Mental health rehabilitation inpatient services

Results from the 2019 information request

Contents

Summary

Mental health rehabilitation inpatient services are an essential element of our mental health care system. They work with people with complex psychosis, or other serious mental health problems, whose needs cannot be met by general adult mental health services. The aim of these services is to provide specialist assessment, treatment and support to stabilise people's symptoms and help them gain/regain the skills and confidence to live successfully in the community.

In our report *The State of Care in Mental Health Services 2014 to 2017* we raised concerns about the high number of rehabilitation beds that were situated a long way from the patient's home.[1] 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 find out more, in 2017 we asked providers about the mental health rehabilitation inpatient services that they manage. As a result of our information request, we recommended that the Department of Health and Social Care, NHS England and NHS Improvement work together to reduce the number of patients receiving inpatient mental health rehabilitation outside their home area. As part of this work, NHS England subsequently launched the Getting It Right First Time (GIRFT) programme for mental health rehabilitation. Also, in August 2020, the National Institute for Health and Care Excellence (NICE) released guidance for the rehabilitation of adults with complex psychosis. This makes recommendations for a system-wide approach to rehabilitation within a patient's home area.[2]

In 2019, we sent a second information request to providers to review progress.

This report presents the data from this information request. Although our information request was only a snapshot in time, we are concerned that:

- there had only been a small increase in the number of people receiving rehabilitation care close to home
- too many people continued to be sent far from home for treatment
- people being cared for by independent providers were still staying longer in hospital, and were further away from home, than those in NHS services
- a high number of wards continued to identify as locked rehabilitation – this is against the least restrictive principle and potentially represents a breach of human rights.

It must be noted that this information request was carried out before the coronavirus pandemic reached the UK. We recognise that there were many possible reasons for why progress was slow in addressing this situation. In some cases, for example, people may have particularly complex problems that can only be provided in highly specialist settings, which may have to be provided outside the person's home area.

Nevertheless, we remain concerned that the results from our information request suggest that a very large number of people continue to be sent many miles from

[1] Care Quality Commission, *The State of Care in Mental Health Services 2014 to 2017*, July 2017

[2] National Institute for Health and Care Excellence, *Rehabilitation for adults with complex psychosis*, NICE guideline [NG181], NICE, August 2020

home for standard inpatient rehabilitation. This is a situation that we do not think would have changed during the pandemic.

Based on the findings of our information request, we make further recommendations to help commissioners, NHS England, and ourselves address this as a matter of urgency at the end of our report.

How we carried out the information request

The information request was sent to 114 mental health inpatient providers over a two-week period in April 2019. We asked providers just to tell us about the patients that were occupying a mental health bed at the time of the information request.

In our information request, we asked:

- How many wards and beds are there in England designated as providing inpatient mental health rehabilitation care?
- How many patients are currently occupying a bed in such a ward?
- How long have these patients have been in that particular ward; and in hospital continuously if transferred from another ward/hospital?
- How far are these patients from their original home area?
- Which commissioning bodies are funding the care of these patients?
- Which NHS provider will be responsible for the patient's aftercare?
- How many of the patients are detained under the Mental Health Act 1983 and how many of these are subject to a restriction order (that is, subject to Ministry of Justice oversight)?
- How many of the patients are on a ward that is locked?[3]

Eighty-nine per cent of providers responded to the initial data request. Following conversations with the remaining providers, we identified a total of 320 mental health rehabilitation wards, including 21 wards that were not included in the 2017 data collection.

Caveats and limitations

Data quality and completeness

Following the initial data collection, a further eight providers confirmed their mental health rehabilitation wards. It is unlikely that there are further in-scope providers that the Care Quality Commission (CQC) are not aware of, but as CQC does not register services at ward-level, there may be in-scope wards that were not included.

Due to some incomplete data returns, the denominator for some measures vary between questions.

Distance from home analysis

When referring to distance travelled this was calculated as 'the crow flies' between two fixed points and as such may not reflect actual distance travelled. Of the 3,212 patients we received patient-level data for, valid home postcode data was submitted for 2,303 (72%).

The distance was calculated from the central point of patient's postcode district, which may vary from the person's actual postcode.

[3] The 2019 information request questions were the same as we used in 2017, but in this information request we did not ask providers to detail the locked characteristics of their wards or their annual budgets.

What we found

Inpatient mental health rehabilitation ward characteristics

The mix of mental health rehabilitation ward types and beds has changed from those reported in 2017 (figures 1 and 2). 'Locked rehabilitation' wards remained the most commonly reported type of rehabilitation ward. However, providers reported having fewer 'locked rehabilitation' wards and more high dependency rehabilitation wards than in 2017.

Figure 1: Number of mental health rehabilitation wards by ward type, 2017 and 2019

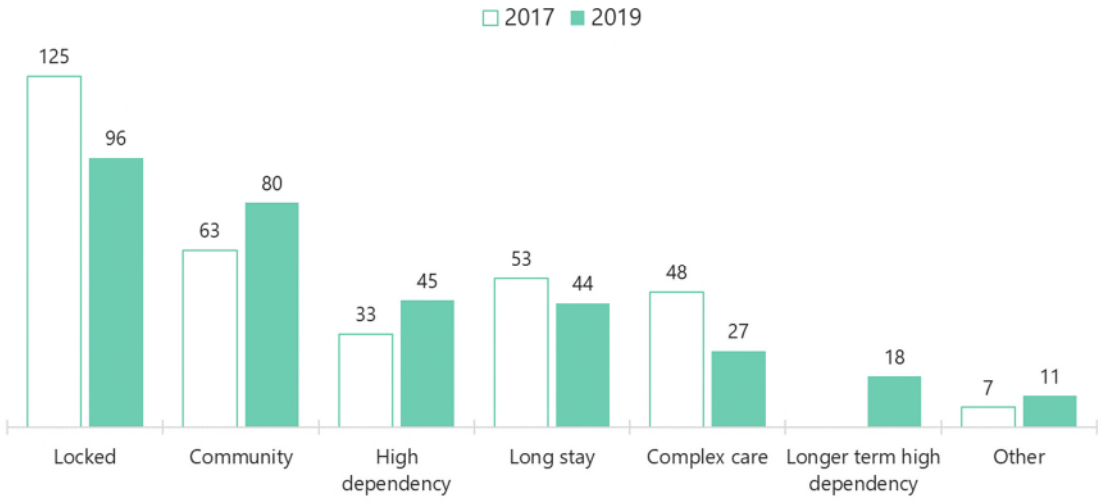
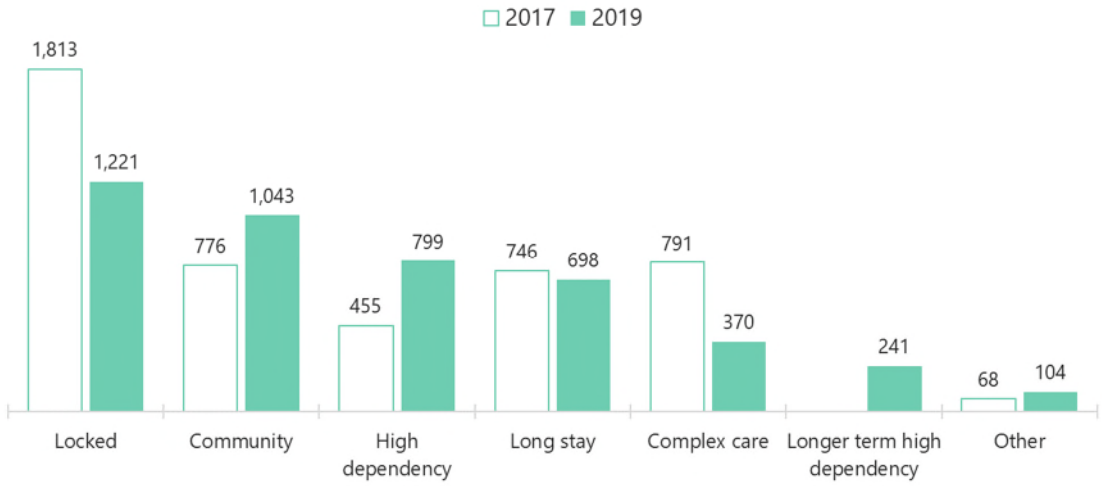


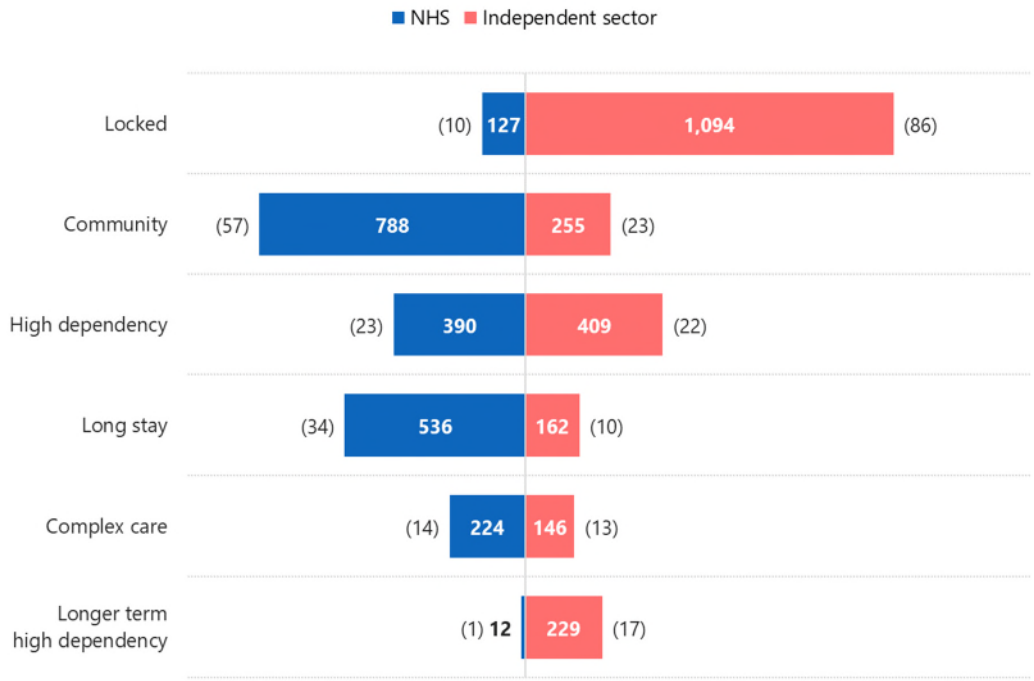
Figure 2: Number of mental health rehabilitation beds by ward type, 2017 and 2019



Note to figures 1 and 2: One ward categorised itself as both categorised itself as both a community rehabilitation ward and a high dependency rehabilitation ward. The ward and beds are counted under both ward type categories on the charts above. The longer-term high dependency ward type was not included in the 2017 data collection.

Despite the change in the types of wards and beds reported, the percentage of inpatient rehabilitation beds being provided by the independent sector had hardly changed (55% in 2017 and 53% in 2019). The independent sector also continued to provide most of the beds categorised as ‘locked rehabilitation’ (90% in 2019, 86% in 2017) (figure 3).

Figure 3: Number of mental health rehabilitation beds by ward type and sector, 2019

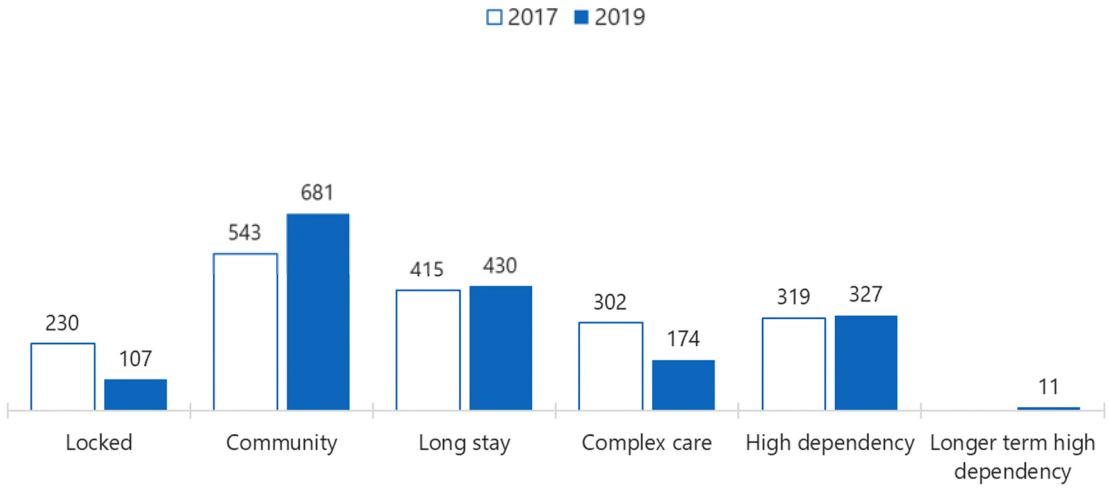


Note: The chart only includes the six largest categories of ward type. Number of wards shown in brackets. Ten wards categorised as ‘other’ have been excluded. One NHS ward categorised itself as both a community rehabilitation ward and a high dependency rehabilitation ward. The ward and beds have been counted under both ward type categories.

Providers told us that there were 3,622 people occupying a mental health rehabilitation bed in 2019. This is a decrease of 3% from 2017.

For NHS services, ‘locked rehabilitation’ wards and complex care rehabilitation wards saw the biggest decline in the number of occupied beds, with 53% and 42% fewer beds occupied respectively. Community rehabilitation wards saw the largest rise in the number of occupied beds, increasing by 25% from 543 in 2017 to 681 in 2019 (figure 4).

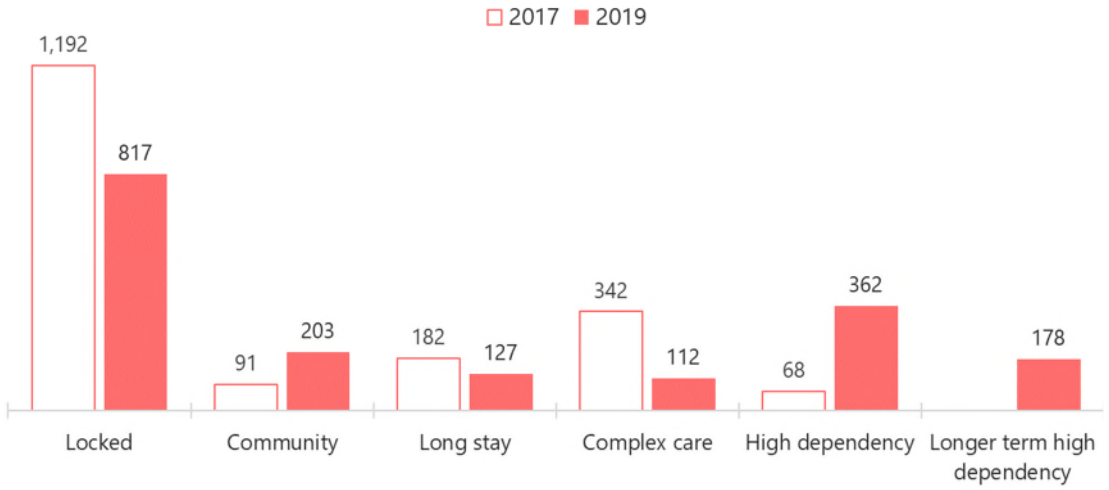
Figure 4: Number of occupied NHS mental health rehabilitation beds by ward type, 2017 and 2019



Note: The chart only includes the six largest categories of ward type. Longer-term high dependency ward type not included in 2017 data collection.

In independent sector services, complex care wards saw a 67% drop in the number of occupied beds (from 339 in 2017 to 112 in 2019). Locked rehabilitation wards and long stay wards also both had reductions of 32%. In contrast, the number of people in high dependency inpatient rehabilitation wards saw a fivefold increase, with 362 people were reported as receiving treatment in 2019, compared to 68 in 2017 (figure 5).

Figure 5: Number of occupied independent sector mental health rehabilitation beds by ward type, 2017 and 2019



Note: The chart only includes the six largest categories of ward type.

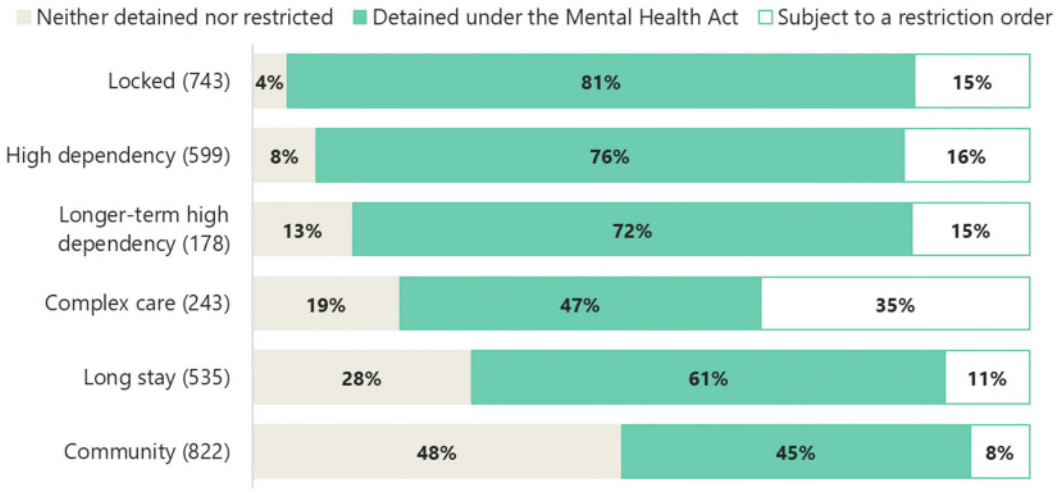
It should be noted that the changes that we saw in 2019 could be due to how the wards were categorising themselves, rather than any actual change in the type of inpatient rehabilitation services people were receiving.

Patient characteristics

We received patient-level data for 3,212 of the 3,622 (89%) patients reported as occupying an inpatient rehabilitation bed. Of these, 65% were men, 78% were detained under the Mental Health Act 1983 (MHA) and 14% were subject to a Ministry of Justice restriction order. This was an increase from 2017, where 75% were reported as detained under the MHA and 11% were subject to a restriction order.

Locked wards had the highest proportion of people detained under the MHA or subject to a restriction order, with the lowest proportion reported for community rehabilitation wards. A small number (4%) of people in 'locked rehabilitation' wards were not detained under the MHA, suggesting that they may have been receiving care in a more restrictive setting than necessary (figure 6).

Figure 6: Legal status of patients by ward type, 2019



Note: The chart only includes the six largest categories of ward type. Number of patients shown in brackets. Thirty-seven patients were excluded from analysis as their legal status was not supplied.

Length of stay

The median length of stay on NHS and independent rehabilitation wards was 308 days, but this ranged from less than a month to over 20 years. People being cared for on rehabilitation wards in the independent sector wards stayed longer on average than people on NHS wards (415 days compared to 225 days). This was similar to our findings in 2017 (figure 7).

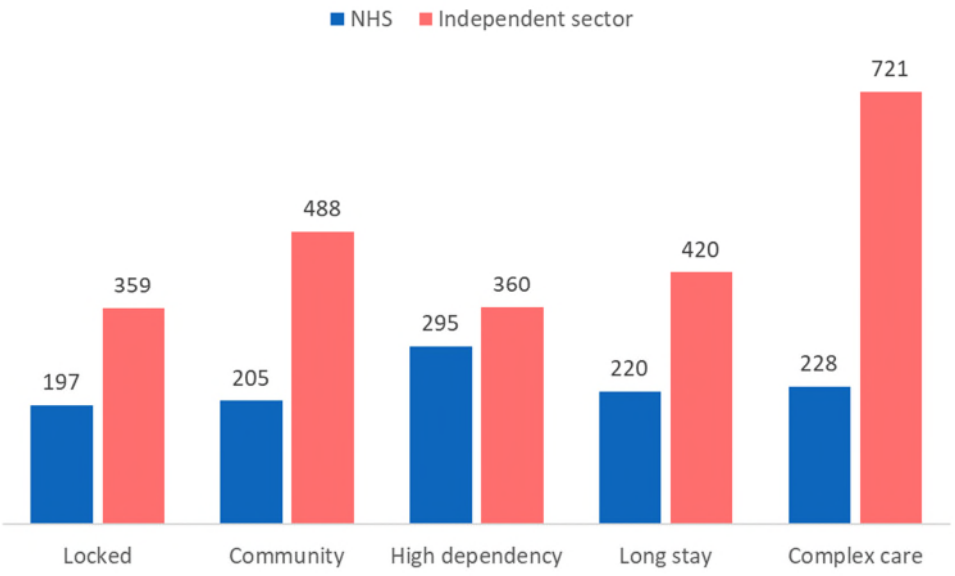
Figure 7: Median length of stay on current ward (days), 2017 and 2019

	2017	2019
NHS wards	230	225
Independent sector wards	444	415
All patients	**323**	**308**

Note: Twenty patients were excluded from 2019 figures due to data quality issues (12 patients on NHS wards and eight on independent sector wards).

We looked at the median length of stay across the five main ward types ('locked rehabilitation', community, high dependency, long stay, and complex care). We found that the median length of stay across these wards was higher in the independent sector than the NHS. This difference was largest for patients receiving care on complex care rehabilitation wards (figure 8).[4]

Figure 8: Median length of stay on current ward by ward type and sector (days), 2019



Note: The chart only includes the five largest categories of ward type. Twenty patients were excluded from analysis due to data quality issues (six on locked rehabilitation wards, six on community wards, one on a high dependency ward, three on long stay wards and four on complex care wards).

[4] See appendix A for table of 2017 and 2019 median length of stays at ward type-level.

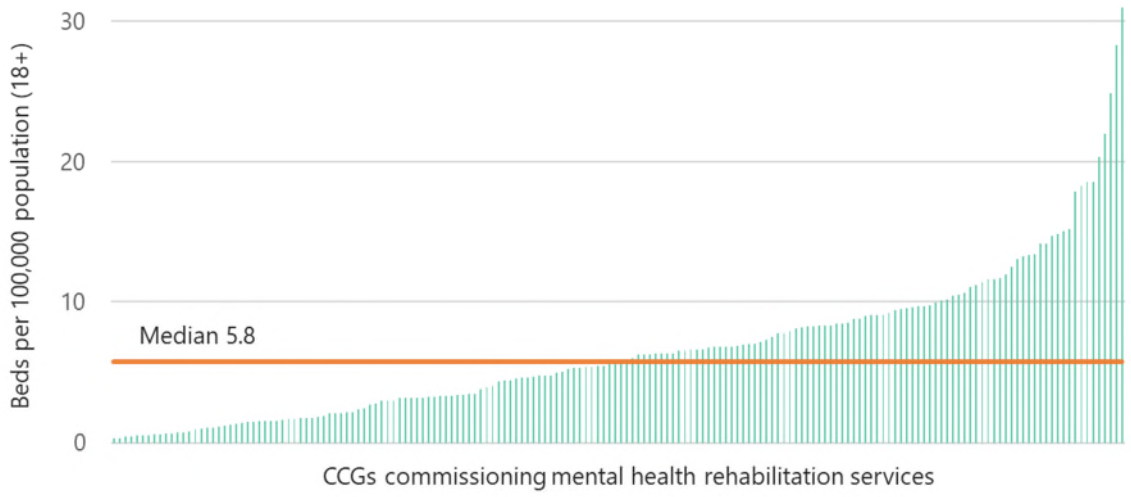
Commissioning

Of the 3,212 patients that we received patient-level data for, the vast majority (90%, 2,903 patients) had their care funded by clinical commissioning groups (CCGs). This was a slight decrease from 92% in 2017.

Across the country, we found that most CCGs were commissioning inpatient rehabilitation beds. In 2019, 174 out of 191 CCGs (91%) had commissioned inpatient rehabilitation beds. This was less than 2017 when we found that 95% (196 of 207) commissioned these types of beds.

We looked in more detail at the number of rehabilitation beds commissioned at CCG level. We found that the number of rehabilitation beds commissioned beds per 100,000 population ranged from 0.3 by Cambridge and Peterborough CCG to 31.0 for Leicester City CCG. Excluding the CCGs that commissioned no beds, the median number of beds per 100,000 population (18+) commissioned was 5.8 (figure 9).

Figure 9: Number of mental health rehabilitation beds commissioned by CCGs per 100,000 population (18+), 2019



Figures 10, 11, and 12 map the distribution of CCG commissioned inpatient rehabilitation beds across England in 2019. The top 20 commissioning CCGs are highlighted on each map. See Appendix C for a list of these CCGs and the corresponding CCGs from the 2017 data collection.

Figure 10: Map of the number of mental health rehabilitation beds commissioned per 100,000 population (18+), 2019

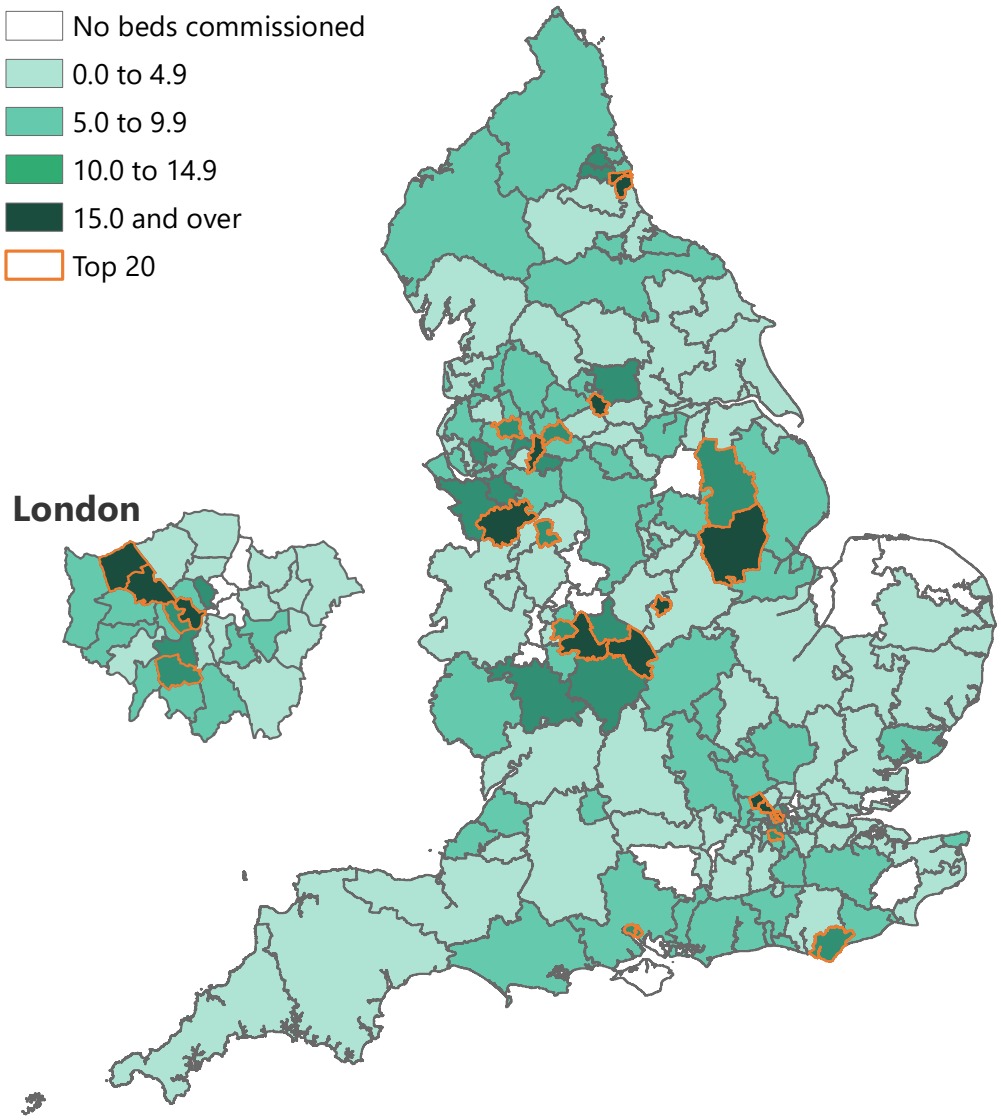


Figure 11: Map of the number of NHS mental health rehabilitation beds commissioned per 100,000 population (18+), 2019

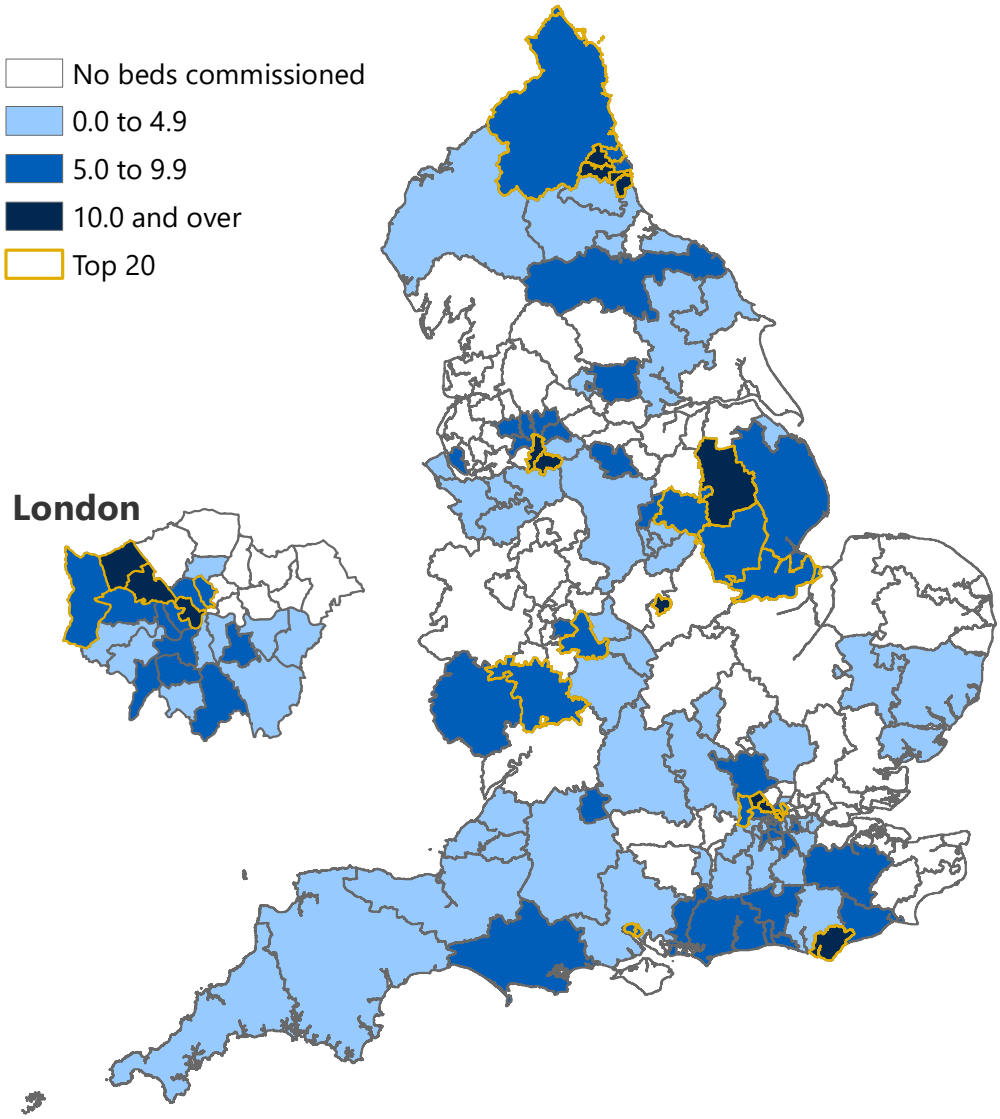
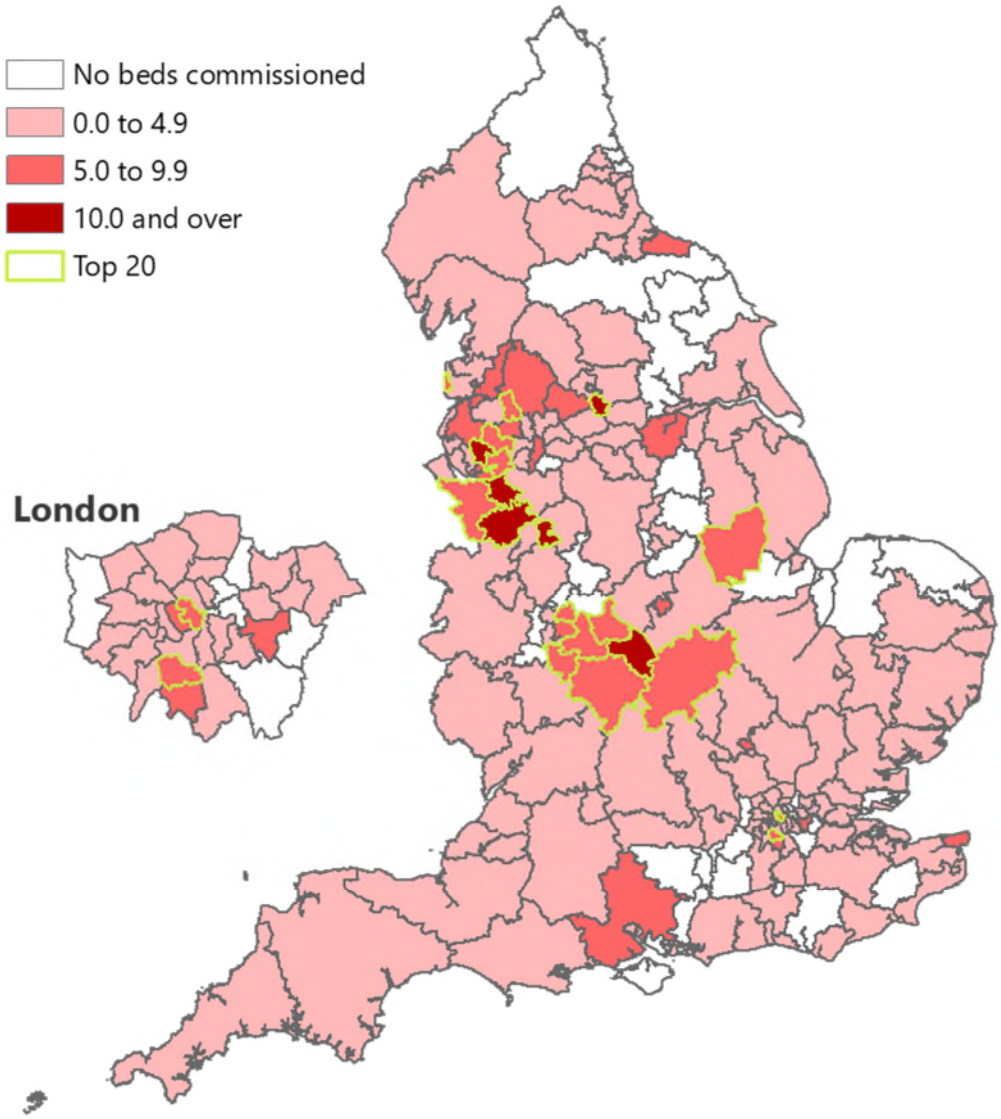


Figure 12: Map of the number of independent sector mental health rehabilitation beds commissioned per 100,000 population (18+), 2019



Social dislocation

Distance from home

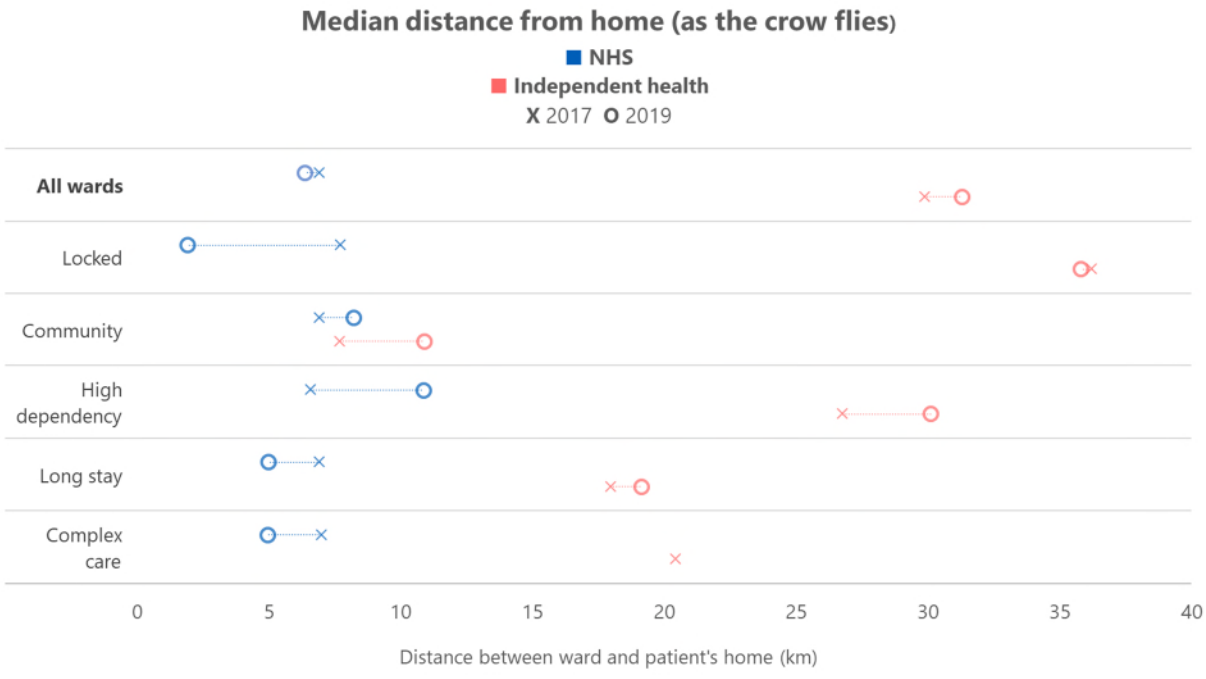
We looked at how far people in rehabilitation wards were placed from home compared to 2017. Across NHS and independent sector wards we found that there has been little change in patients' median distance from home (12.6km in 2017 compared to 11.5km in 2019).

However, we found that on average in 2019 people receiving care in the independent sector were further away from home than people on NHS wards. The median distance for patients in independent sector wards had increased from 29.9km in 2017 to 31.3km in 2019. In contrast, the median distance for NHS patients had decreased slightly from 6.9km in 2017 to 6.4km in 2019.

At a ward level, we saw the biggest reduction in median distance from home for NHS locked rehabilitation wards, which had decreased by 5.8km. However, the median distance for people on NHS high dependency rehabilitation wards had increased by 4.3km.

In the independent sector, we saw the biggest changes for high dependency rehabilitation wards, which had increased by 3.3km, and community rehabilitation wards, which had increased by 3.2km (figure 13).[5]

Figure 13: Median distance from home, as the crow flies by ward type and sector (km), 2017 and 2019



[5] See appendix B for table of 2017 and 2019 median distance from home at ward type-level.

Out of area treatment

What is an out of area placement?

An ‘out of area placement’ (OAP) for mental health rehabilitation inpatient care is defined as happening when: a person with complex mental health needs who requires adult mental health rehabilitation inpatient care, is admitted to a unit that does not form part of their usual local network of services. By this we mean an inpatient rehabilitation unit that does not usually admit people living in the catchment of the person’s local community mental health service. For example, an OAP is a placement of a patient to any other provider that is not the patient’s home provider, including:

- Any other NHS inpatient mental health rehabilitation unit, regardless of distance travelled.
- Any independent service provider (ISP) inpatient mental health rehabilitation unit, regardless of distance travelled.

We looked at whether patients were receiving inpatient rehabilitation ‘out of area’. To do this, we looked at:

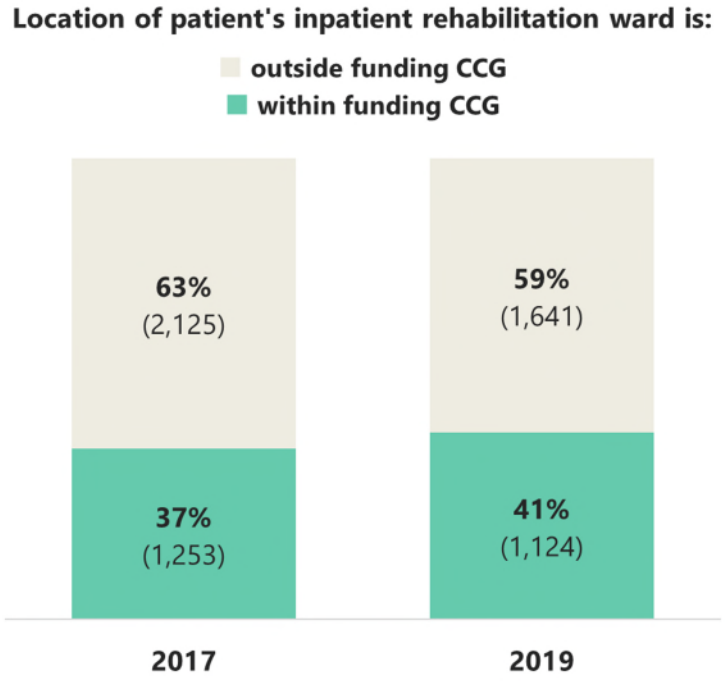
- whether the ward they were being treated in was different from the location of the CCG funding their treatment
- whether the provider of the patient’s inpatient treatment considered them to be ‘out of area’ – this varied depending on local arrangements between neighbouring CCGs to share resources
- whether patients were receiving treatment in the NHS trust responsible for their aftercare.

We found that a slightly lower proportion of CCG-funded patients were reported as receiving care outside of the area funding their care (59% in 2019 compared to 63% in 2017) (figure 14).

Patients receiving mental health rehabilitation in an independent sector ward were more likely to be outside of the CCG area funding their care (74%) than those receiving treatment in an NHS ward (41%) (figure 15).

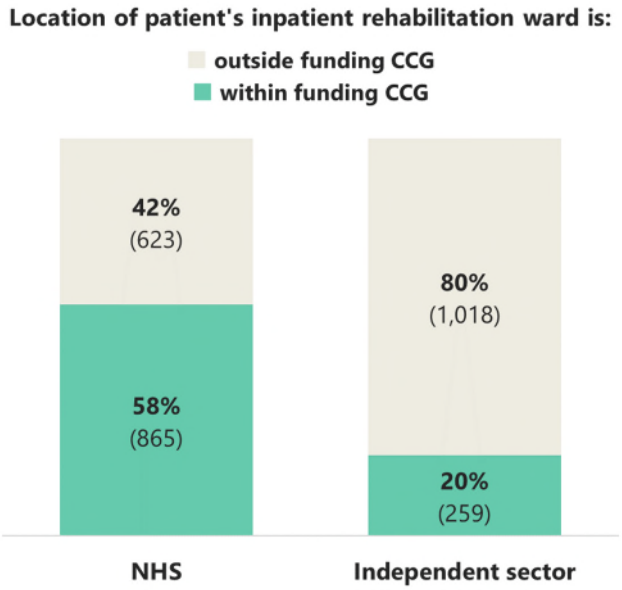
At a ward level, ‘locked rehabilitation’ wards had the highest proportion of patients receiving treatment outside their funding CCG area (figure 16).

Figure 14: Percentage of patients receiving mental health rehabilitation outside/within the CCG funding their care, 2017 and 2019



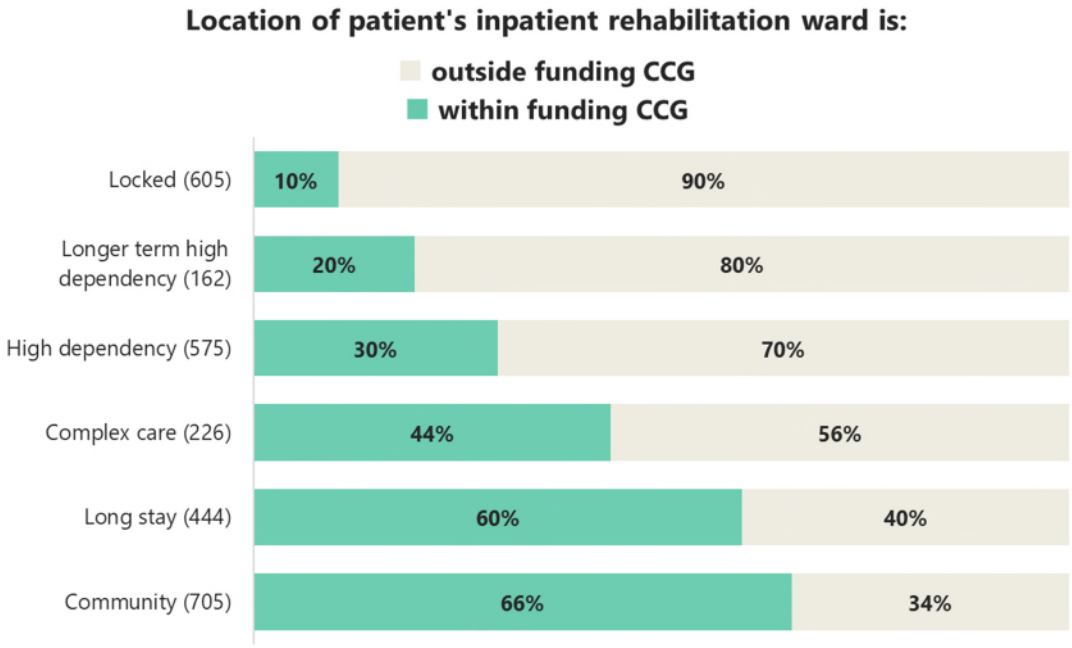
Note: Number of patients shown in brackets. 30 and 138 CCG-funded patients excluded from 2017 and 2019 analysis respectively as funding CCG had not been reported.

Figure 15: Percentage of patients receiving mental health rehabilitation outside/within the CCG funding their care by sector



Note: Number of patients in brackets. One hundred and thirty-eight CCG-funded patients were excluded from analysis as funding CCG had not been reported (46 on NHS wards and 92 on independent sector wards.

Figure 16: Percentage of patients receiving mental health rehabilitation outside/within the CCG funding their care by ward type, 2019

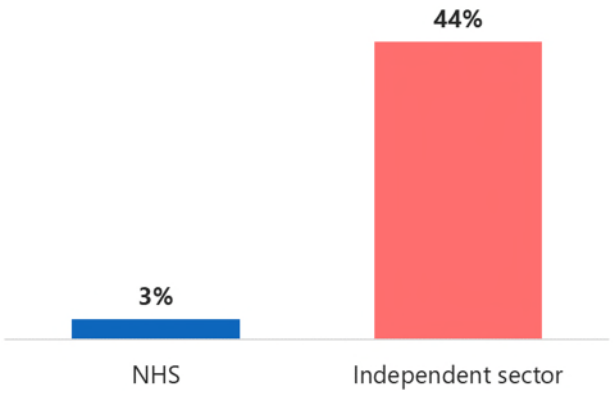


Note: The chart only includes the six largest categories of ward type. Number of patients in brackets. One hundred and thirty-eight CCG-funded patients were excluded from the analysis as funding CCG had not been reported.

Overall, we found that independent sector wards had a higher percentage of CCG-funded patients who providers considered to be out of area than NHS wards (figure 17).

At a ward level, longer-term high dependency wards and locked rehabilitation wards had the highest proportions of CCG-funded patients that were considered to be 'out of area' (figure 18).[6]

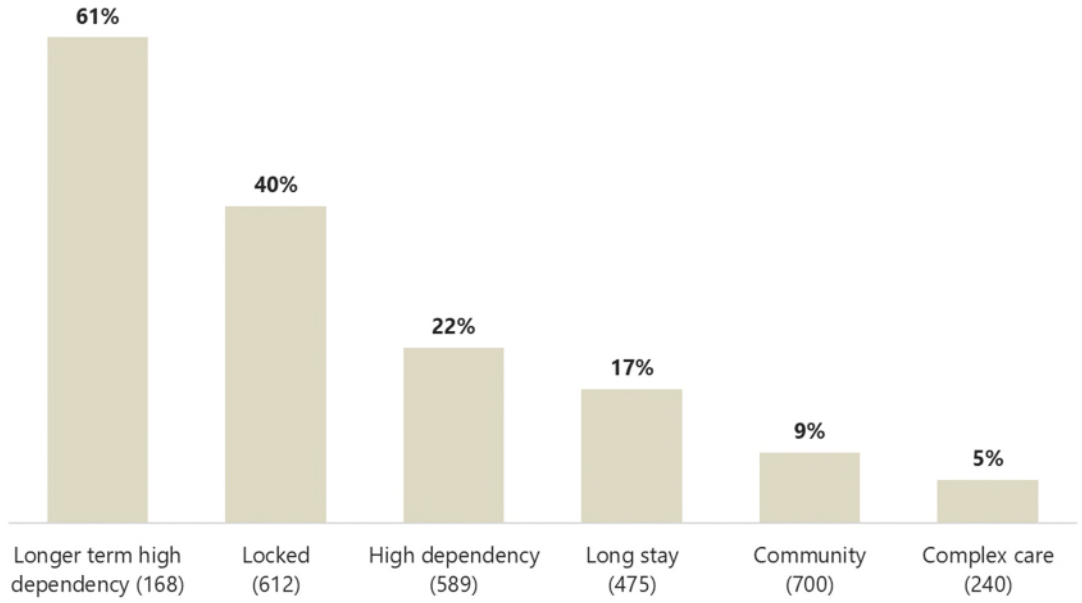
Figure 17: Percentage of CCG-funded patients considered 'out of area' by providers by sector, 2019



[6] Note: Providers' interpretation as to what constituted 'out of area' may have varied.

Note: Seventy-one patients were excluded from analysis as the question had not been answered (one patient on an NHS ward and 70 on independent sector wards)

Figure 18: Percentage of CCG-funded patients considered 'out of area' by ward type, 2019

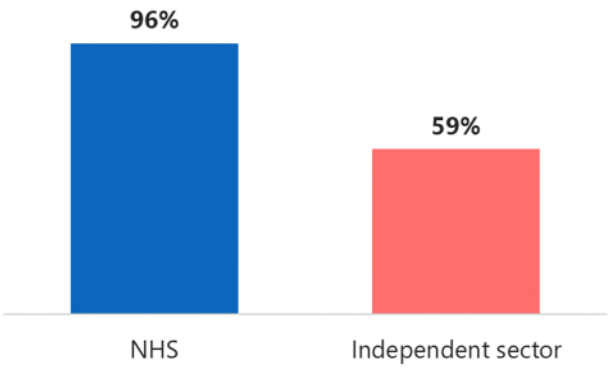


Note: The chart only includes the six largest categories of ward type. Total number of CCG-funded patients by ward type shown in brackets. Seventy-one patients excluded from analysis as question had not been answered (56 patients on locked rehabilitation wards, 14 on community wards and one on a long stay ward).

In 2017 it was noted that independent sector ward managers were only able to name the NHS mental health trust responsible for aftercare for 53% of their patients, whereas NHS ward managers were able to name the responsible trust in 99% of cases.

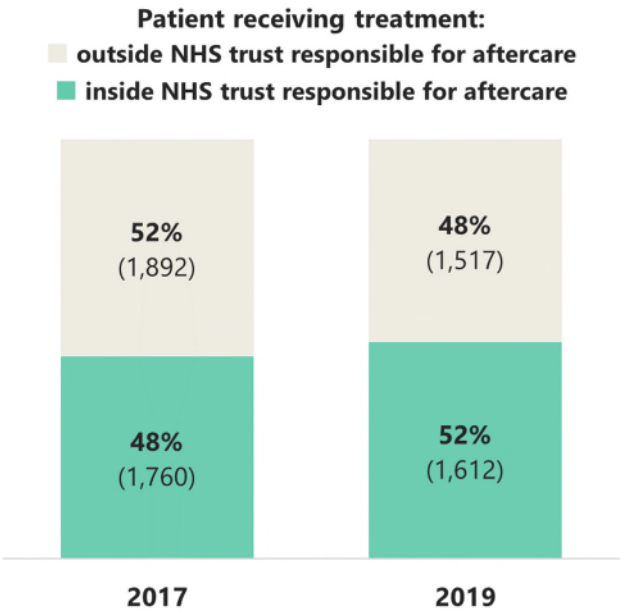
Our information request in 2019 showed little change with only 59% of independent sector ward managers able to name the NHS mental health trust responsible for aftercare for 59% of patients. This had decreased slightly for NHS ward managers, with 96% able to name the trust responsible for aftercare (figure 19).

Figure 19: Percentage of patients with an NHS mental health trust stated as responsible for aftercare by sector, 2019



The percentage of people receiving inpatient rehabilitation outside of the NHS mental health trust responsible for their aftercare had decreased slightly in 2019 (48%) compared to 2017 (52%) (figure 20).

Figure 20. Percentage of patients receiving mental health rehabilitation outside/within the NHS mental health trust responsible for their aftercare, 2017 and 2019



Note: Number of patients in brackets. Where NHS trust responsible for aftercare was unknown by providers, we have used the expected aftercare trust based on patient's funding CCG. Patients excluded from analysis where the NHS trust responsible for aftercare; and funding CCG has not been provided or patient is not CCG-funded – 69 patients in 2017 and 83 in 2019.

Recommendations

Based on the results of our 2019 information request, and in line with the NICE guidance for the rehabilitation of adults with complex psychosis, we have made the following recommendations for commissioners, NHS England and CQC to improve the care for people in mental health rehabilitation inpatient services.

Recommendations for commissioners

To minimise the use of out of area services, we recommend that commissioners of mental health services use the following questions when planning for the provision of appropriate local mental health rehabilitation services:

- How many people with severe and complex mental health needs are you currently responsible for funding and how many new cases are there per year? This should include the number who:
  - Are currently placed out of area.
  - 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 supported accommodation.
  - Are receiving care from forensic services, but will need to continue their rehabilitation locally when discharged from forensic services.
  - Are physically frail and may need specialist supported accommodation.
  - are receiving care from early intervention for psychosis services (of whom 10% to 20% will develop complex problems over three years)
  - Are young adults moving from children and young people's mental health services to adult mental health services.
- How well does your local mental health rehabilitation pathway meet the needs of people with severe and complex mental health needs? Consider:
  - ward types
  - bed numbers
  - the amount of supported accommodation services
  - the amount of local authority housing with personalised community care packages
  - the availability of community rehabilitation teams?
- What is your model of planning? Is this based on assessed needs and capacity modelling for inpatient rehabilitation services, community rehabilitation team caseloads, supported accommodation, housing and personalised care packages?
- How many people do you currently fund for treatment in inpatient rehabilitation wards out of area?

- What is their average length of stay and cost and what outcomes do you use to evaluate value for money?
- What is your process for reviewing these people and helping them to move back to their local area successfully?
- Are you working with neighbouring clinical commissioning group (CCGs) and providers to ensure your mental health rehabilitation pathway includes regional highly specialist rehabilitation wards for the small number of people who have especially complex problems?

Recommendations for NHS England

In order to increase momentum and support for the work that NHS England has already begun to try to address the over reliance on out of area inpatient rehabilitation services, we recommend:

- The Getting It Right First Time (GIRFT) programme for mental health rehabilitation should continue in order to support CCGs to invest in local mental health rehabilitation pathways for people with severe and complex needs.
- NHS England oversees the annual monitoring of the number of people in inpatient rehabilitation beds provided by the NHS and independent sector. Lengths of stay should be included in the National Mental Health Minimum Data Set, reported at individual CCG level and in terms of the number provided within and outside the CCG area.

Recommendations for CQC

Our findings highlight that we need to continue to closely monitor the provision of inpatient rehabilitation care, and to hold providers to account for the quality of care delivered. This includes ensuring that:

- The type of inpatient rehabilitation provided is in line with the Royal College of Psychiatrists' recognised specifications.
- There is adequate staffing and supervision to deliver effective, evidence-based, recovery-focused, rehabilitative treatment and care for the target patient group.
- Patients who are detained under the Mental Health Act have access to appropriate and timely reviews of their legal status through Mental Health Review Tribunals and Managers' Hearings.
- All patients have access to an advocacy service, including those who are detained under the Mental Health Act and those who are in hospital voluntarily.
- The hospital and community teams work together proactively on discharge planning.
- The NHS trust responsible for providing aftercare has systems in place to minimise the length of time people have to stay in hospital. This includes reviewing the progress of all inpatients on rehabilitation wards, both locally and out of area, and identifying suitable community-based accommodation and appropriate support at the earliest opportunity.

Appendices

Appendix A: Median length of time on current ward by ward type and sector (days), 2017 and 2019

	2017			2019		
Ward type	**NHS**	**Independent**	**All**	**NHS**	**Independent**	**All**
Locked	406	409	409	197	359	341
Community	176	466	206	205	488	240
High dependency	281	358	294	295	360	329
Long stay	170	417	241	220	420	268
Complex care	317	593	452	228	721	277
All wards	230	444	323	225	415	308

Appendix B: Median distance from home by ward type and sector (km), 2017 and 2019

	2017			2019		
Ward type	**NHS**	**Independent**	**All**	**NHS**	**Independent**	**All**
Locked	7.7	36.2	30.9	1.9	35.8	28.9
Community	6.9	7.7	7.0	8.2	10.9	8.9
High dependency	6.6	26.8	7.7	10.9	30.1	17.0
Long stay	6.9	18.0	8.5	5.0	19.1	5.8
Complex care	7.0	20.4	10.9	4.9	No wards in 2019	4.9
All wards	6.9	29.9	12.6	6.4	31.3	11.5

Appendix C: CCGs commissioning the most mental health rehabilitation beds per 100,000 population (18+), 2017 and 2019

The following tables list the 20 CCGs commissioning the most mental health rehabilitation beds per 100,000 population (18+) in each data collection in alphabetical order.

Figures calculated using mid-2017 (2017 figure) and mid-2018 (2019 figure) clinical commissioning group population estimates (ONS).

Note: NHS Birmingham Cross City, Birmingham South and Central and Solihull CCGs merged between data collections to form NHS Birmingham and Solihull CCG.

Top 20 clinical commissioning groups commissioning the most mental health rehabilitation beds per 100,000 population (18+) (in alphabetical order)

2017	2019
Birmingham CrossCity	Birmingham and Solihull
Birmingham South and Central	Bolton
Brent	Brent
Camden	Central London (Westminster)
Canterbury and Coastal	Coventry and Rugby
Central London (Westminster)	Eastbourne, Hailsham and Seaford
Darlington	Harrow
Doncaster	Leicester City
Harrow	Lincolnshire West
Islington	Manchester
Leicester City	Merton
Lincolnshire West	North Kirklees
Manchester	Oldham
North Kirklees	Sandwell and West Birmingham
Redditch and Bromsgrove	South Cheshire
Scarborough and Ryedale	South West Lincolnshire
South Tees	Southampton
South West Lincolnshire	Stoke on Trent
Vale Royal	Sunderland
West London	West London

Top 20 clinical commissioning groups commissioning the most NHS mental health rehabilitation beds per 100,000 population (18+) (in alphabetical order)

2017	2019
Birmingham CrossCity	Birmingham and Solihull
Bradford City	Brent
Brent	Central London (Westminster)
Camden	Eastbourne, Hailsham and Seaford
Canterbury and Coastal	Harrow
Central London (Westminster)	Hillingdon
Darlington	Islington
Doncaster	Leicester City
Hammersmith and Fulham	Lincolnshire West
Harrow	Manchester
Hastings and Rother	Newark and Sherwood
Islington	Newcastle Gateshead
Leeds South and East	North Tyneside
Leicester City	Northumberland
Lincolnshire West	South Lincolnshire
Manchester	South West Lincolnshire
Newcastle Gateshead	South Worcestershire
South Tyneside	Southampton
Sunderland	Stockport
West London	Sunderland

Top 20 clinical commissioning groups commissioning the most independent mental health rehabilitation beds per 100,000 population (18+) (in alphabetical order)

2017	2019
Birmingham CrossCity*	Birmingham and Solihull*
Birmingham South and Central*	Blackburn with Darwen
Blackburn with Darwen	Blackpool
Bolton	Central London (Westminster)
Coventry and Rugby	Coventry and Rugby
Eastern Cheshire	Merton
Hardwick	Nene
Merton	North Kirklees
North Kirklees	Redditch and Bromsgrove
Redditch and Bromsgrove	South Cheshire
Scarborough and Ryedale	South Warwickshire
South Devon and Torbay	South West Lincolnshire
South Tees	St Helens
South West Lincolnshire	Stoke on Trent
St Helens	Vale Royal
Stoke on Trent	Walsall
Vale Royal	Warrington
Walsall	Warwickshire North
Warrington	West Cheshire
West London	Wigan Borough

Appendix D: Types of rehabilitation unit[7]

	High Dependency Rehab Unit	Community Rehab Unit	Complex Care Rehab Unit	Longer Term High Dependency Rehabilitation Unit	Low Secure
Client Group	Severe symptoms (multiple) co-morbidities, significant risk histories, ongoing challenging behaviours. Most patients detained under MHA. Most referrals (80%) come from acute inpatient units and 20% from forensic units.	Ongoing complex needs so cannot be discharged directly from high dependency unit to supported accommodation. Most referrals come from high dependency rehab or acute inpatient unit. Can only take detained patients if registered as a ward (may have CTO/S41 patients if not registered as a ward).	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.	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 from high dependency rehab unit.	History of offending and/or severe challenging behaviour. All detained under the Mental Health Act (usually Part 3). **Key task** - accurate assessment and management of risk. **Commissioned by NHS England.**
Commissioned by	Local Clinical Commissioning Groups (CCG)	CCGs	CCGs	CCGs	NHS England

[7] Joint Commissioning Panel for Mental Health

Focus	Thorough assessment, engagement, maximising benefits from medication, reducing challenging behaviours, psychosocial interventions, re-engaging with families and communities. Step down for forensic services and repatriation of people from out-of-area placements.	Facilitating further recovery, managing medication (self-medication programmes), 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.	To stabilise symptoms adequately such that function improves and move on to less supported component of the rehabilitation pathway becomes feasible. Interventions as for high dependency and community rehab units in a highly supported setting.	Thorough assessment, engagement, maximising benefits from medication, reducing offending/challenging behaviours, encouraging ADL skills.
Recovery goal	Move on to community rehabilitation unit or supported accommodation.	Move on to supported accommodation.	Most move to supported accommodation or residential care.	Move on to community rehabilitation unit or supported accommodation.	Most move to another component of the rehabilitation pathway, often high dependency or community rehab.
Location	Usually hospital based	Community based	Hospital campus or community	Usually hospital based	Hospital based regional secure services
Length of stay	up to 1 year	1-2 years	5-10 years	1-3 years (can be longer - variable)	2+ years – highly variable
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.	Domestic services provided, but ADL skills encouraged through OT.	Domestic services provided and ADL skills encouraged through OT.

Risk Management	Controlled access ('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 unit.	Controlled access. Higher staffed, full MDT. May have air lock and higher staffing than standard HDRU if target client group require this.	Locked. High-staffing, MDT. Physical, procedural and relational security, specialist risk assessment and management skills.
Provision per population	Every Trust. One unit per ~300,000	Every Trust. One unit per ~300,000.	Every Trust. One unit per ~600,000.	Every Trust. One unit per ~600,000.	Regional. One unit per ~1 million.

How to contact us

Call us on:	03000 616161
Email us at:	enquiries@cqc.org.uk
Look at our website:	www.cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA

Follow us on Twitter: @CareQualityComm

CQC-462-102020