Item: 16

NHS
North East and North Cumbria

REPORT CLASSIFICATION	✓	CATEGORY OF PAPER	✓
Official	✓	Proposes specific action	
Official: Sensitive Commercial		Provides assurance	
Official: Sensitive Personal		For information only	✓

BOARD

25 NOVEMBER 2026

Report Title:	**Adult Mental Health Out-of-Area Placements and the Future Commissioning of Locked Rehabilitation**

Purpose of report

The Medium-term Planning Framework requires all Integrated Care Boards (ICBs) to work towards commissioning services in line with the national Inpatient Commissioning Framework from 2027/28, including the ambition to end out-of-area placements and the use of locked rehabilitation by March 2028.

This paper provides the Board with assurance on the current position in relation to adult mental health, learning disability and autism out-of-area and locked rehabilitation placements. It sets out the ICB's strategic direction and seeks the Board support for a planned and phased transition away from the routine commissioning of locked rehabilitation services. This approach recognises the national direction of travel while ensuring that change is progressed safely and realistically, with alternative provision developed at sufficient scale and pace to meet individual clinical need and maintain quality, safety and continuity of care.

Key points

- The ICB maintains comprehensive oversight of people placed out-of-area and those receiving inpatient care in settings that do not align with the ICB's three-year transformation intentions.
- The ICB's strategic direction is to reduce and ultimately cease the routine commissioning of locked rehabilitation services. Locked rehabilitation should not be regarded as a default or long-term destination within adult mental health pathways, with greater emphasis placed on local, least restrictive and needs-led alternatives.
- This represents a clear direction of travel rather than an immediate blanket cessation of commissioning. Decisions for people currently in services, and for any future admissions, must remain person-centred, clinically led and lawful, reflecting individual need, risk, choice and circumstances.
- Existing placements will be carefully transitioned and will occur only where an appropriate and sustainable alternative has been identified, commissioned and mobilised.
- Achieving this ambition will require planned investment and service development across the wider pathway, including community rehabilitation, housing and supported accommodation, crisis alternatives, local specialist inpatient provision and discharge support. The pace of change should therefore be aligned with the development and mobilisation of these alternatives.
- The ICB recognises that a small number of people may continue to require highly specialist inpatient provision due to factors including forensic pathways, Mental Health Act or Ministry of Justice restrictions, safeguarding considerations or particularly complex clinical needs. These cases should be exceptional, regularly reviewed and supported by appropriate senior oversight.
- The ICB will continue to work towards ending avoidable adult mental health out-of-area placements by March 2028 while recognising that not every placement outside the ICB footprint will necessarily represent an inappropriate placement. There may remain circumstances where an out-of-area placement is clinically appropriate because of individual choice, specialist need, legal restrictions or other person-specific circumstances.

Risks and issues

- Premature withdrawal of locked rehabilitation capacity before alternatives are available could result in unsafe discharge, delayed transfer of care, increased pressure on acute or secure services, or unintended out-of-area placements.
- Community alternatives must be further developed as a whole pathway and will require sufficient multidisciplinary clinical capacity alongside suitable housing and supported accommodation, social care, responsive crisis provision and sustainable funding. These components will need to continue to develop in a coordinated way.
- Not all discharge and transfer timescales are within the ICB's control. Some people currently receiving care are subject to Part III of the Mental Health Act or Ministry of Justice restrictions. Legal and statutory requirements may therefore appropriately determine or influence the timing and nature of discharge or transfer.
- A categorical commitment to end every locked rehabilitation placement could conflict with individual clinical need, safeguarding requirements and the importance of maintaining appropriate family and community connections.
- Quality risks within existing provision must continue to be actively managed during transition. Small stand-alone inpatient units may present challenges in relation to workforce resilience, clinical sustainability and the risk of closed cultures. These risks require robust quality surveillance while services continue to be commissioned.
- Financial savings should not be assumed in advance. Investment may be required before inpatient capacity can be safely reduced. Financial benefits are dependent on successful pathway redesign and subsequent reductions in inpatient utilisation.

Assurances and supporting documentation

- Comprehensive patient-level oversight will be maintained, including regular review of clinical need, quality and safety, legal status, barriers to discharge and the individual's wishes and preferences.
- No placement will be ended without an individual transition plan and confirmation that the receiving service can safely meet assessed need.
- A phased implementation plan will be developed with NHS and independent-sector providers, local authorities, housing partners, clinical leaders, people with lived experience and families.
- Future commissioning and decommissioning decisions will be supported by quality, equality, clinical and financial impact assessments, with clear escalation arrangements where safe alternatives are not available.
- Progress will be subject to established ICB and provider governance arrangements, including exceptions, emerging risks, delays, pathway capacity and any continued use of locked rehabilitation.

Recommendation/action required

The Board is asked to:

- **note** the current position and the assurance provided in relation to out-of-area and locked rehabilitation placements;
- **support** the strategic intention to progressively reduce reliance on, and ultimately cease the routine commissioning of locked rehabilitation services;
- **endorse** a phased, clinically led and person-centred approach to implementation, with the pace of change determined by the availability of safe, appropriate and sustainable alternatives.
- **recognise** that a small number of people may continue to require inpatient provision where this is justified by individual clinical need, safeguarding considerations, patient choice or legal restrictions and;
- **request** a system implementation plan setting out milestones, required alternative provision, financial and workforce implications, quality safeguards and reporting arrangements;
- **support** the principle that no placement should be ended solely to meet the March 2028 ambition.

Acronyms and abbreviations explained	
ICB – Integrated Care Board NENC – North East and North Cumbria NHS – National Health Service PICU – Psychiatric Intensive Care Unit	
Sponsor/Approving Chief Officer	Jacqueline Myers, Chief Operating Officer
Date approved by Chief Officer	19 November 2026
Report author	Lee Anderson, Head of Commissioning

Link to ICP strategy priorities	
Longer and Healthier Lives	✓
Fairer Outcomes for All	✓
Better Health and Care Services	✓
Giving Children and Young People the Best Start in Life	

Relevant legal/statutory issues						
Mental Health Act 2025 and associated statutory requirements; Human Rights Act 1998; Equality Act 2010; Care Act 2014; Mental Capacity Act 2005; and relevant national commissioning and inpatient quality guidance. Individual legal advice and statutory decision-making will continue to apply where required.						
Any potential/actual conflicts of interest associated with the paper?			**No**	✓	**N/A**	
Equality analysis completed	**Yes**		**No**	✓	**N/A**	
If there is an expected impact on patient outcomes and/or experience, has a quality impact assessment been undertaken?	**Yes**		**No**	✓	**N/A**	

Essential considerations	
Financial implications and considerations	A detailed financial assessment is required. The transition may require upfront investment and double-running costs while community, housing and local specialist alternatives are developed. Savings should not be assumed until safe service changes have been implemented and independently tested.
Contracting and Procurement	The commissioning implications are material. Contractual arrangements should support a managed reduction in reliance on locked rehabilitation, avoid creating perverse incentives for long stays, maintain continuity for existing patients and permit exceptional use where clinically and legally justified.
Local Delivery	Local delivery arrangements will need to align inpatient, community, housing, social care and crisis services around an agreed implementation plan.
Digital implications	None
Clinical involvement	Clinical leadership is essential. Patient-level decisions must remain multidisciplinary, evidence-based and subject to appropriate legal and safeguarding processes.
Health inequalities	People placed at distance from home or in restrictive settings may experience poorer access to family, advocacy and local services. The transformation programme should monitor differential impacts and ensure reasonable adjustments and culturally appropriate support.

Patient and public involvement	People using services, families and carers should be involved in pathway design and in individual transition planning. Advocacy must be available where required.
Partner and/or other stakeholder engagement	Implementation will require joint work with NHS Foundation Trusts, independent-sector providers, local authorities, housing partners, Ministry of Justice stakeholders where relevant, advocacy services and people with lived experience.
Other resources	Not applicable

1. Introduction

The Commissioning Framework for Mental Health Inpatient Services (2024) www.england.nhs.uk/long-read/commissioning-framework-for-mental-health-inpatient-services/ establishes a clear expectation that local strategies address how systems will cease sending people to inpatient services at distance from home and move away from outdated or higher risk models of provision. This direction applies across both acute and rehabilitation pathways.

Delivering this ambition requires more than reducing inpatient capacity. Sufficient community-based alternatives need to be developed alongside changes to inpatient provision including appropriate housing, support and clinical services that enable people to return to or remain in, the place they call home. Planning should be undertaken with individuals, particularly those who have experienced lengthy hospital admissions or out-of-area care, so that their preferences about where, how and with whom they would like to live are central to decisions about their future care.

Through the ICB's Inpatient Quality Transformation Programme, work continues to develop and implement local plans that reshape inpatient provision around the needs of the NENC population. The intention is to improve the quality and experience of care, make more effective use of available resources and support people to receive care within their local communities wherever this can be achieved safely and appropriately.

Out-of-area inpatient care is associated with concerns including longer lengths of stay, poorer experience and clinical outcomes. This reinforces the importance of developing local pathways that can meet people's needs closer to home, while recognising that individual circumstances will continue to determine the most appropriate setting for care.

Localisation of care therefore remains the primary strategic approach. The ICB intends to progressively reduce reliance on and ultimately cease the routine commissioning of locked rehabilitation services, alongside its commitment to eliminate avoidable out-of-area placements. This requires whole-pathway redesign so that locked rehabilitation is not used as a default or long-term destination and people are supported in the least restrictive, clinically appropriate setting as close to home as reasonably possible.

This ambition will be implemented cautiously and realistically. It does not represent an immediate prohibition on locked rehabilitation, nor a requirement to move people simply to achieve a target. No placement should end until a safe, sustainable and individually appropriate alternative is available. The ICB will continue to recognise circumstances in which specialist inpatient care may remain necessary, including forensic pathways, legal restrictions, safeguarding considerations and highly complex clinical need.

2. Background

Prior to the establishment of the ICB, the North East and North Cumbria system had a significant reliance on out-of-area provision, including people receiving care in long term placements away from their local communities. Work had commenced to support some individuals to return closer to home, but out-of-area care remained an established feature of the system.

Over the past 3 years, the ICB has undertaken a comprehensive review and identification of people placed out of area, including those in longer-term hospital settings. This has

enabled the ICB to provide a clearer basis for individual review, commissioning oversight and pathway planning.

A key principle of this work is that localisation of care should not simply mean moving someone from an out-of-area placement into a service within the NENC footprint. The purpose is to secure better, more appropriate and sustainable outcomes for the individual. The ICB therefore engages directly with people and their families to understand their wishes, preferences and aspirations, alongside ensuring appropriate advocacy arrangements and maintaining robust oversight of individual circumstances.

Importantly oversight continues after an individual has returned closer to home. The ICB engages with people following their return to NENC to understand their experience and whether the change has improved their quality of life and well-being. This provides an important means of assessing whether localisation is delivering meaningful benefits for individuals, rather than measuring success solely through reductions in out-of-area numbers.

3. Current position

The NENC system has maintained zero out-of-area rehabilitation placements for the past three years, demonstrating sustained progress in supporting people to receive rehabilitation care closer to home.

There are currently eight individuals receiving care in longer-stay hospital settings outside of the NENC footprint. These placements remain subject to individual review and oversight as part of the ICB's wider approach to localisation of care.

Within NENC NHS mental health foundation trusts, there are currently 17 people detained within locked forensic rehabilitation provision. Many of these individuals have a learning disability and are detained under Part III of the Mental Health Act, reflecting their position within the forensic pathways. This group of people therefore requires careful individual consideration, recognising that legal restrictions and clinical requirements may influence opportunities and timescales for transition and discharge.

A further 19 individuals are receiving care at Billingham Grange, an independent hospital located within the NENC footprint. Although these placements are not geographically out of area, they remain relevant to the ICB's wider view of locked rehabilitation provision and its strategic intention to reduce reliance on this model of care.

Provider out-of-area placements remained relatively low across NENC during the first seven months of 2026, although some month-to-month variation was evident. The number of individuals placed out-of-area was one in January, five in February, none in March, one in April, seven in May, two in June and five in July.

Overall, the position demonstrates sustained progress in reducing reliance on out-of-area care, particularly rehabilitation placements. However, the continuing use of longer-stay out-of-area and locked rehabilitation provision reinforces the need for ongoing patient-level oversight and development of safe and sustainable local alternatives.

The strategic priorities for implementation are:

3.1 Person-level oversight and regular review of need, rights, quality, legal status and discharge barriers, supported by accurate system-wide data on out-of-area and locked rehabilitation placements and patient pathways

3.2 Prevention of avoidable admission and reduction of unnecessary length of stay. Development of community rehabilitation, housing, social care, crisis and early-intervention alternatives

3.3 Quality, safety and safeguarding assurance across all commissioned provision with robust quality, safety and safeguarding oversight. A phased commissioning and contracting plan that protects continuity of care during transition

3.4 Individual transition planning, with no discharge or transfer driven solely by a numerical target. Clinical and legal review of exceptional cases where specialist inpatient care remains necessary

3.5 System collaboration across commissioners, providers, local authorities, housing and justice partners. Transparent Board reporting on progress, risks, exceptions, investment requirements and outcomes

4. Recommendations

The Board is asked to:

- note the current position and the assurance provided in relation to out-of-area and locked rehabilitation placements;
- support the strategic intention to progressively reduce reliance on, and ultimately cease the routine commissioning of locked rehabilitation services;
- endorse a phased, clinically led and person-centred approach to implementation, with the pace of change determined by the availability of safe, appropriate and sustainable alternatives.
- recognise that a small number of people may continue to require inpatient provision where this is justified by individual clinical need, safeguarding considerations, patient choice or legal restrictions and;
- request a system implementation plan setting out milestones, required alternative provision, financial and workforce implications, quality safeguards and reporting arrangements;
- support the principle that no placement should be ended solely to meet the March 2028 ambition.

Name of Author: Lee Anderson, Head of Commissioning

Name of Sponsoring Director: Peter Rooney, Director of Commissioning

Date: 4th November 2026