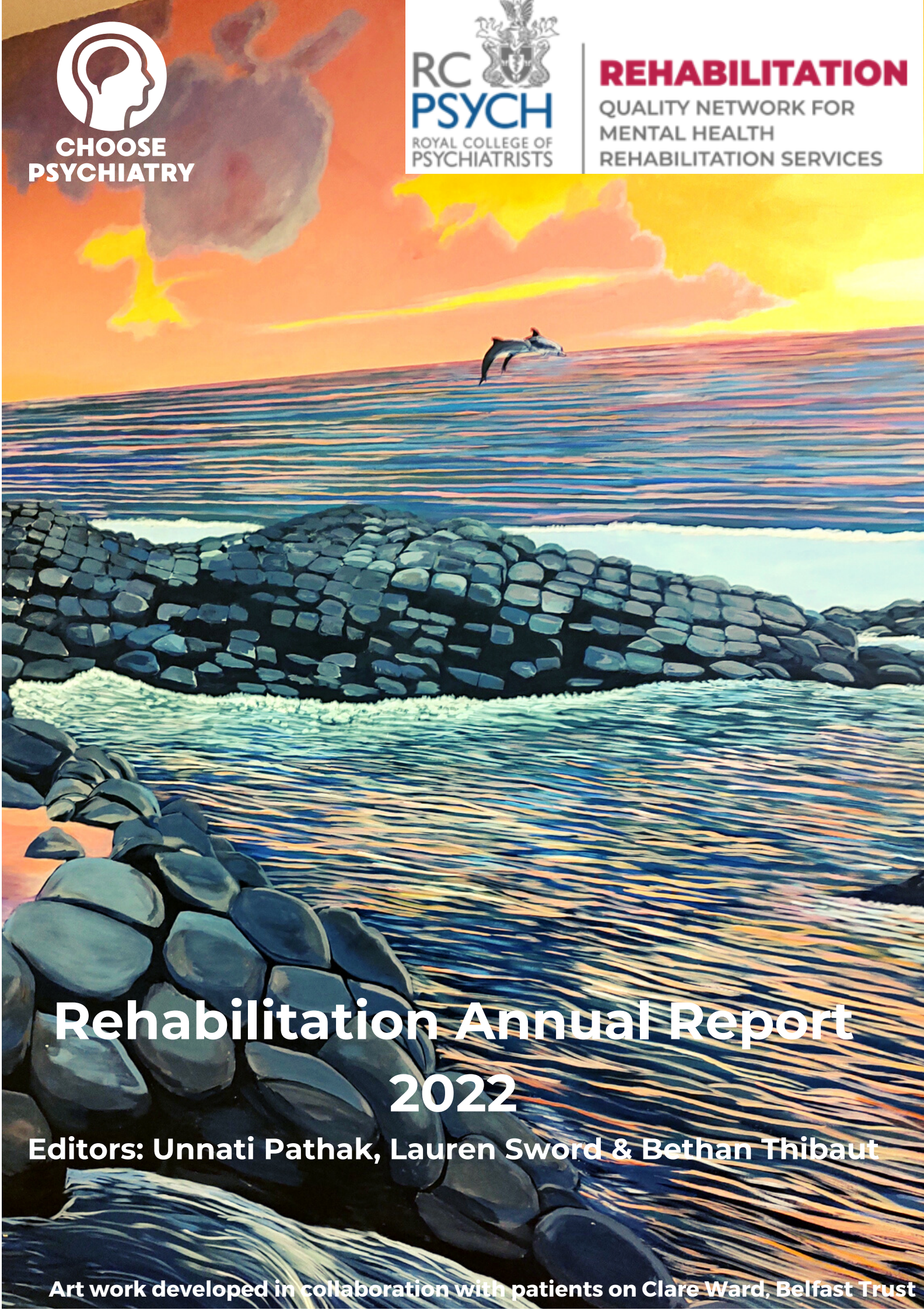
CHOOSE PSYCHIATRY

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

REHABILITATION
QUALITY NETWORK FOR MENTAL HEALTH REHABILITATION SERVICES



Rehabilitation Annual Report 2022

Editors: Unnati Pathak, Lauren Sword & Bethan Thibaut

Art work developed in collaboration with patients on Clare Ward, Belfast Trust

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Foreword

We hope you find this year's annual report an interesting and stimulating read. As well as continuing our work with inpatient mental health rehabilitation services, in May 2022 we launched our first set of standards for community mental health rehabilitation teams. This was the culmination of a major piece of work undertaken over the last three years and the publication of the standards was very timely, given the considerable investment in these services that has been made across England as part of the NHS Long Term Plan and Community Framework. Community rehabilitation teams are also recommended in the NICE Guideline for Rehabilitation for People with Complex Psychosis (NICE Clinical Guideline 181) to provide specialist clinical input to people living in supported accommodation. Currently there are around 40 such teams in England, with more in development, and we hope that as many as possible will join the Quality Network. We have 55 inpatient mental health rehabilitation services across the UK that are members of the Quality Network as well as our burgeoning group of new community rehabilitation team members – this represents a significant proportion of all UK rehabilitation services. The increasing numbers of services wishing to join the network is a marker of the growing awareness of the importance of mental health rehabilitation services and a clear sign that the work of the network is valued in helping us learn from each other. The Quality Network depends on the invaluable contributions and enthusiasm of its members and I would like to take this opportunity to thank you for all your input and support over the last year.
It's been a long time coming, but now that mental health rehabilitation is back in fashion; let's work together to ensure that we continue to optimise the quality of care and support we provide to all those who use our services.

Professor Helen Killaspy
Chair, Advisory Group
REHAB – the Quality Network for Mental Health Rehabilitation Services

Foreword

Invited to contribute to this foreword, I benefit from professional experience facilitating quality, innovation and productivity improvement through partnership working. Family carers, I am one, are said to provide services equivalent in value to those of the paid mental health and social care staff. They, as others, would rejoice in prevention of mental illnesses; hence the carers' interest in what was called 'QIPP'.
The College is steadily refining the mode of involvement of both service users and carers towards 'co-production', the aim being to create partnerships of equals. This is refined further by approaches to remove any adverse performance within equality, diversity and inclusion. Having served for a decade on reviews of acute wards, I transferred just before Covid to the Rehab team. On rehab wards, I find their physical facilities vary considerably, some finding it difficult to simulate independent living. However, there is usually a recognizable communal spirit for 'moving forward', usually towards discharge into a suitably protected residence in the community. Some wards have the ambition to re-engage with carers who may have felt need to step back at an earlier stage in the patient's journey. This environment seems a fertile one in which the College may act as catalyst to the creation of co-production and possibly EDI, primarily between the ward and others active within CCQI, but potentially between each ward and its present or past patients and their respective carers. The concept of peer review should encourage the exchange and distribution of best practice

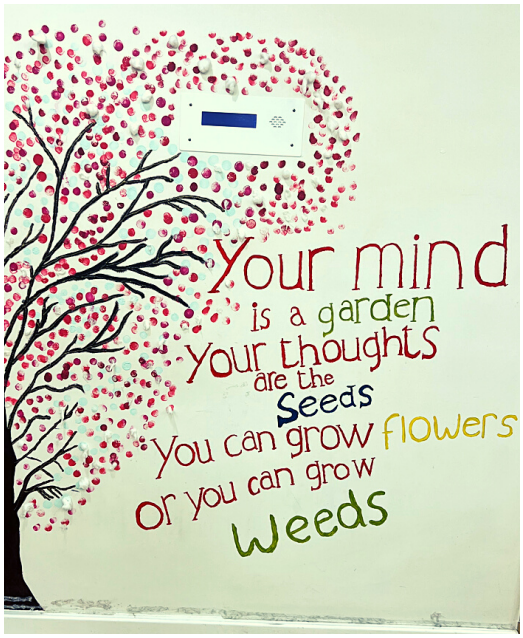
John Copping, Carer Representative, Royal College of Psychiatrists

Art work by: Patients on Westways Rehabilitation Unit South London and Maudsley NHS Foundation Trust

Foreword

My name is Katherine Barrett and I have been a service user for 30 years so I have lots of experiences. I have been involved at the Royal College of Psychiatry on the Rehabilitation Quality Network for the past few years.
At the moment, I am part of the Advisory Group team. In this group we organise the Rehabilitation Annual Forum, review updates and everything to do with the department at the CCQI. I also take part in the Rehabilitation Quality Network reviews both online and in person. I really enjoy these reviews because you get a clear overview of what makes a good ward for service users and what makes a good staff team.
The standards in the review allow the review team to get a good picture of the ward that is participating. I was involved in the standards review; there is less of them now and they are more specific. It's good experience to be part of these review and I recommend to professionals that they should work with the Royal College of Psychiatry to take part in them. They will learn a lot. I think that this report gives you lots of information you need for improvements.
I look forward to more involvement with the Rehabilitation Quality Network team in all aspects of their work. Most of my reviews have been online recently and it is surprising how well they run. However, I think face to face meetings are better for the Rehabilitation Quality Network as you get a real sense of the ward environment and you can see whether the service users are happy.
I learn something new every time I do a review both from the professionals on the team and on the review day. I have learnt to make sure all of the documents that are reviewed are in date and to take service users discussions seriously so we can feed back to the ward. This learning helps with other service user involvement that I do. I look forward to attending face to face meetings in 2023.

Katherine Barrett, Patient Representative, Royal College of Psychiatrists



Art work by: Patients on Roseacre Ward, Cygnet Hospital

Foreword

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I have been a RCPsych patient representative since 2004 and I joined AIMS Rehab in 2017 through my activities with the Rehabilitation Faculty. My main role is with the Accreditation Committee. This is interesting work as one learns to contribute more as meetings progress. I endeavour to give a patient perspective in committee meetings and also a general public viewpoint. The business of the committee is somewhat demanding, requiring in depth preparation. We always try to look positively on the services that apply for accreditation and give helpful guidance where it is required.

I also act as a patient representative with the accreditation review teams who visit services around the United Kingdom, to ensure that RCPsych standards are being met. I bring patient perspectives to matters including the physical environment of wards as well as practicalities and care and treatment.

My main role within the team is to facilitate interviews with the inpatients, asking questions from a prescribed questionnaire. Having been a patient myself, I endeavour to create a rapport with interviewees, who may then be able to talk freely with a sense of trust and empathy.

Maurice Arbuthnott, Patient Representative, Royal College of Psychiatrists

Art work developed in collaboration with patients on Clare Ward, Belfast Health and Social Care Trust

Introduction

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS | REHABILITATION QUALITY NETWORK FOR MENTAL HEALTH REHABILITATION SERVICES

The Quality Network for Mental Health Rehabilitation Services works with wards and units to improve the quality of care patients with complex and enduring mental illnesses receive. The network engages staff, patients, and their carers in a comprehensive process of self and peer review to enable services to identify areas of good practice and areas for development. Member services are encouraged to use peer review visits, and other member events, to share knowledge and ideas with others, thereby creating a mutually supportive environment which encourages learning, and leads to positive change.
The network also offers accreditation for those members who can demonstrate a high level of compliance with the standards.
The data presented in this report covers 28 rehabilitation services (24 of which were finalised reports) which were conducted between July 2021 to November 2022. All of these services were reviewed under the 4th Edition standards through a process of data collection of patient, staff and carer questionnaires, health record audits, interviews with patients, carers, staff and service management.
Services are also requested to submit evidence such as policies. Each service is reviewed by a peer review team, consisting of a member of the Rehab project team, two clinicians from participating services, and a patient or carer representative.

There was a lot of variety between services, for example, the breadth or diversity of their geographical coverage, the make-up of their staffing complement, and the interventions offered. This highlighted the importance of standardisation in order to ensure equality of access for patients, but also made apparent just how much our teams have to offer others in the way of experience and innovation.

Outline

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS | REHABILITATION QUALITY NETWORK FOR MENTAL HEALTH REHABILITATION SERVICES

Overview of membership

Membership numbers, location, types of membership, standards used by members, regulatory bodies

Reviews

This report includes data from 2021-2022 reviews, reviewed against the 4th edition inpatient rehabilitation standards. These standards had been published in July 2021 and the report particularly focuses on the 4th edition and provides an overview of the adherence to the 4th editions standards, from 29 services across the United Kingdom and Ireland.
The project team collated data from all 29 services, including 3 developmental and 26 accreditation reviews, to ascertain the pattern and compliance to the 4th Edition Standards.

The project team have conducted a thematic analysis of the unmet standards.

Current developments and future plans

The report presents an overview of the development and publication of the 1st edition community rehabilitation standards. These standards were launched in July 2022 and the project team are currently in the process of supporting community rehabilitation services, in beginning their review process.

4th Edition Standards

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The standards are used to generate a series of data collection tools for use in the self and peer review processes. Participating teams rate themselves against the standards during their self-review. Standards are for service providers and commissioners of mental health rehabilitation services to help them ensure they provide high quality patient-centred care to people with complex mental illness and their carers.
It is recognised that there are a wide range of services within the 'mental health rehabilitation' umbrella which have different functions, purposes, and work with different patient groups. The majority of these standards are applicable to all rehabilitation services, however services will only be measured against the standards that relate to their specific service; other standards will be scored as not applicable. The standards have been developed with extensive consultation with multidisciplinary professionals involved in the provision of inpatient mental health rehabilitation services, and with experts by experience who have used services in the past.

To achieve every standard is aspirational, and it is not expected that a service would meet every standard on the day of their peer-review visit. Every standard has been categorised as either type 1, 2 or 3. To achieve accreditation, services are required to meet 100% of type 1, 80% of type 2 and 60% of type 3 standards.

The Rehab 4th Edition Inpatient Standards are grouped into 5 domains:

Physical Environment
Admission and Discharge
Care and Treatment
Staffing
Service Management

1st Edition Community Rehabilitation Standards

The first edition standards were drawn from key documents and expert consensus, as well as from the fourth edition inpatient standards and work completed within the College Centre for Quality Improvement (CCQI.) The standards have been subject to extensive consultation with multidisciplinary professionals involved in the provision of inpatient and community mental health services, and with experts by experience and carers who have used services in the past.

Who are these standards for?

These standards are for service providers and commissioners of mental health rehabilitation services, to help them ensure they provide high quality patient-centred care to people with complex mental illness and their carers. These standards are designed to be applicable to all community rehabilitation services. It is recognised that there are a wide range of services within the 'mental health rehabilitation' umbrella which have different functions, purposes, and work with different patient groups.

How were these standards developed?

The standards have been developed with extensive consultation with multidisciplinary professionals involved in the provision of inpatient and community mental health rehabilitation services, and with experts by experience who have used services in the past.

The standards were developed in five key stages:

1. Standard mapping – The Rehabilitation project team reviewed the previous edition of inpatient standards alongside key documents and guidelines to create a working sheet, to allow members to comment on existing standards and create new standards for consideration.
2. Electronic consultation – All Rehabilitation members and contacts were provided the opportunity to review the working sheet electronically and provide their ideas and feedback.
3. Standards working group consultation – Member services, experts by experience and members of the Rehabilitation Advisory Group and Accreditation Committee met remotely to review member comments and worked together to make key changes and create new standards, resulting in the first draft of the first edition standards.
4. Advisory Group Review – The Rehabilitation Advisory Group reviewed the first draft created and made changes to key areas where necessary.
5. Review within the CCQI – The standards were then reviewed within the College Centre for Quality Improvement (CCQI) and following consultation with the Rehabilitation project team, were approved for use.

A full copy of this document is available on our website at:
https://www.rcpsych.ac.uk/improving-care/ccqi/quality-networks-accreditation/rehabilitation-services/news-and-events

Membership

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56 Members

England

Ireland

Northern Ireland

Scotland

Wales

Breakdown of memberships

Membership Type	Members
Accreditation	47
Developmental	8
Associate	0

Our members

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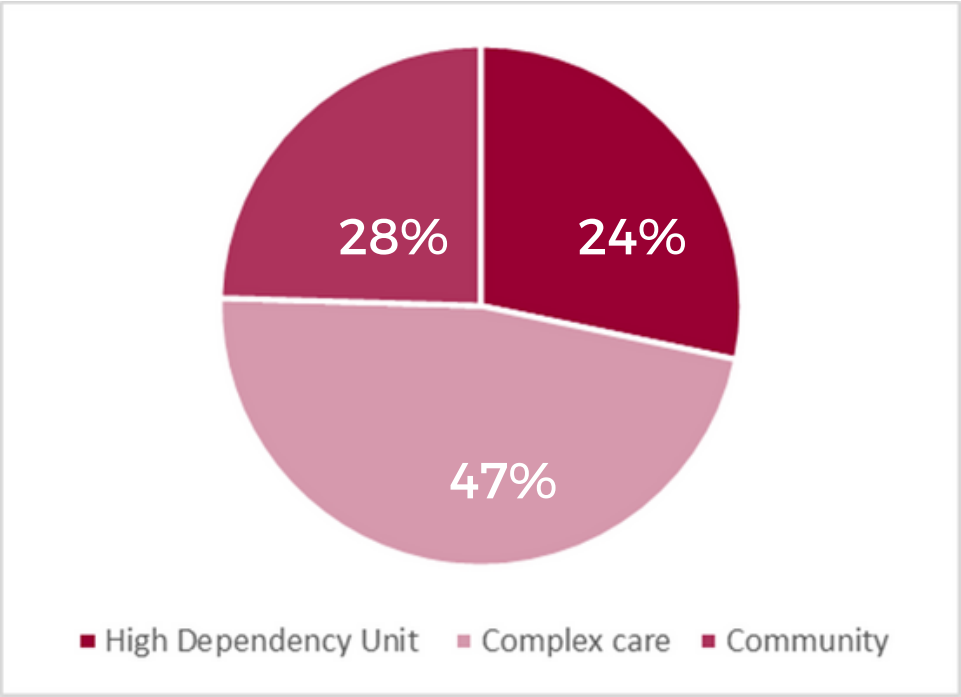
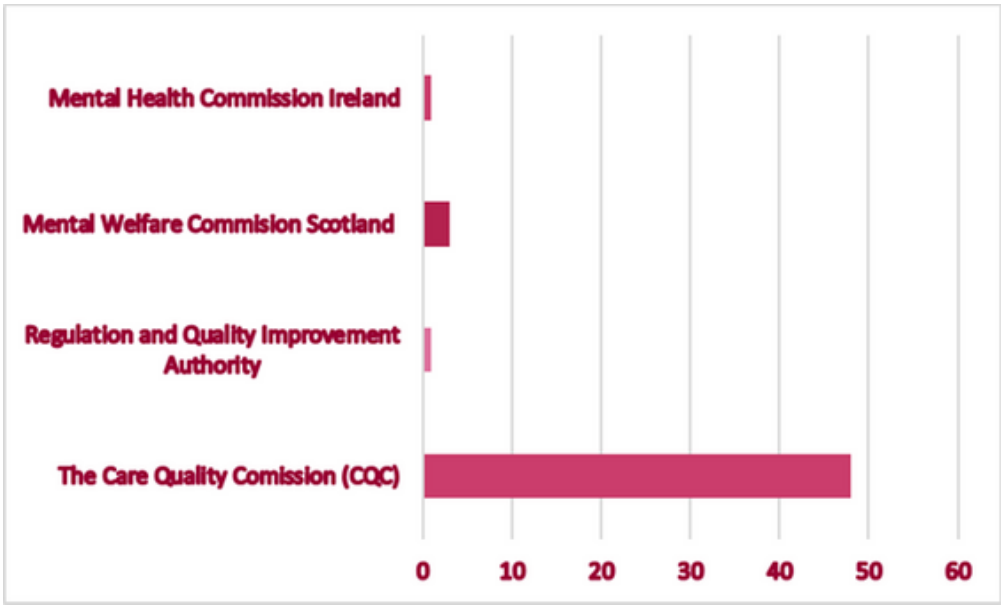


Typology: Please note, 'complex care unit' will not be a term we use moving forward, in rehab services and we must categorise units according to the Royal College of Psychiatrists' typology guide (Appendix, P.45)

Regulatory bodies within our network



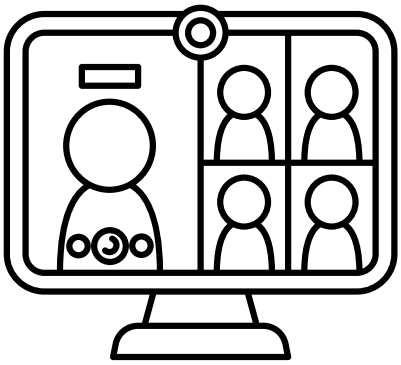
Overview of reviews

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS | REHABILITATION QUALITY NETWORK FOR MENTAL HEALTH REHABILITATION SERVICES

28 Peer Reviews (2021-2022)

4 Developmental Reviews

24 Accreditation Reviews



18 Remote Reviews

10 Face-to-Face Reviews

Contextual data

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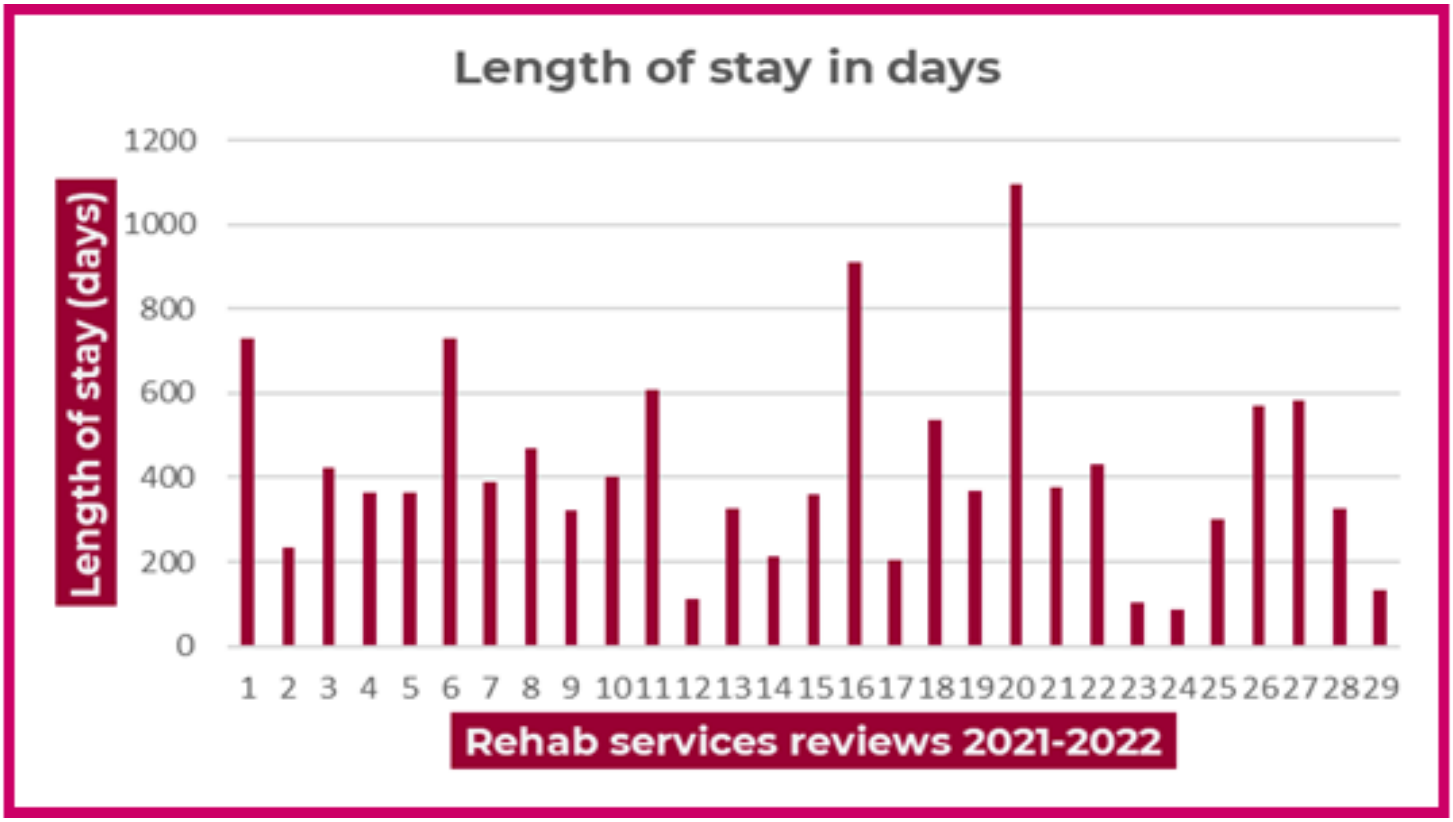
Data taken from the 28 inpatient services' self reviews:

The average number of beds is 16, ranging from 10 to 30 per service



Contextual data

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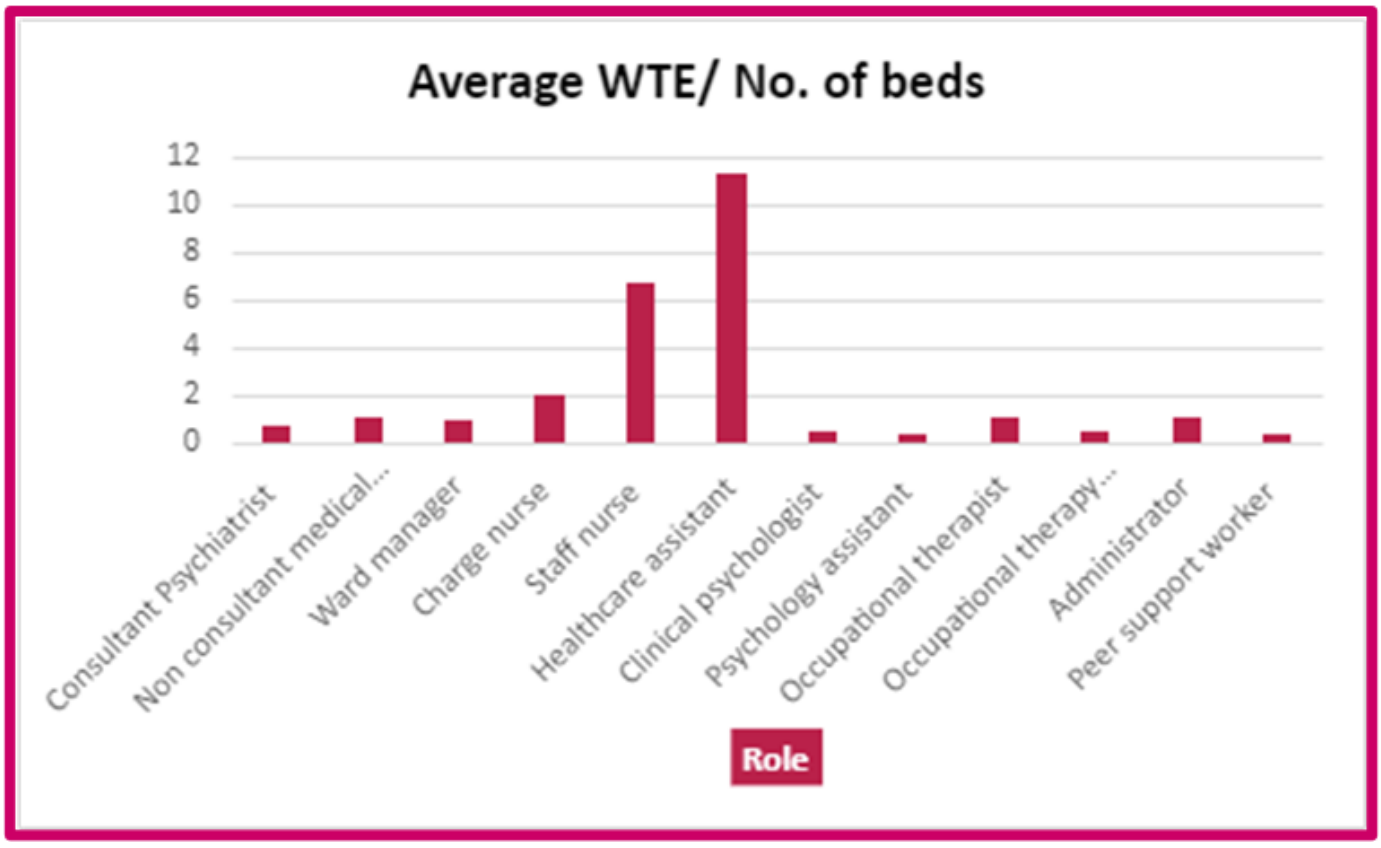
Average WTE of service occupations in relation to numbers of beds



Commonly met Standards

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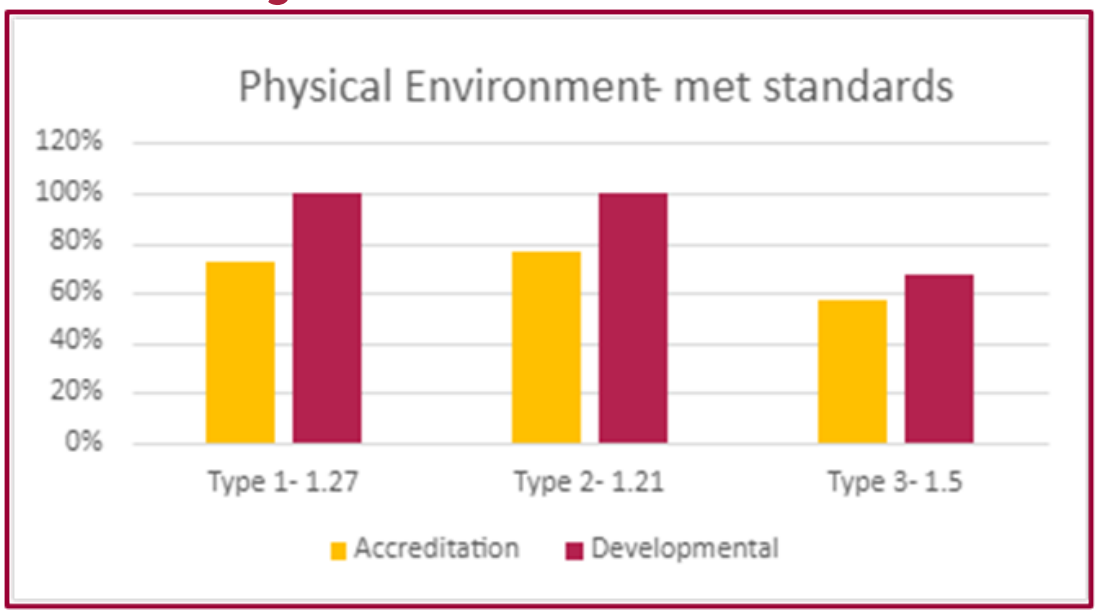
Data taken from the 28 inpatient services' self reviews:

Physical Environment



Across all services the average compliance, for Developmental and Accreditation reviews, was 86%.

Type 1 (1.27)- The ward/unit should have a pleasant environment, ensuring that the ward/unit is not overly clinical and has a therapeutic feel. The average compliance was 86.5%.

Type 2 (1.21)-There are facilities for patients to make their own hot and cold drinks and snacks which are available 24 hours a day.
The average compliance was 88.5%.

Type 3 (1.5)-Every patient has an en-suite bathroom.
The average compliance was 62%.

Commonly met Standards

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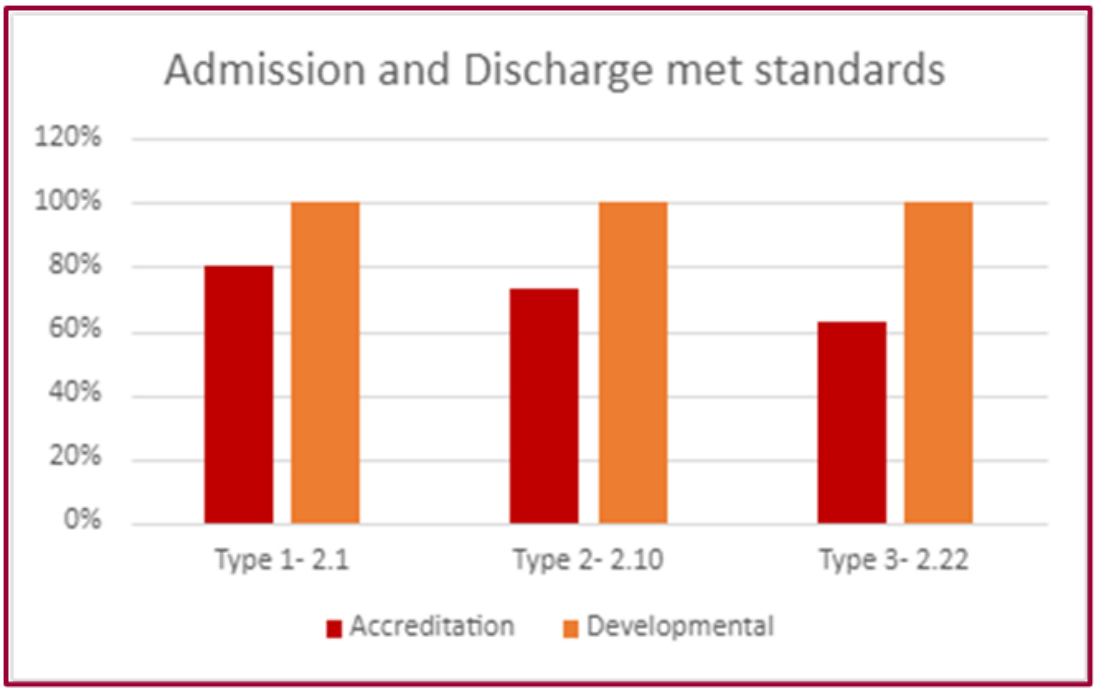
Admission and Discharge



Type 1 (2.1)- On admission to the ward/unit, patients feel welcomed by staff members who explain why they are in hospital.
Guidance: Staff members show patients around and introduce themselves and other patients; Offer patients refreshments; Address patients using the name and title they prefer.
The average compliance was 90%.

Type 2 (2.10) -Patients are able to visit the ward/unit prior to formal admission, allowing them to meet other patients and staff and get to know the unit and its approach better.
The average compliance was 86.5%.

Type 3 (2.22)-The ward team are able to discharge patients into the care of a community rehab team when appropriate.
The average compliance was 81.5%.

Commonly met Standards

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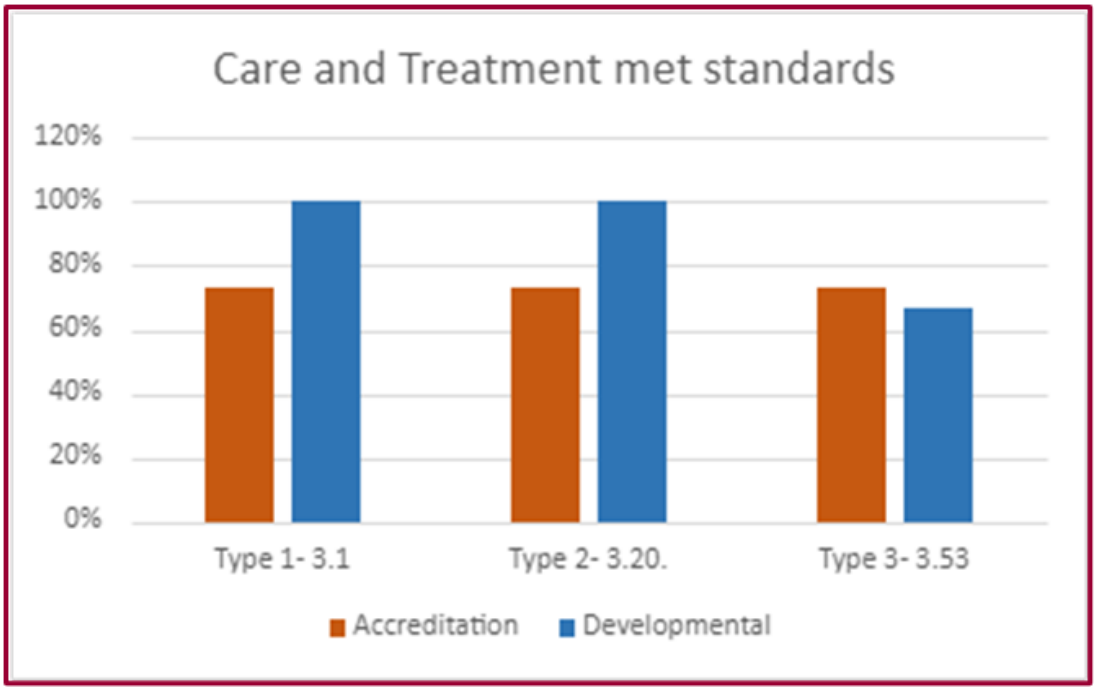
Care and Treatment



Type 1 (3.1)- Patients know who the key people are in their team and how to contact them if they have any questions.
The average compliance was 86.5%.

Type 2 (3.20)-Patients are able to maintain and develop friendships and social networks outside of the hospital environment and have the resources and support to do this remotely when they are unable to leave the unit. The average compliance was 86.5%.

Type 3 (3.53)-The team able to access to supported accommodation services for people leaving hospital including staffed and floating outreach services. The average compliance was 70%.

Commonly met Standards

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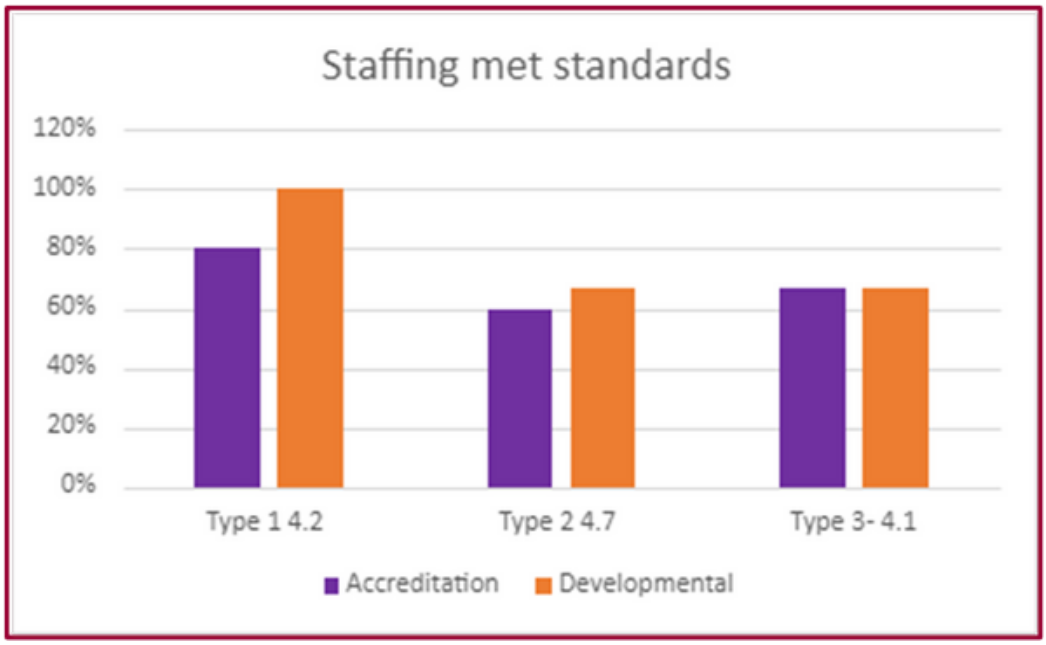
Staffing



Type 1 (4.2)- Staff members feel able to challenge decisions and to raise any concerns they may have about standards of care. They are aware of the processes to follow when raising concerns or whistleblowing. The average compliance was 90%.

Type 2 (4.7)-All staff members receive line management supervision at least monthly.
The average compliance was 63.5%.

Type 3 (4.1)-Staff members are able to access reflective practice groups at least every six weeks where teams can meet together to think about team dynamics and develop their clinical practice.
The average compliance was 67%.

Commonly met Standards

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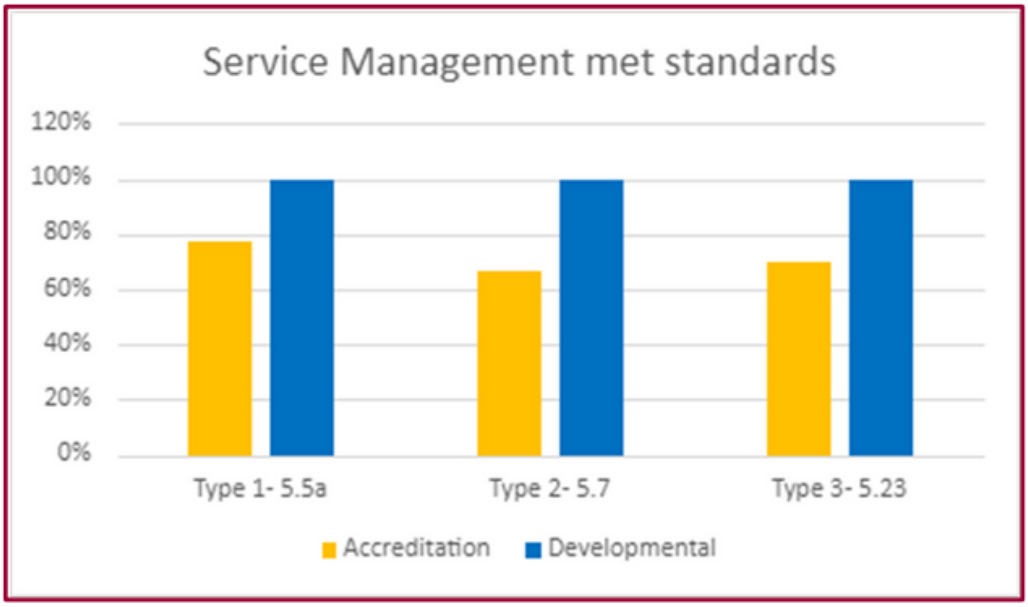
Service Management



Type 1 (5.5a)- A High Dependency Unit, Complex Care Unit or Community Unit that admits detained patients with up to 16 beds has at least one qualified nurse and one unqualified member of staff on shift at all times. The average compliance was 88.5%.

Type 2 (5.7)-The ward/unit has access to:
Vocational trainers, welfare rights specialists and speech and language therapists
The average compliance was 83.5%.

Type 3 (5.23)-Where possible, patients are provided the opportunity to attend and input on any pre-planned meetings regarding them outside ward rounds and MDT meetings.
The average compliance was 85%.

Commonly met Standards

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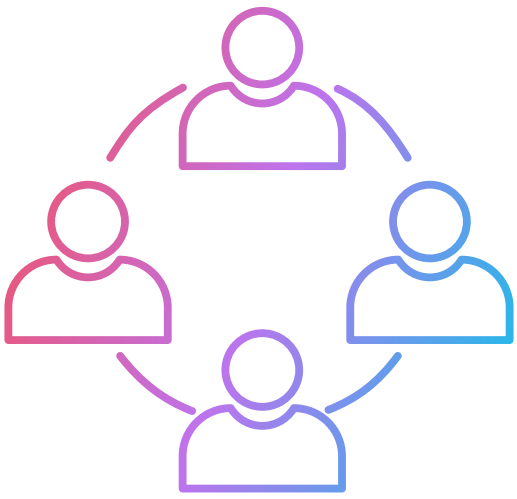
The commonly met standards presented, particularly focusing on the Type 1 standards, highlight that, overall services:

- Have a pleasant environment
- Patients feel welcomed by staff members
- Patients know who the key people are in their team
- Staff members feel able to challenge decisions and feel confident to raise concerns they may have regarding the standards of care
- Units overall meet the standard requirement of; A High Dependency Unit, Complex Care Unit or Community Unit that admits detained patients with up to 16 beds has at least one qualified nurse and one unqualified member of staff on shift at all times.



Commonly unmet Standards

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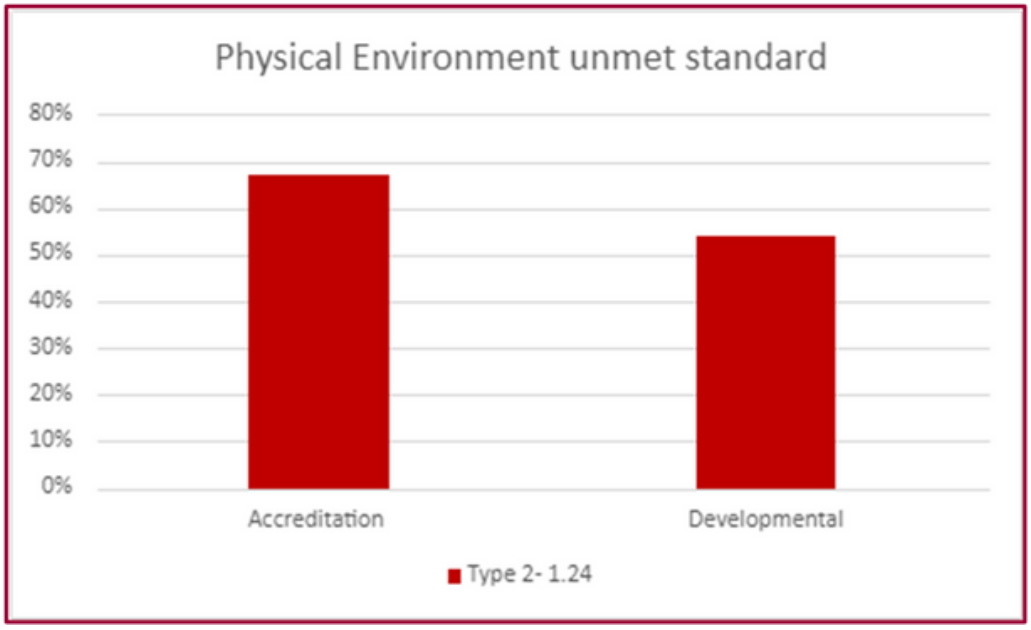
Physical Environment



Type 2 (1.24)-Examples of recovery stories are visible/readily accessible on the ward.

On average, across Accreditation and Developmental reviews, 60.5% of services did not have adequate examples of recovery stories, that were visible or accessible on the ward.

The average unmet scores, for Type 1 and 3 standards were not significant to report.

Commonly unmet Standards

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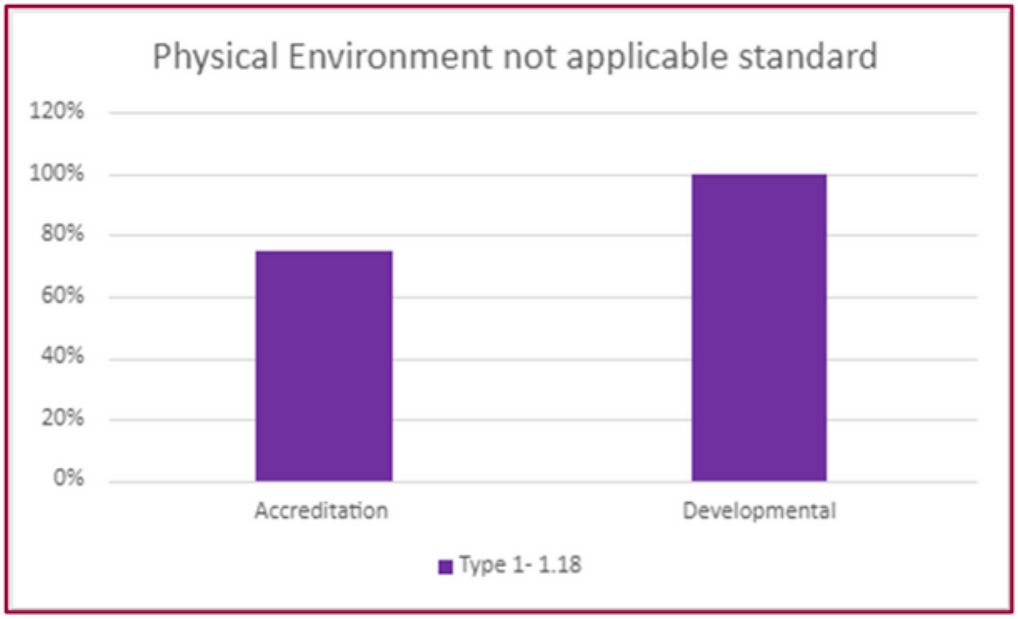
Physical Environment- commonly 'not applicable' scored standard



Type 1 (1.18)-In wards/units where seclusion is used, there is a designated room that meets the following requirements: it allows clear observation, it is well insulated and ventilated, it has adequate lighting, including a window(s) that provides natural light; it has direct access to toilet/washing facilities; it has limited furnishings (which includes a bed, pillow, mattress and blanket or covering); it is safe and secure – it does not contain anything that could be potentially harmful; it includes a means of two-way communication with the team; it has a clock that patients can see

During reviews, 75% Accreditation members and 100% of Developmental members scored 1.18 as 'Not Applicable'.

Majority of rehabilitation members stated that incorporating seclusion spaces in a rehab unit 'contradicted core rehab principles.'

Commonly unmet Standards

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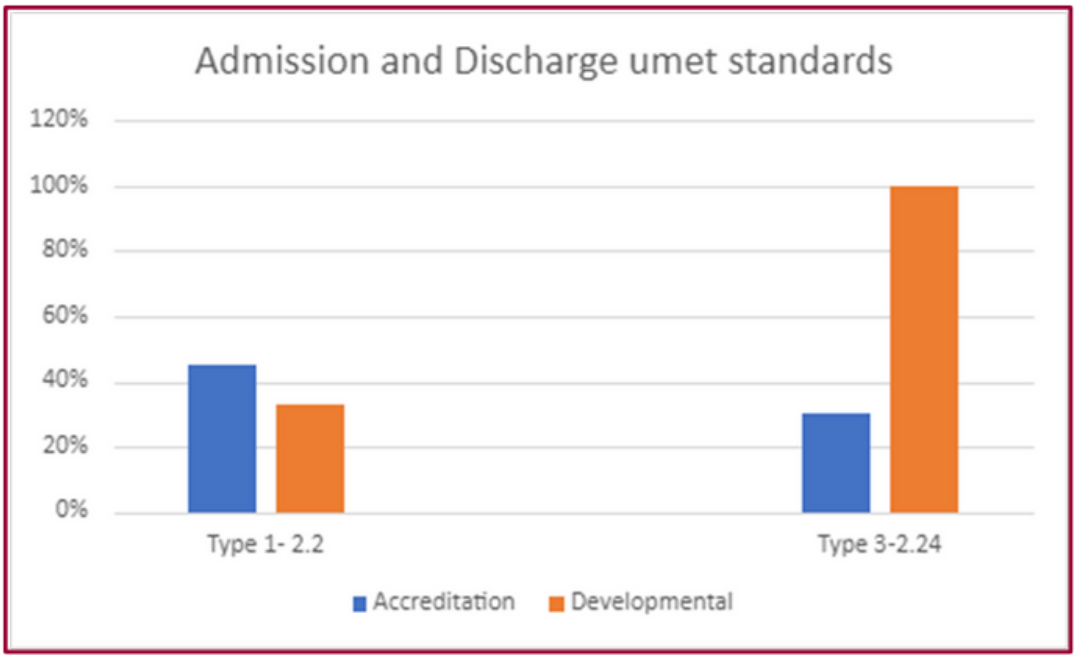
Admission and Discharge



Type 1 (2.2)- The patient's carer is contacted by a staff member (with patient consent) to notify them of the admission and to give them the ward/unit contact details. On average, across Accreditation and Developmental reviews, 39% of services did not contact patient's carers (patient consent), to notify them of the admission.

Type 3 (2.24)-Training is provided to Community Mental Health Teams (CMHTs), other mental health teams and supported housing projects to ensure that they are adequately trained and supported to continue to support the patient in their new placement/circumstances.
On average, across Accreditation and Developmental reviews, 65% of services did not have the resources, to provide training to CMHTs, other mental health teams and supported housing projects.

The average unmet scores, for Type 2 standards were not significant to report.

Commonly unmet Standards

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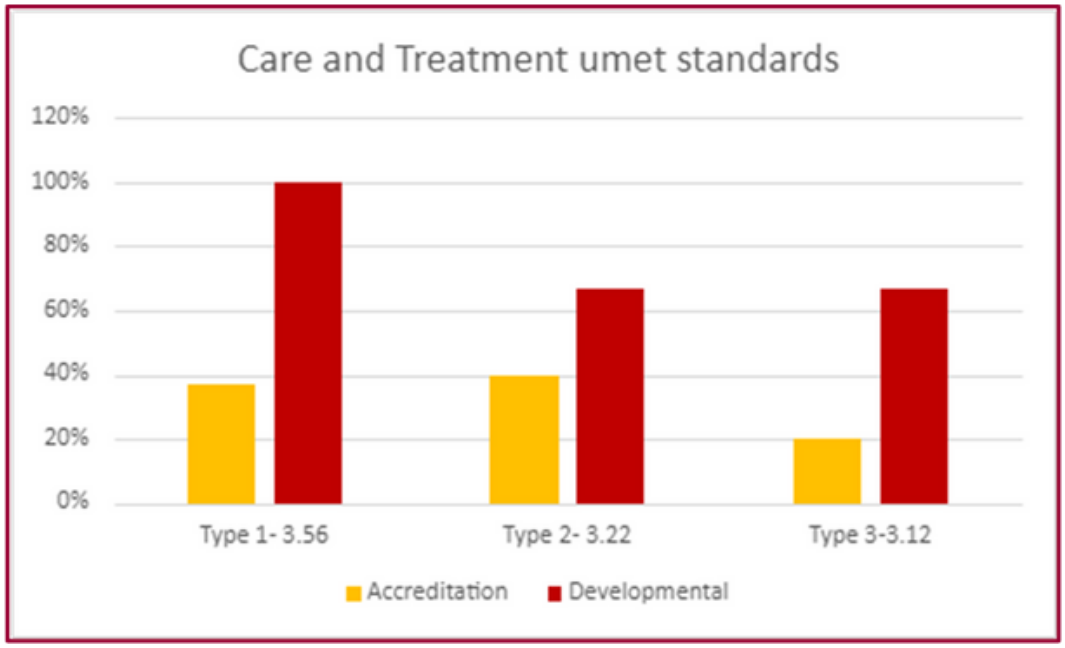
Care and Treatment



Type 1 (3.56)- Carers are supported to access a statutory carers' assessment, provided by an appropriate agency. On average, across Accreditation and Developmental reviews, 68.5%, carers had not been signposted or supported to access a statutory carer's assessment. Within some services, carers were not aware of what a carer's assessment entails.

Type 2 (3.22)-Carers are able to access regular group meetings that have a psychoeducational focus. On average, across Accreditation and Developmental reviews, 53.5%, carers did not have access to regular group meetings with a psychoeducational focus.

Type 3 (3.12)-There is dedicated sessional input from creative therapists. On average, across Accreditation and Developmental reviews, 43.5% did not have dedicated sessional input from creative therapists.

Commonly unmet Standards

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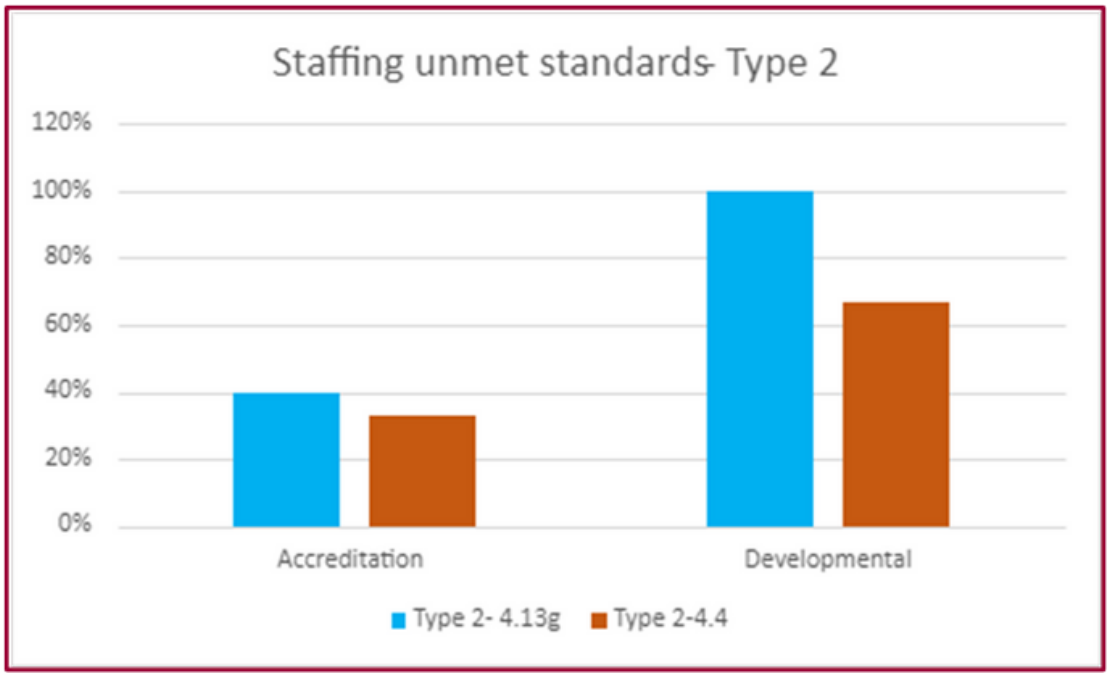
Staffing



Type 2 (4.13g)- Staff members receive training consistent with their role, which is recorded in their personal development plan and is refreshed in accordance with local guidelines. This training includes Carer awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality. On average, across Accreditation and Developmental reviews, 70% of staff were not aware of or had not undertaken carer awareness training.

Type 2 (4.4)- Appropriately experienced patient or carer representatives are involved in the interview process for recruiting potential staff members. On average, across Accreditation and Developmental reviews, 50% of services did not involve experienced patient or carer representatives in staff interview processes. The average unmet scores, for Type 1 and Type 3 standards were not significant to report.

Commonly unmet Standards

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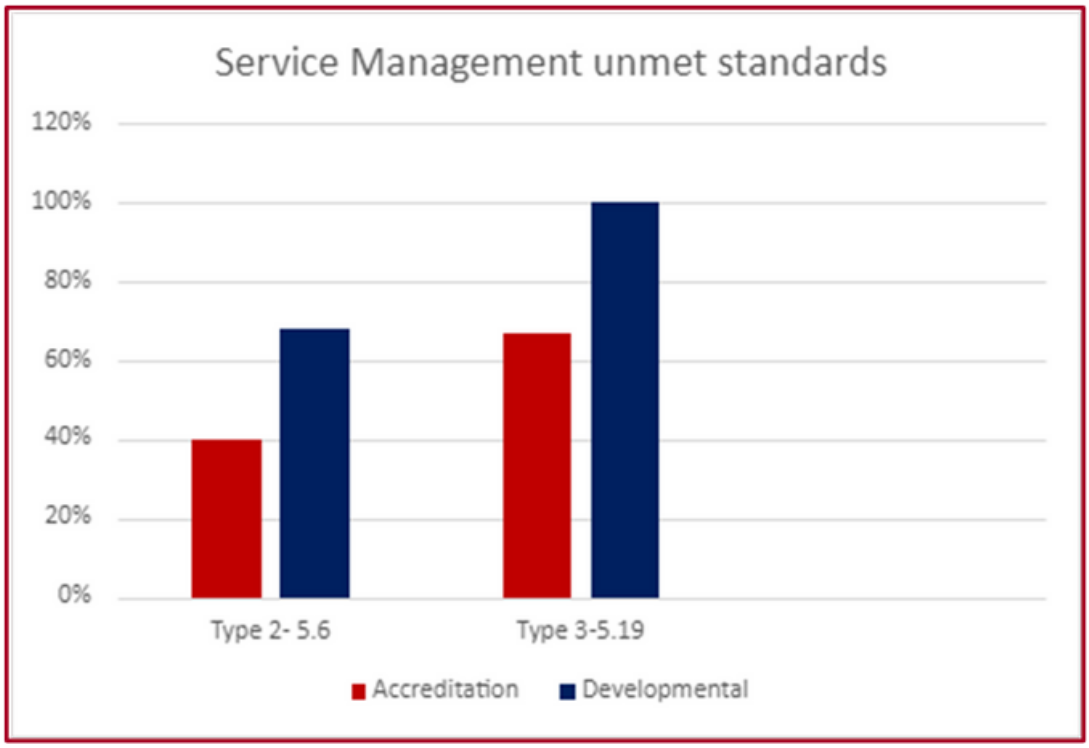
Service Management



Type 2 (5.6)-Input from an activity co-ordinator. On average, across Accreditation and Developmental reviews, 54% of services did not have input from an activity co-ordinator.

Type 3 (5.19)-On a High Dependency Unit, Complex Care unit or Community Unit that admits detained patients with 16 beds has 0.5 WTE registered specialist physiotherapist as part of the Multi-Disciplinary Team (MDT). On average, across Accreditation and Developmental reviews, 83.5% of services did not have 0.5 WTE registered specialist physiotherapist as part of their MDT.

The average unmet scores, for Type 1 standards were not significant to report.

Method and Results

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The process began with the collection of average percentage of unmet standards across 28 inpatient and community, accreditation and developmental services. These were reduced down to only frequently unmet standards (with 'frequently unmet standards' being defined as standards that were unmet by approximately 20% or more).

The project team then grouped the standards into "themes" formulated from the standards description. These themes shed a light on the common aspects of a rehabilitation service that do not meet the 4th edition inpatient standards. The themes are:

Carer engagement and support

This theme contains standards that relate to how a service supports families and/or partners of patients through various methods.

Training provisions for staff and external teams

This theme contains standards which refer to the information, training and supervision provided to staff to help promote excellence and safety within the service.

Utilising Patient and Carer Experience

The standards in this theme relate to how services use lived experience from their past and current patients/carers to impact their service.

Staffing Levels

The standards in this theme relate to services having access to expertise and skills of different professionals to assess, plan and manage care jointly.

Overall results

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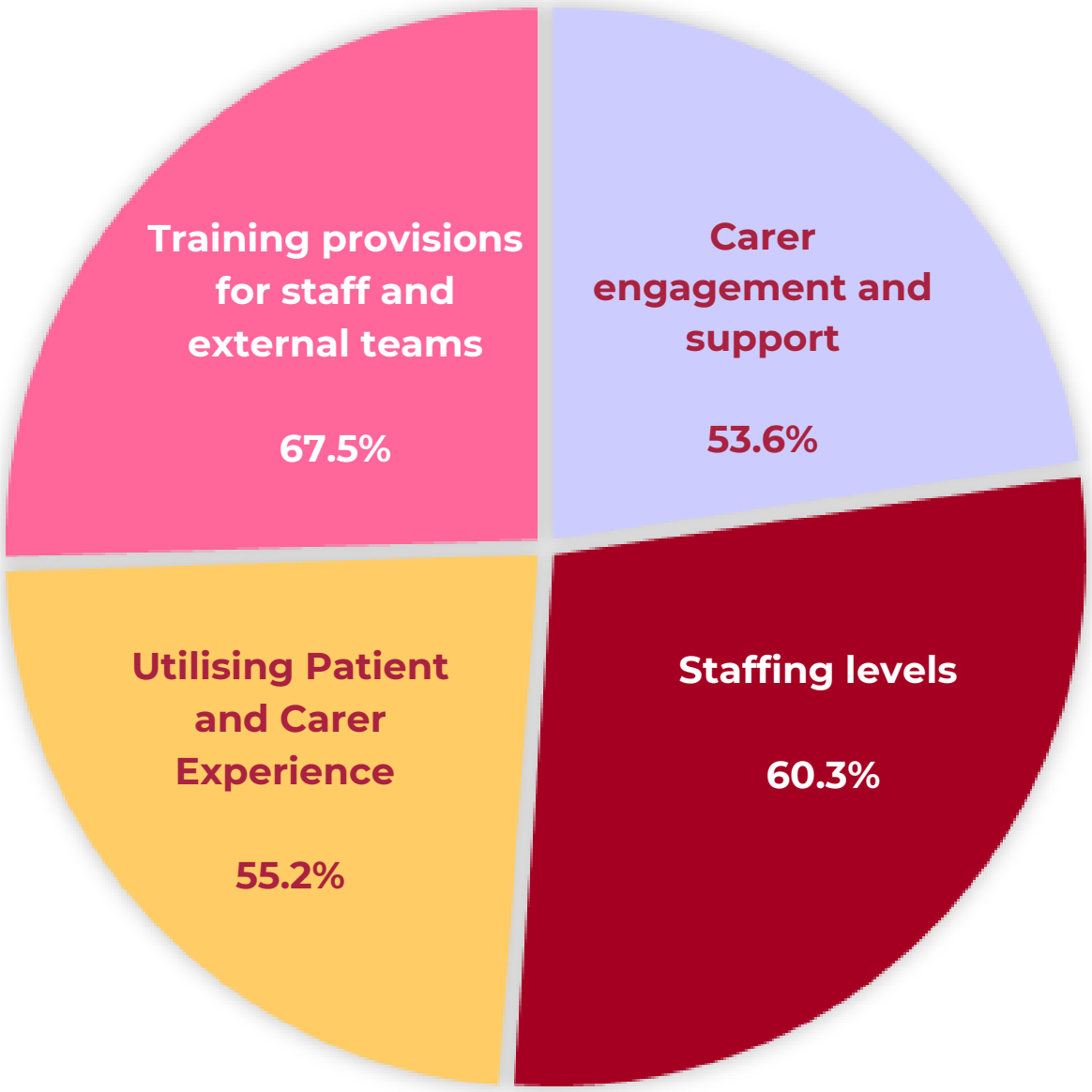

Carer engagement and support

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Carer and Engagement and Support theme relates to how services support patients' families and/or loved ones. Through the analysis, it was found that this comprised 53.6% of all unmet standards.

This highlights a need to integrate carers support within the service as carers can often be overlooked. Carers must be supported, to help with the ongoing pressures of looking after their loved ones.

Recommendations:

Services are encouraged to organise, or re-introduce carers forum, to provide a safe and supportive space for carers. During COVID, there had been a decline in face-to-face contact however, this would be beneficial for carers are some have fed back:

> "Ongoing communication would help for us to understand how we can help"

> "It would be great to touch base with the team"

Carer engagement and support

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For further support, services are also encouraged to contact Donna Bradford,
Head of Carer and Relative Experience at Lincolnshire Partnership NHS Foundation Trust. A Mental Health Nurse of over 30 years, Donna has experience of working in and managing Acute, Rehabilitation and Forensic services and is also a member of the Advisory Group for the Rehab network.
Donna has worked as the Project Manager with Carers Trust Triangle of Care programme previously and still has strong links with them. Donna is passionate about ensuring the carer and relative voice is heard in services.
Also, Donna runs a very successful Carers Education and Support group every fortnight, which always has a guest speaker and the focus is on educating carers about the mental health system and related issues and services. A MH Pharmacist and their third party organisation also attend each time. Carers can ask questions around their loved ones medication and carers who are not known to the third party organisation can receive individual support outside of the group and access a carers assessment.

Donna also runs a successful Carers Council made up of around 12 carers and the role of the Council is to influence the Trust by developing information leaflets, surveys and give opinions on Trust documents. The Trusts CEO also attends the group to ensure that the carers views are heard at the highest level of the Trust. A wide variety of information can be found on the Carers section on the Trust website that have been developed by the Trust's carers.
Donna is also a Meriden Family Therapy trainer and delivers around 4 courses a year. The Trust now has over 100 staff trained to deliver this.

If anyone would like any further information, Donna can be contacted to explain and assist other services: donna.bradford@nhs.net

Utilising Patient and Carer Experience

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This theme relates to how services use lived experience from their current and discharged patients and carers to improve their service. Through the analysis, it was found that this comprised 55.2% of unmet standards.
Patient and Carer experiences are vital perspectives that are required to be embedded in services.

Recommendations:

Services are encouraged to involve patient and carer representatives in the interview process for recruiting staff members.

Also, it would be beneficial for services to actively co-facilitate training, with patient and carer representatives, as some members have noted

> "It is helpful to have both representatives involved, as it provides a well-rounded perspective and opens up conversations."

> "Involving patients in the development and presentation of their recovery stories can be empowering and valuable to a patient's recovery journey."

Training provisions for staff and external teams

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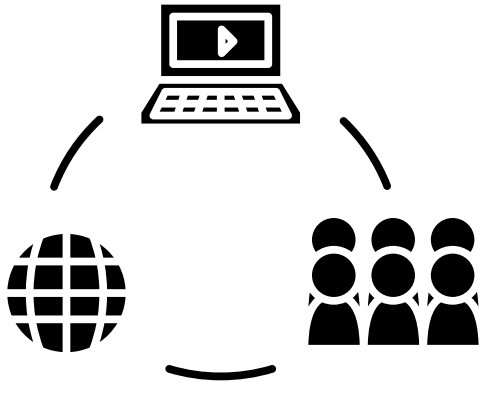
This theme relates to the information, training provided to staff to help promote personal and professional development. Through the analysis, it was found that this comprised 67.5% of unmet standards.

Providing adequate training will improve the quality of care and boosts morale within the service.

Recommendations:

Services are encouraged to review training focusing particularly on carers awareness. Also, it would be beneficial for rehabilitation services to introduce and implement training targeted specifically for community mental health teams (CMHTs) and other mental health teams, that are directly involved in patient's care. This will ensure integration and continuation of care between services.



Staffing Levels

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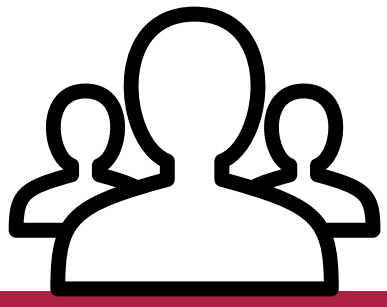
The standards in this theme relate to services having access to skills of different professionals to assess, plan and manage care jointly. Through the analysis, it was found that this comprised 60.3% of unmet standards.

Recommendations:

Services are encouraged to incorporate additional roles i.e. activity co-ordinator, fitness instructor, within the Mult-Disciplinary Teams (MDT) and providing adequate training and support.



Themes: Conclusion

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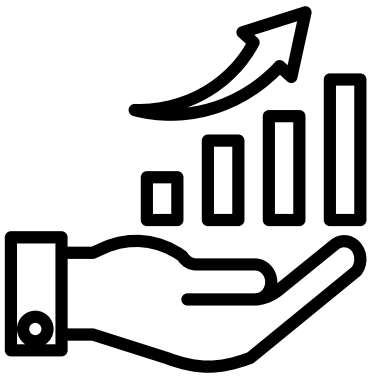
The four themes highlighted from the analysis have hopefully indicated the areas within rehabilitation services, that require improvement.

Two of the four themes are surrounding patient and carers involvement, support and engagement, with the most common being "carer support". These issues could be due to a host of issues, including the effects of the pandemic, which has seen an increase in remote communication, resulting in a loss of meaningful communication.

The last two themes are surrounding training and staffing levels. These could have also been a result of the pandemic, as mental health rehabilitation services across the United Kingdom and Ireland have seen a decrease in staffing levels, as well as, dealing with new ways of working i.e. loss of face-to-face training.

The Rehab Project team thank the organisations that have taken part in the past reviews and hope that services can recognise their achievements, as there has been evidence of great initiatives and systems in place. The care that the services deliver is patient centred and this is recognised as such.

We also hope services can utilise the report to guide future adaptations to protocol and implementation of care they provide.



Support available to members

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QUALITY NETWORK FOR MENTAL HEALTH REHABILITATION SERVICES

We support services through:

Sharing examples of good practice with the network.

Organising and facilitating tailored training/learning events

Regular meetings to support services during their review process

Discussion forums

Newsletters

Resources:

Website: Rehabilitation services | Royal College of Psychiatrists (rcpsych.ac.uk)

Knowledge Hub: Welcome - Knowledge Hub (khub.net) |

Looking Ahead: 2023

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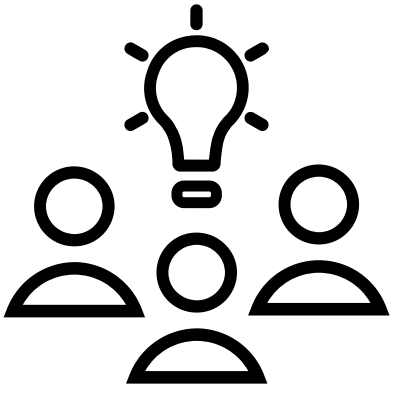
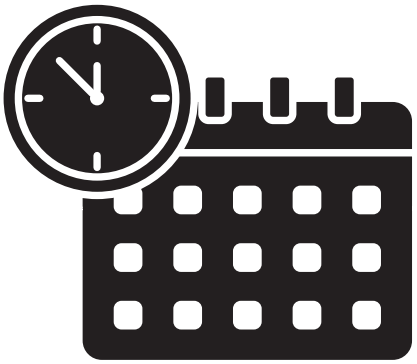
We are looking forward to working with our existing and new developmental, associate and accreditation members.
Having worked with services who have been through reconfigurations, we are aware that there are a growing number of specialist rehabilitation services, hence will work towards supporting services through:

- Organising a webinar focusing on carer engagement and support, supported by Donna Bradford, Head of Carer and Relative Experience for Lincolnshire Partnership NHS Foundation Trust.
- Ongoing face-to-face and remote reviews, for our inpatient and community rehabilitation members.
- Supporting services working with the first edition community rehabilitation standards
- Conducting Special Interest Days
- Facilitating peer reviewer training days
- Attending and presenting at wider external events i.e. Joint Congress of the World Association of Social Psychiatry and the Faculty of Rehabilitation and Social, Royal College of Psychiatrists
- Introducing feedback mechanisms covering all aspects of membership to shape innovation to members' needs.



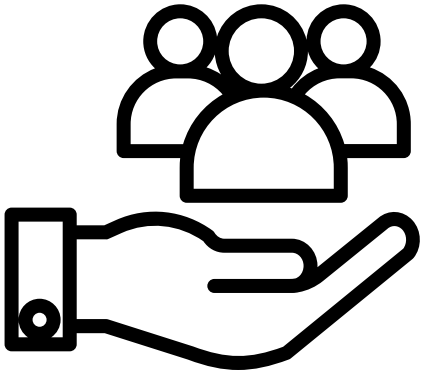


Conclusion

The Quality Network for Mental Health Rehabilitation Services is stronger than ever. The healthy membership base is continually expanding and participation in events and reviews is increasing. New membership types are allowing more services to participate and a new set of standards is enabling the network to measure quality improvements over time.

However, there is still more work to be done. We have seen few services withdraw due to service reconfiguration and there is anecdotal evidence of a trend throughout England, at least, for trusts and commissioners to re-evaluate the way that rehab services are being commissioned and delivered. This will not be a surprise to many working within the field and makes it even more important that there are strong messages about the value of providing good quality, effective rehab services.

The network will continue to expand its profile and support services in this endeavour.



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Service users co- produced artwork

Westways Rehabilitation Unit
South London & Maudsley NHS Foundation Trust

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' Light at the end of the bricked up tunnel '

Service user produced artwork

Sheffield Health and Social Care NHS Foundation Trust

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Artwork created by patients on Cygnet Hospital,
Cygnet Healthcare

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Artwork co-produced by patients on Clare Ward,
Belfast Health and Social Care Trust

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To find out more about the quality network and how to join, visit our website:

www.rehab@rcpsych.ac.uk/rehabilitation-services

Or contact a member of our team:

Quality Network for Mental Health Rehabilitation Services

Rehab The Royal College of Psychiatrists
21 Prescot Street London E1 8BB

rehab@rcpsych.ac.uk

0208 618 4113

Appendix: List of services involved

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- Cygnet Healthcare
- South London and Maudsley NHS Foundation Trust
- Central and North West London NHS Foundation Trust Oxford Health NHS Foundation Trust
- Making Space
- Highfield Healthcare
- NHS Highland
- Coventry & Warwickshire Partnership Trust
- Sheffield Health & Social Care NHS Foundation Trust
- Oxleas NHS Foundation Trust
- Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust
- Belfast Health and Social Care Trust
- Cornwall Partnership NHS Foundation Trust
- Priory Group
- Somerset Foundation Trust
- Lincolnshire Partnership NHS Foundation Trust

Evidence Guidance

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Throughout accreditation review processes, it was noted that some standards were regularly scored as unmet, due to incorrect or insufficient evidence submission.
Below are some suggestions and advice for services regarding evidence guidance.

- **Label all evidence** – Please label each document with the relevant standard number.
- **Redact all evidence** – Please ensure you have fully redacted all documents of any identifying information (this includes patients and staffs' full names). Anything that is not fully redacted will be sent back.
- **Your Response** - Providing a short, written response to each standard scored as 'not met' along with evidence is helpful for the committee. This gives you the chance to explain the evidence provided in your own words, or any inaccuracies in the report.
- **Training Standards** – If you need to provide evidence in relation to any standards about training, it is advisable to provide this in a matrix format. Where training is out of date you should provide evidence of training having been booked for the near future. The Project Team have a matrix template – if you have not received this please request this from the team.
- **Patient Notes** – Some of the standards are best evidenced from health records/patient notes e.g. standards from the 'Admission and Discharge' and 'Care and Treatment' sections. If you have 'not met' a standard that would be traditionally evidenced using patient notes the committee request that the service provides 1 example from patient notes (redacting identifying information) and an audit to show that this has been completed in each record. If you are sending a long document (e.g. minutes from a meeting or long care plan, please highlight the relevant sections).
- **Policies** – Policies must be ratified (not in draft format) and up to date. If this isn't possible it is advisable to provide email evidence that this has been flagged to the relevant people or include this in your service response.
- **If in doubt** – use the discussion forum to get advice from other members or ask the project team for advice. We're happy to help!

Please note that while the project team can provide advice/suggestions, the Accreditation Committee is responsible for scoring standards and decisions regarding whether evidence is sufficient to meet the standard

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QUALITY NETWORK FOR MENTAL HEALTH REHABILITATION SERVICES

Mental Health Rehabilitation Services Typology Table

Faculty of Rehabilitation & Social Psychiatry

Royal College of Psychiatrists

March 2019

	High Dependency Rehabilitation Unit	**Community Rehabilitation Unit**	**Longer Term High Dependency Rehabilitation Unit**	**Highly Specialist High Dependency Rehabilitation Unit**	**Low Secure Rehabilitation Unit**
Client group	Severe symptoms, (multiple) co-morbidities, significant risk histories, ongoing challenging behaviours. Most referrals (80%) come from acute inpatient units, and 20% from forensic units. Most patients detained under MHA.	Ongoing complex needs so cannot be discharged directly from high dependency rehab unit to supported accommodation. Most referrals from high dependency rehab unit or acute inpatient unit. Can take detained patients if registered as a ward (may have CTO/S41 patients if not registered as ward).	High levels of disability from treatment refractory symptoms and/or complex co-morbid conditions that require longer period of inpatient rehabilitation to stabilise. Significant associated risks to own health/safety and/or others. Most referrals from high dependency rehab unit. Most patients detained under MHA.	Specific co-morbidities that require very specialist approach e.g. psychosis plus traumatic brain injury, degenerative neurological disorder or Autism Spectrum Disorders. Challenging behaviour is often a significant issue. Most referrals from acute inpatient units and other inpatient rehabilitation units. Most patients detained under MHA.	History of offending and/or severe challenging behaviour. Most referrals from medium secure or other components of forensic system. All patients detained under the Mental Health Act (usually Part 3).
Commissioned by	Local Clinical Commissioning Groups (CCG)	CCGs	CCGs	NHSE (individual places can be commissioned by CCGs)	NHS England.
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), psychosocial interventions (CBT, family work), gaining skills for more independent living including ADLs and community activities (leisure, vocational).	To stabilise symptoms and challenging behaviours adequately such that function improves and move on to a less supported component of the rehabilitation pathway becomes feasible. Interventions as for high dependency and community rehabilitation units but in a highly supported setting.	To stabilise symptoms and challenging behaviours adequately such that function improves and move on to a less supported component of the rehabilitation pathway becomes feasible. Managing challenging behaviours and physical aspects of co-morbidities are most common areas for intervention.	Assessment and management of risk alongside complex mental health problems. Includes therapeutic 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	Move on to community rehabilitation unit or supported accommodation.	Move on to a specialist, long term supported accommodation facility.	Move on to high dependency rehabilitation unit, community rehabilitation unit or supported accommodation.
Location	Usually hospital based	Community based	Usually hospital based	Hospital based	Hospital based regional secure services
Length of stay	Up to 1 year	1-2 years	1-3 years (can be longer – variable)	2+ years	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, but ADL skills encouraged through OT	Domestic services provided. Physiotherapy, speech and language therapy and OT provided to improve all aspects of functioning	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.	Controlled access. Higher staffed, full MDT May have air lock and higher staffing than standard HDRU if target client group require this.	Usually controlled access. Higher staffed, full MDT plus physiotherapy and SALT. Unlikely to need airlock.	Controlled access with air lock. High staffing with MDT. Specialist physical, procedural and relational security skills and facilities.
Provision per population*	Every Trust. One unit per ~300,000.	Every Trust. One unit per ~300,000.	Every Trust. One unit per ~600,000	Regional One unit per ~1m	Regional. One unit per ~1m

*** Local provision should be based on the Joint Strategic Needs Assessment and will thus vary according to local morbidity (e.g. prevalence of complex mental health problems) and the availability of other components of the rehabilitation pathway**