and complete before April 2024.

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
2. (continued)	**g** Commissioning to ensure local care, and length of stay (LoS) to be monitored to facilitate least restrictive options.	Health commissioners and social care commissioners, in close collaboration with providers. GIRFT/NHS England and NHS Improvement to track this.	Able to see local rehabilitation needs assessments and subsequent development plans.	All trusts commence with immediate effect and complete before April 2024.

Bringing patients treated out of area back to their local area

As discussed, people placed in an OPP may have a worse experience and OPPs are a cost to the system. The cost is tied up within the inpatient hospital setting and community supported accommodation care, in particular residential care – which need data to be gathered for effective monitoring. Currently, OPPs are often spot purchased by health and social care commissioners, or mental health trusts where the placement budget is delegated to them by commissioners, and the contact between the placing authority (for example, health commissioner, social care commissioner or mental health trust) can be variable. Additionally, there are often unclear expected outcomes from such an OPP. A standardised framework for procurement of inpatient rehabilitation OPPs has been developed by the NHS London Procurement Partnership and the North of England Commercial Procurement Collaborative, with input from GIRFT clinical leads. the aim of the framework is to be used nationally to provide a recognised standard and to reduce unwarranted variation – see *Standardisation of procurement processes and protocols* page 104. Use of this framework when commissioning OPPs across the country will be valuable to improve quality and increase personalisation (yet reduce variation) in OPPs. This can also be used for non-NHS (i.e. independent provider) placements even within the local health commissioner/social care commissioner area.. A similar template for supported accommodation in OPPs is important to develop.

Of note, there have been significant safeguarding issues raised in OPP settings. One of the worst outcomes for those in OPPs is when there are safeguarding concerns, with abuse levelled at vulnerable service users. This is due to a closed system operating many miles from service users' families and home clinical teams, as well as the health commissioners who have placed them. In some independent sector provider units, there are people from many different health commissioners. As a result, keeping track of, and in close contact with, the placing trust/health commissioner staff is more challenging for the providers, and for the placing authorities. Human rights safeguarding cases, such those that have occurred at Winterbourne Hall, then Whorlton Hall and more recently at Cygnet Healthcare Yew Trees hospital, highlight how care can go very wrong, particularly when people are placed 'out of sight and out of mind.'

CASE STUDY

The Community Enhanced Recovery Team (CERT)

Sheffield Health and Social Care NHS Foundation Trust

The Community Enhanced Recovery Team (CERT) was developed at Sheffield Health and Social Care NHS Foundation Trust in 2014 as alternative service provision to out of area long stay or locked rehabilitation placements, with an original budget of £2m. CERT provides service users with intensive support in the community to work on collaboratively generated recovery goals. CERT also works closely with Forest Close (a 30-bed inpatient rehabilitation service) to support some service users who require inpatient stays as part of their recovery.

At the time of the services' development there were 35 people in OAPs who were relocated back into community support in Sheffield over a period of three years. The fiscal savings made from bringing services users back to Sheffield from OAPs, were invested back into the CERT service, allowing it to develop into a larger service with capacity for 45 service users, supported by around 60 members of staff.

CERT developed a partnership with South Yorkshire Housing Association to provide service users with supported tenancies in the community. Regular joint meetings ensure service users have a joined-up approach to supporting their management of a tenancy.

The CERT team is an MDT of recovery workers, care co-ordinators, registered nurses, occupational therapists, an art therapist, clinical psychologists and psychiatrists. There is an emphasis on integrated leadership across the team and service user's needs are discussed in regular psychologically-led case formulation meetings. A large number of recovery workers provide intensive support to service users. Recovery workers are recruited for their values, supported by lived or working experience of mental health needs, and are encouraged to explore innovative and creative approaches to rehabilitation activities such as music production, horse riding, and camping.

The majority of service users have experienced significant levels of trauma, and the team is supported in providing the high levels of empathy needed to encourage change through a trauma informed, whole team approach. All mental health practitioners are encouraged to contribute their understanding of service user's needs in regular weekly meetings, where maintaining empathy, encouraging functional responses to overwhelming feelings, and managing interpersonal push and pull are the focus of discussion. Weekly reflective practice and training and development time is also provided to encourage staff wellbeing and support safe and effective care.

Since its inception CERT have supported around 80 service users. Outcomes have been measured using the REQOL and show some increase in quality of life, although there have been challenges to collecting data routinely. Around 50% of users of the CERT service have been discharged to other mental health services. Of those discharged around 70% have moved to the CMHT, and the remaining service users to more secure settings. For those service users who remain with the service it has been possible to show an overall reduction in their general service use across the trust.

When individuals are placed in spot purchased individual placements, the reviewing team may find it challenging to establish effective and close working relationships with many different inpatient units. Such quality issues can be improved by using fewer providers, with a dedicated staff member assigned per unit. Collaboration between a neighbouring trust(s) to use the same provider may support this closer quality assurance too. The CQC report looking at the state of care in mental health services from 2014-2017[50] highlighted concerns with the high number of people in out of area 'locked rehabilitation' wards. The CQC described how a hospital should not be considered a 'home' for people with a mental health condition, particularly when situated a long way from the patient's actual original home. The CQC stated health and social care commissioners must ensure that suitable accommodation and intensive community mental health support is available in the person's home area. This supports the wellbeing and recovery of the individual and their friends and family, as well as making economic sense.

[50] *Care Quality Commission (CQC): https://www.cqc.org.uk/publications/major-report/state-care-mental-health-services-2014-2017*

The CQC survey on inpatient rehabilitation care in England[51] noted that there had only been a small increase in the number of people receiving inpatient rehabilitation care close to home since their previous survey in 2017.[52] The report states that too many people continued to be sent far from home for treatment. GIRFT data suggests there is significant provider variation, ranging between 0 and 26 per 100K weighted population being sent out of area. The NHS Long Term Plan states there should be local investment in community pathways and GIRFT recommends that this should be used to support the aim that no one receives rehabilitation support outside of their local network of care. Additionally, there remain concerns about the high number of wards continuing to identify as 'locked rehabilitation'. This goes against the least restrictive principle that mental health services should be using. These points reinforce the need for the GIRFT rehabilitation work through NHS England and NHS Improvement.

An important point is that 2016 NICE guidance on the transition between inpatient mental health settings and community or care home setting recommends working with the person to restart activities before they are discharged.[53] Additionally, NICE guidance on service user experience in adult mental health recommends discussing and planning changes of services or discharge with the service user.[54] If OPP is deemed necessary, we recommend the national procurement framework should be used with clear oversight and monitoring systems and arrangements in place to ensure care is appropriate to the person's needs. Additionally, plans should be made to proactively bring the person back to their local area. As part of monitoring OPPs, standards must be maintained around the care, interventions, staffing, cost, measurement of outcomes and the communication with the placing clinical and commissioning team in line with NICE guidance.[55] We recommend a six-week initial placement review by the placing clinical and commissioning team followed by a minimum of three-monthly reviews to ensure active rehabilitation and develop plans to repatriate/step-down to local rehabilitation care services as soon as is appropriate and possible for that person.

Of note, all systems are expected to develop a PHB offer for people who are eligible. It is important to use PCSPs to ensure care is aligned to peoples own identified health and wellbeing outcomes and 'what matters to me'. [56]

[51] *Care Quality Commission: https://www.cqc.org.uk/sites/default/files/20201016_MH-rehab_report.pdf*

[52] *Care Quality Commission: https://www.cqc.org.uk/sites/default/files/20201016_MH-rehab_report.pdf*

[53] *NICE (2016) Transition between inpatient mental health settings and community or care home settings. NICE. www.nice.org.uk/guidance/ng53*

[54] *NICE (2011) Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health service. NICE. www.nice.org.uk/guidance/CG136*

[55] *https://www.nice.org.uk/guidance/ng181*

[56] *NHS England and NHS Improvement (2019) Guidance on the legal rights to have personal health budgets and personal wheelchair budgets. NHS England and NHS Improvement. www.england.nhs.uk/publication/guidance-on-the-legal-rights-to-have-personal-health-budgets-and-personal-wheelchair-budgets/*

Recommendations

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
3. All trusts, health commissioners and LAs should develop robust systems to bring patients treated out of area back to their local area.	**a** A senior named placements co-ordinator, as part of the CRT, to review and plan the person's move back to local care, and in the community wherever possible. Need to have or be directly linked with commissioning powers under the Care Act (e.g. social worker involved in reviews), or Mental Health Act Section 117, Continuing Care, or the Children and Family Act 2014 (up to 25 years old). Education, health and social care to support planning or work directly with commissioners to bring the person back into local care.	Provider trusts, through their CRT.	OPPs numbers reduced. Sustained local community living for more of those previously in OPPs.	All trusts commence with immediate effect and complete before April 2024.
	b All systems are expected to develop a PHB offer for those eligible and use PCSP to ensure care is aligned to people's own identified health and wellbeing outcomes.	Health commissioners and LAs.	OPPs numbers reduced. Sustained local community living for more of those previously in OPPs.	All trusts commence with immediate effect and complete before April 2024.
	c Develop an adequate complement of supported housing of different levels of support and expertise (using the NHS Digital accepted terminology).	GIRFT/NHS England and NHS Improvement to monitor this centrally.	OPPs numbers reduced. Sustained local community living for more of those previously in OPPs.	All trusts commence with immediate effect and complete before April 2024.
	d Should OPPs be deemed necessary, the national procurement framework should be used, with clear oversight and monitoring systems in place and arrangements to ensure care is appropriate to the person's needs, with contracts to work towards discharge back to the person's local team.	Health commissioners	OPPs numbers reduced. Sustained local community living for more of those previously in OPPs.	All trusts commence with immediate effect and complete before April 2024.
	e Consider whether mental health rehabilitation could be explicitly included for support from the Better Care Fund 2021/22, in order to develop local community mental health rehabilitation pathways and repatriate people back to their funding LA.	Social care commissioners	OPPs numbers reduced. Sustained local community living for more of those previously in OPPs.	All trusts commence with immediate effect and complete before April 2024.

Developing community rehabilitation teams across health commissioning (CCGs) and social care commissioning (LAs)

The NHS Long Term Plan Implementation Framework[57] pre-pandemic stated that in addition to health commissioner baseline funding all local areas will receive an additional fair share funding allocation to support the delivery of nationwide mental health priorities. One of these priorities includes the development of local dedicated mental health rehabilitation services/functions. All health and social care commissioners can do this using both new NHS Long Term Plan funding, as well as freeing up funding currently tied up in expensive placements, as part of ICS-driven local plans to implement community mental health transformation. The GIRFT data collection found that 54% of mental health providers in England did not have separate community rehabilitation provision in 2018/19. In these trusts, generic psychiatric teams are often the teams supporting people with complex needs in supported accommodation. Trusts should ensure that the new models of community mental health care they are developing as part of the NHS Long Term Plan include dedicated, specialist community mental health rehabilitation services that can focus on people with complex needs. These teams have multiple functions, including specialist support to increase levels of sustained community living.[58]

We found that dedicated CRTs/services have a varied remit – **Figure 19** illustrates CRT functions from RCPsych.[59] Ideally, the dedicated CRT/service needs to care co-ordinate and support all service users with complex needs in local funded placements. This includes highly supported accommodation – 24-hour, and in some services, those in 9-5pm care and people living in independent accommodation with high support/ expensive individual care packages. Some people who are stable, and not under active rehabilitation, who step into a more independent placement may require placement review only. The team can then provide care management, which is more about oversight that a placement still meets the needs of the patient, maintenance and not active rehabilitation. When under care co-ordination, there is far more active support, input and treatment from the MDT, with a minimum of a monthly contact and active rehabilitation in all the areas needed. Moves to more independent settings may also be part of the plans.

Funded placement refers to a placement that is either a health (CCG) or social care (LA)-funded placement, where the patient's complex needs require a complex care package and often for 24-hour care (also includes OPPs). Many CRTs do not cover all the different functions required of such a team. Consequently, there is an impact on patient access to timely rehabilitation around the mental health system. This can include poor access to supported accommodation in the community for ongoing rehabilitation. Additionally, there may be an 'out-of-sight, out-of-mind' consequence with OPP rehabilitation individuals. Lastly, patients may end up with longer LoS on acute inpatient units, or recurrent readmissions, because the level of care in the community is not sufficient for their needs, so they are unable to step down and out into the community.

This is compounded as the effectiveness (and blockages) of CRTs are not routinely measured through useful outcome monitoring. This causes challenges in understanding the full functioning of these teams, including where there may be the opportunity to improve. Without this understanding, it will be difficult to differentiate the functions of new rehabilitation services being set-up and existing services. The census approach can help to surface the needs of the patients who are currently in and who may need rehabilitation services in the future. The census approach involves keeping a unified record of all those in a placement funded by the local health commissioner and social care commissioner, for how long they will be in that placement and which type of placement they will move to next. This allows for timely preparation and service development, so that people are not stuck at higher levels of support when they no longer need it. The census supports an understanding of where there may be blocks in the care pathways at a systemic level, which can then be investigated and addressed, allowing for patients to move through the system in a timelier manner. Finances can also be tracked, managed, and planned in this way. The census also allows for a whole system and multi-agency approach, to ensure the right care, at the right time, in the right place, is possible for people, with commissioners, clinicians, housing and care providers, all working together to develop and sustain the right complement of placement types. This is alongside the right complement of clinical and social care and treatment.

It is important to have clear criteria (with a level of flexibility that allows for personalised, responsive care), to outline the point at which rehabilitation care and treatment happens. The transfer out may be at the point, for example, when less than 9-5pm care is needed, or when the patient is in their own flat with some floating support coming in and no further moves of accommodation are envisaged in the reasonable future.

[57] *NHS England NHS Improvement (2019) NHS Long Term Plan Implementation Framework. NHS England NHS Improvement. www.longtermplan.nhs.uk/wp-content/uploads/2019/06/long-term-plan-implementation-framework-v1.pdf*

[58] *AIMS Rehab CCQI (2016) Standards for Inpatient Mental Health Rehabilitation Services: Third Edition. Royal College of Psychiatrists. www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/rehabilitation-wards-aims-rehab/aims-standards-for-inpatient-mental-health-rehabilitation-services-third-edition.pdf*

[59] *Royal College of Psychiatrists (2012) Community Psychosis Services: the role of community mental health rehabilitation teams – Faculty Report. Royal College of Psychiatrists. www.rcpsych.ac.uk/docs/default-source/members/faculties/rehabilitation-and-social-psychiatry/rehab-fr-rs-07.pdf?sfvrsn=e8837342_4*

Figure 19: CRT functions

Source: Royal College of Psychiatrists 2012

It is important for there to be coverage of local CRTs across all health and social care commissioners. The RCPsych Rehabilitation and Social Psychiatry Faculty is developing a standardised service framework which will be published imminently. The College Centre for Quality Improvement (CCQI) Community Teams Standards for Rehabilitation Services, once completed, will also be a helpful guide as to good CRT function and practice and should be followed by trusts.[60] The framework will need to be translated into operational policy that is then implemented, with outcome and process measures in place and iteratively improved.

The CQC does not currently have community rehabilitation services as a core service for inspection. The core service the CQC inspect against is called 'long stay rehabilitation mental health wards for working age adults'. There is no specific inspection programme for 'community rehabilitation pathways', but they would be considered against the framework of the existing core service and whether there is signposting to community services. There is an opportunity for the CQC to work to align core service inspections with NICE guidance, CQC 2019 survey data, and this GIRFT report to address how best to define/inspect rehabilitation services. Teams should collaborate across the system to ensure that a rehabilitation intervention is provided at all necessary levels with patients. This ensures that access to dedicated community rehabilitation services when needed is possible.

[60] *Standards for Community Mental Health Rehabilitation Services. Royal College of Psychiatrists.*

Developing evidence-based standardised care pathways for community and inpatient rehabilitation services

During our deep dives, we found there was wide variation in the mental health rehabilitation provision around the country. There has been some guidance on what a good whole system rehabilitation pathway looks like from the Joint Commissioning Panel for Mental Health Rehabilitation Commissioning Guidance and various Rehabilitation and Social Psychiatry Faculty documents from the RCPsych over the years, and more recently from the NICE rehabilitation guidance[61], as well as the Long Term Plan Implementation Framework[62]. It will be useful to incorporate learning from good models of whole system rehabilitation, of which there are a number around the country, along with learning from the NHS-led provider collaboratives and the evidence base as it currently exists, to show what works.

Many trusts did not have the whole system rehabilitation pathway in place during the deep dives and consequently patients were likely to be in other parts of the mental health system, not receiving rehabilitation care and treatment. For example, if there was no CRT with oversight of everyone in a funded rehabilitation placement, with good, supported accommodation pathways, those needing rehabilitation may spend longer on acute wards and be more likely to be sent to an OPP.

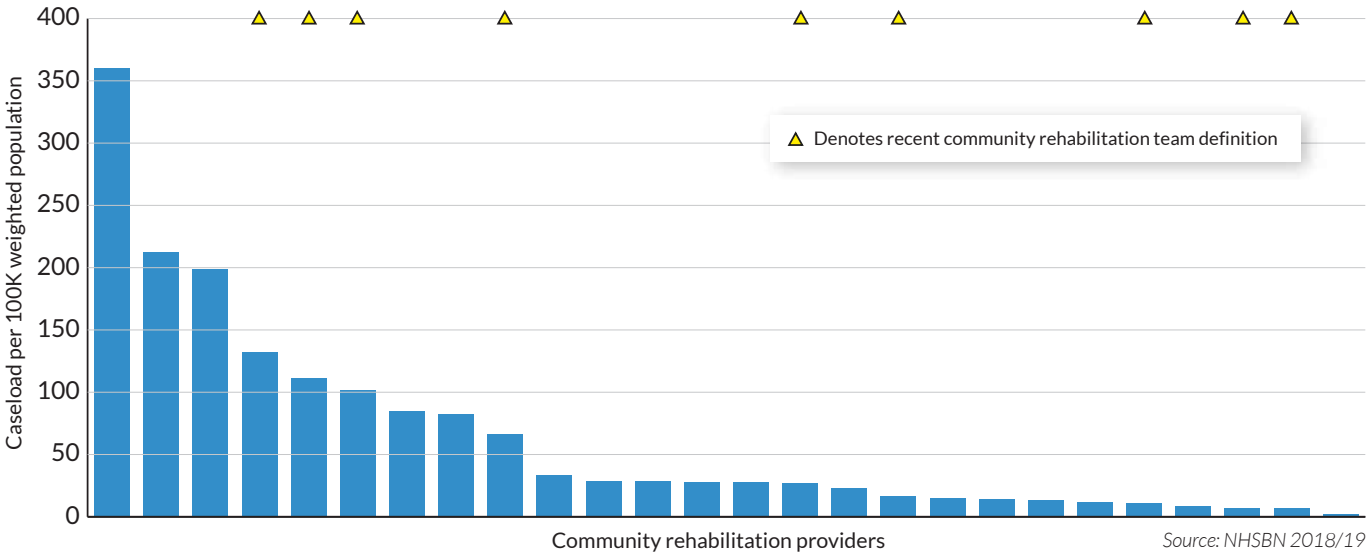
The tasks of a CRT are described in the Community Rehabilitation document by the RCPsych.[63]

AIMS-Rehab, CCQI, and RCPsych have developed quality standards for inpatient rehabilitation which 2/3 of the inpatient rehabilitation units in England have signed up to for accreditation. The Community Rehabilitation Standards are currently being piloted by teams working with CCQI. Standards around ensuring a good MDT with the right skills to provide good rehabilitation care and treatment were developed in the AIMS-Rehab programmes. In the Long Term Plan guidance it is clear that the MDTs could include VCSE colleagues too.

A suggested good way to measure outcomes has arisen from a piece of work from the RCPsych Rehabilitation Faculty. The AIMS-Rehab network also had input to this, with MDT, lived experience and carer expert input also. See the GIRFT website at ***https://www.gettingitrightfirsttime.co.uk/medical-specialties/mental-health/*** for more details.

Figure 20 illustrates the broad range of CRT caseloads of a small number of national providers per 100K weighted population. Without standardised terminology and frameworks at a high level for rehabilitation, the ability to share good practice based on the evidence is less easily replicated.

Figure 20: Community rehabilitation team caseload per 100K weighted population



Source: NHSBN 2018/19

With no service standardisation, based on the evidence of what works well in rehabilitation, there is a greater risk of institutionalisation and poorer service user experiences with people being stuck in more restrictive settings than necessary. Additionally, institutionalisation not only results in human cost but also a financial cost to the system, with poorer pathway flow.

[61] *https://www.nice.org.uk/guidance/ng181*

[62] *NHS England and NHS Improvement Community Mental Health Framework (2019)*

[63] *Royal College of Psychiatrists: https://www.rcpsych.ac.uk/docs/default-source/members/faculties/rehabilitation-and-social-psychiatry/rehab-fr-rs-07.pdf?sfvrsn=e8837342_4*

Standardising community and inpatient rehabilitation terminology

A recommendation to support the standardisation of rehabilitation care is for all trusts to use the NHS Digital definitions, which have come from the RCPsych Rehabilitation and Social Psychiatry Faculty definitions, of different inpatient rehabilitation service types. Of note, the CQC also uses this terminology when inspecting services. Trusts could use this terminology to base their service frameworks on – see '*Patient pathways*', page 57. It should be noted, the CQC presents types of rehabilitation units in its 2019 information request on mental health rehabilitation services. An outline service framework for each of the service types also needs to be developed. This allows for local adaptations, ensuring that units can provide what is needed for the local population. There also needs to be a standard framework which is locally informed, based on the local needs-assessment for CRTs and supported accommodation at a high level. This supports good practice which, based on evidence, can be more easily replicated. There should be enough flexibility to enable local tailoring based on need and allowing for dynamic changes if needed. Inpatient spot purchases would benefit from standardised contracts, using the National Procurement Framework. The National Procurement Framework Specification can be found on the GIRFT website at ***https://www.gettingitrightfirsttime.co.uk/medical-specialties/mental-health/***

The CQC report on the state of care in mental health services from 2014-2017 highlighted how 'locked rehabilitation' wards (a term not recognised by the RCPsych Rehabilitation and Social Psychiatry Faculty), are in fact long stay wards that institutionalise patients.[64] These wards do not act as a step to returning to a more independent life in the person's home community. The report found approximately 3,500 beds were in locked mental health rehabilitation wards, with about two-thirds being provided in the independent sector. Additionally, these wards were often OPPs leading to the person feeling isolated from their support network. The CQC reported that, in a high number of cases, these hospitals did not have staff with appropriate skills to deliver high-quality, intensive rehabilitation care required to support recovery. In 2019, the CQC estimated that the annual expenditure on mental health rehabilitation beds was about £535 million, with OPPs accounting for about two-thirds of this expenditure.[65]

It is also important to ensure that PCSP and PHB are included to reflect legislation (Section 117), and expectations on systems align to Mental Health Frameworks for Adults and Older Adults. This is particularly necessary as universal personalised care and PCSP replaces the Care Programme Approach (CPA).

In line with NICE guidance specifying staffing roles that the MDT should involve and have access to[66], it is essential MDT working is highlighted when standardising rehabilitation care. This includes a multidisciplinary senior leadership team. Also essential are the following:

- Clinical psychologists;
- Occupational therapists;
- Registered mental health nurses;
- Social workers (may be based within the LA);
- Mental health pharmacists;
- Support time and recovery workers (star workers) – who may be peer support workers or more generic support workers (e.g. healthcare assistants);
- Junior medical staff;
- Independent prescribers;
- Approved mental health professional(s) (AMHPs);
- Housing workers, employment specialists (IPS);
- Drug and alcohol specialists;
- Administrative assistants; and
- GP link workers.

[64] *Care Quality Commission: https://www.cqc.org.uk/sites/default/files/20180301_mh_rehabilitation_briefing.pdf*

[65] *Care Quality Commission: https://www.cqc.org.uk/sites/default/files/20201016_MH-rehab_report.pdf*

[66] *https://www.nice.org.uk/guidance/ng181*

Some teams may employ a registered adult nurse/registered mental health nurse to lead their clozapine clinics. Following NICE guidance on staffing, it is important to highlight the support pharmacists can provide around medication reviews, STOMP-STAMP reviews, clozapine initiation, and reconciliation. System level working should ensure the pharmacy needs of rehabilitation patients are met as part of the overall pathway.

Table 6 shows the number of actual clinical staff distributed across four types - HDRs, CRUs, LTC/CCU, and CRTs (see *Glossary*, page 114). Each service should have a mechanism for responding to low/unsafe staffing levels if this is below minimum agreed levels. For example, a process needs to be in place for staff to report staffing level concerns, easily access additional staff members, and agree a contingency plan such as reducing non-essential services temporarily.

Table 6: Clinical staff comparison

Service	Clinical staff (actual)	Benchmark		
HDR	1,232	16.2 clinical staff per 10 beds	4.8 and 26.4	39.3% (22/56)
CRU	1,557	15.7 clinical staff per 10 beds	7.1 and 26.6	50% (28/56)
LTC/CC	1,196	18.2 clinical staff per 10 beds	11.6 and 27.9	37.5% (21/56)
Community rehabilitation teams	633	2.5 clinical staff per 100K weighted population	0.2 and 15.9	37.5% (21/56)

Source: GIRFT/NHSBN 2018/19

Other services

The explicit mention of MDT working, and the roles within the team, will ensure there is consistency across rehabilitation services as to who is part of service delivery. Additionally, the standardisation should state the other services individuals have access to as part of rehabilitation care. These include access to a wide variety of secondary services such as smoking cessation services, physical healthcare services (primary and secondary care), dieticians, personal trainers for tailored exercise plans, speech and language therapy (SALTs), chiropodists, optometrists, therapists for music, drama and art, educational (including recovery colleges) and wider vocational services (including VCSE offers).

Summary

It is important service frameworks are developed for inpatient rehabilitation units and CRTs, which the Rehabilitation and Social Psychiatry Faculty at the RCPsych has agreed to facilitate with other key stakeholders. In the interim, local service frameworks, which follow best practice and the evidence base, would suffice.

Additionally, a national housing standards and outcomes framework needs to be developed and agreed jointly by the DHSC and Ministry of Housing, Communities & Local Government (MHCLG), as well as the NHS Confederation Mental Health Network. The core frameworks should have enough flexibility to enable local tailoring, based on need and allowing for dynamic changes. The frameworks should also include advice on staffing complement. The MHCLG published a national statement of expectations in 2020. While not statutory, the statement mentioned LAs should develop practices to identify and meet needs in their area.[67] It is important processes are in place for those refused rehabilitation in how we monitor them and meet their needs. There also needs to be good practice around agreeing responsible commissioners (including for homeless people).

[67] *Tolhurst, K., Stedman-Scott, D. (2020) Supported housing: national statement of expectations. Department for Work & Pensions. www.gov.uk/government/publications/supported-housing-national-statement-of-expectations/supported-housing-national-statement-of-expectations*

Recommendations

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
4.1 Trusts and health commissioners should develop standardised care pathways and service frameworks in line with NHS Digital definitions from the service framework of community rehabilitation teams and typology of different inpatient rehabilitation services from RCPsych Rehab Faculty. Provider collaboratives will come into play.	**a** Trusts to use these definitions to develop a whole system rehabilitation pathway.	Health commissioners and social care commissioners. RCPsych, involving all relevant stakeholders for multidisciplinary representation.	Definitions will show in the rehabilitation data dashboard and in provision of services. Nationally agreed standardised framework development will be completed by RCPsych and all other relevant stakeholders, and then implemented by all.	For immediate progress upon publication. 100% of trusts to have fully developed local rehabilitation services by March 2024.
	b Co-develop service frameworks covering inpatient rehabilitation units and CRTs. Coverage of inpatient rehabilitation units would be similar to that of the Secure Care Programme. The frameworks would be developed with multidisciplinary input, and in co-ordination with developing guidance products from NHS England and NHS Improvement related to provider collaboratives and the Long Term Plan.	Health commissioners and social care commissioners. RCPsych, involving all relevant stakeholders for multidisciplinary representation.	Definitions will show in the rehabilitation data dashboard and in provision of services. Nationally agreed standardised framework development will be completed by RCPsych and all other relevant stakeholders, and then implemented by all.	For immediate progress upon publication. 100% of trusts to have fully developed local rehabilitation services by March 2024.
	c Include advice on staffing complement.	Health commissioners and social care commissioners. RCPsych, involving all relevant stakeholders for multidisciplinary representation.	Definitions will show in the rehabilitation data dashboard and in provision of services. Nationally agreed standardised framework development will be completed by RCPsych and all other relevant stakeholders, and then implemented by all.	For immediate progress upon publication. 100% of trusts to have fully developed local rehabilitation services by March 2024.
	d Ensure that PCSP and PHB are included to reflect legislation (Section 117).	Health commissioners and social care commissioners. RCPsych, involving all relevant stakeholders for multidisciplinary representation.	Definitions will show in the rehabilitation data dashboard and in provision of services. Nationally agreed standardised framework development will be completed by RCPsych and all other relevant stakeholders, and then implemented by all.	For immediate progress upon publication. 100% of trusts to have fully developed local rehabilitation services by March 2024.

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
4.2 NHS-led provider collaborative programmes to consider provider collaborative model for whole care pathway for people with complex emotional needs.	**a** The provider collaborative programme to develop clear outcomes to be delivered by a Complex Emotional Needs/EUPD, provider collaborative model.	NHS-led provider collaborative	There will be clear outcomes delivered by the complex emotional needs/EUPD PC model. They will be within their own specialist pathway in line with NICE guidance on personality disorders: borderline and antisocial.[68]	Within two years of publication.

[68] *NICE (2015) NICE guidance on personality disorders: borderline and antisocial https://www.nice.org.uk/guidance/qs88. https://pathways.nice.org.uk/pathways/personality-disorders*

Community rehabilitation and supported housing

CRTs work intensively with people needing rehabilitation who are in supported accommodation and, at times, in independent accommodation with high support/ expensive individual care packages care, as well as reviewing those in OPPs to facilitate a return to local services at the earliest opportunity. CRTs can focus on this cohort with complex needs, hold them in mind as a whole team and support their ongoing rehabilitation, to greater levels of independence and social inclusion, in a personalised manner. When the care for this patient cohort is from more generic community mental health teams, often the ongoing rehabilitation is not so front of mind or as effective.[69] With community teams that are not rehabilitation teams having much higher caseloads and many more people in their own accommodation with little or no support, it is understandable how this comes to be. This can, however, result in patients being in more intensive and occasionally more institutionalised settings, such as residential care homes, for longer than needs be or than they would wish for. There is a cost both to the patients and financially, with community supported accommodation costing on average £317 per week per person.[70] This is now likely to be a significantly higher cost. The significant investment being made to community mental health services through the Long Term Plan offers the opportunity to transform how community mental health teams offer dedicate rehabilitation services to this more complex patient cohort.

It is imperative that the right type, quantity and quality of supported housing in a flexible model of care (e.g. 24-hour, 9-5pm, staffed and floating support), and general housing to move onto, is available for those with rehabilitation needs and more broadly for those with other mental health needs. The evidence shows the importance of supported housing in sustaining patients in the community, supporting avoidance of hospital admissions and being sent OPP. Without the right complement of supported housing, people become stuck at higher levels of care – such as in residential care homes, or indeed, hospital beds.[71] It should be noted that the NHS Confederation briefing on supported housing has a number of good case studies and recommendations for the system.[72]

In the following section, community rehabilitation functions are outlined, and the role of supported housing discussed. The two services must work closely together, with the patients and their families/carers at the centre, to achieve good, timely outcomes for the patient and the system.

[69] *Lavelle, E., Ijaz, A., Killaspy, H., et al (2012) Mental Health Rehabilitation and Recovery Services in Ireland: A Multicentre Study of Current Service Provision, Characteristics of Service Users and Outcomes for Those with and without Access to these Services (Final Report). Mental Health Commission of Ireland.*

[70] *Killaspy H, Priebe S. Research into mental health supported accommodation - desperately needed but challenging to deliver. Br J Psychiatry. 2020 Apr 23:1-3. doi: 10.1192/bjp.2020.74. Epub ahead of print. PMID: 32321596.*

[71] *Centre for Mental Health: https://www.centreformentalhealth.org.uk/sites/default/files/2018-09/More_than_shelter_pdf.pdf*

[72] *https://www.nhsconfed.org/sites/default/files/media/MHN_Supported%20housing_4.pdf*

Recommendations

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
5. Trusts, health commissioners and LAs should ensure that a dedicated community mental health rehabilitation service/team is developed across all health commissioners/LAs.	**a** Trusts to develop a robust system to ensure oversight of community provision for those in placements or with complex care packages.	Health commissioners and social care commissioners.	Rehabilitation data dashboard incorporates key community rehabilitation data variables.	Within two years of publication. All trusts by March 2024.
	b All trusts or health commissioners should have a dedicated community mental health rehabilitation service/team which should be NICE guidance concordant for the cohort of people with complex psychosis.	Mental health trusts.	All trusts have a specialist dedicated community mental health rehabilitation service/team.	Within two years of publication. All trusts by March 2024.
	c Trusts to follow the standards outlined in the CCQI AIMS-Rehab Community Teams (currently being piloted). Include MDT – as per NICE guidance.[73] Caseload numbers to be outlined. Interface with Community Mental Health Framework to be considered.	CQC and AIMS-Rehab.	CQC and AIMS-Rehab to work towards inspecting/ assessing community rehabilitation services regularly to ensure they meet the required standards, including for quality.	Within two years of publication. All trusts by March 2024.
	d Ensure LA secondment of staff into this team, who can operate the Care Act collaboratively. An integrated team, and jointly set up, to run the responsibility for rehabilitation.	Health commissioners and social care commissioners.		Within two years of publication. All trusts by March 2024.

Rehabilitation and the importance of supported housing

Supported housing provision often does not match the local population rehabilitation need. Additionally, trusts often do not know what the local provision available is for those they serve.

However, the importance of supported housing as a mental health intervention is clearly illustrated by the Centre for Mental Health (*https://www.centreformentalhealth.org.uk/sites/default/files/2018-09/More_than_shelter_pdf.pdf)* - see **Figure 21**. There are examples of what is possible for patients and the whole system when CRTs and supported housing providers work well together.

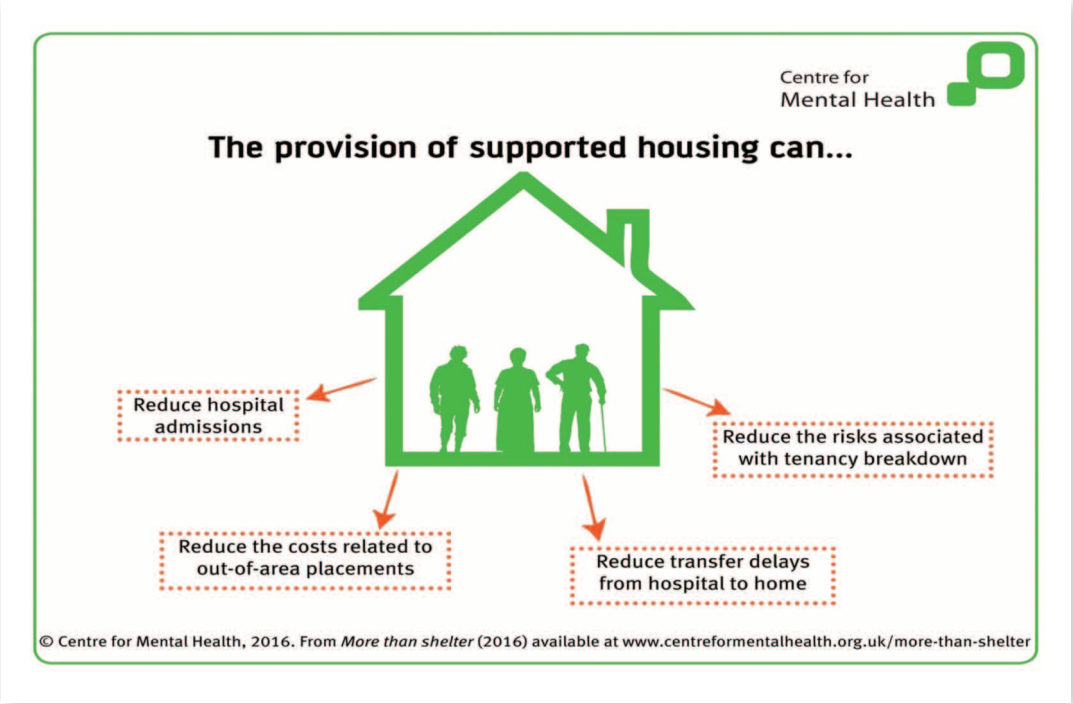
Tile House in Camden and Islington was evaluated as saving the system £443,964 per annum.[74]

It is good practice to have housing officers incorporated into local mental health trust pathways and processes. For example, those housing officers from the LA who oversee the access to supported housing and general housing should attend key advisory panels with the CRT to advise and plan the best next steps for patients being brought for advice. Regular whole system stakeholder mental health housing summits are helpful to bring together all the key people across the system, to understand, problem solve and implement the service development and required changes for the needs of the rehabilitation cohort and, indeed, the whole local population with mental health needs.

[73] *https://www.nice.org.uk/guidance/ng181*

[74] *HACT (2016) Housing and Health: Mental health and housing – housing on the pathway to recovery. HACT. https://hact.org.uk/sites/default/files/uploads/Archives/2016/09/H&H%20Mental%20Health%20and%20Housing%20report%20Sept2016.pdf*

Figure 21: The importance of supported housing provision



Source: Centre for Mental Health, 2016

NICE guidelines[75] also highlight the importance of senior clinicians in the CMHT working with commissioners and supported accommodation providers to:

1. hold an overview of the local mental health supported accommodation services, including current vacancies and the quality of care provided and outcomes;
2. ensure that the rehabilitation pathway continues to develop in line with changes in the needs of the local population.

Camden & Islington NHS Foundation Trust has developed a service specification for Mental Health Supported Accommodation Services: see the GIRFT website at GIRFT rehabilitation:
https://www.gettingitrightfirsttime.co.uk/medical-specialties/mental-health/

CRTs should serve the function of a repository of knowledge on matching patients with supported accommodation providers, based on the expertise of the housing and in-house care provision. When well-matched, patient outcomes are likely to be improved.

We recommend data on supported housing (current and future demand) should be collated for service provision and development, and according to local need. This report recommends a need to work with relevant stakeholders, and across ICS/STP areas, to ensure that local supported housing is available for all mental health conditions. This includes those needing forensic and learning disability pathways (in line with NICE guidance[76]), and those stepping up from CMHT but not needing formal rehabilitation. Additionally, NICE guidance[77] recommends the consideration of the needs of people with coexisting severe mental illness and substance misuse in other local needs assessment strategies, for example on housing. Lastly, a national housing standards and outcomes framework needs to be developed. DHSC and MHCLG understand the importance of supported housing in the rehabilitation pathway, and work is currently underway to consider how best to support this need.

An example of where a whole system has developed a much-needed housing strategy for those with mental illness is in Sussex[78], where the ICS has decided to ensure a housing strategy is one of its key priorities which will pay dividends for all concerned as they move to implementation.

[75] *https://www.nice.org.uk/guidance/ng181*

[76] *NICE (2018) Learning disabilities and behaviour that challenges: service design and delivery. NICE. www.nice.org.uk/guidance/ng93*

[77] *NICE (2016) Coexisting severe mental illness and substance misuse: community health and social care services. NICE. www.nice.org.uk/guidance/ng58/chapter/Recommendations#partnership-working-between-specialist-services-health-social-care-and-other-support-services-and*

[78] *Sussex Partnership NHS Foundation Trust (2020) Mental health and housing: A strategic plan for integrating housing and mental health across Sussex. NHS. www.sussexpartnership.nhs.uk/sites/default/files/documents/shcp_mental_health_and_housing_strategy_final.pdf*

Recommendations

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
6. All trusts should work with their local partners to proactively improve provision of different levels of supported housing in their area, aligned to the local level of need, using a flexible model.	**a** Urgently improve the availability and provision of specialist supported housing in each area, proportionate to the local need.	DHSC and MHCLG.	Access and wait times for housing for those in the rehabilitation pathway will be reasonable and the capacity and flow will be good.	Within two years of publication, contingent on adequate funding.
	b LAs, health commissioners and provider trusts to use the needs assessment to develop a housing strategy over each ICS/STP. This should be an integrated commissioning strategy.	ICS/STP - with statutory responsibility at health and social care commissioner level.	Access and wait times for housing for those in the rehabilitation pathway will be reasonable and the capacity and flow will be good.	Within two years of publication, contingent on adequate funding.
	c LA supported housing framework (including outcomes) to be developed for different types of rehabilitation supported housing with health partners, in which the needs of mental health are understood and met.	NHS Confederation Mental Health Network's Mental Health and Housing Forum.	Access and wait times for housing for those in the rehabilitation pathway will be reasonable and the capacity and flow will be good.	Within two years of publication, contingent on adequate funding.
	d Ensure strategic optimisation of funding for supported housing e.g. such as Greater London Authority grants which can be accessed by housing providers for capital funds; housing associations have access to specific capital grants for specialist supported housing and can also adapt existing housing too to meet needs. The Care and Support Specialist Housing Fund (CASSH funding) should also be looked into.	DHSC and MHCLG.	Access and wait times for housing for those in the rehabilitation pathway will be reasonable and the capacity and flow will be good.	Within two years of publication, contingent on adequate funding.
	e Follow MHCLG supported housing national expectations. This reiterates the need for local needs mapping and also provision to an agreed standard.	ICS/STP - with statutory responsibility at health and social care commissioner level	Access and wait times for housing for those in the rehabilitation pathway will be reasonable and the capacity and flow will be good.	Within two years of publication, contingent on adequate funding.

Developing collaborative and integrated rehabilitation systems

When services can place patients and their carers at their heart and integrate around them, the patient experience is better, and outcomes improve – clinical and financial. There is ample evidence for this being the case. However, often the multiple services and interfaces patients must traverse are not as joined up as they could be.

The move to ICSs is a significant opportunity to make services work better for those they serve – the patients and their families. In mental health rehabilitation, there are several interfaces which can impact positively or negatively on the patient journey and outcomes. These include commissioning interfaces. People move between services commissioned by NHS England and NHS Improvement – secure services to health commissioner to social care commissioner. Where there are good relationships and processes in place, the transitions between services commissioned by different commissioners can be smooth, with minimal delay between the change in need being identified/planned for and a planned move, such as from an inpatient rehabilitation unit to supported accommodation in the community. Where the interface does not work well, people can become stuck at usually higher levels of care and restriction than necessary for long periods of time, while commissioners and/or services work out their differences. There is also a capacity and demand issue.

Work between mental health trusts establishing rehabilitation services across a greater patch is showing positive results (e.g. South London Mental Health and Community Partnership Complex Care Programme). Managing this cohort over a larger footprint enables optimal and innovative use of existing services, and the opportunity to consider service development in a way that may not be possible with the smaller numbers of patients in sub-cohorts when only one trust is involved.

Ensuring clinical teams and those teams providing the housing support are aligned and working closely can make the difference between everyone working efficiently in the same direction, supporting patient goals, or having a lack of direction and the patient not receiving optimal rehabilitation and ongoing recovery in the community. It is clear from the GIRFT data that people with SMI from rehabilitation services have a higher average usage of non-planned care - for example, urgent/emergency admissions to acute care physical healthcare hospitals, at great personal cost to patients and their families, as well as financially to the system and increasing the workload to the acute system.

Improving upstream physical healthcare screening and intervention, by closer working between primary care, secondary care mental and physical health colleagues, will undoubtedly improve this.

Integration across the rehabilitation pathway itself is also essential for efficient and effective rehabilitation. With clinical and operational structures that facilitate oversight and management of the whole rehabilitation system together, optimal results are more likely to follow.

The approach to commissioning services

Local rehabilitation care has advantages over OPP care, with care being delivered closer to home in line with NICE guidance, and with a more accessible supportive network and step-down services nearby for the individual as well as a more joined up approach. This is in terms of electronic patient notes, and access to all the services which keep people well and in the community. Both the trusts and commissioners have a responsibility to provide care for their local population. For this delivery of care to be effective, local commissioning relationships are key to ensure a solid pathway foundation. A lack of collaborative working, and less than optimal working with LA budgets, local housing, and social care commissioners, can disrupt pathway movement. Currently, a number of people are placed in OAP for inpatient and community rehabilitation. Furthermore, there is significant variability in willingness and capability within services to provide rehabilitation locally. A national directive on place-based commissioning is key to ensuring high quality rehabilitation is being delivered against a systematic framework.

Table 7: Community rehabilitation placement process

	Community Rehab teams*		Community rehab teams (recent definition and older definition)
	England Yes	Responses	
Do you have clinical/operational staff sitting on CCG funding panel for placements?	66.7% (4/6)	75.0% (6/8)	30.8% (8/26)
Do you have clinical/operational staff sitting on LA funding panel for placements?	66.7% (4/6)	75.0% (6/8)	30.8% (8/26)
Does your team manage rehab out of area placement (this function includes preventing OAPS, clinical monitoring and repatriation of OAPS)?	80.0% (4/5)	62.5% (5/8)	23.1% (6/26)
Does your team manage the placement budget?	57.1% (4/7)	87.5% (7/8)	34.6% (9/26)
Is there clear governance of the placement budget?	83.3% (5/6)	75.0% (6/8)	30.8% (8/26)

Source: NHSBN 2018/19

While **Table 7** highlights how 80% (4/5) of CRTs who responded to the questionnaire report they manage rehabilitation OPPs, there are still high numbers of individuals being placed out of their local area. This needs to account for reviews of people in LA community OPPs, as well as inpatient rehabilitation OPPs.

NICE guidance[79] recommend health and social care commissioners to work together with health services, LA, housing providers and other partners (third sector and independent sector providers, service users, and families and carers). The aim is to ensure rehabilitation is provided as locally as possible for those identified in the local rehabilitation service needs assessment – see *Patient pathways*, page 57.

NICE guidance recommends the lead commissioner to work together with service providers to deliver a truly integrated rehabilitation pathway by ensuring that:

- regular communication is supported between senior service managers and senior clinicians across providers of different services within the pathway;
- budgets and other resources are shared between local authorities and health services, so that local and regional rehabilitation services meet the local population's needs;
- funding mechanisms support collaboration between service providers and do not create unhelpful or perverse funding incentives that undermine people's progression through the rehabilitation pathway;
- clinical records and care plans are shared between providers;
- service level agreements are developed so that relevant services and agencies can work together in a timely and flexible way, including for transitions between services;
- services within the pathway are staffed by appropriately skilled staff;
- the remit for each of the services making up the pathway is clearly specified, including the population they cover.

NICE also recommends a designated care manager (or 'out-of-area placement review officer'), based within the community mental health rehabilitation team, who should review the person's placement after the first three months and then every three months to ensure it still meets their needs.

We recommend all mental health trusts use the needs assessment and, where it will be helpful, develop or use existing NHS-led provider collaboratives and ensure that rehabilitation services are commissioned and provided within their local areas. Across the NHS, provider collaboratives will play an increasing role in driving collaboration between providers within local systems and places. The vision for mental health is for NHS-led provider collaboratives to play a greater role in managing the whole mental health pathway, building on the success of NHS-led provider collaboratives in specialised services. The rehabilitation pathway would benefit from this approach, bringing together all funding for the rehabilitation pathway to be

[79] *https://www.nice.org.uk/guidance/ng181*

redistributed into local rehabilitation pathways to meet local needs. The only exceptions should be for those requiring highly specialist care – in this case, provider collaboratives can sub-contract with the relevant specialist provider to provide care for those patients who require such care and treatment. This will enable a focus on quality, outcomes and experience and ensure people receiving specialist care are only away from their home and community for as long as clinically indicated.

Within a provider collaborative area, there should be a consistent alternative to the admission model with consistent levels of funding and staffing. Clinical input and leadership on all funding panels will support optimal decision making, with the patient and family wishes also at the heart of this. There are good examples of the commissioning and budget being delegated to the provider collaboratives, with risk share agreements in place and tracking levels of need over time within each health commissioner/social care commissioner/ICS. The development of solid local rehabilitation pathways is essential, including LA level supported housing to fully reap the benefit from these collaborations. Provider collaboratives would work with partners across the system, including with, for example, Allied Health Professionals in community settings. The other benefit of the NHS-led provider collaborative model is the role of 'experts by experience' working alongside clinical leads to drive decisions about what services are available for local people and driving up quality of care. Examples include paid 'experts by experience' leaders within provider collaboratives and 'experts by experience' employed in the commissioning team to assure the quality of services.[80]

CASE STUDY

Complex Care Single Point of Access

The South London Partnership

The South London Partnership (SLP) is between South London and Maudsley NHS Trust, Southwest London and St George's NHS Trust & Oxleas NHS Trust. The organisations within the SLP work collaboratively to provide a Complex Care Single Point of Access (CCSPA) as an entry point to health funded placements, and to block fund NHS rehabilitation inpatient wards and private inpatient rehabilitation wards within the SLP footprint. The SLP will only place people in private inpatient rehabilitation provision when specialist provision is required outside that provided by the wards. The panel have a key role in working with existing rehabilitation and community mental health teams in managing flow and capacity to support this achievement.

The CCSPA panel is guided by the principle that the placement must be the least restrictive possible, maximise recovery and independence, supported housing or returning home will be the default position for referrals and inpatient rehabilitation and residential care will only be used where necessary, and placements must be as close to home as possible. The panel ensure proactive three-monthly reviews of inpatient rehabilitation admissions, focusing on achieving inpatient rehabilitation goals for the service user, the offer of personalised care in the inpatient rehabilitation setting with emphasis on a biopsychosocial approach and careful discharge planning achieved. A SLP Clinical Assessment Team (CAT) assessor is allocated to work alongside the care coordinator to support the rehabilitation offer.

Using this proactive provider collaborative approach, the SPA panel are able to:

- Ensure consistent clinical decisions supported to reduce variation.
- Provide colleagues with expert advice in community placements and type of rehabilitation support required.
- Allow greater choice for the individual whereby all units can be considered (on agreement of health commissioners that this can be accommodated).
- Have a greater focus on monitoring placement LoS.
- Allow optimisation of inpatient rehabilitation services to support increased repatriation of patients currently being supported out of area, bringing their support closer to home.
- Better analyse demand across South London to understand any gaps in provision and identify where savings can be re-invested to make the most impact, for example investment in mental health rehabilitation initiatives, supported living opportunities, or other community-based services and ways of working.

[80] *NHS England NHS Improvement (2021) Integrating care: Next steps to building strong and effective integrated care systems across England. NHS England NHS Improvement. www.england.nhs.uk/wp-content/uploads/2021/01/integrating-care-next-steps-to-building-strong-and-effective-integrated-care-systems.pdf*

Table 8 shows the comparison of national inpatient LoS, across community rehabilitation units, HDRs and LTC/CCUs. 83% (47/56) of mental health providers in England had some form of inpatient rehabilitation provision based on the service types presented here.

Table 8: Mean LOS for discharges 2018/19

	Community rehabilitation units (CRU)	High dependency rehabilitation (HDR)	Long term care/continuing care (LTC/CC)
Mean LoS (days)	230	331	497
Provider range (days)	15 - 878	50 and 614	130 and 1567
Providers	53.6% (30/56)	51.8% (29/56)	37.5% (21/56)

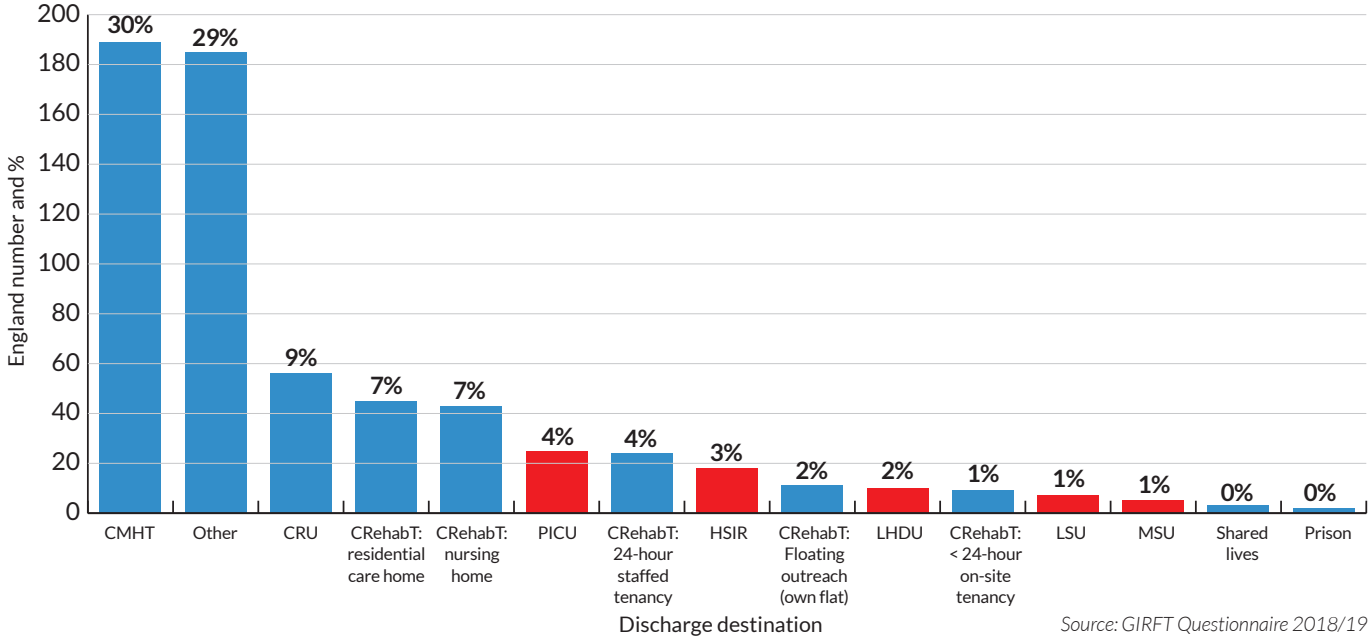
Source: GIRFT/NHSBN 2018/19

As we all recognise, the person needs to be at the centre of their care. The care, treatment, and support services they receive need to be aligned to agreed patient/carer-led outcomes where possible. The processes of individual institutions are not always flexible enough to work around the person. When organisational processes and interfaces are in place, individuals may not always receive the appropriate care and treatment for their needs. For example, if the shared outcome is for an individual to be placed in supported accommodation in the community from an inpatient bed, and the LA is funding the community placement, it may not wish to take on that cost from the health commissioner. There is then an interface/block over the bed. Consequently, this negatively impacts the individual with poor pathway movement to support their rehabilitation and is also an overall more financially costly outcome for the rehabilitation system.

Without a fully functioning rehabilitation system, there may be increases in OPPs and LoS > 60 days on acute wards. The following charts provide further information highlighting the variety of destinations across the rehabilitation system. **Figures 22 and 23** illustrate the HDU and CRU discharge destinations, respectively. The red bars in **Figure 22** indicate the number and % of discharges that stepped up from HDU units nationally. It should be noted that a large proportion of discharges were recorded as 'Other' and a manual review of the other services indicate discharges to adult acute services, usual residence, and temporary residence. The red bars in **Figure 23** indicate the number and % of discharges that stepped up from CRU units nationally. Similarly to the HDU data, a large proportion of discharges were recorded as 'Other' and a manual review of the other services indicate discharges to adult acute services, Assertive Outreach Teams (AOT), CMHT, usual residence, temporary residence and unknown (or unable to map to the services provided). With the discharge destinations in mind, it is useful to truly understand the value-add of a rehabilitation admission. The majority of those placed in rehabilitation settings should be moved to more independent settings for recovery.

Figure 22 illustrates the discharge destination in England for patients that are stepped up from HDU: PICU - 5.6%; HSIR - 4%; LSU - 1.6%; MSU - 1.1%; Shared Lives - 0.7%; Prison - 0.4%.

Figure 22: HDU discharge destination

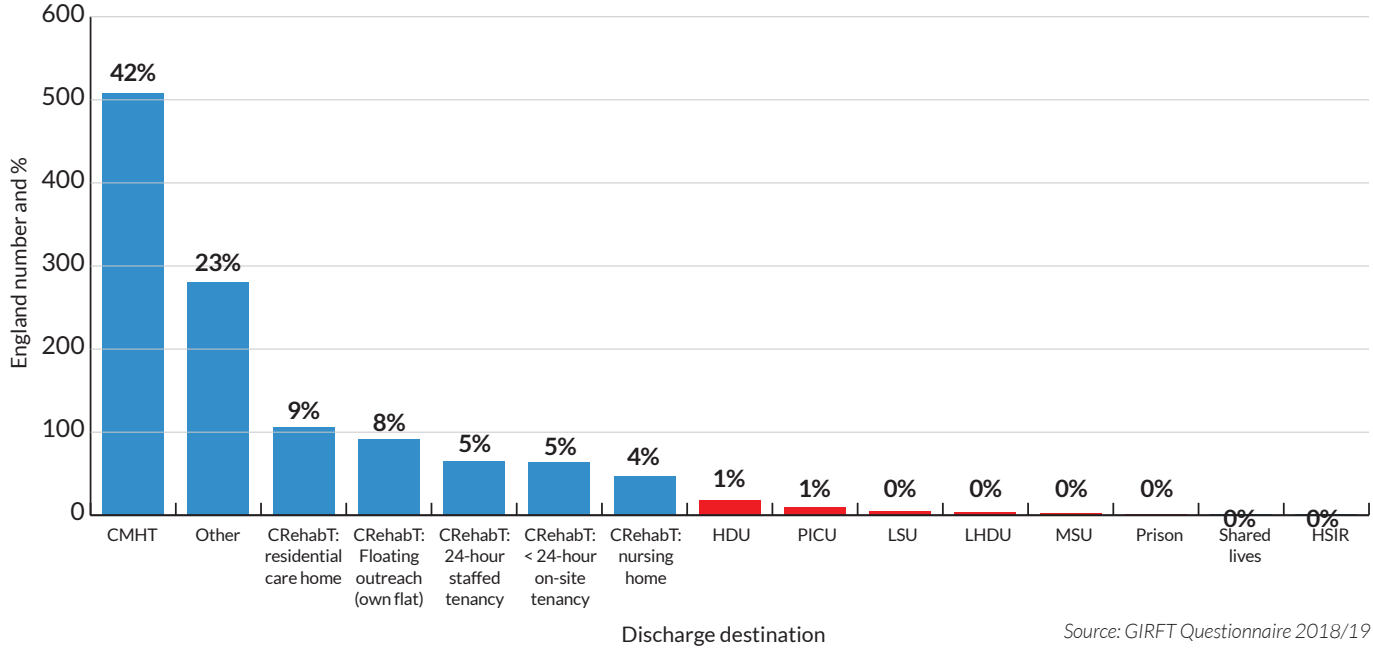


Source: GIRFT Questionnaire 2018/19

The discharge destination in England for patients that are stepped up from CRU can be seen in **Figure 23** and illustrates: HDU - 2.0%; PICU - 1.1%; LSU - 0.5%; LHDU - 0.4%; MSU -0.2%; HSIR - 0.1%.

As expected, a higher proportion of step-down is seen from CRUs as the inpatient rehabilitation treatment and support helps patients to improve.

Figure 23: CRU discharge destination



Source: GIRFT Questionnaire 2018/19

NICE guidance[81] suggests joint working to ensure a truly integrated rehabilitation pathway. The guidance highlights the importance of regular communication between services across providers along the pathway to ensure care is optimally delivered.

We recommend clear systems for all relevant stakeholders to work collaboratively and, where possible, in an integrated manner to provide local rehabilitation and recovery services. This will be between and within mental health trust providers, social care, housing, VCSEs or independent, the social care and health commissioners, educational and vocational organisations, primary care/primary care networks (PCNs) and secondary acute care. The aim is to ensure services offered for those in rehabilitation can be formulated optimally. Central to the development of services will be the input from those with lived experience of rehabilitation services and their carers. Integration between different parts of the rehabilitation system should be in place as much as is possible. This will improve continuity, reduce LoS, and maintain community-facing care.

Recommendations

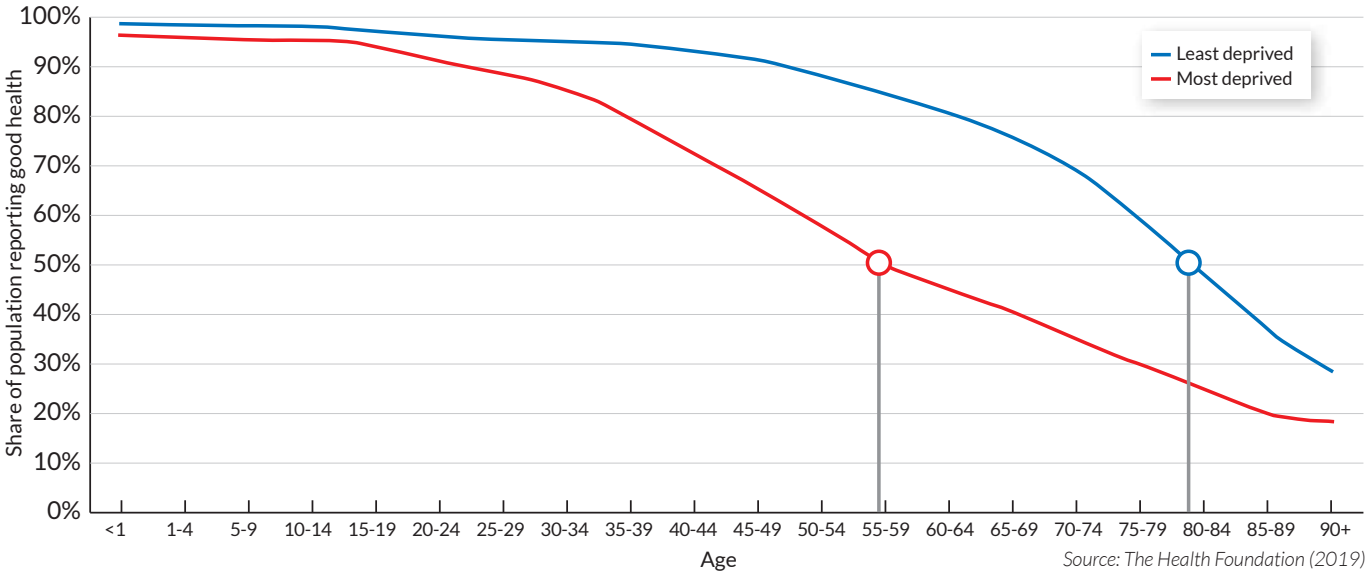
Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
7. Develop and optimise partnership working to improve patient and system outcomes and value. **7.1** All trusts and health commissioners should develop Local Provider Collaboratives (LPC) when commissioning services. These may extend to include supported housing and other VCSE care provision.	**a** Giving due regard to the approach of and opportunities provided via the national NHS England and NHS Improvement Provider Collaboratives in Mental Health Programme, systems should be clear for all relevant stakeholders, including patients and carers, to work collaboratively and, where possible, in an integrated manner, to provide local rehabilitation and recovery services.	Provider trusts.	Patients kept in area, in the community as much as is possible.	Within two years of publication.
	b Use the needs assessment to understand whether a provider collaborative between mental health trusts would benefit a local system. This can help support rehabilitation services to be commissioned and provided, within their local areas.	Health commissioners.	Patients kept in area, in the community as much as is possible.	Within two years of publication.
	c Health commissioners to consider delegated budgets, with clear risk sharing should demand increase. Financial efficiencies to be kept by the collaboratives to develop local rehabilitation pathways, strengthening community provision especially.	Commissioners and providers of health, social care and housing, patients and families together	Patients kept in area, in the community as much as is possible.	Within two years of publication.
	d Consider provider collaborations across the whole pathway, including housing and VCSE providers.	Commissioners and providers of health, social care and housing, patients and families together	Patients kept in area, in the community as much as is possible.	Within two years of publication.

[81] *https://www.nice.org.uk/guidance/ng181*

Integrating physical health care

As shown in **Figure 24**, social deprivation varies hugely across England. **Figure 24** demonstrates the impact of deprivation and quality of life, with an approximate 15-year mortality gap between the most deprived and least deprived in England.

Figure 24: People in the most deprived areas of England

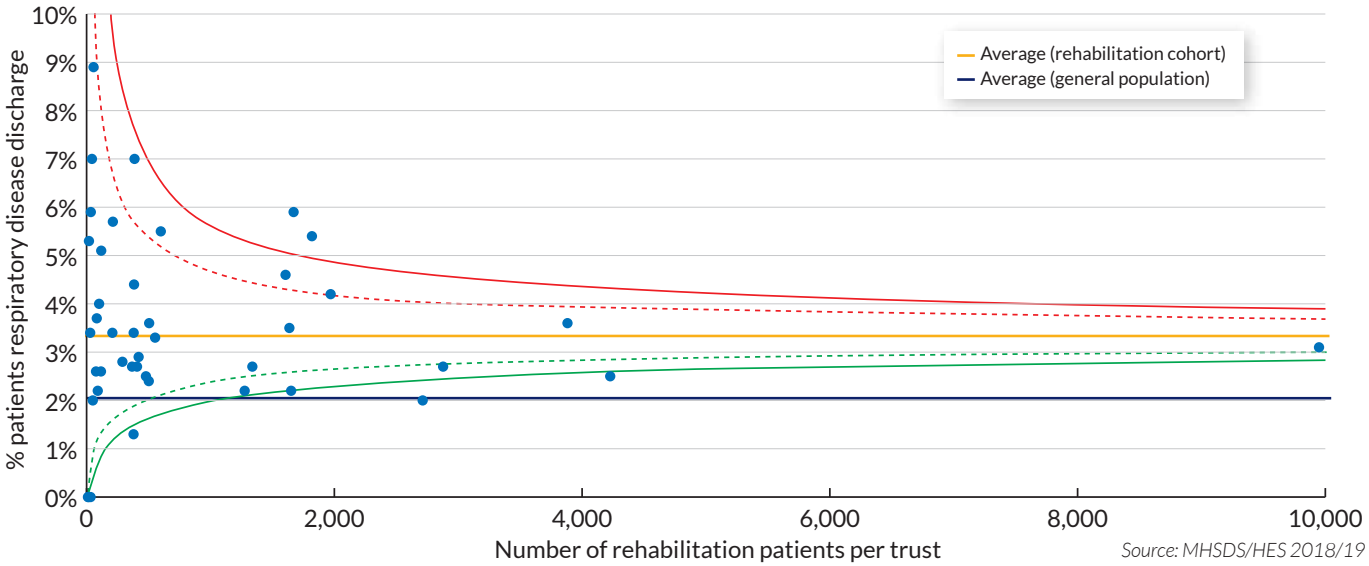


Source: The Health Foundation (2019)

For those with SMI the premature mortality gap is even greater, at 20-25 years. The physical health care received by those with rehabilitation needs is variable, impacting on service user outcomes. Service users may have executive function issues, making it difficult to engage with these services. This means that the path to receiving physical care services for mental health rehabilitation individuals is not straightforward. People with SMI should receive a comprehensive annual physical health-check, and follow up interventions. This is vital for all people with SMI, but of upmost importance for people who are prescribed anti-psychotics because of the impact they can have on people's physical health.

The variability across physical health is evidenced in **Figure 25** showing the provider variation when discharging rehabilitation patients with a diagnosis of respiratory disease from non-elective care - i.e. urgent and emergency inpatient admissions to physical health hospitals. There are higher numbers of discharges of patients diagnosed with respiratory who are part of the rehabilitation cohort compared to the general population with 3.4% compared to 2.0%.

Figure 25: Rehabilitation patients discharged from acute wards (non-elective medical) in the previous 12 months, respiratory disease



Source: MHSDS/HES 2018/19

NICE guidelines[82] discuss the importance of integrating physical and mental health care for people having inpatient or community rehabilitation. The guidelines describe how local protocols should:

- promote access to national physical health screening programmes, health promotion, monitoring and interventions;
- ensure there is a system to monitor and report people's access to physical healthcare and outcomes that takes into account the increased physical health risks for specific subgroups, for example the higher prevalence of metabolic syndrome and diabetes in people from BAME groups;
- ensure that any physical health conditions are assessed and treated;
- ensure practitioners in primary care, secondary physical care and rehabilitation services work collaboratively and flexibly, drawing together the necessary expertise and capacity to manage physical health conditions;
- ensure that the processes of the Mental Capacity Act (including Court of Protection decisions) do not delay care and treatment.

It is essential to ensure reasonable adjustments for this patient cohort in the physical health care pathways to ensure equitable access and treatment.

[82] *https://www.nice.org.uk/guidance/ng181*

CASE STUDY

Care pathway for prevention, early intervention & treatment of tobacco dependence in psychiatric rehabilitation services

South London and Maudsley NHS Foundation Trust

Mary Yates, registered nurse consultant at South London and Maudsley NHS Foundation Trust, has developed a comprehensive, step-by-step protocol on the tobacco dependence treatment pathway for the trust's inpatient and community rehabilitation services. The treatment objective is preventative for those who have never smoked, or cessation for those who have or do smoke. Although individual needs will vary, there are essential steps within the treatment pathway that apply to all.

Aims of the pathway

- Identify the smoking status of every current patient in receipt of inpatient and community care.
- Ensure early comprehensive assessment of tobacco dependence.
- Offer every smoker Nicotine Replacement Therapy (NRT) or e-cigarette starter pack within 30 minutes of arrival to an inpatient service.
- Offer evidence-based pharmacological, psychological, and psycho-education treatment to all smokers in receipt of inpatient and community care.
- Offer psycho-education to all non-smokers in receipt of inpatient and community care, and to all relevant patients regarding the interaction between some medications and smoking.
- Ensure smokers receive continuous, efficient tobacco dependence treatment throughout the care pathway and especially at transition points.
- Ensure that smokers' family/friends/significant others are offered smoking cessation support if required/so desired by the patient.
- Ensure that online, text, telephone, college support make treatments accessible to patients.
- Ensure services meet the recommendations of the NICE guidelines for smoking: acute, maternity and mental health services, and smoking: harm reduction.

The comprehensive pathway can be found on the GIRFT website at GIRFT rehabilitation
https://www.gettingitrightfirsttime.co.uk/medical-specialties/mental-health/

CASE STUDY

Monitoring and improving physical healthcare for service users

Central & North West London NHS Foundation Trust

The trust has been building upon progress in improving physical health in patients with serious mental illness, with a continuation of the drive to improve patient care across all its services, including mental health rehabilitation. The trust has an existing Physical Health Strategy Group and a dedicated Physical Health in Mental Health clinical lead, who devised a three-year continuous QI strategy in a range of workstreams, including; cardiometabolic assessment and intervention, smoking cessation, developing co-produced work with service users, and building transformative working partnerships with primary care and other service providers.

Cardiometabolic assessments

Using the Tableau software programme, the team developed real-time data analysis which could be presented by senior clinical representatives in each borough/service to the Physical Health Strategy Group, providing reasons for suboptimal performance and suggestions for service improvement. Despite success in other areas of the trust, and great effort by staff, inpatient rehabilitation services, with one of the biggest bed bases, continued to have consistent underperformance in cardiometabolic assessments. An effective MDT collaborative was established consisting of junior doctors, pharmacists, nursing staff, the Mental Health Act law office, and rehabilitation bed management, senior administrative members of performance and governance and IT services. The team was able to create an efficient system to combine automated performance assessment with manual audit, and plan to expand the role of Tableau to include all physical health measures, as far as possible.

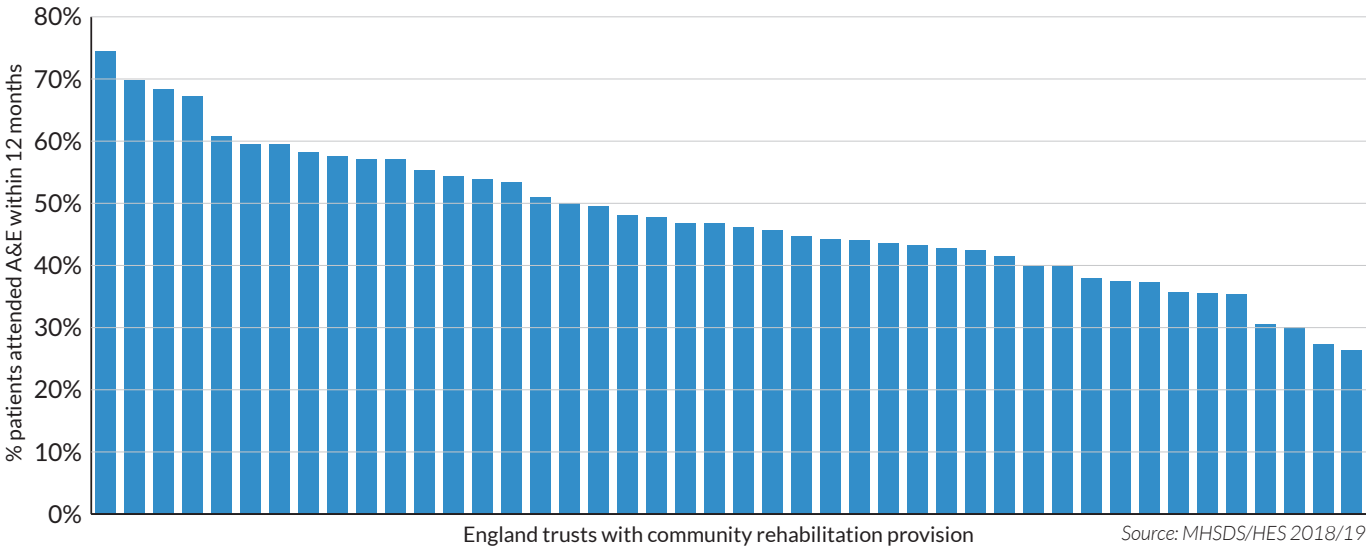
Short and long-term successes

Over a six-week trial period that included 152 inpatients, the trust cited significant improvement in physical health performance throughout rehabilitation services in the trust. All the patients (100%) had VTE assessments completed, including new patients within 24 hours of admission. Of these, 95.3% received annual physical health examinations and ECGs and 93.4% of patients had annual screening blood tests. Also, 99.3% of patients had cardiometabolic risk factors and substance misuse assessed, and of these 97.0% received the recommended interventions.

The trust is continuing work to ensure this practice becomes fully ingrained in its rehabilitation services and continues to lead to a sustained improvement in physical health of patients. Much of the success was attributed to the effective MDT collaborative approach throughout various stages of development and application, as well as utilising existing data analysis software, Tableau, to implement change. Tableau is widely used by NHS trusts and such, makes this approach cost effective and reproducible.

Figure 26 shows the comparison of providers with community rehabilitation provision and the usage of A&E. This demonstrates the high proportion of physical health care required from providers with a rehabilitation component, ranging from 26% to 74%.

Figure 26: Rehabilitation cases: % patients that attended A&E in the previous 12 months



Source: MHSDS/HES 2018/19

Table 9 shows the comparison of discharges of rehabilitation patients compared to the general population across four specialities. The data shows a higher proportion of rehabilitation patients requiring both elective medical and non-elective surgical specialities in comparison to the general population.

Table 9: Rehabilitation cohort, % of patients discharged in the previous 12 months by speciality

	Rehab patients	General population
Elective surgical specialties	7.6% (n 3,303)	6.7% (n 2,970,266)
Non elective surgical specialties	14.3% (n 6,247)	3.7% (n 1,638,803)
Elective medical specialties	6.5% (n 2,820)	5.2% (n 2,306,522)
Non elective medical specialties	19.2% (n 8,356)	8.2% (n 3,620,620)

Source: MHSDS/HES 2018/19

The aim of **Table 9** is to compare the general population and rehabilitation cohort within non-elective medical and surgical healthcare usage. The analysis illustrates the impact of a strong physical health strategy/implementation and potentially anonymised trusts with high levels of non-elective medical usage.

This report recommends physical healthcare of those in rehabilitation services to be prioritised, and effective arrangements for access to physical health referrals to be in place. This includes reasonable adjustments to facilitate access and care. This is aligned to recent NICE guidance recommending the rehabilitation team should ensure health checks, treatment of physical health conditions and other healthcare needs are addressed for people having inpatient rehabilitation.[83] The support includes essential input from primary care.[84] People with SMI should receive a comprehensive annual physical health check and follow up interventions. This is vital for all people with SMI, but of upmost importance for people who are prescribed anti-psychotics and whose lifestyles may have a negative impact on their physical health.

The Community Mental Health Framework[85] transformation funding guidance recommends physical health checks for those with SMI to consider the use of PHBs and ensure that they use the expertise and resource of their community health provider colleagues. There are local examples of using PHBs within recovery pathways to support access to care and activities addressing physical and mental health*. They can support a particular focus on health inequalities, and there are examples of where they have been developed in an area with high levels of deprivation and ethnic diversity. This personalised approach increased uptake from ethnic minority groups compared to traditional services.

There needs to be standardised data on comorbidities, and access to care and outcomes, for systematic improvement to be optimised. This includes mortality data, which is currently not routinely collated at trust and national level for those using rehabilitation care, or for those using secondary care mental health services. COVID-19 has highlighted further the importance of integrated physical and mental healthcare, with clinicians and staff needing to work together closely and share information and resources to ensure best patient care when patients with SMI have contracted COVID-19 and, indeed, to prevent them becoming infected wherever possible too.

Examples of such physical healthcare pathways incorporating reasonable adjustments pre-COVID-19 include the Guys and St Thomas' cancer pathway, and the work undertaken in the diabetes mellitus pathways which is yet to be published. One of the drivers of non-planned medical admissions is multiple morbidities and social deprivation. A key challenge for rehabilitation services is to help this population avoid future multiple morbidities or at least delay their appearance. Collecting metrics and ensuring systematic prevention of long-term conditions, such as cardiovascular disease and diabetes, and acting on them, will likely reduce non-planned medical admissions. It should be noted that the COVID-19 vaccine guidance includes people with schizophrenia in the clinical high-risk group.[86]

There is a need for ICSs to feedback to individual trusts. Data collected would be tracked within each ICS using linkage data. This will be used to improve and streamline the offer they receive to be as preventative as possible. Furthermore, the data will help to identify and develop local pathways that incorporate reasonable adjustments for individuals to receive physical health care. Tracking supports understanding of shifts in the use of non-elective and elective medical and surgical care. Costing across the ICS, for shifts in access and use, will also be monitored for physical healthcare aspects. This gives opportunities for improvement in the triple bottom line:

1. Patient experience.
2. Clinical outcomes.
3. Financial cost.

** unpublished correspondence from PHB team at NHS England and NHS Improvement.*

[83] *https://www.nice.org.uk/guidance/ng181*

[84] *NHS England and NHS Improvement (2019) 2019/20 General Medical Services (GMS) contract Quality and Outcomes Framework (QOF): Guidance for GMS contract 2019/20 in England. NHS England and NHS Improvement.*

[85] *NHS England and NHS Improvement Community Mental Health Framework*

[86] *Department of Health and Social Care (2020) Priority groups for coronavirus (COVID-19) vaccination: advice from the JCVI. Department of Health. www.gov.uk/government/publications/priority-groups-for-coronavirus-covid-19-vaccination-advice-from-the-jcvi-30-december-2020*

Recommendations

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
7.2 All trusts and health commissioners should create systems to provide an integrated model of physical and mental health care, ensuring the physical healthcare of those in rehabilitation services is prioritised and effective arrangements for access to physical health referrals are in place. This includes reasonable adjustments to facilitate access and care.	**a** Record mortality data per mental health trust routinely and centrally. Rehabilitation patients should be included as a key cohort within overall local plans (at primary care or ICS level) to improve the physical health care of people with SMI, both in the community as well as in inpatient settings.	Mental health trusts, rehabilitation teams, NHS Digital. Mental health trusts and GPs as part of the Quality and Outcomes Framework and LTC work. ICS leaders and secondary care acute care trusts CEOs and medical and nursing directors.	Over time, premature mortality rates due to physical health long term conditions will be reduced. Measures of usage of inpatient acute care for those with SMI. Reduce uptake of physical healthcare upstream is improved.	Within two years of publication.
	b All patients should have: • a GP (including inpatients - an SLA may be needed by the trust for inpatients); • a shared care arrangement in place; • physical health checks and screening; • tailored plans for smoking cessation for those with SMI and to reduce obesity, are likely to be the most effective way of reducing long term conditions. The 2020 NICE Mental Health Rehabilitation guidance, including the four-week comprehensive assessment, should be used to ensure all is covered. It is important to track: • physical health commissioning for quality and innovation (CQUIN) data in rehabilitation teams; • that shared care is signed up to and what this looks like in the new Community Mental Health Frameworks; • rehabilitation patients using acute physical healthcare beds.	Mental health trusts, rehabilitation teams, NHS Digital. Mental health trusts and GPs as part of the Quality and Outcomes Framework and LTC work. ICS leaders and secondary care acute care trusts CEOs and medical and nursing directors.	Over time, premature mortality rates due to physical health long term conditions will be reduced. Measures of usage of inpatient acute care for those with SMI. Reduce uptake of physical healthcare upstream is improved.	Within two years of publication.

Investing in a skilled MDT workforce

As previously discussed, many MDTs are not sufficiently well trained in rehabilitation to enable high quality, intensive rehabilitation provision. Planned transformation of community mental health services offers a key opportunity to improve competence and confidence in the workforce so that they can support complex rehabilitation cases.

Currently, psychiatrists and occupational therapists are some of the only disciplines to receive specialist rehabilitation training. Psychiatry trainees must spend one year out of their three-year training as a higher trainee, with a trainer who is recognised as a rehabilitation specialist in a rehabilitation post. There are specific competencies and a curriculum that must be covered and signed off during that time for the trainee to receive a rehabilitation endorsement as a part of their Certificate of Completion of Training. They are registered with the General Medical Council as being qualified in this specialism. Occupational therapists receive specialist rehabilitation training during their core training and are integral to the mental health rehabilitation workforce and improving patient participation. It is imperative that other disciplines also receive good rehabilitation training, such as psychologists, registered nurses, social workers, and support workers. Skilling up will lead to better patient experience and outcomes and is likely to reduce LoS on inpatient wards.

The role of clinical psychologists providing specialist therapies as described in NICE guidance[87], facilitating reflective practice and supervising therapeutic skills amongst the wider staff team, is also relevant particularly with this patient group.

The CQC report looking at the state of care in mental health services from 2014-2017[88] reported that well-led providers trained, developed, and sometimes employed those who used or had used their services. They could work alongside mental health care professionals to assure and improve the quality of the service. However, this practice was not widespread across mental health services causing inconsistencies in the skillsets of the mental health workforce. Additionally, some providers filled staff vacancies with bank or agency staff.

NICE guidance[89] recommends the following universal staff competencies for those working in rehabilitation services:

- Ensure that staff training emphasises recovery principles so that all rehabilitation staff work with a recovery-orientated approach.
- Staff should establish and maintain non-judgemental, collaborative relationships with people with complex psychosis.
- Provide support for staff to acknowledge and manage any feelings of pessimism about people's potential for recovery. Support could include helping staff to share experiences and frustrations with each other, for example through supervision, reflective practice and peer support groups.
- Ensure that staff attend appropriate diversity training and have the skills and competence to deliver non-discriminatory practice. They should understand that people may experience stigma resulting from their mental health condition, which could add to the stigma that people in a minority group (for example people from BAME groups) may already experience.
- Ensure that all staff are trained and skilled in supporting structured group activities and promoting daily living skills.
- Ensure that staff have skills and competence in risk assessment and management to an appropriate level for the service they work in. For example, staff in high-dependency units should be able to work with people who have a history of, or currently present with, serious risks to themselves or others.
- Rehabilitation services should ensure that their healthcare staff are competent to recognise and care for people with psychosis and coexisting substance misuse.

Additionally, NICE recommends consideration of training all rehabilitation staff in psychologically informed approaches – for example, motivational interviewing, positive behaviour support, behavioural activation, trauma-informed care, and simple techniques for supporting people who are having troubling thoughts and feelings. This should also include recovery-oriented rehabilitation which needs to include meaningful occupations and everyday activities, and ensuring people keep links with local employment and education, as well as social skills and community activities. Training in relevant physical healthcare skills and competencies, with support from primary care, regarding long term condition prevention and management is also essential. Skills to recognise and care for people with psychosis and co-existing substance misuse, learning disability, autism, and co-existing EUPD are also important. Skills to support family members or carers, including family work are needed. In addition to having a rehabilitation competency framework, it is important to ensure a read across to existing programmes of work underway for this workforce.

[87] *NICE (2014) Psychosis and schizophrenia in adults: prevention and management. NICE. www.nice.org.uk/Guidance/CG178*

[88] *Care Quality Commission (CQC): https://www.cqc.org.uk/publications/major-report/state-care-mental-health-services-2014-2017*

[89] *https://www.nice.org.uk/guidance/ng181*

CASE STUDY

Individual Placement & Support (IPS): Supported employment

Devon Partnership NHS Trust

Workways Supported Employment team has been a founder member of the Centre for Mental Health's IPS Centres of Excellence programme since 2009. The service itself covers the county of Devon, except Plymouth, and has been provided within Devon Partnership NHS Trust (funded by Devon CCG) since 2001.

The success of the service relies upon the long-standing commitment from commissioners to ensure it is fully resourced, has strong clinical leadership within the service and from the adult service clinical directorate, and support from the trust executive team and board.

The Workways Supported Employment team use the IPS approach; an evidence-based model of vocational rehabilitation for people with a mental health condition who want to find paid employment. The IPS model is based on eight principles:

- The focus is to help people find "competitive employment" i.e. regular jobs in the community, rather than sheltered or therapeutic work.
- The IPS service will support anyone working with a Recovery and Independent Living Mental Health team who is looking for paid employment.
- Job search will be based entirely on the service users' preferences for employment.
- Job search begins quickly.
- Employment specialists work closely with the community mental health teams and other health professionals involved in the service users care.
- Employment specialists will approach local employers in your area to find vacancies and educate employers about mental health.
- Support is time-unlimited for as long as the service user wants paid employment and continues once they are in work. However, the aim is to support the service user to feel confident to manage independently, so a "stepping down approach" is discussed and agreed when appropriate.
- 'Better off in work' calculations will be provided, and service users are supported with any contact with Job Centre Plus.

The team help find and retain paid employment by providing practical, one-on-one support, to service users. For example, job searching, interview skills, CV writing and personal statements, completing applications, discussing careers plans and further exploration using online tools, support with attending interviews and appointments, and providing information and support for employers.

Between April and December 2020, despite challenging economic circumstances, the team received 140 new people on the caseload, and created 68 new job outcomes in a variety of settings, including retail, education, administration, care work, and NHS clinical and support roles.

CASE STUDY

Tailored substance misuse services

Central & North West London NHS Foundation Trust

A number of staff within the service had attended training in relation to people with a dual diagnosis pertaining to substance use. Psychology staff were also working with some individuals, but they described the system as being very limited. Around two years ago, the team began discussions regarding how the service could be improved, through the care quality processes. As a result, the following structure was implemented:

- Two workbooks were introduced. One looking at patterns of behaviour, and the other looks at the process of change. These were designed either for patients to do themselves and then discuss with their key registered nurse, or to undertake with their key registered nurse, dependent upon the person's ability and motivation.
- Individual psychology sessions continue for those who require them, particularly for those who are more reluctant to consider the impact of substance use on their mental health.
- A working group was formulated specifically related to substance misuse. It was initially facilitated by a member of ward staff, and a member of the clinical education team who had previously worked as a dual diagnosis lead in the trust.

Successes and lessons learnt

Resistance around use of the workbooks was mitigated by refresher training for all staff, and through the supervision processes. The trust continues to monitor this aspect of practice to ensure that the quality is maintained.

Members of staff within the group and a number of others had completed comprehensive training in working with people who use substances. The group was available for patients on all wards and was being held in the Recovery Centre. Information was made available to patients through the community meeting and wards were reminded prior to the group starting each week. Twenty-eight patients attended the group, all of whom were positive about its impact and the need to reduce their use of substances. Some feedback was that the group helped them to manage their cravings, reminded them of why they did not want to use substances, and they found it insightful and helpful.

Rehabilitation staff require sufficient support themselves to support this group of people, who can be challenging. For example, the use of two-weekly reflective practice groups offers teams an opportunity to meet, think about team dynamics and develop their clinical practice. It is particularly important to support the workforce with the likely additional demand and strain linked to COVID-19.

The *We are the NHS: People Plan 2020/21 – action for us all* document focuses on the need to make changes to NHS culture and leadership. The publication addresses the new challenges facing the workforce in light of COVID-19, as well as offering measures to improve support to staff for their physical health and mental health. The new NHS People Plan also encourages every NHS trust and health commissioner to publish progress ensuring all levels of the workforce are representative of the BAME community.[90]

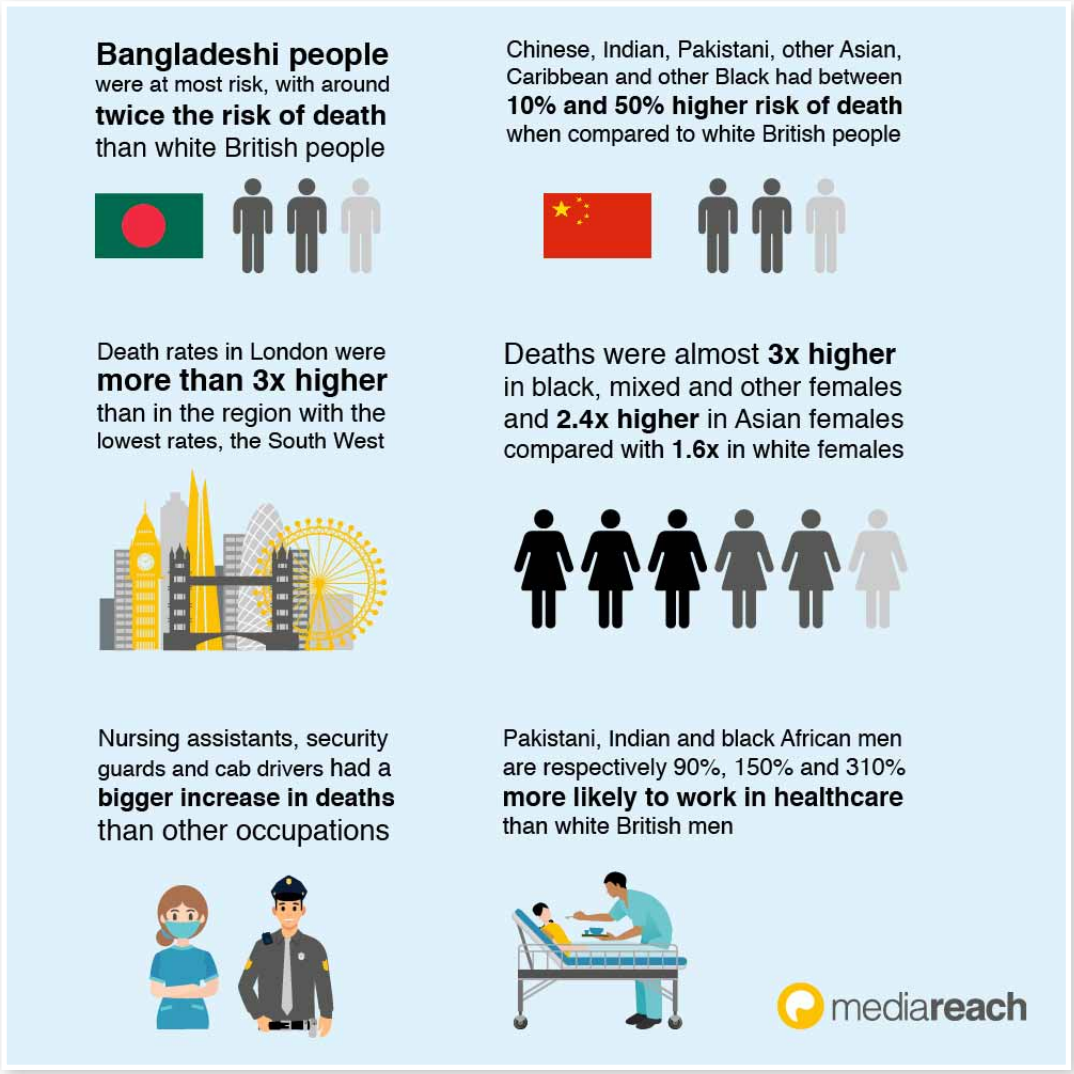
We recommend HEE, alongside a whole system approach and in collaboration with all relevant stakeholders, continues to consider the training needs of the MDT workforce to provide best practice, skills, and competencies. Additionally, this approach should consider those particularly which are generic or specialist in the context of mental health rehabilitation, whether that rehabilitative approach be residential or community focused, across health and social care.

Consideration should be given to resourcing HEE to commission specific scoping activity in this field to identify best practice in service models and workforce deployment. Transformation will underpin an opportunity for HEE to produce work which articulates competencies. HEE, if afforded resources from the appropriate agency tasked with development of these services, would then be in a position to further commission the articulation of these competencies more formally, harnessing this in an overarching framework.

[90] *NHS England NHS Improvement (2020) We are the NHS: People Plan for 2020/21 – action for us all. NHS England NHS Improvement. www.england.nhs.uk/wp-content/uploads/2020/07/We_Are_The_NHS_Action_For_All_Of_Us_FINAL_24_08_20.pdf*

The issues around inequality and inequity in experience and outcomes for both patients and staff, linked to protected characteristics such as race, gender and the others, are well evidenced and established. The disproportionate number of deaths from BAME staff and patients from COVID-19 further evidences this inequality. The pandemic exposed and exacerbated longstanding inequalities affecting BAME groups in the UK. Public Health England commissioned an enquiry into COVID-19 deaths, and it revealed higher BAME death rates – see **Figure 27**. A clear set of recommendations were developed.

Figure 27: COVID-19 deaths within certain groups



Source: Public Health England

It is clear further work to reduce this inequity is needed. It is vital that rehabilitation services address inequalities due to ethnicity for patients and carers, as well as crucially for staff. This includes reviewing leadership, considering both gender and BAME distribution amongst organisational structures. In addition, it is essential that training in rehabilitation must include an understanding of institutional racism and how each staff member can do their part, as well as what their organisations must do to address this inequality, which can cost BAME people – staff and service users – their lives. Ensuring other protected characteristics are also considered, including gender, to provide good outcomes for all, is essential. Data collation needs to be incorporated in the data collation to reduce inequalities.

Recommendations

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
8. All trusts, health commissioners and social care commissioners should invest in developing a skilled and competent MDT workforce within their mental health rehabilitation systems, particularly as part of local ICS community mental health transformation plans.	**a** Routinely consider skill mix in any workforce reviews or developments.	Providers.	Improved skills of staff and teams, leading to improved care, treatment and outcomes, as measured on the local rehabilitation data dashboard.	Within two years of publication.
	b HEE, alongside a whole system approach and with all relevant other stakeholders, to continue to consider the training needs of the MDT workforce to provide best practice, skills and competencies needed and applied in context into mental health rehabilitation.	HEE, alongside all relevant stakeholders across the system.	Improved skills of staff and teams, leading to improved care, treatment and outcomes, as measured on the local rehabilitation data dashboard.	Within two years of publication.
	c Consideration given to resourcing HEE to develop the articulation of these competencies more formally, harnessing this in an overarching framework, across the whole system.	HEE, alongside all relevant stakeholders across the system.	Improved skills of staff and teams, leading to improved care, treatment and outcomes, as measured on the local rehabilitation data dashboard.	Within two years of publication.
	d Assess existing guidance so as not to replicate some of the core training that some specialties, particularly occupational therapy and psychiatry, already incorporate.	HEE, alongside all relevant stakeholders across the system.	Improved skills of staff and teams, leading to improved care, treatment and outcomes, as measured on the local rehabilitation data dashboard.	Within two years of publication.
	e Ensure staff wellbeing is a core part of the regular reviews with a clear implementation plan.	Providers.	Improved skills of staff and teams, leading to improved care, treatment and outcomes, as measured on the local rehabilitation data dashboard.	Within two years of publication.
	f Ensure inequalities monitoring of patient experience, outcomes and staff progression is undertaken and reviewed. Ensure the incorporation of training and actions to address inequalities are embedded in rehabilitation services.	Providers.	Improved skills of staff and teams, leading to improved care, treatment and outcomes, as measured on the local rehabilitation data dashboard.	Within two years of publication.
	g Education providers to develop rehabilitation training to be delivered to staff.	HEE and education providers.	Improved skills of staff and teams, leading to improved care, treatment and outcomes, as measured on the local rehabilitation data dashboard.	Within two years of publication.

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
8. (continued)	**h** Support and train patients and carers to access and use digital support, care and treatment.	Providers.	Improved skills of staff and teams, leading to improved care, treatment and outcomes, as measured on the local rehabilitation data dashboard.	Within two years of publication.
	i All staff to have training on access and funding for housing and housing-related issues.	Providers.	Improved skills of staff and teams, leading to improved care, treatment and outcomes, as measured on the local rehabilitation data dashboard.	Within two years of publication.

Data driven continuous QI

There remains patchy engagement with robust QI programmes across inpatient units and missed opportunities to implement QI initiatives across provider collaboratives.

Table 10 shows the differences in accreditation across both HDU and CRU units. There is no consistency across rehabilitation services in the level of QI adoption, with some organisations not having begun their QI journey. There is a wealth of evidence suggesting organisations with mature QI programmes have improved patient outcomes and more engaged staff.

Table 10: Peer accreditation system/quality forum

	Accreditation				
	AIMS-Rehab	NICE audit	POMH UK	Other	One or more identified accredition identified
HDU	73.0% (27/37)	46.7% (14/30)	46.9% (15/32)	10.0% (2/20)	74.4% (32/43)
CRU	47.5% (28/61)	42.1% (23/57)	34.5% (19/58)	16.7% (6/42)	56.2% (41/73)

Source: GIRFT Questionnaire 2018/19

NICE guidance[91] recommends rehabilitation services consider joining a peer accreditation or QI forum. This is because rehabilitation services often exist in isolation, so it is important for them to share good practice with other practitioners.

Our aim is for every rehabilitation service to have access to high-quality QI. With QI aiming to improve outcomes for all and help address the gradient of health inequalities, rehabilitation services should support and encourage its implementation. We recommend all rehabilitation pathways should demonstrate use of routine clinical data to drive QI programmes. The expertise should be at the trust and provider collaborative level. The RCPsych AIMS-Rehab quality network and accreditation system[92] can inform and support local rehabilitation QI programmes.

[91] *https://www.nice.org.uk/guidance/ng181*

[92] *https://www.rcpsych.ac.uk/improving-care/ccqi/quality-networks-accreditation/rehabilitation-services*

CASE STUDY

Quality Improvement

City and Hackney Community Rehabilitation Service, East London NHS Foundation Trust

The City and Hackney Community Rehabilitation Service integrates mental health and social care to support the rehabilitation of people with severe and enduring mental illnesses. The MDT includes medical, nursing, social work, occupational therapy, psychology and support work input. The service aims to support people to live within their own community, and benefit from enhanced support to avoid hospital admission. The trust believes that supporting people to maintain stability and access rehabilitation within the community is the right thing to do.

The team care co-ordinates 80 people who have prominent positive and negative symptoms, treatment resistance and poor activities of daily living function, and provides clinical input to the mental health supported accommodation pathway.

Using a placement review tool, the service carries out annual reviews of all funded placements (150 per year) on behalf of the local authority and CCG, and plans step-down. If required, the service also provides case management for transitions and moves, or when changes in needs are identified. The service provides acute inpatient liaison and assessment to facilitate timely discharge, by identifying placements and signposting housing panel processes swiftly. Staff have developed pre-panel consultation sessions for discussion about appropriate accommodation options for community teams (including forensic). They co-facilitate the Mental Health Supported Accommodation Panel, liaising with providers across the pathway and managing housing quota allocation.

In addition, the service has made effective use of the Quality Improvement (QI) approach, running a project which aims to increase throughput along the mental health supported accommodation pathway by 25% over an 18-month period. A range of outcome measures were evaluated frequently to improve the process in an iterative manner. Looking at data for total number of funded placements and weekly cost over time provided robust ways of tracking progress. Process measures, such as completion of reviews and actions and process mapping as a system with local authority and accommodation provider partners, helped to create a shared vision of the work and ensured that reviews had a meaningful and timely impact.

This is in the context of City and Hackney having had no inpatient rehabilitation beds for ten years, lower than national average length of stay on acute adult wards, and not using any acute adult or rehab extra contractual referral/out of area beds for many years. Inpatient rehabilitation work does take place on the acute inpatient wards, with some patients needing longer admissions as necessary, at times up to a year or more.

The service has maintained a CQC rating of 'outstanding' for the past six years.

Successes and lessons learnt

The trust says it has developed the approach over many years and, crucially, has fitted into the local system rather than coming in with a rigid model or approach.

- Over the last ten years there has been a shift away from care co-ordination towards specialist placement review and resettlement and complex case management.
- Moved from ad hoc reviews directed by accommodation manager to the rehabilitation team systematically reviewing people in funded placements annually.
- Initially lots of straightforward moves – moving more out than coming in and the overall number coming down from 150+ to 130.
- Cases becoming more complex and requiring specialist knowledge and skills to facilitate move-on and maintain placements.
- Number of funded placements stabilised at 130, reflecting continued and consistent throughput – despite cuts to local authority housing-related support. Stabilising the budget for this for several years has been a key outcome and factor in positive relationships with local system partners.
- By working closely with the local acute inpatient team, the aim is to facilitate discharge as soon as possible. The team takes a proactive role in seeking referrals through the housing panel, and through in-reach to the inpatient unit. The team's role within the housing panel means they have access to accommodation solutions where this is an issue.
- The service has increased trust and communication between system partners, and improved relationships so that they are invited to provide clinical expertise to commissioning and procurement.

CASE STUDY

Quality Improvement (continued)

- Having a view of the whole accommodation pathway is a key rehab function in a local system, so that transitions are as seamless and smooth as possible.
- Clinicians have learned to value the resources available and consistently scrutinise the quality and value for money.
- Providing easy access to support (such as supervision, advice and clinical input) for providers in order to maintain placements and manage periods of instability.
- QI methodology has helped to involve all stakeholders, tracking data over time and evidencing the impact of this rehab function.
- The evolution of the team and development of this rehab expertise, alongside ongoing work with the care-coordinated patient group, adds value to the broader system.

CASE STUDY

A carer's experience of rehabilitation services – the triangle of care

Kent & Medway NHS and Social Care Partnership Trust

Throughout the deep dive visits, we encouraged attendance from experts by experience. We followed up with one carer who is prime carer for her daughter, who gave us an insight into the support shown by the trust for patients placed both locally and out of the provider footprint. She said that knowing who to phone when her daughter is beginning to become unwell is vital.

"For me it is essential to know that my thoughts, worries and feelings are going to be acted upon. This is the most important thing; to not feel disregarded or have concerns left invalidated. If you are not listened to or heard, then carers are unlikely to contact mental health services, and attempt to cope with it alone, until at absolute breaking point and crisis."

It was clear from her experience that feeling valued and listened to was crucial. Building trust and getting help in a timely manner, to prevent having to cope alone, has been important. When describing the benefits of the rehabilitation service during a crisis, she said: "For me, it was peace of mind and space. A time to breathe and space so the rest of the family could reflect on what had happened, as it was often traumatic for us all…my daughter, during her admission of five months, learnt how to cook, share her experience [through] peer support, and was valued. Rehabilitation gave her space to think about the next steps in her life, working towards more independent living."

This mother works with other carers to support them through shared experience and reassures them that their loved ones are safe and being cared for. She said: "I believe that the rehabilitation service has a higher value than perhaps is placed on it, especially compared to some services. For me, it is the jigsaw that holds everything together."

A national and regional Rehabilitation Quality Network will be set up to support this ongoing work, with the RCPsych CCQI and the Rehabilitation and Social Psychiatry Faculty to co-ordinate, and GIRFT programme implementation managers to possibly support.

In terms of implementing recommendations in this report, GIRFT works in partnership with NHS England and NHS Improvement regional teams to help trusts and their local partners to implement improvements and address the issues raised in both the trust data packs and the national specialty reports. The GIRFT team will also work with national NHS England and NHS Improvement teams supporting systems to transformation community mental health services and to develop the provider collaborative response on rehabilitation. The GIRFT team provides support at a local level, advising on how to reflect the national recommendations into local practice and supporting efforts to deliver any trust specific recommendations emerging from the GIRFT visits. GIRFT also helps to disseminate best practice across the country, matching up trusts who might benefit from collaborating in selected areas of clinical practice. Through all its efforts, local or national, the GIRFT programme strives to embody the 'shoulder to shoulder' ethos that has become GIRFT's hallmark, supporting clinicians nationwide to deliver continuous QI for the benefit of their patients.

Recommendations

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
9. All trusts, health commissioners and LAs housing providers should use data informed continuous QI approaches across the whole system of mental health rehabilitation.	**a** All rehabilitation pathways should demonstrate use of routine clinical data to drive QI programmes. The expertise should be at the trust and provider collaborative level.	Provider trusts and provider collaboratives.	QI initiatives in place and continuous improvement being seen across rehabilitation services in key areas.	Within 12 months of publication.
	b Trusts to work with RCPsych AIMS-Rehab to inform and support local rehabilitation QI programmes. This could include using tools such as Quality Indicator for Rehabilitative Care [QuIRC]/(QuIRC-SA)	Provider trusts and provider collaboratives.	Routine quality network meetings, with data being discussed and good practice shared.	Within 12 months of publication.
	c Regional quality networks should be established. Include LA and supported housing and care staff and partners. This may be through the RCPsych regional College Engagement Networks.	Provider trusts and provider collaboratives.	A learning and mutually supportive environment developed in each region.	Within 12 months of publication.

Utilising digital technology

Deep dive feedback during the COVID-19 crisis suggests that the use of videoconferencing has resulted in improved ability to review more people, especially with OPP. However, prior to COVID-19, the use of videoconferencing for reviews was uncommon.

As a result of the pandemic, video conferencing is now commonplace, with clinicians from teams coming together more easily and more frequently, for patient reviews on inpatient units for example. The reviews of rehabilitation patients in their supported accommodation have increased significantly, with accommodation care providers ensuring digital equipment is available and that they facilitate the use of technology with patients, so the clinical reviews can take place.

We have also heard of digital developments in the secure mental health estate which have served to make services less restrictive. In particular, the introduction of virtual visiting across services, where appropriate, has been received positively. In some cases, this has offered patients the ability to interact with their families/carers on a more frequent basis and remain connected with them during the lockdowns and when physical visits to the units have not been possible. This has also been used for professional visits, including solicitors/barristers, while maintaining the confidentiality between the legal professional and their client.

These examples of learning from COVID-19, and others, will be taken to consider how to move forward, incorporating beneficial improvements, rather than just reverting to old practices. This will involve being able to offer a greater mixture of approaches and interventions for patients to access. Some of the advancements seen as a result of COVID-19 have occurred a good 18 months+ ahead of when they may have occurred, and the benefits they have offered should not be lost.

It is vital the learning and technology adaptations during the COVID-19 pandemic continue to drive better communication and engagement from CRTs. This links to 2020 work between the Association of Mental Health Providers and the NHS Confederation into digital inclusion in mental health.[93] We recommend recording how many reviews are conducted face-to-face versus virtual, and ensuring the reviews are keeping with guidance i.e. three-month reviews for OPPs, and monthly reviews minimum for community care co-ordinated service users (yet to be published on writing of this report).

[93] *Association of Mental Health Providers and NHS Confederation (2020) Digital inclusion in mental health: A guide to help increase choice and improve access to digital mental health services. NHS Confederation. www.nhsconfed.org/-/media/Confederation/Files/Publications/Documents/Digital-Inclusion-in-Mental-Health-Dec-2020.pdf?la=en&hash=9A3CCF796B398327328BDE9B0E613643CABB96A0*

Although large improvements in digital infrastructure and capability have been developed because of the COVID-19 pandemic, it is not yet clear how outcomes are affected for patients having digital appointments in comparison to in-person appointments. As digital technology is rolled out to deliver rehabilitation services, the effectiveness of its use and any inequalities that may arise should be monitored. Staff need to have digital literacy to be able to assess their patients and carers also need to be trained in digital skills. This is essential given the proportions of key services being delivered online now – for example, booking a GP appointment. This should be considered an Activity of Daily Living.

Recommendations

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
10. Trusts and other service providers should utilise digital technology in developing and delivering rehabilitation services.	**a** All rehabilitation units/services to invest in and improve digital technology to ensure good communication and to facilitate frequent clinical reviews.	Provider trusts and providers of other services.	Improved use of technology, facilitating clinical reviews and staff with the skills to support patients to access digital support care and treatment. Reduced levels of digital exclusion.	Within 12 months of publication.
	b Staff skills and competencies to reflect supporting and training patients and carers to access and use digital support, care and treatment. To include social prescribing and enable digital access.	Local digital transformation opportunities.	Improved use of technology, facilitating clinical reviews and staff with the skills to support patients to access digital support care and treatment. Reduced levels of digital exclusion.	With immediate effect. To be in place within two years of publication.
	c Consider the issue of digital exclusion and how to overcome this.	Local digital transformation opportunities.	Improved use of technology, facilitating clinical reviews and staff with the skills to support patients to access digital support care and treatment. Reduced levels of digital exclusion.	Within 12 months of publication.

Standardisation of procurement processes and protocols

As previously mentioned in the *Patient pathways* section (page 57), to bring patients back to their local area and standardise the offer of placements when they OPPs, we recommended the use of the national procurement framework with clear oversight and monitoring systems and arrangements in place to ensure care is appropriate to the person's needs – see **recommendation 1.2** page 52, and **recommendation 3** page 68.

There is enormous unwarranted variation in the contracts drawn up with inpatient rehabilitation providers when spot purchasing with independent providers. This also exists with community supported accommodation placements.

This can be a relatively easy win to standardise/reduce cost of placements, particularly when economies of scale with several provider trusts/ health commissioners working together are brought to bear. Block contracting in some instances, when providers are of a high enough quality with good outcomes, may also be considered rather than spot purchasing. The standards expected in terms of service provision, care, support, treatment, communication with placing teams, reporting, measuring progress and outcomes, costs, are all variable. A national procurement framework, highlighting best practice and a fair and equitable system, should be in place. Local services can adjust, ensuring care is always personalised, with the support of a national level agreement. Local methods to ensure personalised approaches are embedded and incentivised should be in place.

There are large savings available in rehabilitation based on negotiating placement costs, block purchasing and using the nationally agreed framework. The London Procurement Pathway is being adapted to become the national procurement pathway.

The CQC identified that staff skills are one of the issues that contribute to patients not making progress in their rehabilitation and recovery and consequent ability to step down back into community settings or continue with their rehabilitation.[94] Hence, all providers, including in the private sector, both inpatient and community, must ensure that they are training and employing staff with the right skill set to provide ongoing active rehabilitation. These standards must be incorporated into regular OPP contracts by those commissioning such services.

Recommendations

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
11. Standardise and systemise processes and protocols around procurement.	**a** Use trusted providers, fewer and as close to home as possible, while still optimising care and outcomes. The national OPPs framework to be used and this to be updated to reflect current best practice annually.	Whoever is placing, monitoring and paying for placements.	There will be fewer providers and people will be placed near their homes while retaining quality. All providers of OPPs will use the standardised framework which gives greater consistency of quality of care and reporting back to the placing authorities.	Within two years of publication.
	b Standards around specialist rehabilitation staff training need to be incorporated into standardised OPP contracts.	Provider trusts, and health and social care commissioners.	There will be fewer providers and people will be placed near their homes while retaining quality. All providers of OPPs will use the standardised framework which gives greater consistency of quality of care and reporting back to the placing authorities.	With immediate effect. To be in place within two years of publication.

[94] *https://www.cqc.org.uk/publications/major-report/state-care-mental-health-services-2014-2017*

Litigation

Reducing the impact of litigation

Each of the GIRFT programme teams has been asked to examine the impact and causes of litigation in their field with a view to reducing the frequency of litigation and, more importantly, reducing the incidents that lead to it. It is important for clinical staff to have the opportunity to learn from claims in conjunction with learning from complaints, serious incidents (SIs)/patient safety incidents (PSI) and inquests will lead to improved patient care and reduced costs both in terms of litigation itself and the management of the resulting complications of potential incidents.

It was clear during GIRFT visits that many providers had little knowledge of trends in the claims against them. Consequently, the opportunity to learn from the claims to inform future practice is lost. Further work is needed at both a local and national level to analyse claims to maximise this opportunity to improve patient care.

Clinical negligence claims volume and costs

Data obtained from NHS Resolution reveals the clinical negligence claim costs in adult acute mental health, community mental services and psychology combined, as detailed in **Table 11**.

The number of claims has steadily increased from 2015/16 with an increase of 25% from 2018/19 to 2019/20. Total claims costs have been variable with a large increase, 131% from financial year 2016/17 to 2017/18. This spike in costs represents an increase in the small number of high value claims with 12 claims being valued at greater than a £1 million in that year. The themes for these high value claims are the same throughout the five-year period and include: claims relating to brain injury, spinal injury or multiple injuries due to an alleged failure in risk assessment or supervision resulting in self-harm and suicidal actions.

Table 11: Volume and cost of medical negligence claims related to adult mental health, community mental services and psychology notified to NHS Resolution 2015/16 to 2019/20

Notification year	No. of claims	% change in no. of claims	Total claim cost (£ million)	% change in claim costs
2015/16	289		42	
2016/17	323	12%	36	-13%
2017/18	339	5%	84	131%
2018/19	358	6%	72	-14%
2019/20	447	25%	64	-11%
Grand Total	**1756**		**298**	

Source: NHS Resolution

Claims trends and causes

Table 12: Most frequent causes for litigation in adult mental health, community mental health services and psychology 2015/16 to 2019/20

Item	No. of claims	% of total claims
Fail / Delay Treatment	294	17%
Unexpected Death	200	11%
Assault, Etc By Hospital Staff	195	11%
Self Harm	192	11%
Inappropriate Treatment	140	8%
Fail To Supervise	96	5%

Source: NHS Resolution

Causes

Using the NHS Resolution data, common causes for litigation in adult mental health, community mental services and psychology were identified. Across all three specialties, failure/delay to treatment was the most frequent cause of claim. It is important to note that more than one cause can be assigned to each claim. It is recognised that many claims may be reasonably attributed to areas of the healthcare system that require improvement.[95] Some of the claim cause codes, including failure to supervise and inadequate nursing, suggest further scrutiny of claims that feature these codes and will enable clinical staff to learn and improve delivery of care.

Suicide

When a person takes their own life it has a devastating, lifelong impact on the family, carers and staff involved in that person's care. As shown by **Table 13**, the number of clinical negligence claims relating to suicide is small, but it does account for over 10% of the number of adult mental health claims and of the estimated potential costs associated with these claims.

The NHS Resolution safety and learning team had undertaken further thematic analysis of claims related to suicide[96] to better understand the clinical and non-clinical themes in care from attempted and completed suicide that resulted in a claim for compensation. Their analysis demonstrated that recurrent themes were consistent through many of the incidents associated with these claims, including poor management of substance misuse, difficulties with community especially in inter-agency working, inaccurate and poorly documented risk assessments and inconsistent observation processes. Furthermore, the SI investigations that followed the incident in these claims often lacked involvement of the family and the reports that were produced lacked robust recommendations that were consequently unlikely to impact on future practice. The NHS report produces nine recommendations that guide mental health departments to improve clinical and non-clinical practice in this area and focus on a systematic approach to communication through all bodies involved in patient care in mental health.

[95] *Kaplan, C. (2006) Reducing Risk in Mental Health Services: the Work of the NHS Litigation Authority. Mental Health Review Journal, Vol. 11 No. 1, pp. 34-37.*

[96] *Oates A. (2018) Learning from suicide-related claims: A thematic review of NHS Resolution data. NHS Resolution. https://resolution.nhs.uk/resources/learning-from-suicide-related-claims/*

Table 13: Volume and cost of suicide related medical negligence claims notified to NHS Resolution 2015/16 to 2019/20

Notification year	No. of claims	% change in no. of claims	Total claim cost (£ million)	% change in claim costs
2015/16	27		3.2m	
2016/17	29	7%	4.4m	39%
2017/18	40	38%	5.4m	22%
2018/19	48	20%	5.5m	1%
2019/20	37	-23%	4.4m	-20%
Grand Total	**181**		**22.8m**	

Source: NHS Resolution

Table 14: Causes of medical negligence claims related to suicide notified to NHS Resolution 2015/16 to 2019/20

Cause	No. of claims
Self Harm	151
Inappropriate Discharge	7
Fail / Delay Treatment	7
Unexpected Death	6
In Patient Suicide: Non-Collapsible Rails	3
Fail/Delay Admitting To Hosp.	2

Source: NHS Resolution

Recommendations

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
12. Reduce litigation costs by application of the GIRFT programme's five-point plan.	**a** Clinicians and trust management to assess their litigation claims covered under Clinical Negligence Scheme for Trust (CNST) notified to the trust over the last five years.	Clinicians and trust management	Findings will be shared with staff and staff will be cognisance of issues around litigation and ways to reduce the risk.	Within six months of publication.
	b Clinicians and trust management to discuss with the legal department or claims handler the claims submitted to NHS Resolution to confirm correct coding to that department. Inform NHS Resolution of any claims which are not coded correctly to the appropriate specialty via CNST.Helpline@resolution.nhs.uk	Clinicians and trust management	Findings will be shared with staff and staff will be cognisance of issues around litigation and ways to reduce the risk.	Upon completion of **a**.
	c Once claims have been verified clinicians and trust management to further review claims in detail including expert witness statements, panel firm reports and counsel advice as well as medical records to determine where patient care or documentation could be improved. If the legal department or claims handler needs additional assistance with this, each trusts panel firm should be able to provide support.	Clinicians and trust management	Findings will be shared with staff and staff will be cognisance of issues around litigation and ways to reduce the risk.	Upon completion of **b**.
	d Claims should be triangulated with learning themes from complaints, inquests and SI/ PSI and where a claim has not already been reviewed as SI/PSI we would recommend that this is carried out to ensure no opportunity for learning is missed. The findings from this learning should be shared with all staff in a structured format at departmental/directorate meetings (including MDT meetings, morbidity and mortality meetings where appropriate).	Clinicians and trust management	Findings will be shared with staff and staff will be cognisance of issues around litigation and ways to reduce the risk.	Upon completion of **c**.
	e GIRFT clinical leads and regional teams to share with trusts examples of good practice where it would be of benefit.	GIRFT Clinical Leads	Findings will be shared with staff and staff will be cognisance of issues around litigation and ways to reduce the risk.	For continual action throughout GIRFT programme.

Notional financial opportunities

Calculating gross notional financial opportunities and cost implications in GIRFT reports

GIRFT reports provide financial opportunity figures to illustrate how improving clinical care will also improve productivity, using a methodology endorsed by the Healthcare Financial Management Association (HFMA). These figures are calculated after the report's draft recommendations are finalised, and after establishing what changes to clinical metrics they would be expected to deliver. The financial opportunity figures are not used to inform the report's findings or the development of the recommendations.

The financial opportunities provided are gross and notional. They are not inherently cash-releasing and apply a notional financial value to activity, ordinarily using figures from national prices or reference costs. They are not a net figure, because implementation costs could not usually be calculated in this way: costs may be locally contingent or otherwise not calculable using reference costs or national prices. Instead, implementation costs are identified separately, in consultation with colleagues in NHS England and NHS Improvement, once draft recommendations have been finalised from a clinical perspective.

The opportunities figure includes reductions to:

- LoS;
- planned admissions where no procedure took place;
- re-operation rates;
- readmissions;
- outpatient attendances and follow-ups; and
- unnecessary procedures and appointments.

Financial opportunities and potential cost implications from this report

There is an opportunity to create better value and improve the quality of mental health rehabilitation, including the treatment of patients closer to home, if there is investment in the service. Evidence showed that the cost of rehabilitation in OAPs costs around 65% more than local placements, mainly due to longer LoS and variable quality. This was not caused by the patients placed out of area being more complex or more difficult to treat.

A whole system rehabilitation service offer would encompass all the key components - for example in-reach to acute wards, advice and consultation to those with complex needs in other parts of the mental health system such as the community, as well as a local rehabilitation service (including inpatient and community). The offer will support reduction in acute admissions, reduction in long stay people on acute wards, and provide a streamlined pathway to community support, including supported housing and care packages. Ongoing rehabilitation in community settings is also a core element of the service, with further progress to greater independence and the avoidance of continued re-hospitalisation for many. This report makes practical recommendations that will address many of the pressures faced by the mental health rehabilitation service. However, it is recognised investment will be required in many areas if services can be substantially changed.

It should be noted that the poor data reporting causes challenges in tracking data across the system to ensure mental health rehabilitation services are used optimally. Currently, coding is not accurate and is not consistent. This makes it difficult to pull out rehabilitation data for a dashboard and to make subsequent improvements. Without a comprehensive, granular, nuanced body of data, mental health rehabilitation services are unable to thoroughly assess services across and within trusts. Local knowledge should be segmented and combined with data enabling meaningful and tailored service planning.

Taking into consideration the lack of robustly coded data, the psychiatric rehabilitation financial opportunities in **Table 15**, below, is illustrative only. It includes examples of areas identified within the national report where there is potential to make significant changes that could contribute to an overall reduction in hospital bed days. The examples are not mutually exclusive i.e. there is overlap between them. Furthermore, they may also duplicate elements identified as opportunities within other GIRFT national reports related to reductions in LoS.

It should be noted that the potential opportunities linked with wait times are not explored in the table below. As shown above in this report (see **Figure 11**, page 46), the median HDU provider waiting time for admission is eight weeks with a range between 0 and 44 weeks. Data from NHSBN shows the average one-week wait cost of £3,129, which means for the average wait a cost of £24.8K. Further work is required to develop a thorough understanding of what is being spent while the person is waiting elsewhere. Opportunities arising from reducing litigation costs are also not included in this table, but are discussed earlier in this report.

Potential costs have been considered carefully in finalising this report, and the recommendations are consistent with funding arrangements established to deliver the Long Term Plan. The Plan significantly increases funding to provide a higher quality of services for people with severe mental health problems, including those with highly complex needs and with respect to rehabilitation services/pathways. Plans to support whole system improvement of rehabilitation pathways can be put forward for funding from the NHS Long Term Plan and Community Mental Health Framework to health commissioners. Costs sitting outside the health care system have also been considered and reflected in the report. Our implementation plans for increasing access to support housing, for example, are contingent on funding arrangements to be established.

Table 15: Notional financial opportunities

Improvement	Standard			Target		
	Target	**Activity opportunity***	**Gross notional financial opportunity****	**Target**	**Activity opportunity***	**Gross notional financial opportunity****
All trusts and health commissioners should develop robust systems to bring patients treated out of area back to their local area *(recommendations 3, 6)*	*Clinical View*			*Clinical View*		
Opportunity = Reduce out of area bed days *Base data: MHSDS/HES 2018/19* *Cost estimated based on average admitted MH care cluster (MHCC currencies) bed day cost (18/19 ref costs uplifted to 20/21 prices).*	10% reduction in OPP bed days	59,700 bed days	£25.75m	20% reduction in OPP bed days	119,500 bed days	£51.54m

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Table 15: Notional financial opportunities (continued)

Improvement	Standard			Target		
	Target	Activity opportunity*	Gross notional financial opportunity**	Target	Activity opportunity*	Gross notional financial opportunity**
Ensure people do not become stranded in inpatient services by increasing generic mental health rehabilitation capacity and capability *(recommendation 2)* Opportunity = Reduce length of stay of patients staying over 60 days *Base data: MHSDS/HES 2018/19* *Cost estimated based on average admitted MH care cluster (MHCC currencies) bed day cost (18/19 ref costs uplifted to 20/21 prices.* *Note: the same calculation included within the adult acute MH FIS is utilised here, which assumes an overall reduction of 28 bed days per 'stranded' admission. The potential activity opportunity shown here assumes an estimated 20% of this overall LOS reduction could be achieved through proactive MH rehabilitation input*	*National average* 14.3% inpatient stays over 60 days	8,900 bed days	£3.84m	*Best quartile* 10.6% inpatient stays over 60 days	18,700 bed days	£8.07m
Mental health rehabilitation should work alongside physical rehabilitation in acute hospitals *recommendation 7)* Opportunity = Reduce non elective acute care lengths of stay (note: cancer, cardiac, respiratory, diabetes and stroke looked at here - the opportunity calculated relates to acute hospital bed days, rather than mental health Trust bed days) *Base data: MHSDS/HES 2018/19* *Cost estimated based on average general medicine non elective excess bed day cost (17/18 ref costs uplifted to 20/21 prices).*	*Clincal view* % reduction in non elective bed days	2,500 acute hospital bed days	£0.82m	*Clincal view* 10% reduction in non elective bed days	5,000 acute hospital bed days	£1.63m

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Table 15: Notional financial opportunities (continued)

Improvement	Standard			Target		
	Target	Activity opportunity*	Gross notional financial opportunity**	Target	Activity opportunity*	Gross notional financial opportunity**
Ensure consistency in community based rehabilitation provision *(recommendation 7)* Opportunity = Reduce [Mental Health rehab cases] A&E attendances (note: the opportunity here would accrue to the acute hospital rather than the mental health Trust) *Base data: MHSDS/HES 2018/19* *Cost estimated based on average A&E non admitted attendance cost (18/19 ref costs uplifted to 20/21 prices)*	*Clinical view* 5% reduction in A&E attendances	1,000 A&E attendances	£0.12m	*Clinical view* 10% reduction in A&E attendances	2,100 A&E attendances	£0.25m
Total			**£30.53m**			**£61.49m**

* Activity opportunities are annual figures, based on one year of activity data (2018/19). Unless specified, activity that could be avoided is shown

** Costing of financial opportunity: unless otherwise stated, cost estimates are based on national average 2018/19 reference costs, uplifted to 2020/21 pay and prices using tariff inflation

About the GIRFT programme

Getting It Right First Time (GIRFT) is a national programme designed to improve medical care within the NHS. Funded by the Department of Health and Social Care and jointly overseen by the Royal National Orthopaedic Hospital NHS Trust and NHS England and NHS Improvement, it combines wide-ranging data analysis with the input and professional knowledge of senior clinicians to examine how things are currently being done and how they could be improved.

Working to the principle that a patient should expect to receive equally timely and effective investigations, treatment and outcomes wherever care is delivered, irrespective of who delivers that care, GIRFT aims to identify approaches from across the NHS that improve outcomes and patient experience, without the need for radical change or additional investment. While the gains for each patient or procedure may appear marginal, they can, when multiplied across an entire trust – and even more so across the NHS as a whole – deliver substantial cumulative benefits.

The programme was first conceived and developed by Professor Tim Briggs to review elective orthopaedic surgery to address a range of observed and undesirable variations in orthopaedics. In the 12 months after the pilot programme, it delivered an estimated £30m-£50m savings in orthopaedic care – predominantly through changes that reduced average LoS and improved procurement.

The same model is now being applied in 40+ different areas of clinical practice. It consists of four key strands:

- a broad data gathering and analysis exercise, performed by health data analysts, which generates a detailed picture of current national practice, outcomes and other related factors;
- a series of discussions between clinical specialists and individual hospital trusts, which are based on the data – providing an unprecedented opportunity to examine individual trust behaviour and performance in the relevant area of practice, in the context of the national picture. This then enables the trust to understand where it is performing well and what it could do better – drawing on the input of senior clinicians;
- a national report, that draws on both the data analysis and the discussions with the hospital trusts to identify opportunities for NHS-wide improvement;
- an implementation phase where the GIRFT team supports providers to deliver the improvements recommended.

GIRFT and other improvement initiatives

GIRFT is part of an aligned set of workstreams within NHS Improvement. It is the delivery vehicle for one of several recommendations made by Lord Carter in his February 2016 review of operational efficiency in acute trusts across England.

As well as support from the Department of Health and Social Care and NHS England and NHS Improvement, it has the backing of the Royal Colleges and professional associations.

GIRFT has a significant and growing presence on the Model Hospital portal, with its data-rich approach providing the evidence for hospitals to benchmark against expected standards of service and efficiency. The programme also works with a number of wider NHS programmes and initiatives which are seeking to improve standards while delivering savings and efficiencies, such as NHS RightCare, acute care collaborations (ACCs), and sustainability and transformation partnerships (STPs).

Implementation

GIRFT has developed an implementation programme designed to help trusts and their local partners to address the issues raised in trust data packs and the national specialty reports to improve quality. The GIRFT team provides support at a local level, advising on how to reflect the national recommendations into local practice and supporting efforts to deliver any trust specific recommendations emerging from the GIRFT visits. GIRFT also helps to disseminate best practice across the country, matching up trusts who might benefit from collaborating in selected areas of clinical practice. Through all its efforts, local or national, the GIRFT programme strives to embody the 'shoulder to shoulder' ethos that has become GIRFT's hallmark, supporting clinicians nationwide to deliver continuous quality improvement for the benefit of their patients.

Glossary

Approved Mental Health Professional(s) (AMHPs)
Work on behalf of local authorities to carry out a variety of functions under the Mental Health Act (MHA). One of their key responsibilities is to make applications for the detention of individuals in hospital, ensuring the MHA and its Code of Practice are followed.

Assertive Outreach Teams (AOT)
Part of secondary mental health services and are usually attached to the community mental health team. They work with people who are 18 to 65 years old who have particularly complex needs and need more intensive support to work with services. Guidance suggests that people may need assertive outreach if they have a set of specific criteria linked to severity and complexity of their illness and a number of hospital admissions.

Black, Asian, and Minority Ethnic (BAME)
Defined as all ethnic groups except white ethnic groups.

Care Programme Approach (CPA)
A package of care for people with mental health problems. Usually for people with more severe or complex needs and risks.

Alternatively, if symptoms are moderate to severe, people may be entered into a treatment process known as a care programme approach (CPA).

CPA is a way of ensuring that people receive the right treatment for their needs. There are four stages:

- an assessment of health and social needs;
- a care plan – created to meet the person's health and social needs;
- the appointment of a care co-ordinator (keyworker) – usually a social worker or registered nurse and the first point of contact with other members of the CMHT;
- reviews – where treatment is regularly reviewed and any necessary changes to the care plan can be agreed.

Care Quality Commission (CQC)
The independent regulator of health and social care in England, making sure health and social care services provide people with safe, effective, compassionate, high-quality care and encourage care services to improve.

Clinical Commissioning Group (CCG)
Clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area.

Clinical Negligence Scheme for Trust (CNST)
Handles all clinical negligence claims against member NHS bodies where the incident in question took place on or after 1 April 1995 (or when the body joined the scheme, if that is later).

Care and Support Specialist Housing Fund (CASSH funding)
Aims to support and accelerate the development of specialist affordable housing which meets the needs of older people and adults with disabilities or mental health problems.

Community Mental Health Teams (CMHTs)
Made up of a team of people from different health and social care professions, working in the community to help people recover from, and cope with, a mental health problem.

Community Rehabilitation Service / Teams (CRT)
Teams or services providing specialist skills and care co-ordination to identify and address people's rehabilitation needs in the community. These teams can work in all community settings, but commonly work with people living in supported accommodation, often over many years, to enable their optimum level of functioning and independence.

Community Rehabilitation Units (CRU)
Inpatient rehabilitation units that are set outside hospital grounds. These units provide the full complement of multidisciplinary treatment and support for people with ongoing complex needs that prevent them from being discharged from a high-dependency rehabilitation unit directly to supported accommodation. They build on the progress made in the high-dependency inpatient rehabilitation unit and have a strong focus on promoting independent living skills and community participation. Most referrals come from high-dependency rehabilitation units or acute inpatient units. Community rehabilitation units can only care for detained people under the Mental Health Act 1983 if the unit is registered as a ward. If they are not registered as a ward, they can care for people who are voluntary or those subject to a community order (for example, a community treatment order, guardianship, or conditionally discharged Section 37/41). The expected length of stay in a community rehabilitation unit is 1 to 2 years.

Delayed Transfers of Care (DTOC)

A delayed transfer of care from NHS-funded acute or non-acute care occurs when an adult patient is ready to go home and is still occupying a bed.

Department of Health and Social Care (DHSC)

The UK department responsible for government policy on health and adult social care matters in England.

Dialectical Behaviour Therapy (DBT)

A type of therapy specifically designed to treat people with borderline personality disorder, based on the idea that two important factors contribute towards borderline personality disorder:

- the person is particularly emotionally vulnerable – for example, low levels of stress make them feel extremely anxious;
- the person grew up in an environment where their emotions were dismissed by those around them.

DBT introduces the concepts of:

- validation: accepting emotions are valid, real and acceptable;
- dialectics: a school of philosophy that says most things in life are rarely "black or white" and that it's important to be open to ideas and opinions that contradict your own.

Health Education England (HEE)

The national leadership organisation for education, training and workforce development in the health sector.

High Dependency Unit (HDU)

Inpatient rehabilitation units for people with complex psychosis whose symptoms have not yet been stabilised and whose associated risks and challenging behaviours remain problematic. These units aim to maximise benefits of medication, address physical health comorbidities, reduce challenging behaviours, re engage families and facilitate access to the community. Most people in high-dependency units are detained under the Mental Health Act 1983. Most (80%) referrals to high-dependency units are from acute inpatient units and 20% from forensic units, with only occasional referrals of people living in the community. The expected length of stay is around 1 year.

Highly Specialist Inpatient Rehabilitation (HSIR)

Inpatient rehabilitation units for people with psychosis and comorbid conditions who need a specialist programme tailored to their specific comorbidity (such as acquired brain injury, severe personality disorder, autism spectrum disorder or Huntingdon's disease). Often, the complexity of the person's coexisting conditions is associated with greater support needs (more challenging behaviours and/or a greater risk to themselves and others) than people having treatment in a high-dependency rehabilitation unit. Referrals come from acute inpatient units or high-dependency rehabilitation units, and the expected length of stay is over 3 years.

Hospital episode statistics (HES)

Data on all admissions, outpatient appointments and A&E attendances at NHS hospitals in England. The aim is to collect a detailed record for each 'episode' of admitted patient care commissioned by the NHS and delivered in England, by either an NHS hospital or the independent sector. HES data is used in calculating what hospitals are paid for the care they deliver.

Individual Placement and Support (IPS) approach

A method of supporting people with severe mental health problems into work. IPS finds people a job quickly and then provides time-unlimited individualised support to keep the job and manage their mental health.

Improving Access to Psychological Therapies (IAPT)

IAPT (Improving Access to Psychological Therapies) services offer:

- talking therapies, such as cognitive behavioural therapy (CBT), counselling, other therapies, and guided self-help;
- help for common mental health problems, like anxiety and depression.

Integrated care systems (ICS)

Advanced local partnerships involving primary and secondary care, local councils and others, taking shared responsibility to improve the health and care system for their local population.

Joint Strategic Needs Assessment (JSNA)

Looks at the current and future health and care needs of local populations to inform and guide the planning and commissioning of health, wellbeing and social care services within a local authority area.

Key Performance Indicators (KPIs)
A quantifiable measure used to evaluate the success of an organisation or employee for example in meeting objectives for performance.

Length of stay (LoS)
The length of an inpatient episode of care, calculated from the day of admission to day of discharge, and based on the number of nights spent in hospital.

Local Authority (LA)
An organisation that is officially responsible for all the public services and facilities in a particular area.

Local Provider Collaboratives (LPC)
As detailed in the NHS Mental Health Implementation Plan, an NHS-led provider collaborative is a group of providers of specialised mental health, learning disability and autism services who have agreed to work together to improve the care pathway for their local population. They will do this by taking responsibility for the budget and pathway for their given population. The collaborative will be led by an NHS provider. The lead provider remains accountable to NHS England and NHS Improvement for the commissioning of high-quality, specialised services.

Locked mental health rehabilitation wards
Locked mental health rehabilitation wards have no clear definition and the term is not recognised by the RCPsych Rehabilitation and Social Psychiatry or by CQC in its inspection regime. They are similar to High Dependency Rehabilitation.

Longer-term care/continuing care unit (LTC/CCU)
A rehabilitation inpatient unit which supports people with high levels of disability from treatment refractory symptoms and/or complex co-morbid conditions that require longer inpatient rehabilitation to stabilise. Significant associated risks to own health/safety and/or others. Most patients detained under MHA. Most referrals come from high dependency rehabilitation units. It is usually hospital based and lengths of stay are between 1-3 years (can be longer, it is variable).

Low secure units (LSUs)
Low secure units deliver intensive, comprehensive, multidisciplinary treatment and care by qualified staff for patients who demonstrate challenging or disturbed behaviour in the context of a serious mental disorder, usually with complex co-morbidities and who require the provision of security.

Medium secure units (MSUs)
Medium secure services provide inpatient treatment and care for adults with complex mental health problems who have been in contact with the criminal justice system and who present serious risk to themselves or others, combined with the potential to abscond.

Mental Capacity Act 2005
Designed to protect and empower people who may lack the mental capacity to make their own decisions about care and treatment.

Mental Health Act 1983
The main piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder. People detained under the MHA need urgent treatment and are at risk of harm to themselves or others.

Mental Health Services Data Set (MHSDS)
Brings together information captured on clinical systems as part of patient care. It covers services provided in hospitals as well as in outpatient clinics and the community.

Ministry of Housing, Communities & Local Government (MHCLG)
The Ministry of Housing, Communities and Local Government's (formerly the Department for Communities and Local Government) job is to create great places to live and work, and to give more power to local people to shape what happens in their area.

Multidisciplinary team (MDT)
A team of healthcare professionals from different disciplines.

National Institute for Health and Care Excellence (NICE)
Provides evidence-based guidance, advice, quality standards, performance metrics and information services for health, public health and social care.

NHS Benchmarking Network (NHSBN)
A benchmarking service of the NHS which enables performance comparison between more than 300 health and social care organisations in the UK.

Occupied Bed Days (OBD)
A bed which is used by an inpatient at the bed count is counted as one occupied bed day.

Office for National Statistics (ONS)
The Office for National Statistics (ONS) is the UK's largest independent producer of official statistics.

Out of provider placement (OAP)
When a patient is transferred to a facility outside of their local provider for inpatient treatment.

Patient-level costing information (PLICS)
Patient-Level Information and Costing Systems (PLICS) bring together healthcare activity information with financial information in one place. PLICS provides detailed information about how resources are used at patient-level, for example, staff, drugs, and diagnostic tests.

All acute trusts are required by NHS England and NHS Improvement to calculate their costs at patient level, and over the next couple of years the same will be true for mental health, community and ambulance services, with early adopters already having achieved this. Reference costs are gradually being replaced by PLICS, and from 2019 the national cost collection for acute trusts is PLICS rather than reference costs.

Person-based Resource Allocation for Mental Health (PRAMH)
A statistical formula for need per head for specialist mental health services.

Personalised Care and Support Planning (PCSP)
The plan sets out a person's personal health and wellbeing needs, the health outcomes they want to achieve, the amount of money in the budget and how it will be spent.

Personal health budgets (PHB)
money to support a person's health and wellbeing needs, which is planned and agreed between the service user (or someone who represents them), and the local NHS team. It allows the person to manage their healthcare and support such as treatments, equipment and personal care, in the way that suits them.

Psychiatric Intensive Care Unit (PICU)
A ward designed to provide care for patients who cannot be managed on other wards due to the risk that they pose to themselves or others.

Primary Care Network (PCN)
A network of GP practices covering a population that develops services across a geographic area of between 30-50,000 people.

Quality Indicator for Rehabilitative Care [QuIRC]/(QuIRC-SA)
The QuIRC (Quality Indicator for Rehabilitative Care) is the first internationally agreed tool to assess quality of care for people with longer term mental health problems in psychiatric and social care units.

The QuIRC-SA (Quality Indicator for Rehabilitative Care - Supported Accommodation) is a tool which can be used to assess quality of care for people with longer term mental health problems living in supported accommodation facilities (residential care, supported housing and floating outreach).

Royal College of Psychiatrists (RCPsych)
The professional medical body responsible for supporting psychiatrists throughout their careers from training through to retirement, and in setting and raising standards of psychiatry in the United Kingdom.

Serious incidents (SI) /Patient Safety Incidents (PSI)

A serious incident requiring investigation is defined by the NPSA in the National Framework for Reporting and Learning from Serious Incidents Requiring Investigation as an incident that occurred in relation to NHS-funded services and care resulting in one of the following:

- Unexpected or avoidable death of one or more patients, staff, visitors or members of the public.
- Serious harm to one or more patients, staff, visitors or members of the public or where the outcome requires life-threatening intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm (the includes incidents graded under the NPSA definition of severe harm).
- A scenario that prevents or threatens to prevent a provider organisation's ability to continue to deliver health care services, for example, actual or potential loss of personal/organisational information, damage to property, reputation or the environment, or IT failure.
- Allegations of abuse.
- Adverse media coverage or public concern about the organisation or the wider NHS.
- One of the core set of Never Events: never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by providers. All Never Events should be reported as SIs. The Operating Framework for the NHS in England 2010/11 reaffirms that PCTs should use the national set of eight Never Events as part of their contract arrangements with providers; ensure that patient safety incidents which are Never Events are reported to the NPSA and publish the numbers and types of events on an annual basis.

Patient safety incidents are any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving healthcare. Reporting them supports the NHS to learn from mistakes and to take action to keep patients safe.

Service Level Agreements (SLA)

Service level agreements (SLAs) are usually required when either purchasing or providing specific and discrete elements of healthcare services or any other services from/to other healthcare bodies (for example, NHS Trusts and Foundation Trusts, CCGs, GPs, local authorities, schools, registered charities).

Speech and Language Therapy (SALTs)

Speech and language therapy provides life-changing treatment, support and care for children and adults who have difficulties with communication, eating, drinking and swallowing. It helps people who, for physical or psychological reasons, have problems speaking and communicating.

Serious mental illness (SMI)

A blanket term for psychological problems, such as schizophrenia and bipolar disorder, that are often so debilitating that a person's ability to engage in functional and occupational activities is severely impaired.

Social Prescribing (SP)

Social prescribing - sometimes referred to as community referral - is a means of enabling GPs, registered nurses and other health and care professionals to refer people to a range of local, non-clinical services.

Support Time and Recovery Workers (STAR Workers)

May be peer support workers or more generic support workers (e.g. healthcare assistant).

Sustainability and Transformation Plans (STPs)

Five-year plans covering all aspects of NHS spending in England. Forty-four areas have been identified as the geographical 'footprints' on which the plans are based.

Voluntary Community and Social Enterprise (VCSE)

Made up of groups that are independent of government and are constitutionally self-governing. They exist for the good of the community, to promote social, economic, environmental or cultural objectives to benefit society as a whole, or particular groups within it.

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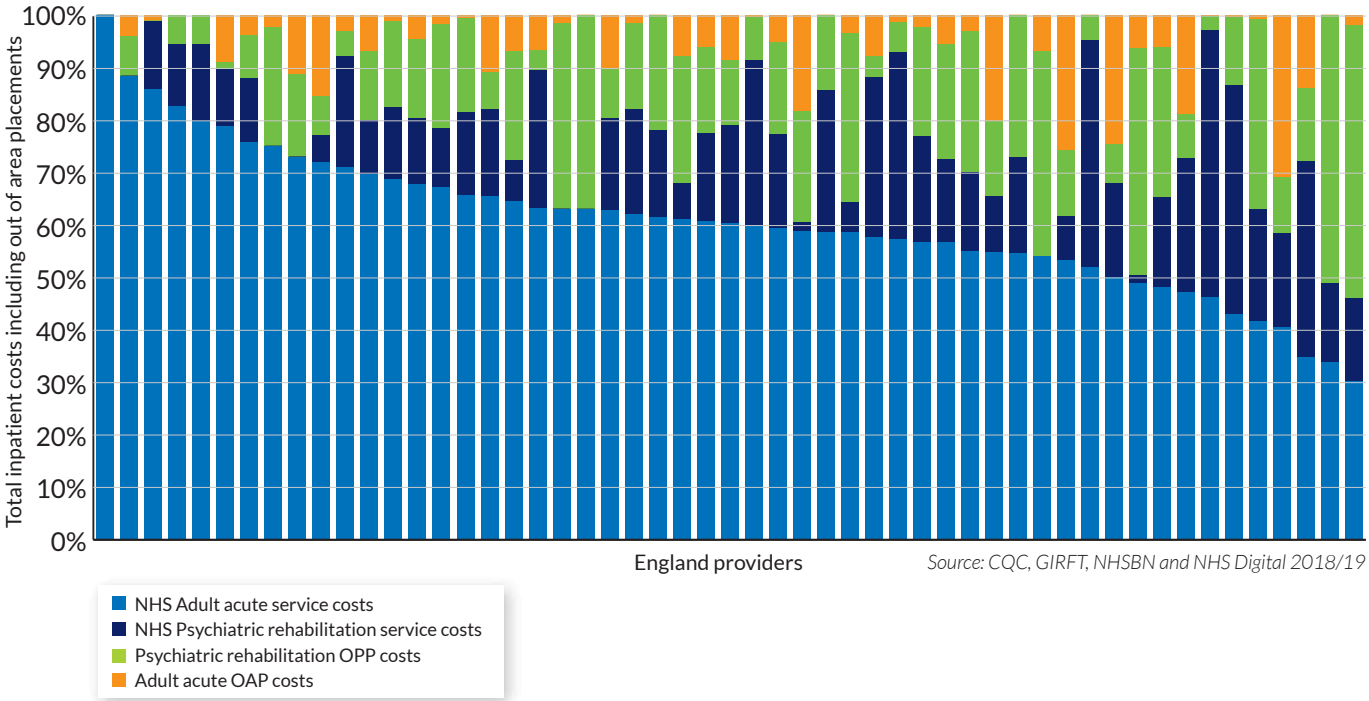
Appendix

Appendix 1: Balance of financial investment - inpatient care



Source: CQC, GIRFT, NHSBN and NHS Digital 2018/19

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