GIRFT national report for mental health rehabilitation aims to bring more patients closer to their home

Enabling more people to receive mental health rehabilitation in a setting closer to their home – and in the community, whenever possible – is one of the overarching objectives of a new national report from the Getting It Right First Time (GIRFT) team.

There are around 3,500 people in inpatient mental health rehabilitation beds in England but just over half receive care outside of their local area (out of provider placements – OPPs), mainly with independent providers, away from their families and support networks.

The new GIRFT report, written by Dr Sridevi Kalidindi CBE, a consultant rehabilitation psychiatrist at the South London & Maudsley NHS Foundation Trust and chair of the Association of Mental Health Providers, shows that in 2018/19 rehabilitation inpatient care in the NHS cost around £279m, with another £281m spent on OPPs, the majority of which are in the private sector. There is significant variation in the number of people placed in OPPs, depending on their local provider trust and health commissioner; some trusts and commissioners keep all patients 'in sight and in mind' while others place more than 100 patients outside their local area.

The GIRFT report advocates adopting a whole-system approach and closer collaboration between trusts, commissioners (health and social care), housing and Voluntary Community and Social Enterprise (VCSE) partners, patients and their carers to help improve the quality of care and bring more patients closer to home, in a community setting as far as possible.

This in turn can result in better value for the NHS. Rehabilitation in OPPs costs around 65% more than local placements, mainly due to patients remaining in inpatient units for longer when placed away from their local area. A financial illustration in the report shows how, if all mental health trusts could achieve a 20% reduction in OPP bed days by adopting GIRFT's recommendations, 119,500 bed days could be saved, freeing up £51.54m for the NHS.

Mental health rehabilitation is the treatment and rehabilitation of adults with severe mental illness, both in the community and in hospital. Rehabilitation services are predominantly received by people with complex psychosis, who may display behaviour that challenges, prefer not to engage with services, or pose a risk to themselves or others. Around 80% of people who are referred have a primary diagnosis of schizophrenia, schizoaffective disorder or other psychoses, while 8% have a diagnosis of bipolar affective disorder, and 12% have other diagnoses. Approximately two-thirds are men.

The GIRFT review of services has so far involved meetings with 42 of 53 mental health trusts, and uses data gathered via a detailed GIRFT's questionnaire, as well as data from the NHS Benchmarking Network, NHS Digital and Care Quality Commission (CQC). The report presents 12 recommendations designed to address variation observed in patient pathways, the provision of community rehabilitation and housing and the use of data, as well as promoting a more collaborative and integrated service which considers a whole system approach.

Consultation over the findings and recommendations of the report has taken place with professional bodies and other stakeholders, including the CQC and Royal College of Psychiatrists.

In the report, Dr Kalidindi outlines how the opportunity to improve services has never been stronger or more compelling, with policy, practice and finances currently aligned. The GIRFT report builds on the ambitions of the NHS Long Term Plan – which incorporates community rehabilitation as a core part of the Community Mental Health Framework, with funding assigned to develop services and teams in all trusts by 2024 – as well as NICE guidance for people who have complex psychosis which was published in 2020.

Dr Kalidindi said: "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.

"The resounding feedback has been that this is a much needed, long overdue, welcomed report. More importantly, this report is a crucial 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."

Rehabilitation often leads to successful discharge from inpatient care into supported accommodation, and there are around 100,000 people live in mental health supported accommodation in England. Ensuring there is adequate supported housing, using a variety of models (from units staffed around the clock to others with floating support), can help to prevent acute admissions and OPPs.

By ensuring there is the right complement of supported housing available for people cared for in the community or leaving inpatient care, patients are less likely to be 'stranded' or stay longer than necessary on high dependency rehabilitation units (HDUs) or as acute psychiatric inpatients. The report highlights that the mean length of stay for a patient in an inpatient HDU ranges from 50 to more than 1,500 days.

The GIRFT review also showed that 46% of providers did not offer community mental health rehabilitation services in 2018/19. The national report highlights actions which trusts, commissioners and local authorities can take to ensure they have a dedicated community mental health rehabilitation team in place. It also outlines how providers can work with local partners to proactively improve the provision of supported housing in their area. This supports NICE guidance which recommends that rehabilitation services for people with complex psychosis should be offered in the least restrictive environment and should aim to help people progress from more intensive support to greater independence.

The report also addresses workforce shortages and skills gaps for staff working in the specialty, and suggests nine actions to help trusts, health commissioners and social care commissioners clarify and develop training across the MDT workforce as well as protecting staff wellbeing.

Overall, it is noted that the key to improving care is first improving the quality and use of data collected for the specialty. The report recommends developing local rehabilitation dashboards to assess need, access, length of stay in different parts of the system, outcomes, patient experience, and the effectiveness of the whole system, with a view to reducing reliance on OPPs. Detailed recording and monitoring of all OPPs, and reporting on them at least quarterly, is also recommended.

Dr Kalidindi said: “There are dedicated funds via the Long Term Plan specifically for the development of community rehabilitation services as part of the CMH Framework Transformation, and part of the funds may be used for residential rehabilitation.

“It is important that teams and trusts are putting plans forward to their CCG for this earmarked funding.”

Report recommendations

The report makes 12 recommendations across seven areas of focus:

Using data to support improvement

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.

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.

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.

1.4 Coding - rehabilitation care should be coded consistently and accurately.

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.

Patient pathways

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.

3 All trusts, health commissioners and LAs should develop robust systems to bring patients treated out of area back to their local area.

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.

4.2 NHS-led provider collaborative programmes to consider provider collaborative model for whole care pathway for people with complex emotional needs.

Community rehabilitation and supported housing

5 Trusts, health commissioners and LAs should ensure that a dedicated community mental health rehabilitation service/team is developed across all health commissioners/LAs.

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.

Developing collaborative and integrated rehabilitation systems

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.

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.

Data driven continuous QI

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.

9 All trusts, health commissioners and LAs housing providers should use data informed continuous QI approaches across the whole system of mental health rehabilitation.

10 Trusts and other service providers should utilise digital technology in developing and delivering rehabilitation services.

Standardisation of procurement processes and protocols

11 Standardise and systemise processes and protocols around procurement.

Litigation

12 Reduce litigation costs by application of the GIRFT programme's five-point plan.