Health Overview Scrutiny Committee Report 21st July 2026
Cllr Bakul Kumar

Two items on the agenda:

- Adult Mental Health Rehabilitation Redesign
- End of Life Care

Adult Mental Health Rehabilitation Redesign

1. Programme Purpose

- Modernise adult mental health rehabilitation services across Herefordshire & Worcestershire.
- Ensure nationally standardised, evidence-based, high-quality care with consistent patient experience.
- Align inpatient rehabilitation with the Community Mental Health Transformation completed in 2024.
- Embed purposeful admission: every hospital stay has clear aims, timelines, and a safe discharge plan.

2. National Drivers

- Guided by **NHSE Commissioner Guidance (2024)** and **Royal College of Psychiatrists GIRFT** programme.
- GIRFT review identified areas for improvement:
    - Better use of data
    - Integrated rehabilitation systems
    - Workforce development
    - Standardised procurement
    - Continuous quality improvement

3. Programme Objectives

- Reduce unwarranted variation in rehabilitation services.
- Serve patients **locally**, reducing out-of-area placements.
- Create clear, evidence-based treatment pathways understood across providers.
- Establish a **Community Rehabilitation Team** aligned with inpatient services.
- Support NHS 10-Year Plan: *"From hospital to community."*
- Eliminate high-cost agency staffing.
- Strengthen co-production and person-centred care.
- Improve workforce skills, sustainability, and staff experience.
- Review and modernise the mental health estate.
- Deliver a **sustainable, efficient service** through best use of resources.

4. Current Provision

- Three rehabilitation units:
    - **Oak House (Hereford)** – 8 beds
    - **Keith Winter House (Bromsgrove)** – 15 beds
    - **Cromwell House (Worcester)** – 10 beds
- Typical admission: **up to one year**, focused on regaining life skills, confidence, and independence.

5. Redesign Process & Engagement

- Initial 7 ideas → reduced to 4 through hurdle criteria.
- None passed desirable criteria → Nominal Group Ranking used.

6. Preferred Option (Identified & Supported)

- Deliver rehabilitation as a **complete pathway**:
    - **Level 1 inpatient rehabilitation** (local)
    - **Level 1 community rehabilitation**
    - **Level 2 rehabilitation** (higher-intensity, sourced regionally)

- **Level 1 beds centralised in Worcestershire** for both counties.
- **Closure of Cromwell House and Oak House.**
- Creation of an **Enhanced Community Rehabilitation Team**.
- Level 2 provision via **block booking** or **West Midlands procurement framework**.

7. Programme Timeline
Phase 1–2 (2023–2024): Idea development, governance, criteria testing — *Complete* **Phase 3 (2024–July 2026):** Engagement, modelling, option appraisal — *In progress* **Phase 4 (Aug 2026–Jan 2027):** Clinical Senate review, NHSE Stage 2 checkpoint — *Not started* **Phase 5 (Mid-2027 onwards):** Public consultation, mobilisation, implementation — *Not started*
8. Next Steps

- Submit Pre-Consultation Business Case to **Clinical Senate**.
- NHSE Stage 2 Gateway (Nov 2026).
- **Public consultation** likely early 2027 (12 weeks).
- Mobilisation planning mid-2027.

End of Life Care

1. Context & Demographics

- Worcestershire has an **ageing population**, with rapid growth in the 75+ and 85+ cohorts.
- *"The number of people aged 85+ is set to nearly double… by 2045."*
- Frailty and end-of-life patients drive **disproportionate emergency admissions**, long hospital stays, and avoidable harm.

2. Strategic Aim

- Shift from **acute hospital reliance** to **proactive, personalised, community-based care**.
- Early identification, anticipatory planning, and coordinated neighbourhood-level support.
- Enable people to remain independent longer and receive care in their **preferred place of residence**.

3. National Frameworks & Targets

- **NHS Medium Term Planning Framework** & **Neighbourhood Health Framework**:
  - +10% increase in identifying people approaching end of life.
  - –10% emergency admissions and bed days for frailty/EoL cohorts.
- **Ambitions for Palliative & End of Life Care (2021–2026)**:
  - Each person seen as an individual
  - Fair access
  - Comfort & wellbeing
  - Coordinated care
  - Skilled workforce
  - Community involvement

4. Local Strategy (2025–2030) – 8 Key Outcomes

- Earlier identification of people in their last year of life.
- High-quality personalised advance care planning.
- Equitable access to services.
- **24/7 single point of access** for advice and support.
- Skilled workforce across specialist and generalist care.
- Strong patient/carer voice in service improvement.
- Digital innovation (e.g., shared records, ReSPECT).
- Strong, inclusive leadership across the ICS.

5. Delivery Progress (Oct 2025 – May 2026)

- **28,235** frailty assessments completed.

- **1,706** Comprehensive Geriatric Assessments.
- **1,685** advance care planning discussions offered.
- **322** patients added to the EoL register.
- *"Patients spend up to 26% of their last 90 days in hospital."*

6. Major Programmes Underway

Gold Standards Framework (GSF)

- Rolling out across acute & community wards (full accreditation by 2029).
- Supports early identification, coordinated care, and quality assurance.

Digital ReSPECT

- Shared emergency care plans across settings.
- Reduces unwanted interventions and supports preferred place of care.

COMPASS Model

- Specialist palliative clinicians embedded in Emergency Departments.
- Rapid community support to **avoid unnecessary admissions**.
- Integrated with Hospital at Home teams.

24/7 End of Life Phoneline

- Specialist clinical advice for patients, carers, and professionals.
- Aims to reduce hospital deaths and increase home/care-home deaths.

7. Neighbourhood Health Delivery Framework

- 21-month programme across all 15 PCNs.
- Focus on proactive, personalised care for severe frailty and EoL cohorts.
- MDT reviews, medication optimisation, extended appointments, named coordinators.