CareQuality Commission

Mental health rehabilitation inpatient services

Ward types, bed numbers and use by clinical commissioning groups and NHS trusts

March 2018

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Summary

Mental health rehabilitation inpatient services work with individuals with complex psychosis whose needs cannot be met by general adult mental health services. Although they are an essential element of a comprehensive mental health care system, the Care Quality Commission (CQC) is concerned about the high number of beds in mental health rehabilitation wards that are situated a long way from the patient's home. This could result in people becoming isolated from their friends and families and cut off from the local services that will provide care following discharge.

To explore this concern further, we sent an information request to all providers that manage mental health rehabilitation inpatient services. This work was done in collaboration with NHS England and NHS Improvement.

We estimate that the information request yielded data on between 85% and 90% of all rehabilitation wards in England. The analysis was of 3,721 patients on 311 wards, provided at 203 locations, managed by 134 provider organisations.

The independent sector provided 53% of beds (2,347 independent sector beds compared with 2,050 NHS beds). Two-thirds of the patients were men. Eleven per cent of patients were subject to a restriction order and 75% were detained under the Mental Health Act.[1] The median length of stay on the ward where they were at the time of the information return was 323 days but the patients had been in some form of mental health hospital continuously for more than twice as long (median of 683 days).

The main conclusions are:

1. People are often receiving care a long way from where they live and from their support networks, which in turn can affect their onward recovery and wellbeing.

2. People are being accommodated in services that are 'dislocated' from their home areas. This is more prevalent in the independent sector than in NHS services:
   - Independent sector patients were on average further away from their home address (49km) compared with NHS patients (14km).
   - Their patients were much more likely to be on a ward located in a different area to the clinical commissioning group (CCG) that funded the placement (78% of patients placed out of area were in an independent sector bed).
   - Service managers were less able to name the NHS mental health trust responsible for providing aftercare for the patient: managers of independent sector services could name the responsible trust for 53% of patients; managers of NHS services could name the responsible trust for 99% of patients.

[1] There was almost complete overlap between those patients who were noted in the information return as subject to a restriction order and those who were noted as subject to the Mental Health Act.

3. There are also other differences between the two sectors. Compared with the NHS, the independent sector:
   - Provided more wards that were categorised as either locked rehabilitation or complex care (75% of wards of this type) and fewer wards categorised as long stay, community or high dependency (25% of beds of this type).
   - Accommodated patients who had been on that particular ward for longer (median 444 days compared with 230 days in the NHS) and in hospital continuously for longer (median 952 days compared with 492 days in the NHS).
   - Because of the longer length of stay, accommodated patients whose current placement had cost twice as much (median £162K compared with £81K).

4. There is very wide variation between CCG areas in the use of rehabilitation beds, and in the use of beds that are out of area:
   - 11 CCGs did not fund the care of any of the patients in the cohort. The top 20% of CCGs funded 47% of all places (a total of 1,752 beds).
   - We asked the managers of the wards to name the NHS mental health trust that would be responsible for the aftercare of each patient. When we collated this information, we found that the number of patients that NHS trusts had placed out of area with another provider ranged from 0 to 85. The only NHS provider not named as having a patient cared for by another provider was Sheffield Health and Social Care NHS Foundation Trust, which had instituted a programme to return those placed in out of area wards to the care of local services (see page 5).

5. This is a costly element of provision:
   - We estimate that the annual expenditure on mental health rehabilitation beds is about £535 million. Out of area placements account for about two-thirds of this expenditure.
   - We estimate that the 10% of CCGs that fund the highest number of places are spending an average of at least £19,000 per day on this element of provision – of which £8,200 is spent on independent sector provision; the majority of which is out of area.

In response to these findings, we have recommended that the Department of Health and Social Care, NHS England and NHS Improvement agree a plan to engage local health and care systems in a programme of work to reduce the number of patients placed in mental health rehabilitation wards that are out of area.

Introduction

Mental health rehabilitation services are an essential element of a comprehensive mental health care system. They work with individuals with complex psychosis, or other serious mental health problems, whose needs cannot be met by general adult mental health services. Up to 20% of people newly diagnosed with psychosis will develop complex problems and require rehabilitation services. On average, people referred for rehabilitation care have been in contact with mental health services for more than 13 years and have had repeated admissions. The problems they experience include hallucinations and delusions that have not responded to medication, severe 'negative' symptoms that affect motivation and organisational skills, and co-existing physical and mental health problems that further impair their recovery and can result in challenging behaviours.

Mental health rehabilitation services provide specialist assessment, treatment and support to stabilise the person's symptoms and help them gain/regain the skills and confidence to live successfully in the community. They are often the next step in a pathway for people moving on from acute inpatient services or from secure services who have not recovered sufficiently to be discharged home.

In 2016, the Joint Commissioning Panel for Mental Health (JCPMH)[2] issued guidance for commissioners on rehabilitation services for people with complex mental health needs.[3] This stated that good "rehabilitation services operate as a whole system that includes a range of other agencies and organisations. Collaborative and partnership working is key to this. It helps ensure the provision of a holistic and comprehensive care pathway that can support people using services to make incremental improvements in their everyday and social functioning, and to successfully take on increasing levels of responsibility in managing as many aspects of their own life as possible".

For those on the mental health rehabilitation pathway, hospital should never be considered home. To be successful, mental health rehabilitation services must provide an active programme of treatment of their mental disorder and therapy aimed at enabling them to acquire or reacquire the skills needed to live independently. They must also be discharge-oriented and provide a seamless link between inpatient care and life outside of hospital. This can only be achieved if inpatient and community mental health staff work very closely together – or even as members of the same team.

Appendix 1 lists the types of rehabilitation ward, recognised by the JCPMH, that might be commissioned by a clinical commissioning group, and the function played by each.

In our report, the *State of care in mental health services 2014 to 2017*,[4] we expressed concern about the high number of beds in locked mental health rehabilitation wards

[2] The JCPMH is a collaboration co-chaired by the Royal College of General Practitioners and the Royal College of Psychiatrists. It brings together a range of other professional bodies and national charities (including Mind).
[3] https://www.jcpmh.info/wp-content/uploads/jcpmh-rehab-guide.pdf
[4] http://www.cqc.org.uk/sites/default/files/20170720_stateofmh_report.pdf

that “are often situated a long way from the patient’s home, meaning that people are isolated from their friends, families and the mental health team that will be providing care after discharge. Our inspectors were concerned that some of these locked mental health rehabilitation hospitals were in fact long stay wards that risk institutionalising patients, rather than a step on the road back to a more independent life in the person’s home community”.

We know, from the work of NHS trusts that have ‘repatriated’ patients placed in out of area rehabilitation wards, that there is great potential to support these people in less restrictive non-hospital placements closer to home, with ensuing improvements in quality of life and potentially at lower cost.

Example: Sheffield Health and Social Care NHS Foundation Trust

Sheffield began developing a new rehabilitation strategy from 2012. This was a joint venture between Sheffield Health and Social Care NHS Foundation Trust (SHSC, the local provider trust) and NHS Sheffield Clinical Commissioning Group (the local health commissioner). Like many other areas, Sheffield had experienced a substantial increase in the number of people being sent out-of-area to long-term, ‘locked rehabilitation’ hospitals, mainly in the private sector. The trend was growing year on year.

The key enabling step was devolution of the budget to fund these out-of-area placements from the commissioner to the provider trust. This allowed close alignment of the clinical expertise necessary to assess people’s rehabilitation needs with the financial benefit (and risk) of managing the whole system. The associated improved gatekeeping into the system and performance monitoring of the private sector providers allowed Sheffield to reduce the number of people out-of-area by approximately half in the first 18 months, saving £3.5 million for the local health economy.

In the second phase of the strategy, it was recognised that the needs of the people remaining in out-of-area locked rehabilitation placements could not immediately be met by existing local community services. A specialist, enhanced community team was established to return people from out-of-area to their own tenancies in Sheffield. The crucial features of this team were a high ratio of staff to people using services, an emphasis on psychological formulation in management plans, and extended hours of working. Working in partnership with a local housing association allowed flexibility in identifying accommodation that was tailored to individuals’ particular needs. This also involved using health resources to fund specific social care input for tenancy support.

To date, the enhanced community team, working in conjunction with SHSC’s local inpatient rehabilitation services, has returned 37 people to their own tenancies in Sheffield. There has been a 99% reduction in the use of hospital bed nights within this group. The enhanced community team is resource intensive, costing approximately £70,000 annually per person, but the savings made by returning people from out-of-area remain significant and yielded a further £2.6 million saving for the local system after funding the enhanced team.

This concern about the adverse impact of being placed out of area, and the potential value of investment in local services, is echoed by the JCPMH which stated, “It is imperative for local mental health economies that this money is spent effectively. ‘Repatriating’ people to local services and helping them live as independently as possible is likely to benefit the individual, as well as saving money which could be used in more useful ways.”

It is also consistent with the position of the Five Year Forward View for Mental Health that “people living with severe mental health problems, such as schizophrenia or personality disorder, should not be held in restrictive settings for longer than they need to be. The NHS should expand proven community-based services for people of all ages with severe mental health problems who need support to live safely as close to home as possible”. [5]

We decided to explore this issue more fully, to better understand the scope for other providers to replicate the work of trusts that have returned patients to the care of local services. We wanted to determine:

1. How many wards and beds there are in England designated as providing mental health rehabilitation care, what type of wards these are, how many are locked and what they cost.

2. How many people are currently occupying a bed in such a ward and how many of these people are detained under the Mental Health Act.

3. How long these people have been in that particular hospital; and in hospital continuously if transferred there from another hospital.

4. How far these people are from their original home area and how many people are ‘out of area’.

5. Which commissioning bodies are funding the care of these patients and what is the extent of variation between clinical commissioning groups in the number of places funded and in the funding of out of area placements.

6. Which NHS provider will be responsible for the patient’s aftercare.

[5] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

Methods

On 23 October 2017, we sent an information request to all 54 NHS and 87 independent healthcare providers that we identified as managing mental health rehabilitation inpatient services. The deadline for returns was 10 November 2017.

The information request had three parts:

Part 1 asked about the number of locations and wards providing mental health rehabilitation services and the average daily cost of a bed on those wards.

Part 2 asked about the type, size and 'locked' status of the ward. We supplied the Joint Commissioning Panel for Mental Health (JCPMH) definitions as a guide and offered respondents five options for rehabilitation ward types that might be commissioned by a CCG: complex care, community, high dependency, locked rehabilitation and long stay.[6] Although the JCPMH does not recognise the categories of locked rehabilitation and long stay, we offered these as options because they are terms often used by providers to describe their wards.

Part 3 asked about each patient's length of stay, funding authority and the mental healthcare provider that would be responsible for aftercare.

We excluded wards that provided longer-stay treatment and care for people with a learning disability or for older people (most of whom had dementia) and units that specialised in the care of people with acquired brain injury.

Caveats and limitations

We have been cautious in our interpretation of some of the data because:

- For some data items, there were a high number of missing returns. In particular, we were not provided with a home postcode for 23% of patients or an average daily cost for 23% of wards.
- The information request enquired about patients on the wards on a particular day. The length of stay is therefore the time that the patients have been on the ward at that point – as opposed to the duration of stay at the point of discharge. Also, when we project annual figures, for example for costs, we have made that assumption that the profile of patients in hospital on the day of the information return is a typical one.
- Our analyses that relate to the commissioning CCG and to the NHS trust that is responsible for aftercare are based on third party data from the providers that responded to the information request. Because we were not told the identity of the NHS trust responsible for aftercare for 24% of patients, it is likely that we have under-estimated the number of patients for which each NHS trust is responsible.

[6] The survey questionnaire also enquired about low secure wards (which are usually commissioned directly by NHS England) but we do not report the findings for this type of provision here.

Findings

Completeness of the data return

We received a response from 134 of the 141 providers that we sent the information request to. One NHS mental health trust and six independent sector providers did not respond by the deadline. We received information concerning 311 rehabilitation wards, provided at 203 locations. These wards provided 4,397 beds; of these, 3,721 (85%) were occupied at the time of the information request.

Some providers that did respond did not include all locations in the return that we might have expected, from what we know from CQC inspection reports. We estimate this to be 16 locations with 33 wards and approximately 500 beds. Based on this, we estimate that our return included information about between 85% and 90% of all rehabilitation wards in England. If this is correct, the total number of rehabilitation beds in England is between 4,900 and 5,200.

The wards

Fifty-three per cent of all beds were in the independent sector (2,347 compared with 2,050). Figure 1 shows the number of rehabilitation wards of each type and their distribution between NHS and independent health. The independent sector managed 78% of wards that the providers categorised as either locked rehabilitation or complex care. The NHS managed 69% of wards categorised as long stay, community or high dependency.

Figure 1: Number of mental health rehabilitation wards by type and sector

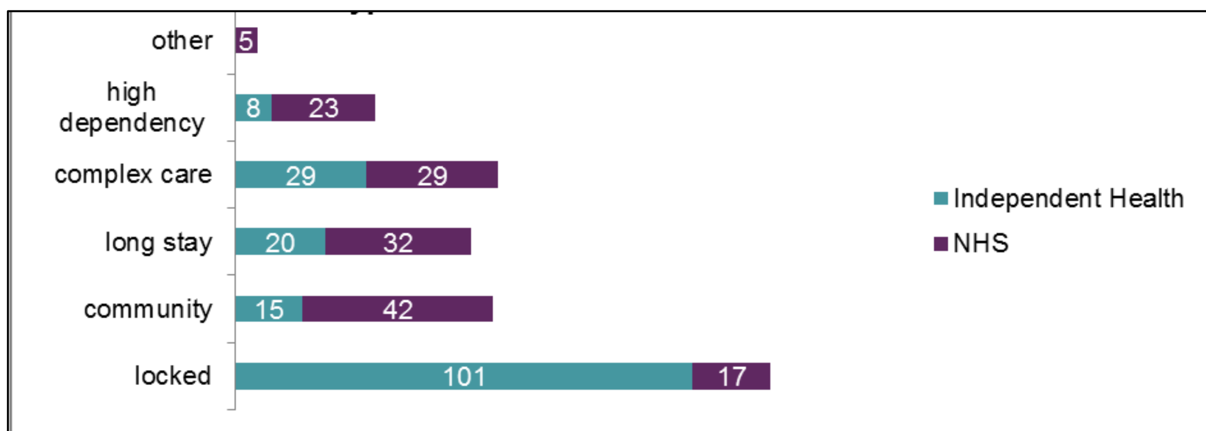


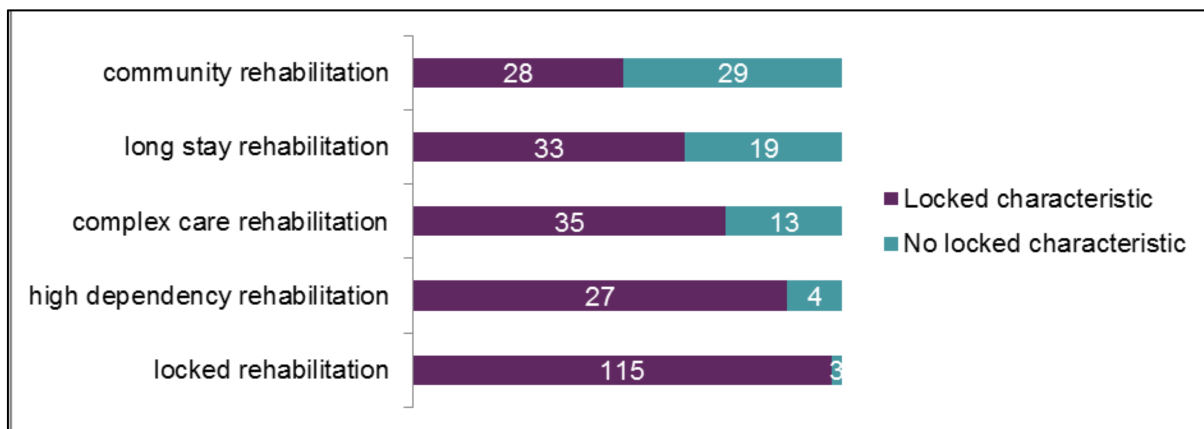
Figure 2 shows the number of beds in each type of ward.

Figure 2: The number and occupancy of beds in each type of ward

Ward type	Number of beds	Number of patients occupying beds	% of patients occupying beds
Locked	1,706	1,422	83%
Complex care	791	644	81%
Community	715	634	89%
Long stay	708	597	84%
High dependency	422	387	92%
Other	55	37	67%
All wards	**4,397**	**3,721**	**85%**

Although providers classified only 38% of wards as being 'locked rehabilitation', 81% of wards had at least one or more locked characteristic: staff control all access, the ward has an airlock or the ward has an external perimeter (figures 3 and 4).

Figure 3: Number of each type of rehabilitation ward with at least one locked characteristic



* Figure 3 excludes five wards classified as 'other'

Figure 4: The ‘locked characteristics’ of each type of ward

	Staff control all access		Ward has an airlock		Ward has a perimeter fence	
Ward type	No. of wards	% of wards	No. of wards	% of wards	No. of wards	% of wards
Locked	111	94%	61	52%	18	15%
High dependency	25	81%	15	48%	9	29%
Complex care	33	69%	14	29%	7	15%
Long stay	33	63%	10	19%	2	4%
Community	24	42%	5	9%	0	0%
Other	3	60%	0	0%	0	0%
All wards	**229**	**74%**	**105**	**34%**	**36**	**12%**

The patients

Two-thirds of the patients were men and 75% were detained under the Mental Health Act (11% of all patients were subject to a restriction order). Not surprisingly, the length of stay varied greatly. The median length of stay of all patients was 323 days. However, as figure 5 shows, because many of the patients had been transferred to their current ward from another mental health unit, the total continuous time that patients had spent in hospital was much higher (median 683 days for all patients).

Figure 5: Median and mean days since first admitted to hospital and since admitted to current ward

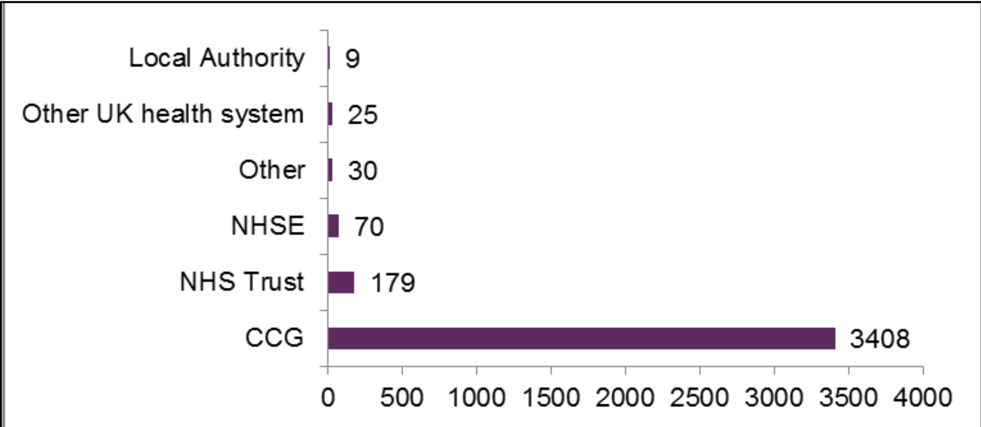
Ward type	Days since first admitted to hospital		Days since admitted to current ward	
	Median	Mean	Median	Mean
Complex care	881	1,768	452	921
Locked	836	1,519	409	669
High dependency	682	1,228	294	556
Long stay	491	1,287	241	438
Community	419	909	206	432
All wards	**683**	**1,384**	**323**	**619**

The median length of stay on NHS mental health rehabilitation wards was 230 days (approximately 7.5 months), while the median length of stay on independent health rehabilitation wards was much higher at 444 days (approximately 14.5 months).

Commissioning

Figure 6 shows which bodies were funding the placements. Clinical commissioning groups (CCGs) funded 92% of the places.

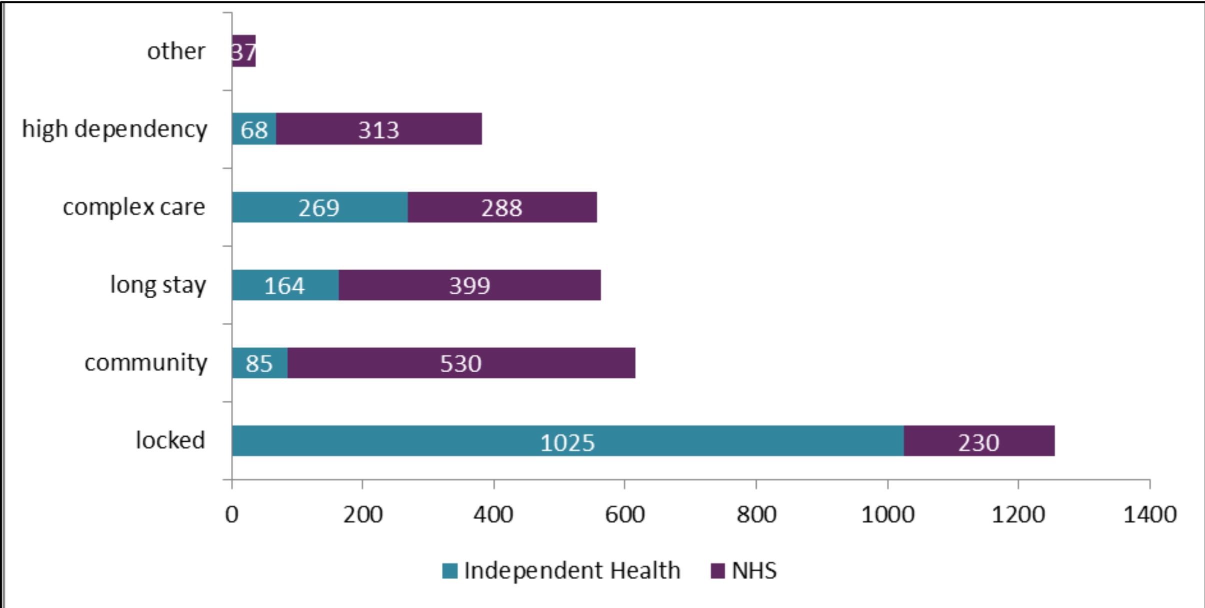
Figure 6: Number of beds funded by different bodies



The remainder of this section refers only to the 3408 patients whose places were funded by a CCG.

As figure 7 shows, the greatest number of beds commissioned by CCGs were in wards that the providers categorised as ‘locked rehabilitation’. As mentioned above, a high proportion of locked rehabilitation wards are in the independent sector.

Figure 7: CCG-funded beds by ward type and sector



There was great variation between CCGs in the number of rehabilitation beds that they commissioned. According to the returns from providers, 11 CCGs commissioned no beds. The variation between CCGs remained after standardising for the size of the population served (figure 8).

Figure 8: Number of beds (per 100,000 of the population) commissioned by each CCG

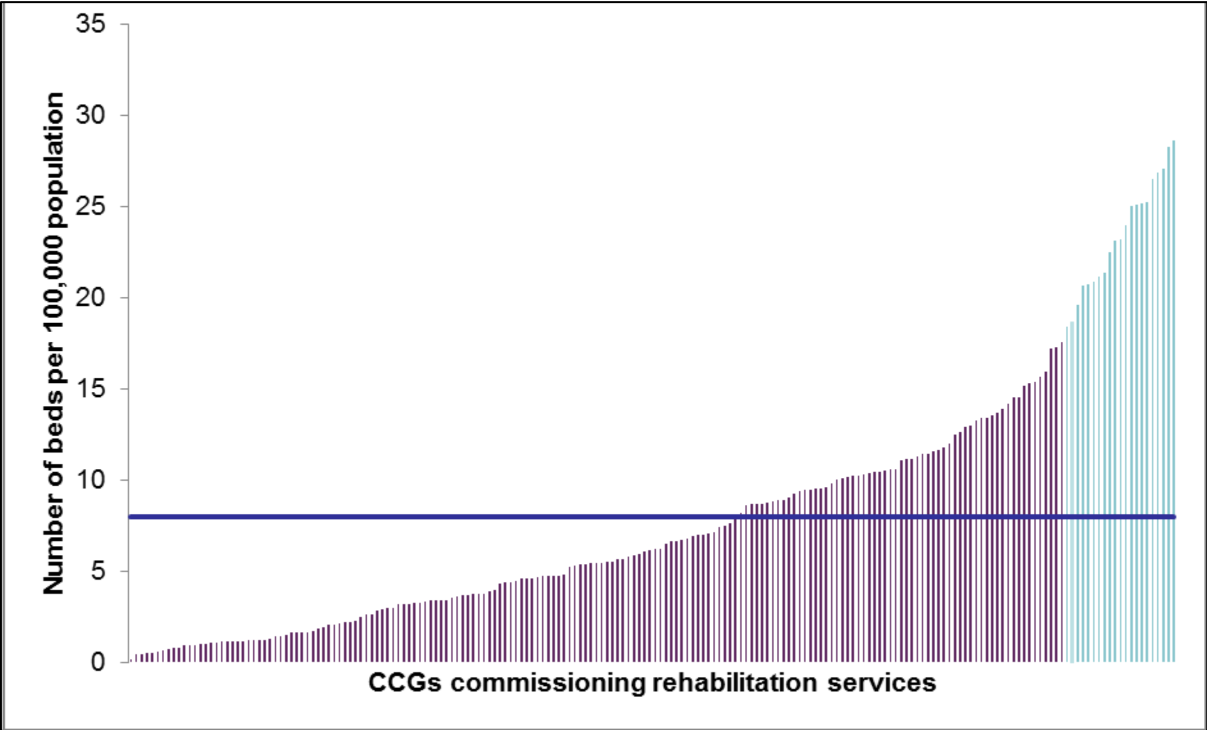


Figure 9 lists the 21 CCGs with the highest rate of commissioning overall (also shown in blue in figure 8). These 10% of CCGs accounted for 30% of all rehabilitation beds commissioned by CCGs nationally. Figure 10 lists the 21 CCGs commissioning the highest number of rehabilitation beds, when standardised for population size.

The prevalence and severity of mental disorder is higher in areas with high levels of social deprivation. Eight of the 21 providers with the highest number of beds commissioned per 100,000 population are among the 10% of areas that would be expected to have the highest level of demand for mental health care (as gauged by the corresponding local authority area's score on the Mental Illness Needs Index). It is likely that high prevalence of severe and enduring mental disorder accounts for some of the variation between CCGs.

Figure 9: The 21 CCGs that commission the most rehabilitation beds overall (decreasing order)

- Birmingham Cross City
- Manchester
- Nene
- Dorset
- Islington
- Brent
- West Kent
- Leicester City
- South Tees
- Doncaster
- Lincolnshire West
- Newcastle Gateshead
- West London
- Harrow
- South Devon and Torbay
- Coventry and Rugby

- Camden
- North Kirklees
- Central London (Westminster)
- Southern Derbyshire
- East and North Hertfordshire

Figure 10: The 21 CCGs that commission the most rehabilitation beds per 100,000 population (decreasing order)

- Brent
- Doncaster
- Redditch and Bromsgrove
- Camden
- Birmingham and South Central
- Harrow
- South Tees
- Scarborough and Ryedale
- Manchester
- West London
- Lincolnshire West
- South West Lincolnshire
- Birmingham Cross City
- Darlington
- Vale Royal
- Central London (Westminster)
- North Kirklees
- Islington
- Canterbury and Coastal
- Leicester City
- South Devon and Torbay

Figures 11 and 12 show, for the 196 CCGs that funded any rehabilitation bed, the range of bed numbers (per 100,000 population) funded in the independent sector (figure 11) and NHS (figure 12) wards. As can be seen, 57 CCGs only funded places in the independent sector and 17 only funded places in the NHS.

Figure 11: Range of independent sector bed numbers (per 100,000 population) funded by CCGs

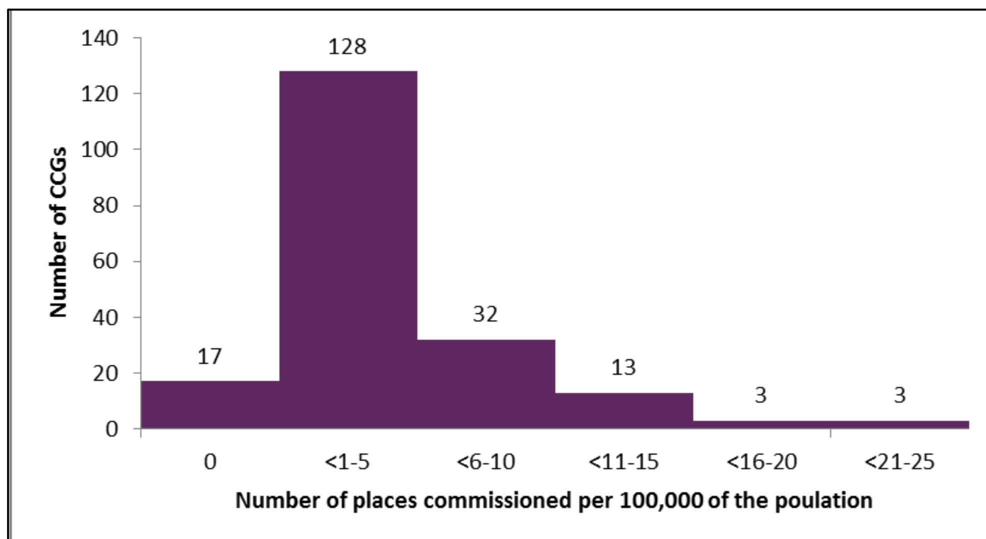
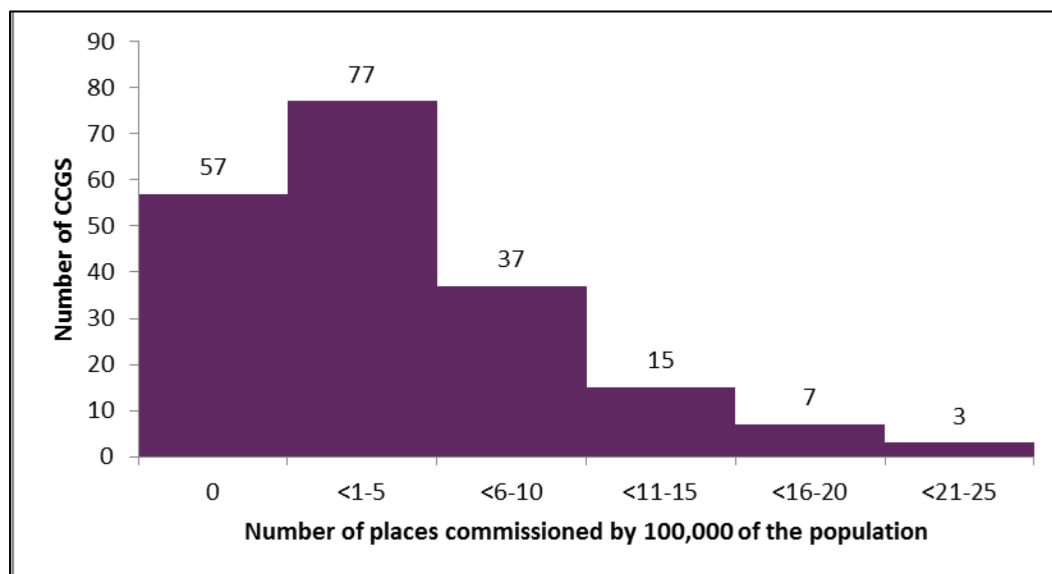


Figure 12: Range of NHS bed numbers (per 100,000 population) funded by CCGs



Figures 13 and 14 list the CCGs that funded more than 10 beds per 100,000 in the independent sector and the NHS respectively.

Figure 13: The 19 CCGs that funded more than 10 independent sector beds per 100,000 population

- North Kirklees
- Vale Royal
- Redditch and Bromsgrove
- South West Lincolnshire
- Scarborough and Ryedale
- Bolton
- South Tees
- South Devon and Torbay
- Birmingham Cross City
- Merton
- Birmingham South and Central
- Blackburn with Darwen
- Warrington
- Hardwick
- Coventry and Rugby
- West London
- Stoke on Trent
- Walsall

Figure 14: The 25 CCGs that funded more than 10 NHS beds per 100,000 population

- Islington
- Darlington
- Central London (Westminster)
- Lincolnshire West
- Harrow
- Camden
- Brent
- Leeds South and East
- Manchester
- Leicester City
- West London
- South Tyneside
- Hammersmith and Fulham
- Canterbury and Coastal
- Sunderland
- Hastings and Rother
- Bradford City
- Doncaster
- Newcastle Gateshead
- Birmingham Cross City
- Lincolnshire East
- Heywood, Middleton and Rochdale
- Lewisham
- Northumberland
- South Eastern Hampshire

Extent of dislocation

For 2,875 patients (77% of all patients), we had sufficient information about their home address to calculate how far the ward on which they were resident was from their home. On average (mean), patients resided on a ward that was 30km from their home address. Those placed in an independent sector unit were further from their home address than those placed in an NHS unit (mean 49km compared with 14km). The distance from home varied by ward type (figure 15). Patients on wards categorised as locked rehabilitation were a considerably greater distance form home than patients on other ward types.

Figure 15: Distance of placement from the patient's home address (in kilometres* by ward type) – mean and median

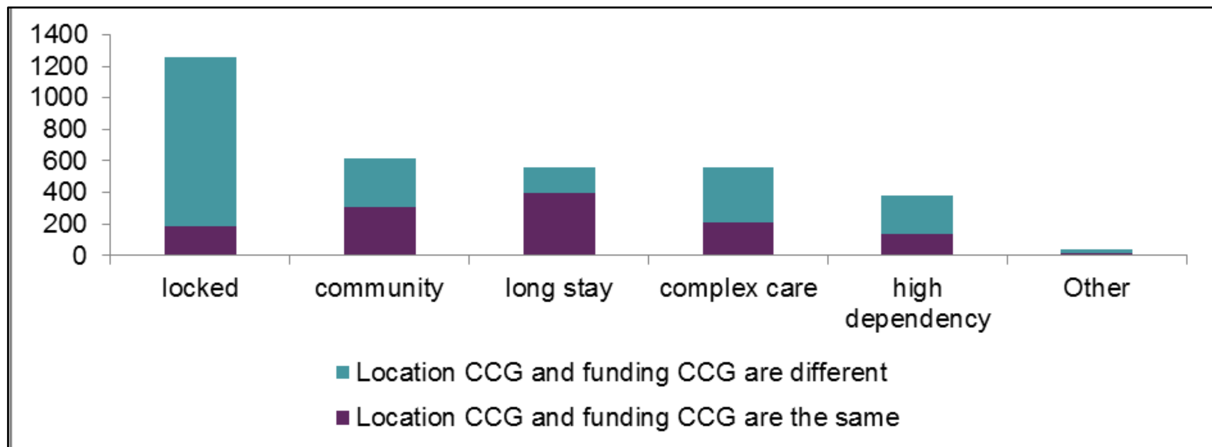
Ward type	Mean distance (km)**	Median distance (km)	Number (and %) of patients placed more than 50km from home address
Locked	51	31	302 (33%)
Complex care	28	11	76 (15%)
High dependency	20	8	30 (9%)
Long stay	17	9	32 (6%)
Community care	14	7	22 (4%)
All wards	**30**	**13**	**463 (16%)**

* These are distances in a straight line, 'as the crow flies'. Actual distances to travel are likely to be considerably longer.

** The mean has been used here to show the average distance from a patient home address, but this is influenced by some large distances.

The majority (63%) of the 3,408 patients funded by a CCG were 'out of area' placements in that the bed was in a different CCG area to the CCG that was funding it. Of the 978 patients who were in a bed in the same CCG area as the CCG funding the bed, 78% were in an NHS ward. People in a ward categorised as locked rehabilitation were more likely to be out of area (figure 16).

Figure 16: Comparison of funding CCG and provider location CCG by rehabilitation ward type



We asked the managers of the rehabilitation services to tell us which NHS provider would be responsible for providing aftercare once the patient was discharged. For 76% of patients, the manager was able to name an NHS mental health trust. Managers of NHS rehabilitation wards were much more likely to be able to name the NHS trust that would provide aftercare than was the case for managers of independent sector wards (99% compared with 53% of their patients). For the remainder, the field was either left blank or the manager named a CCG, local authority or other body.

Based on the information provided about which NHS trust provider was responsible for aftercare, 96% of patients in an NHS bed were in a bed managed by the same provider that would also provide the aftercare. However, every NHS mental health trust in England, with the exception of Sheffield Health and Social Care NHS Foundation Trust, also had one or more patient placed in a rehabilitation ward managed by a different provider – the great majority of which were independent sector providers. The mean number was 20 (range 1 to 85). These figures are under-estimates because, as mentioned above, managers could not name the trust providing aftercare for 24% of patients. Figure 17 lists the 20 trusts with the highest number of patients on a rehabilitation ward managed by another provider.

Figure 17: The 20 NHS mental health trusts with the highest number of patients placed in a mental health rehabilitation wards funded by a different provider (decreasing order)

- Birmingham and Solihull Mental Health NHS Foundation Trust
- Greater Manchester Mental Health NHS Foundation Trust
- Barnet, Enfield and Haringey Mental Health NHS Trust
- Coventry and Warwickshire Partnership NHS Trust
- Tees, Esk and Wear Valleys NHS Foundation Trust
- Northamptonshire Healthcare NHS Foundation Trust
- South London and Maudsley NHS Foundation Trust
- South West London and St George's Mental Health NHS Trust
- Cheshire and Wirral Partnership NHS Foundation Trust
- Surrey and Borders Partnership NHS Foundation Trust
- Worcestershire Health and Care NHS Trust
- Lancashire Care NHS Foundation Trust
- Kent and Medway NHS and Social Care Partnership Trust
- Berkshire Healthcare NHS Foundation Trust
- West London Mental Health NHS Trust
- Hertfordshire Partnership University NHS Foundation Trust
- South West Yorkshire Partnership NHS Foundation Trust
- North Staffordshire Combined Healthcare NHS Trust
- North West Boroughs Healthcare NHS Foundation Trust
- Dudley and Walsall Mental Health Partnership NHS Trust

Costs

Providers reported the cost per day of a bed on 240 of the 311 wards (77%). Several providers chose not to provide information about costs, citing commercial sensitivity. This included one independent sector brand that provided a substantial proportion of all beds categorised as locked rehabilitation.

Based on the information that was provided, the median daily cost of a bed was £354 (£129,000 pa). The median daily cost for a bed on NHS wards was slightly lower than for a bed on a ward in the independent health sector (£350 compared with £364). However, because of the longer length of stay, the median cost for the whole inpatient stay up to the point of the information return was twice as high in independent sector wards than in NHS wards (£162,000 compared with £81,000).

Figure 18 shows the median cost for a bed for each of the ward types, together with an estimated annual expenditure on each type. If we assume that the returns from the information request related to 90% of wards in England, and that the median cost of beds for which we have cost information is the same as for those that we don’t, we estimate that the total annual expenditure on this element of care is £535 million.

Figure 18: median daily cost and estimated annual expenditure of a bed in the different types of rehabilitation ward

Rehabilitation ward type	Median daily cost	Estimated annual expenditure on all beds of this type
Locked	£366	£211,200,000
Complex care	£356	£93,000,000
High dependency	£354	£55,600,000
Community	£339	£87,200,000
Long stay	£316	£76,600,000
All wards	**£354**	**£534,500,000**

Figure 19 shows our estimates of the daily expenditure by the 21 CCGs that commissioned the most rehabilitation beds. This is the daily expenditure calculated using the average daily cost for NHS and IH beds multiplied by the number of places each CCG was funding at the time of data collection.

Figure 19: Estimated daily expenditure by sector and CCG

CCG	Expenditure on NHS beds	Expenditure on independent beds	Total expenditure
Birmingham Cross City	£22,000	£28,400	£50,400
Manchester	£22,700	£13,500	£36,200
Nene	£3,800	£16,700	£20,600
Dorset	£13,600	£6,200	£19,800
Islington	£16,400	£2,900	£19,300
Brent	£15,000	£4,700	£19,800
West Kent	£5,600	£13,100	£18,700
Leicester City	£14,000	£4,000	£18,000
South Tees	£6,600	£12,000	£18,700
Doncaster	£9,800	£8,700	£18,500
Lincolnshire West	£13,300	£3,600	£16,900
Newcastle Gateshead	£16,100	£1,500	£17,500
West London	£8,700	£7,600	£16,400
Harrow	£12,600	£3,300	£15,900
South Devon and Torbay	£3,500	£11,600	£15,100
Coventry and Rugby	-	£15,700	£15,700
Camden	£12,200	£2,500	£14,800
North Kirklees	£1,700	£13,500	£15,200
Central London (Westminster)	£10,800	£3,300	£14,100
Southern Derbyshire	£8,000	£5,800	£13,900
East and North Hertfordshire	£8,700	£5,100	£13,800

Recommendations

CQC's recommendation is that the Department of Health and Social Care, NHS England and NHS Improvement agree a plan of action in response to these findings that results in a reduction in the number of patients placed in mental health rehabilitation wards that are out of area. The plan should:

1. Ensure that the results of this review are shared with all CCGs, NHS mental health trusts and local authorities in a form that shows how many places are commissioned by each CCG, how many patients each trust has aftercare responsibility for, the estimated cost of these places and the number that are out of area placements (NHS England should consider whether this information is shared as part of its RightCare initiative[7]).
2. Require CCGs, NHS trusts and local authorities to work together to identify all patients in mental health rehabilitation wards whose care they are responsible for and to review the appropriateness of these patients' current placement. These reviews should consider whether the care provided is enabling the person's rehabilitation, whether there are active plans for discharge and, particularly for those placed out of area, whether there are close working links with the NHS trusts and local authorities that will provide aftercare. This work might be led by local Sustainability and Transformation Partnerships (STPs).
3. Result in the provision of guidance and improvement support to CCGs and NHS trusts. Guidance should describe good practice, how to provide local services that can better meet the needs of those who require a period of inpatient care on a rehabilitation ward and how to repatriate those currently placed out of area.
4. Require each STP to develop a plan to repatriate patients, prevent future out of area placements and minimise lengths of stay through the development of local service pathways and innovative commissioning models.
5. Require that future local joint (health, social care, housing) commissioning decisions fully reflect these plans; including how current spend on out of area placements on rehabilitation wards will be used to develop local services that strengthen upstream service provision and better meet the needs of this patient group.
6. Ensure that NHS Improvement's Getting it Right First Time programme on rehabilitation and complex care is shaped to support the above programme of work and realise 'quick wins' as well as to support medium -term service redesign.
7. Lead to the introduction of a national data collection system for rehabilitation and complex care out of area placements and routine reporting on key indicators.

[7] https://www.england.nhs.uk/rightcare/

8. Consider what support STPs require to enable them to submit baseline data to national data collection system and refresh quarterly.

Appendix 1: Types of inpatient rehabilitation unit that might be commissioned by a clinical commissioning group (as recognised by the Joint Commissioning Panel for Mental Health)[8]

	High dependency	Community	Complex care
Client group	Severe symptoms, multiple co-morbidities, significant risk histories, ongoing challenging behaviours. Most detained under MHA ~ 20% previous forensic admission.	People who cannot be discharged directly from high dependency due to ongoing complex needs. Most referrals come from high dependency rehab or acute wards.	People who have not progressed from high dependency rehab unit. High levels of disability and risk. Co-morbid serious physical health problems are common. Mix of detained and voluntary patients.
Focus	Thorough assessment, engagement, maximising benefits from medication, reducing challenging behaviours, re-engaging with families and communities. Step down for forensic services and repatriation of people from out-of-area placements to local services.	Facilitating further recovery, managing medication (and self-medication), engagement in psychosocial interventions (CBT, family work), gaining skills for more independent living including ADL skills and community activities (leisure, vocational).	Longer term rehabilitation That provides interventions as described for high dependency and community rehab units.
Recovery goal	Move on to community rehabilitation unit or supported accommodation.	Move on to supported accommodation	Most move to supported accommodation or residential care
Location	Usually hospital based	Community based	Hospital campus or community
Length of stay	1-3 years	1-2 years	5-10 years
Functioning	Domestic services provided, but ADL skills encouraged through OT	Self-catering, cleaning, laundry, budgeting etc with staff support	Domestic services provided and ADL skills encouraged through OT

[8] https://www.jcpmh.info/wp-content/uploads/jcpmh-rehab-guide.pdf

Risk management	Often locked or can be locked Higher staffed, full MDT	"Open" units, Staffed 24 hours by nurses and support workers with regular input from MDT.	Not locked but controlled access. Higher staffed with MDT input, but more support staff than nurses compared to high dependency rehab.
Provision per population	Every trust. One unit per 600,000 to 1 million.	Every trust. One unit per 300,000.	Every trust. One unit per 600,000