Coventry City Council

Market Development Plan for Mental Health (18-64) 2021-2026

Executive Summary

Context

- The Mental Health Market Development Plan (18-64) is one of several commissioning plans that sit under the Market Position Statement published in 2018. These aim to improve supply, quality, and access to appropriate provision in the City according to current and predicted increased future needs.

- This plan focuses on support for a small subset of the population with mental health needs - a group of around 200 people who require accommodation and support funded by the council.

  It is aimed at existing and prospective providers and offers details of the type of high quality, effective services we plan to commission over the next five years.

- This plan links to the One Coventry approach and Adult Social Care Vision. With increasing pressure on budgets and expectations around quality, it challenges providers to offer asset-based, person-centred support, promoting independence and recovery while offering good value for money. Over the next five years, we plan to:

  - Raise the quality of our existing mental health nursing, residential and supported accommodation to ensure evidence-based recovery-focused models are delivered in high-quality settings.

  - Stimulate the market to develop additional capacity to meet the needs of existing service users, Coventry people placed out if city, and increased numbers of service users projected for the next five years. This will include a larger proportion of supported accommodation to promote reablement, recovery and a move back to independence, including specialist supported living for those with more complex needs or risks.

  - Developing and expanding our existing community-based support model to support more people in their own homes and to enable people to move on to independent living with appropriate step-down community support. This aspect is not included in this plan as we intend to investigate internal options first.

Standards

- The plan sets out the standards that the Council expect from all mental health accommodation and support provision that is commissioned. Existing provision, with the support of our quality assurance processes, will be required to reach these standards by 2026 at the latest.

- These standards include a high-quality environment and appropriate accommodation; a co-production, strengths-based approach; investment in staff training; and effective, evidence-based practice and support models.

- Our aims for mental health services specifically are:
    - Promoting the greatest level of independence possible, making use of everyone's personal assets, resources and abilities.
    - Focusing on recovery and helping people progress through and out of services to whatever extent is right for them.
    - Making greater use of community resources and the wider mental health system.
    - Future-proofing the market with increased quantity of provision, and greater use of assistive technology and innovative models of support.
    - Better matching of supply and demand so there is a choice of good-quality, effective provision to suit different needs, giving us the best possible value for money.

Current position

- Currently around half of those we place go into residential provision, and relatively few into supported accommodation. We have a good Council provided community-based support offer which we plan to further develop outside of this plan.

- We have identified a need for specific support for the groups listed below. The document offers criteria for appropriate accommodation for each of these groups and examples of models that have been successful.
    - People with Autistic Spectrum Disorder and a mental health condition
    - People with early onset dementia (aged 30-65)
    - Younger people transitioning from children's services
    - People with dual diagnosis (e.g. mental health with substance issues or LD)
    - People with a forensic history, or with a history of particularly aggressive, challenging or violent behaviour, not in need of a secure facility
    - People particularly vulnerable to abuse or exploitation
    - Very complex cases requiring DoLS/ LPS

Requirements

- All accommodation and support will be expected to meet evidence-based standards set out in the document around the type of accommodation, the staffing and the service provided. This will become part of the quality assurance process for mental health.

- Section 9 sets out detailed descriptions of the types of support we anticipate needing over the next five years, based on evidence of effective practice for people with the needs displayed by each group. This is required to better meet existing need, to enable Coventry people placed out of city to return where appropriate, and to support the projected increased numbers of people requiring support in coming years. The table provides an indication of the type and quantity of provision we are likely to be interested in commissioning over the next five years.

Indicative demand for new services in the next five years

Type of provision	Estimated places needed	Indicative hourly or weekly cost (2020/21 prices)
Supported living (p20)	40	£13.78- £17.20
Staircase supported living for young people (p21)	15	£13.78- £17.20 with initial flexibility
Support for high risk individuals (p22)	25	£800-£1,500
Support for individuals with complex needs (p24)	30	£13.78- £17.20
Residential (p26)	On merit	£650-£1,000
Nursing (p26)	On merit	£1,000-£1,900
Housing with care (p28)	15	£16.25
Housing with care for people with early onset dementia (p29)	10	£16.25
Respite and emergency beds (p31)	5	Flexible depending on support offered

1. Background

Coventry's Market Position Statement (MPS) published in October 2018 aimed to create a common understanding of the local care market covering need and demand for care, current supply of services and commissioning intentions to enable the effective design and delivery of services for people that need care and support now and in the future.

This creates a platform for continued dialogue and collaboration with providers around the challenges facing the local social care and health system, and the market development solutions that exist to improve care outcomes.

Likewise, we recognise and aim to support the market with workforce issues prevalent in the sector such as recruitment and retention, training, issues related to Brexit and mandatory vaccinations and National Living Wage.

The Market Development Plan for Mental Health (for adults aged 18- 64) builds on the MPS and is one of a suite of such plans introduced to help shape the market for adult social care in Coventry, which should be read in conjunction with the overall plan: https://www.coventry.gov.uk/info/192/adult_social_care_strategies_policies_and_plans/2120/market_position_statement_for_adult_social_care/1

The other documents are as follows:

- Market Development Plan for Learning Disability/Autism (published 2019)
- Market Development Plan for older People (in production)

This plan contains details of current supply, current and anticipated future demand and analysis of gaps and what needs to be developed. It aims to ensure:

- **Improved supply** – a better offer of local supply that meets current and future needs. This will include the development of new accommodation schemes and modification of existing ones.
- **Improved quality** – ensuring that all services are of a high quality and offer choice, dignity and privacy, supporting people's recovery. Services will promote independence and help people stay safe and well, making use of assistive technology, evidence-based support models and strong links with other services in the mental health system and wider community.
- **Improved access** - people will be able to quickly access the best type of provision to suit their needs.

We welcome approaches by providers looking to develop high quality new provision relevant to the needs specified in this document. For discussion around this please contact the Mental Health Commissioner at SocialCareCommissioning@coventry.gov.uk.

2. Context and estimated numbers

Coventry is one of the fastest growing cities in the UK, currently having a population of around 371,500[1]. The population is young and there are a high proportion of people from BAME groups living in the city. Although it is still one of the more deprived areas of the country, it has seen a reduction in deprivation over recent years, though health inequalities are still a concern. For more information on the demographics of Coventry please see https://www.coventry.gov.uk/info/195/facts_about_coventry

At least one in four British adults will experience some form of mental health problem in any given year. Those who live in more deprived areas are twice as likely to be affected by mental ill-health. There are many factors that can cause, or be a consequence of, mental health problems such as unemployment, deprivation, substance and alcohol misuse, and crime and violence. There are also concerns around the Covid-19 pandemic and knock-on effects to society exacerbating existing mental health concerns and leading to new ones in an unknown number of people.

The estimated annual cost of tackling mental ill-health in the UK, including spending in health and social care, is now over £20 billion. Projecting Adult Needs and Service Information (PANSI) data for 2020 estimates that almost one in five adults aged 18-64 (46,221) in Coventry were affected by a common mental health condition at any one time. Common mental health disorders include conditions such as depression, anxiety, phobias, obsessive-compulsive disorder (OCD), eating disorders and post-traumatic stress disorder (PTSD). See Figure 1 for estimated numbers of people in Coventry with other specific mental health needs. Based on population estimates, common conditions are projected to increase by 11.1% to 51,343 by 2030. See Table 1 for further projections.

Given that a large proportion of mental health problems are not formally diagnosed and that not all people will actively seek or engage with services, these figures are likely to be an underestimate. The King's Fund estimates that 35% of those with depression and 51% of those with anxiety disorders do not seek support from services. Refer to the Mental Health and Wellbeing information within Coventry's Joint Strategic Needs Assessment for further details: https://www.coventry.gov.uk/info/195/facts_about_coventry/1878/coventry_joint_strategic_needs_assessment_jsna/3

Only a very small proportion of people with common mental health problems, and one in five people with severe mental health problems require housing related support, and for many of these this is support in their own home. This market development plan deals with support for this group of people. Broadly, this is a form of accommodation with added support for those who need more than a usual tenancy would offer. Depending on the individual's needs and circumstances, this may be long or short-term, and could range from 24 hour one to one intensive support to very occasional support in largely independent accommodation.

[1] 2019 ONS population estimate

Figure 1: Estimated number of people with specific mental health needs in Coventry

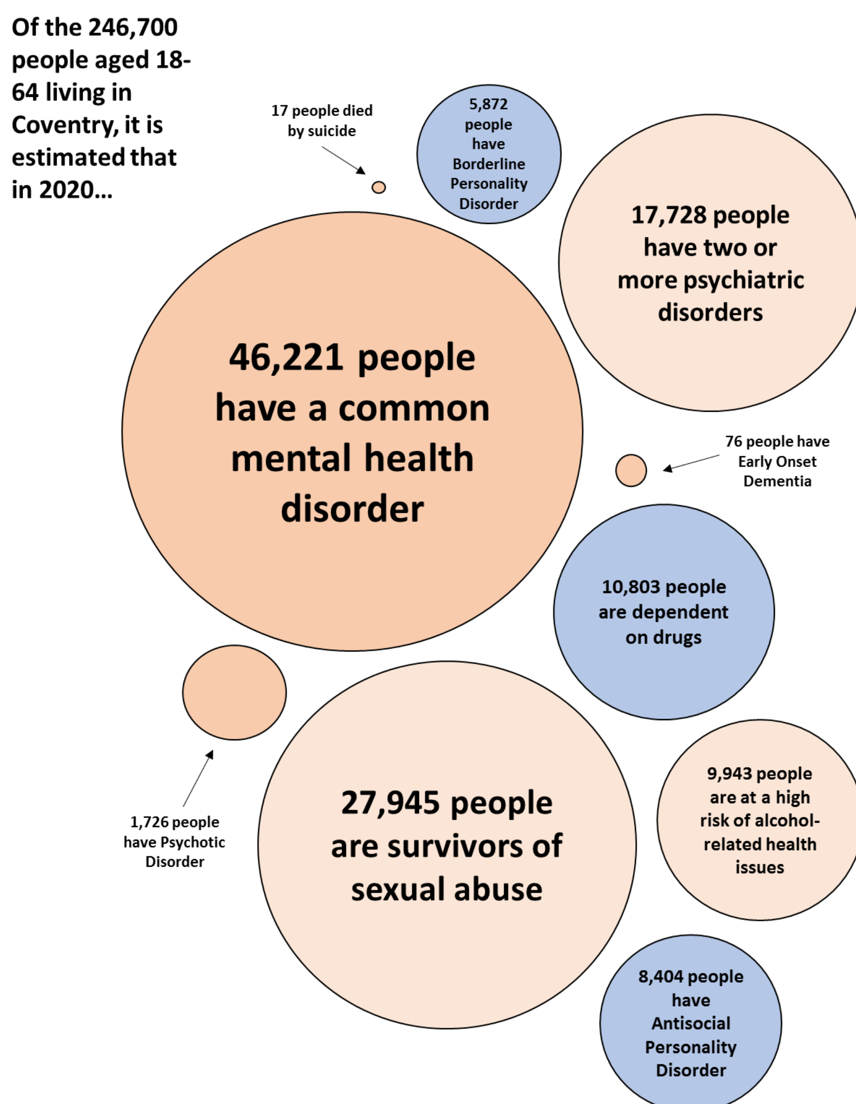


Table 1: Projected numbers of people aged 18-64 in Coventry with specific mental health needs

People aged 18-64	**2020**	**2025**	**2030**	**2035**	**2040**
with a common mental disorder	46,221	48,899	51,343	53,178	54,585
with a borderline personality disorder	5,872	6,214	6,525	6,759	6,938
with antisocial personality disorder	8,404	8,954	9,456	9,832	10,118
with a psychotic disorder	1,726	1,831	1,926	1,997	2,052
with two or more psychiatric disorders	17,728	18,791	19,761	20,489	21,045
at risk of alcohol-related health problems	9,943	10,507	11,072	11,531	11,946
dependent on drugs	10,803	11,491	12,251	12,648	12,738
who are survivors of childhood sexual abuse	27,945	29,510	30,939	32,013	32,838
with early onset dementia	76	80	81	82	88
who will die by suicide	17	18	20	20	21

Source: PANSI data 2020. Note that there will be overlap between these groups.

3. Coventry's vision for adult social care

The Council's One Coventry plan sets out Coventry City Council's vision for a globally connected, locally committed city which delivers its priorities under increasing pressure of reduced resources and a growing population. The full plan can be downloaded at https://www.coventry.gov.uk/downloads/file/11778/one_coventry_plan_council_plan_2016-24

The overall vision for adult social care in Coventry is that it empowers people and their families, drawing on their strengths and assets and those of the communities in which they live to provide person-centred care and support. Where statutory support is required it is to be provided in an enabling way through a Promoting Independence Pathway and people are to be supported to stay out of hospital where feasible. Where hospital stays are required, adult social care seek to assist people in regaining lost skills on discharge through effective reablement. The overarching principle is to assist adults to live their best lives by utilising promoting independence and strengths-based approaches. Figure 2 illustrates the adult social care vision which will be reflected in all provision, and Figure 3 the Adult Social Care Operating Model.

Figure 2: Adult Social Care Vision

Figure 3: Adult Social Care Operating Model

4. Vision for mental health provision

Our specific vision for people with mental ill-heath is that they will have the same range of choices of accommodation and support as the rest of us and will live locally in communities with good access to facilities, transport and other amenities. Where possible, people will be supported to remain in their own homes. To assist with this we plan to develop and expand our internal community-based support offer outside of this plan. Where people do require nursing, residential or supported living provision, we expect to see:

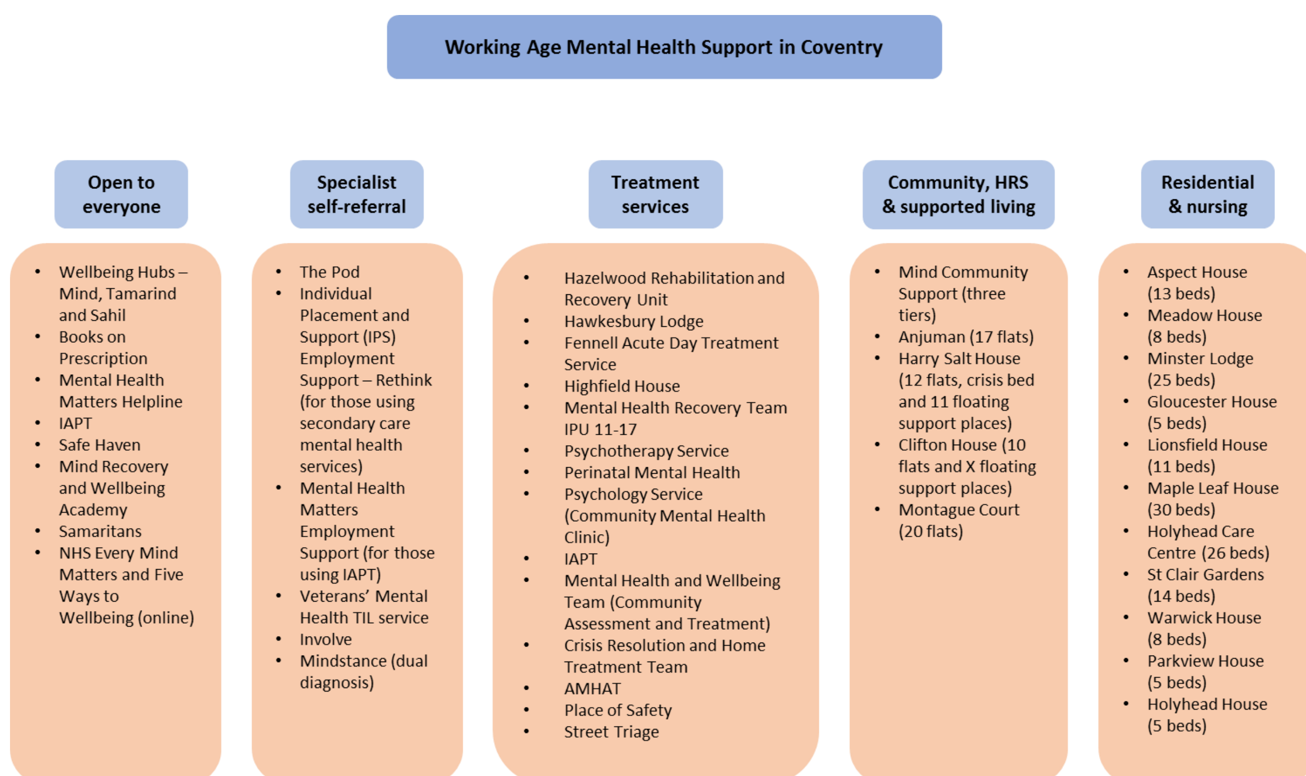
- **Promoting independence** – while it is acknowledged that there will always be a need for high-quality nursing and care home placements to meet complex individual needs, we believe that where possible supported living and community-based support is preferable as it offers greater independence and less intrusive support, enabling people with mental health conditions to be integrated into the community.
- **Asset-based support** – whatever type of support people require, we believe in making the most of people's assets, resources and abilities. We want services that help people recognise, strengthen and develop their assets and use them to live well, exercise choice and control in their lives, and do things that interest and engage them, while being supported to stay safe and well.
- **Recovery focus** – the aim of all support we provide should be to help people develop resilience, coping skills and an understanding of their condition, engage with treatment and learn the skills they require to need us less. We expect all mental health provision to include structured, individualised plans to promote recovery, with the goal that reliance on services will reduce.
- **Choice of good-quality provision** – we welcome the development of a range of high-quality accommodation and support provision. All our residents deserve to live somewhere they feel safe, comfortable and supported. We know that for some it takes a number of different placements before they find one that fits, so it is important that we can access a range of options. A range of provision helps us ensure we are able to cater for everyone's needs and can take into account any specific needs related to gender, religion, race, sexual orientation, gender identity, disability, age, behaviour that challenges or past experiences such as abuse or substance issues.
- **Improving access** – people will be able to access appropriate, high-quality accommodation at the time they need it. Supply and demand will be better matched through management of capacity, voids and vacancies and consistent pathways into accommodation and support. People currently placed out of the city will be offered the option of returning.
- **Improving the standard of accommodation** – we will continue monitoring the effectiveness and quality of services in the city, supporting continuous improvement through our quality assurance processes. As more provision becomes available, we will cease using accommodation that is lower quality or offers poorer quality support or value for money.

- **Bringing people back into the City** – while there are individual cases where an out of city placement is more appropriate for various reasons, we strive to bring back as many as possible of our out of city service users by supporting the development of services which meet specialist needs.
- **Future-proofing and making the most of technology** – we anticipate that demand for services will increase over the coming years while social care budgets will remain tight. We also acknowledge that the impact of the Covid-19 pandemic is likely to be felt for a number of years. We encourage providers to innovate with new care models and support options, environments that help people stay safe and well, and the use of assistive technology.
- **Improved community engagement** – providers will support people to access community activities, meet people, make friends and engage in activities that interest them. People with mental health issues will be encouraged and supported to find work, volunteering or other meaningful activities, and engage in community life. Providers will support service users to engage with the range of support offered in Coventry.
- **Improved value for money** – public sector budgets continue to be tight, and as demand for services grows, our duty to ensure public money is spent in the most efficient and effective way is more important than ever. We will support the development of recovery-focused, cost effective provision such as supported living, housing with care and community support, and ensure we are only using more expensive and restrictive options such as residential and nursing homes when these are truly necessary to keep the service user safe and well.
- **Collaboration and integrated working** – mental health support and provision is becoming more integrated across Coventry and Warwickshire in health and social care, with more effective, recovery-focused support being developed by building on the strengths of different partners. We expect accommodation and support providers to play a part in this by engaging with the wider mental health system and supporting service users to make use of what is available in Coventry.

5. The mental health system

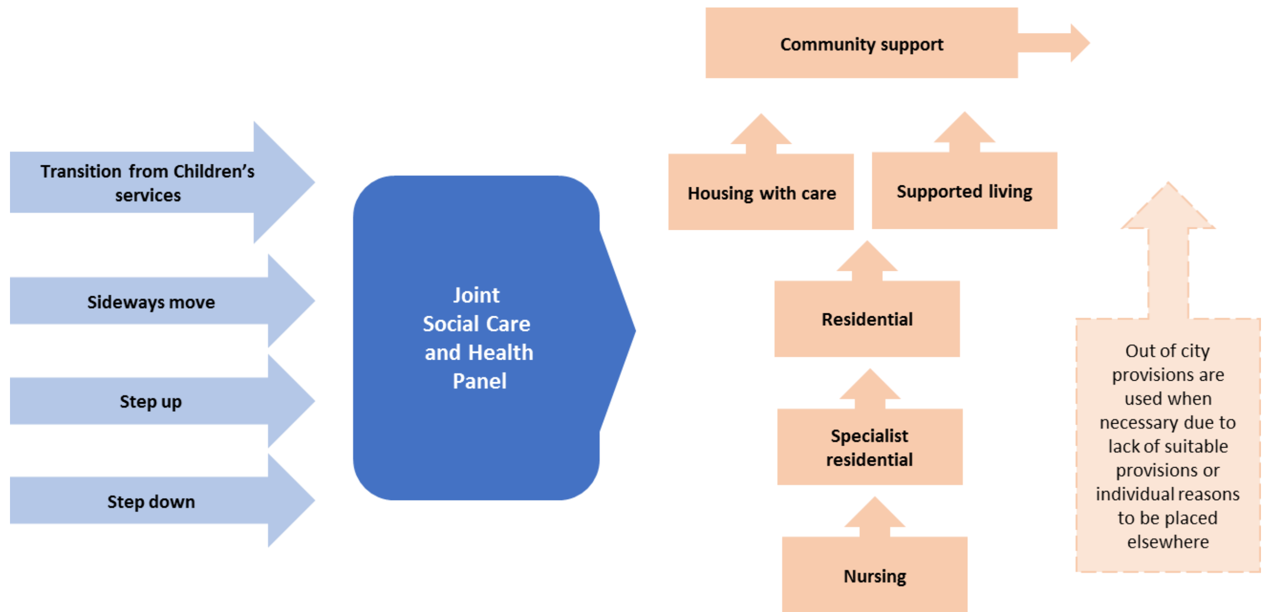
While this market development plan focuses on accommodation-based support, it is important to understand the context within which this sits. The majority of people with mental health needs will not use accommodation-based support, and for most of those that do we aim to support them to move on to more independent living as soon as they are well enough, so accommodation-based support forms a part of the network of support illustrated in Figure 4. There is an expectation that accommodation-based services will build close relationships across the mental health system to ensure holistic support and community engagement for service users. It will also be necessary to make links with CAMHS and older people's mental health services too due to overlap and interdependencies.

Figure 4: Summary of working age mental health provision in Coventry



Individuals who require them access mental health placements via a joint health and social care funding panel held each week. As Figure 5 illustrates, there are four main routes into this panel, and members will look for a placement which offers the greatest level of independence and opportunity for recovery appropriate for the individual, alongside good value for money. Quality of provision is regularly monitored by the Council's Social Care Commissioning Team, which works closely with CQC to ensure we are confident in the safety, quality, effectiveness and value for money of all services.

Figure 5: Routes into accommodation-based support

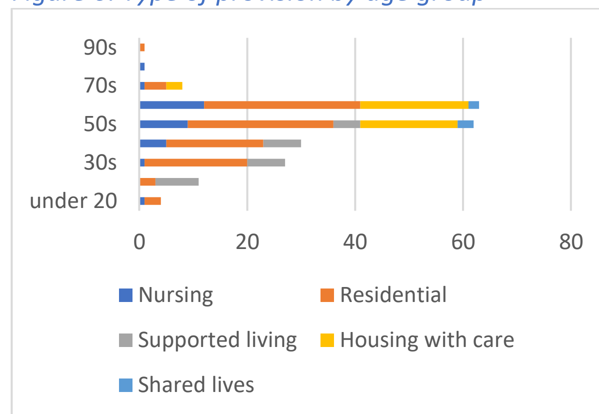


6. Demographics of those using accommodation-based mental health support

In Coventry, we currently support 148[2] social care clients via our mental health teams in our in City provision, with a further 59 people based out of City (207 in total). This is broken down across a combination of nursing, residential, supported living, housing with care and shared lives provision.

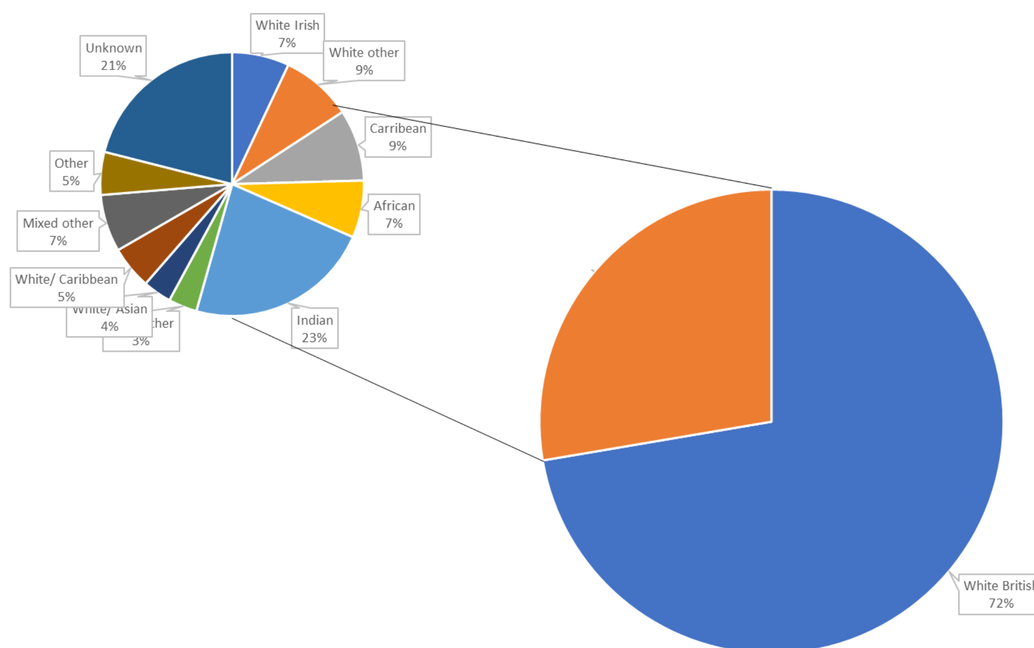
Figure 6 shows the age breakdown of the population and demonstrates that the largest groups being provided for through the council's mental health teams are those in their 50s and 60s. It also illustrates the use of different types of provision for different age groups.

Figure 6: Type of provision by age group



Sixty percent of service users are male and forty percent female. Almost three quarters of service users are White British, with Indian being the most common of other ethnic groups.

Figure 7: Ethnicity of service users



[2] Numbers are indicative based on a snapshot in 2020

7. Demand for accommodation-based mental health services

Coventry City Council currently supports 207[3] people in accommodation-based mental health services across in and out of City provision, but this figure is likely to grow in future years due to increasing populations, increasingly severe presentations of mental illness and pressure on hospital beds.

We currently have over thirty people ready to leave hospitals and around sixty people placed out of City. While for some an out of City placement is appropriate, this is a costly way of providing support and reduces people's links to the local community, so where possible we aim to bring these people back to Coventry.

Additionally, we are aware of some younger people with significant needs likely to enter the adult mental health system in the next few years, so want to ensure we are prepared to support these people in the most appropriate way. Table 2 shows our indicative use and costs for different types of support.

Table 2: Indicative numbers in services

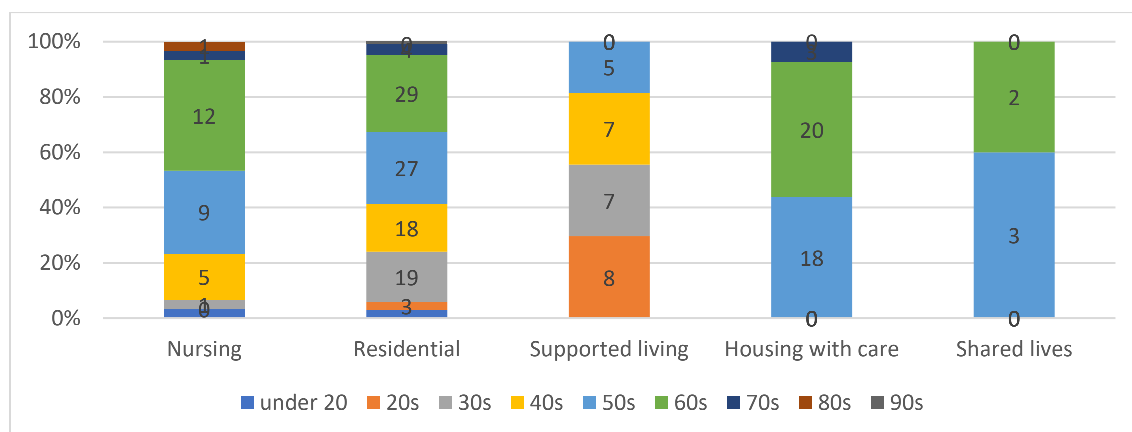
Service type	Cost range	In city	Out of city
Mental health nursing *Facilities staffed 24 hours a day (to include registered nurses) and registered with CQC. Residents have their own room and meals are provided. Personal and nursing care can be provided if required. Staff arrange social activities and accompany residents to appointments. Communal lounges and dining areas are provided.*	£1,050-£1,900	14	16
Residential *Facilities staffed 24 hours a day and registered with CQC. Residents have their own room and meals are provided. Personal care can be provided if required. Staff arrange social activities and accompany residents to appointments. Communal lounges and dining areas are provided.*	£850 - £1,000	71	33
Supported living *Small units of individual flats or studios where a small group of people live as independently as possible in a home setting. Support and care are provided by a staff team on site, and often includes waking or sleep in night staff. Staffing and support levels will vary according to clients' assessed needs but should work towards a goal of more independent living.*	£13.78-£17.20	17	10
Long-term MH housing with care *Units of individual flats for people with moderate, but often stable, mental health support needs, generally aged 55+. Support and care are provided by a staff team on site, and often includes waking or sleep in night staff. This accommodation is intended to be long-term and should have capacity to meet changing physical and mental health needs as clients age.*	£16.49	41	0
Shared lives *Accommodation lived in under an occupancy agreement, where the premises is owned or tenanted by another person who has been approved as a carer by a Shared Lives scheme. This option offers care and support as part of a family or shared household.*	-	5	0
Community support *Support that is delivered in people's own accommodation. The support is entirely separate from the accommodation. The level and volume of support will vary according to need. This would not usually include personal care.*	Block	43	-

This table gives indicative baseline data from a snapshot in 2020

[3] Numbers are indicative based on a snapshot in 2020

The provision people are placed in is based on need level, suitability and availability. We aim to use the least restrictive and most cost-effective option that is available and meets the individual's needs. Figure 8 shows the age make-up of the types of accommodation we use. Supported living is used when possible for younger clients, whereas housing with care is more likely to be used for those in their 50s and 60s.

Figure 8: Age make up in each type of provision



We have seen an increase particularly in clients with multiple, complex needs, and anticipate that this trend will continue. We would therefore like to commission provision to meet specific identified needs, as well as more generic provision. This includes:

- People with Autistic Spectrum Disorder
- People with early onset dementia (aged 30-65)
- People with a history of abuse or who are vulnerable to exploitation
- Younger people transitioning from children's services
- People with a combination of learning disability and mental health needs
- People with current or recent substance misuse issues in addition to mental health conditions
- People with a history of particularly challenging, aggressive or violent behaviour
- People with a forensic history but not requiring a secure facility
- Very complex cases requiring DoLS/ LPS

In line with "One Coventry" we want to reduce our reliance on restrictive, high cost traditional placements. Instead, we will develop a range of alternatives that promote independence, resilience and recovery, building on the assets of service users, alongside an expanded community support offer.

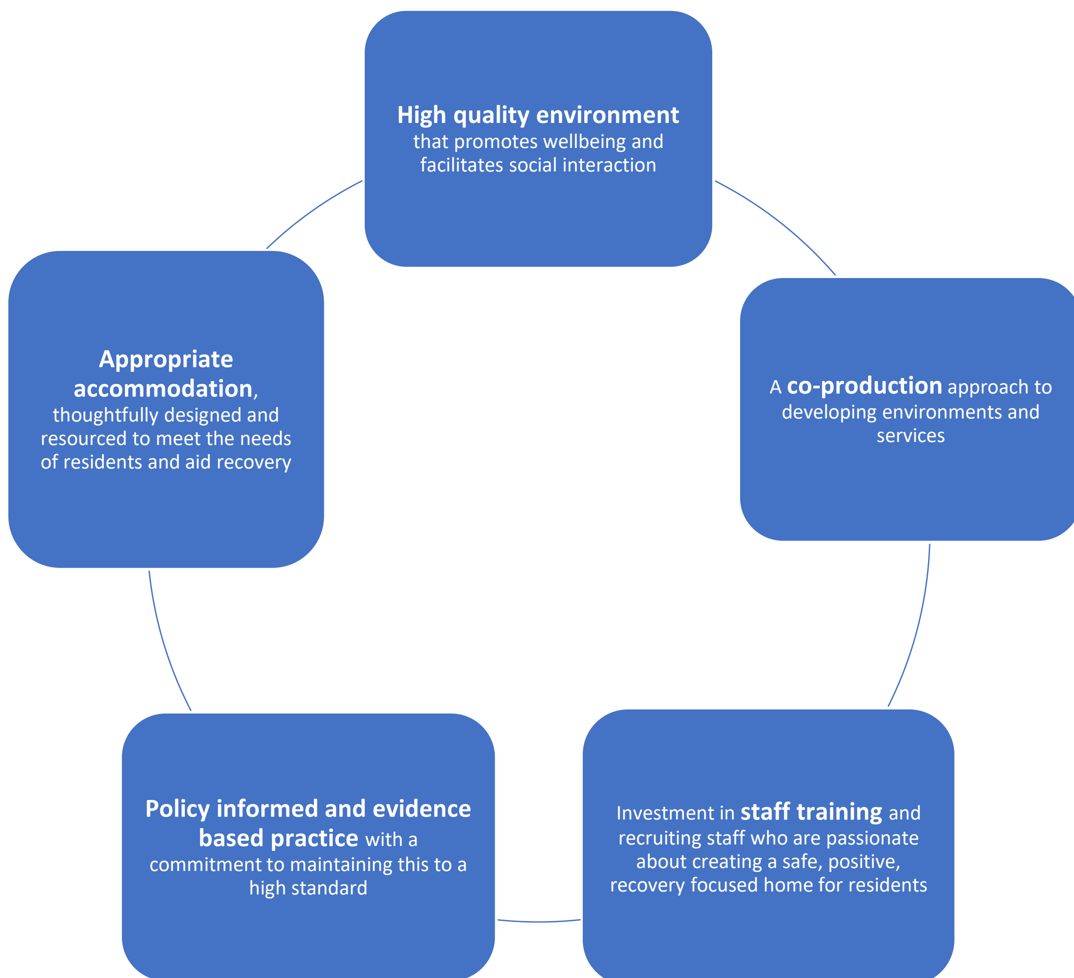
There will remain a place for high quality traditional residential and nursing homes for those where this is truly the best option to meet their needs. However, these will be supplemented by more supported accommodation, housing with care and community support options which are able to cater to a group with higher need and risk levels than our current provision tends to. We would also like a wider range of quality options for people to spend direct payments and personal health budgets on.

Later in this document we provide some examples of innovative models which have successfully supported people with complex needs in creative, less restrictive placements, building on people's strengths and encouraging them to participate in the community and live well with their condition.

8. Standards

Research[4] highlights the importance of a holistic approach to quality in supporting people with mental health issues with recovery. Figure 9 shows the elements that should be in place for successful mental health accommodation, which Coventry City Council will be looking for evidence of in all commissioning and quality assurance.

Figure 9: Standards in mental health accommodation



[4] Mental Health Foundation. 2016. Mental Health and Housing Policy Paper.

We expect all specialist mental health provision to meet the minimum standards shown in Figure 10. All providers we work with will be subject to regular quality review, and where standards drop below this, providers will be required to undertake improvement processes. As our supply of good quality provision increases, we will reduce our use of any provision that consistently falls short of the standard we expect.

Figure 10: Required standards for accommodation-based support

The building

- Well-maintained, comfortable accommodation
- Comfortably sized, well furnished rooms or flats
- Homely, non-institutionalised environment
- Access to shared and personal space
- Access to safe outdoor space
- Appropriate safety measures in and around the building
- All communal areas and some rooms accessible to those with limited mobility
- Consideration of location, avoiding areas that feel unsafe or have particularly easy access to drugs, for example

Staffing

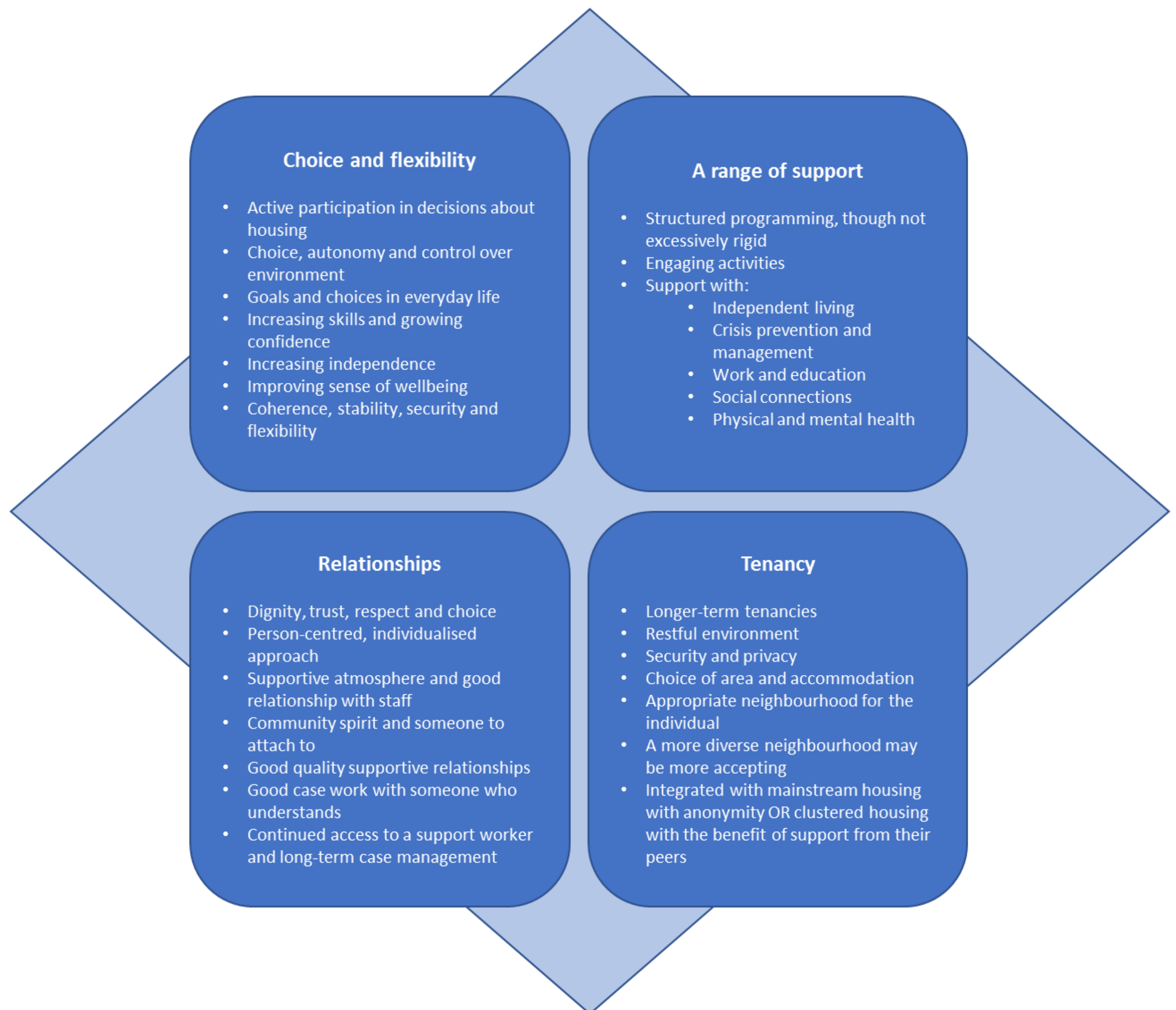
- At a minimum, staff have undertaken mental health awareness training, Mental Health First Aid, training around common mental health conditions and those residents are diagnosed with, as well as support planning and risk assessments. Depending on client group staff should be trained in specific approaches such as Positive Behaviour Support.
- Staff should maintain a good awareness of other support available in the community and wider mental health system, and work collaboratively with partners.
- Staffing levels should be sufficient to meet the needs of the client group, including night staff where required.
- A strong and experienced leadership team is essential.

The service

- Recovery-focused, asset-based approach with clear goals towards further independence
- Co-production with residents, ensuring their ideas are sought wherever possible, aiming to develop with rather than develop for
- Clear, documented and regularly updated individual care and support plans for each service user developed with input from them
- Robust safety and wellbeing measures in place, including managing behaviour, medication, compliance, appropriate mix of service users, adequate staffing etc
- Effective infection control procedures in place, and robust planning for minimising the impact of a coronavirus or other outbreak in the home
- Robust and transparent safeguarding and reporting of incidents
- Our aspiration is for all accommodation based support we use to be rated good or outstanding by CQC.

Research summarised in a report by Centre for Mental Health shows the following factors are important in the success of accommodation-based support for people with mental health issues:

Figure 11: Factors in the success of accommodation-based support



Adapted from Boardman, J. 2016. *More Than Shelter*. Centre for Mental Health

9. Five Year Plan for Developing the Market

This section describes types of accommodation-based support we would like the market to offer within the next five years, which we feel will best meet our current and projected needs. This will complement the community-based support offer we plan to further develop outside this plan. In each section we include an example of good practice, though we would also encourage prospective providers to bring their own ideas and research about what works for a particular client group. We also provide a fictional pen picture illustrating the types of referrals we may make to this kind of service.

The types of support described here are:

1. Supported living
2. 'Staircase' supported living for young people
3. Support for high risk individuals
4. Support for individuals with complex needs
5. Residential and Nursing
6. Housing with care
7. Housing with care for people with early onset dementia
8. Short-term and emergency beds

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9.1. Supported living

Supported living offers high quality accommodation in a self-contained flat or studio, ideally for a small group of people with compatible needs. Residents have personalised support plans aimed at helping them achieve a level of independence that would enable them to move on to a private or council tenancy within 12 to 24 months.

We would like to increase our use of supported living, or progression-based residential, over the next five years, so would encourage the development of this type of provision for males only, females only, and mixed sex accommodation.

Across these categories, we anticipate requiring an additional 40 supported living beds over the next five years. An indicative cost for this type of provision is £13.78 to £17.20 per hour.

Case study – Low-level step-down support

This scheme aimed to prepare clients to move on to successful independent living. It was able to accommodate clients for longer than traditional supported accommodation, but with very flexible support meaning the provision changed significantly from start to finish.

The accommodation:

- Longer-term accommodation with support that drops down as needs change.
- Self-contained, high quality one bedroom flats in the community.
- Flats that are easy to care for and keep clean.
- Well maintained communal entryways and grounds.
- External security features such as a good main door and video entry phone.

The support:

- Floating support – staff based off site
- Lower intensity, less frequent visits
- Focus on developing independence skills and resilience
- Support sessions held in central locations as well as in the home
- Consistent main support assistant for each client, but some support provided by different staff members
- Focus on helping clients attend appointments, use the community and plan activities
- Safeguarding training such as cold calling, letting people in your home and personal safety
- Ongoing, open dialogue about level of support needed and when to move on
- Staff have training and experience in mental health, support planning and risk assessment

Example pen picture - Connor

Connor is 38 and has struggled with his mental health from a young age. He has attempted to work in the past, having had several warehouse jobs, but his schizophrenia can make him agitated and anxious, and he struggles with motivation around personal hygiene, so maintaining a job proves difficult and this has affected his confidence. He has had several hospital admissions when his mental health has been particularly poor. He has settled on to new medication which suits him well and means he has fewer symptoms, though it does make him tired and he sometimes chooses not to take it, which can lead to a relapse in his condition. Connor is passionate about football, and when he is well enough likes to play. He needs support regaining the daily living skills and confidence he has lost, adhering to treatment plans and encouragement with personal hygiene. Connor would also benefit from being in an environment where he has his own space but has staff and friends nearby to talk to. He is interested in trying employment again so has been referred to the IPS supported employment programme.

9.2. ‘Staircase’ supported living for young people

We are seeing an increasing number of young people coming through children’s services with high support packages. Many of these young people have complex needs around issues such as self-harm, vulnerability to exploitation and a long history in services. We find once they enter adult services it is often possible to support them into a much lower-intensity support where they can gain the skills and resilience they need to live more independently.

For these young people we would like to commission a highly flexible staircase model of supported accommodation which could cope with young people used to intensive support but could step this down as they became more independent. This accommodation would be aimed at people from around age 17 to 25.

We would anticipate this would be available for a longer period than usual supported accommodation if needed, enabling young people to stay in their accommodation for up to three years, but with support dropping significantly during their time there.

For young people, we would expect availability of more staff, including night staff. It would also be important that the accommodation included communal areas to encourage young people to socialise and develop support networks, but also high-quality personal space in their own furnished flats.

Individual support plans would be especially important, and we would expect young people to experience a comprehensive, documented programme to develop the skills and resilience they need to live independently. It would also be important that young people were supported to engage in training, volunteering or employment when they are able to do so, and they should be encouraged to participate in other services in the City which can help such as The Pod and Rethink Individual Placement and Support supported employment.

We anticipate requiring around 15 places over the next five years. Pricing structure for this kind of provision would be negotiable due to the anticipated significant change in needs of young people at the start and end of their time in the provision. While we would anticipate the initial support needs to mean a higher cost, the lowest banding should fall in line with adult supported living in the range of £13.78 to £17.20 per hour, with the potential for incentive payments for supporting effective transition through support levels.

Example pen picture - Tembi

Tembi is 18 and has struggled with mental health issues since primary school. Her mother escaped an abusive relationship with Tembi’s father when she was 8 years old, but Tembi and her two sisters had been hugely impacted by the abusive environment and their behaviour at school and home suffered. Tembi was excluded from school for repeated aggression towards teachers and other pupils and had regular stays in hospital due to significant self-harm and aggression. Tembi was diagnosed with a mild learning disability and ASD, and past trauma has had a significant impact on her mental health. Tembi is currently in a children’s mental health facility on 2:1 support, but she finds this suffocating and it impacts on her behaviour. Although Tembi left school without qualifications, she aspires to go to college and get a good job and a flat on her own and would like a relationship and friends she can trust. Though she lacks confidence in her abilities, during some art therapy sessions in hospital her talent for drawing became clear, and this is something she would like to build on.

9.3. Support for high risk individuals

This group are people with severe mental illness where there is also a significant element of added risk which means they may be unsuitable for traditional supported accommodation. This may be due to a forensic history, sexual offences or history of violence or aggression. Clients may have recently left secure units or may have a history of placement breakdowns and repeated admissions to hospital.

We would like to commission supported accommodation that offers steps towards living independently, but where their risks can be managed and highly skilled and experienced staff can work with them on understanding and reacting to triggers, complying with treatment, developing resilience and rebuilding their lives. Note that this would be for people who no longer require a secure facility, but still have risks to be managed.

We would anticipate that clients would stay in this type of accommodation for up to two years before they were ready to move on to independent living in the community or more mainstream supported living.

We would expect staffing to reflect the level of risk and the intensive work some clients will require. Staff need to be sufficiently trained and experienced that they would be able to work with people whose behaviour may challenge, and who are at particular risk of non-compliance with treatment and relapses. For many individuals this will be a last resort before trying a more restrictive placement, or a first step out of a secure setting, so we would expect the service to be able to accept and support people with challenging needs.

We would expect the service to develop excellent links with other services in the mental health system, as many clients will have a range of different needs. Given the level of complexity of clients, we would expect facilities to be relatively small, or with a mix of client needs. Particular attention should be given to location for this group.

We anticipate requiring around 25 places over the next five years. An indicative price for this type of provision would be £800 to £1,500 per week, with flexible bandings depending on need and risk.

Example pen picture - Geoff

Geoff is 42 and is due to be released from a secure unit following a conviction for breaking into the home of a young woman with whom he had had a brief relationship and assaulting her. Geoff has a history of schizophrenia and can become extremely aggressive and at times physically violent when unwell. During his time in the secure unit, Geoff's medication has been reviewed and his aggression and condition has improved somewhat. However, he can easily be provoked when he feels frustrated or dismissed by those around him. While clinicians feel he now poses less risk to women, there is a concern that he may attempt to form relationships with younger or particularly vulnerable women and girls or harass them in the community. it is advised that he lives in an environment without female residents or staff and is initially supervised while in the community. He should be accommodated away from schools and colleges to reduce risk. He will also need supervision to ensure he continues to take his medication, and support around learning to live independently again. Geoff sustained serious injuries in an accident prior to his arrest. As part of his physical recovery Geoff has been working on his fitness after years of self-neglect. He has become quite passionate about exercise and building physical fitness and would like to be supported to continue this on his release. He currently requires an accessible flat as he still walks with a stick.

Case study - Care and Support Plus

Developed in 2012 in Camden and Islington, Care and Support Plus aims to support people with a complexity of need that would make usual supported accommodation unsuitable and who otherwise would need to be accommodated in residential care or hospital. The model balances high quality, purpose-built accommodation with a wrap-around, intensive support package including therapeutic intervention. There is strong evidence that the model can support significant recovery, improve an individual's quality of life, and result in a substantial saving to the health and social care economy.

The accommodation:

- Fully self-contained flats with individual tenancies.
- Provision of essential items to furnish a home.
- Fully accessible building.
- Safety measures such as a front-facing office, airlock doors and sensitive use of CCTV.
- Homely, non-institutional environment.
- Shared lounge and kitchen in addition to self-contained flats to encourage residents to socialise.
- Outside space for residents to share.

The support:

- NHS clinical staff such as a care coordinator, psychologist and occupational therapist subcontracted directly to the scheme to undertake intensive work and address issues quickly.
- Double staff cover 24 hours per day to support higher risk individuals.
- High level of staffing allows intensive work on skills for independence.
- Staff supported by robust risk management procedures embedded in the scheme.
- Daily activities support and enhance the lives of residents.

For more on Care and Support Plus please see: http://www.contactconsulting.co.uk/wp-content/uploads/2015/02/Integration-that-Works-One-Support-Tile-House-Evauation.pdf

9.4. Support for individuals with complex needs

Across our client group we are seeing an increasing number of people with several interacting needs with which they require support – for example a severe mental illness combined with substance misuse, history of offending, a physical health condition or disability, a learning disability or ASD. This may mean multiple services need to be involved in their care package. Evidence suggests that a person-centred approach is most effective, often involving a key worker with whom the client has a good relationship who can navigate services on their behalf.

We would like to commission supported accommodation for people with more complex needs where their primary need is mental health. We would anticipate that clients would stay in this type of accommodation for up to two years before they were ready to move on to independent living in the community or more mainstream supported living.

People in this group will often work with multiple statutory and other teams, including drug and alcohol support, learning disability teams or physical health professionals. It would therefore be important to develop very strong collaborative relationships with other professionals.

Clients may also have additional needs linked to their other condition – for example mobility issues or additional vulnerabilities due to a learning disability. It would be important for the service to understand and cater for these additional issues, including attention to the physical environment and broad staff training and experience. Given the specific needs of clients, we would expect facilities to be relatively small.

We anticipate requiring around 30 places over the next five years. Price may be flexible depending on severity of need, but an indicative price for this type of provision would be £13.78 to £17.20 per hour.

Example pen picture - Baz

Baz joined the army after leaving school and served until, age 24, his behaviour became erratic and he was eventually diagnosed with bipolar disorder. Baz began taking heroin, which he initially felt helped him deal with his feelings about his dream career ending. He has taken several intentional overdoses over the years, and spent a long time living on the streets, where his physical condition declined significantly. Baz is periodically persuaded to try living in a supported environment where his conditions can be monitored. However, now 48, having lived on the streets for so long Baz struggles with an environment where he feels trapped, and he usually ends up being evicted relatively quickly due to drug use and damage to the property when he becomes frustrated. Baz is very protective of people in a similar situation to his own, taking younger people under his wing. He spent a period volunteering as a peer mentor until his health declined again and he returned to heroin. Baz was recently admitted to hospital from the streets and doctors were extremely concerned about his physical condition and have stressed that he is unlikely to survive another winter on the streets, so he needs a placement where he can be supported to recover and will avoid his usual pattern of eviction. He is now receiving support from the Veterans mental health service, and has recently agreed to try addiction support again, though in the past he has quickly disengaged from any support offered.

Case study – Complex needs support for men

A scheme for men who had been excluded from open access homeless support due to complex needs successfully supported clients who had struggled to settle elsewhere. The approach involved providing flats the men could be proud of and think of as home, but also pre-empting the kinds of reasons the men had been excluded from other accommodation and aiming to set them up to succeed, for example with interiors that are hard to damage, staff who recognise their triggers and creative ways to use authority . This person-centred approach enabled men to settle and move to independence who had struggled previously.

The accommodation:

- High quality self-contained flats in an attractive refurbished Victorian building, fully furnished to a high standard including double bed and television to encourage pride in surroundings.
- Consideration to avoiding common reasons for eviction in the environment – for example very robust doors, doorless wardrobes and a wet room instead of a bath.
- Communal lounge and training kitchen.
- Physical environment designed for the client group to avoid triggers.

The support:

- Highly person-centred approach.
- Creative support provision, such as morning tea and toast together rather than knocking doors in the morning, based on Psychologically Informed Environments (PIEs) approach.
- Flexibility around rules depending on an individual's needs.
- Extensive handover between shifts.
- Staff trained in mental health awareness and recognising when a client is deteriorating.
- Staff have extensive knowledge of other support and activities in the community.
- Tenancy Ready support programme individually tailored.
- Flexible move on period.
- Integration and communication across a range of services.

For more on Care and Support Plus please see: http://www.contactconsulting.co.uk/wp-content/uploads/2015/02/Integration-that-Works-One-Support-Tile-House-Evauation.pdf

9.5. Residential and Nursing

While we would like to minimise our use of residential and nursing provision, we recognise that there is a group of clients that will require a relatively high level of support in the long-term, or at a high level for a moderate period. People in this category tend to have severe and enduring mental health needs which are often complicated by the addition of physical health conditions that require monitoring. Others struggle significantly with understanding risks or complying with treatment plans if not closely monitored. Some will be under a DoLS/ LPS.

We want to ensure there are sufficient good quality residential and nursing care places so clients can feel safe and settled and receive the ongoing support they require.

While we have a range of residential and nursing mental health places in Coventry already, our aspiration over the next five years is that all clients who require residential or nursing care can access a choice of high quality, good value provision with well trained staff. We would therefore be interested in additional residential and nursing places that were able to achieve a good or outstanding rating by CQC while being competitively priced. They must meet the quality standards discussed in this document.

We would be particularly interested in provision that could support people with specific needs such as early onset dementia, dual diagnosis, active drug issues or a combination of mental health issues and learning disability. Currently some of our service users with specific or complex needs are placed out of city and we would like to offer them the option of returning to Coventry.

Prospective providers should be aware when planning that we aim to use supported accommodation and community-based support where possible, so residential and nursing accommodation must be able to support people with a relatively high level of need. Nursing must also be able to support people with significant physical care needs alongside mental health.

An indicative price for this kind of provision would be £650 to £1,000 per week for residential, and £1,000 to £1,900 per week for nursing. However, at the more expensive end we would expect the provider to be equipped to support people with very complex needs and higher levels of risk. In cases where risk is such that care packages are much larger, costs may be above this. Figure 11 illustrates the range of packages that have been agreed by the panel in recent months, while Figure 12 shows the complexity of needs in cases recently coming through the panel for residential and nursing care.

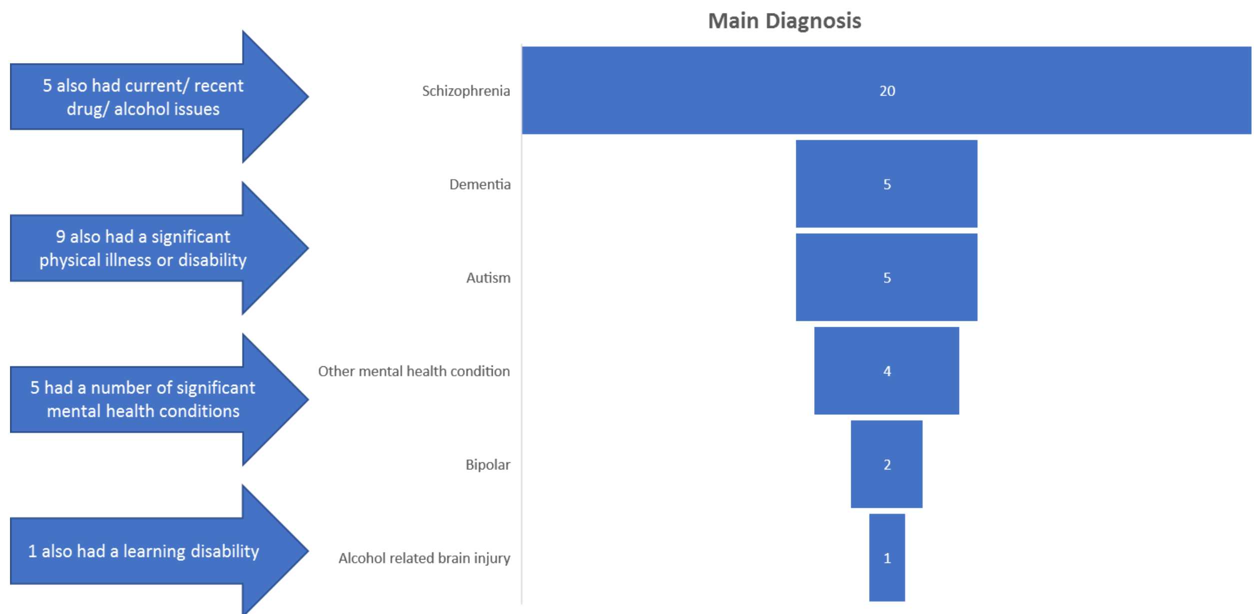
Example pen picture - Pam

Pam is 54 and has schizophrenia and a mild learning disability. She has lived in institutions for most of her adult life and while she can carry out her own personal care, she needs regular support and prompting to take care of herself. On several occasions she has tried living more independently, but self-neglected and was exploited financially by 'friends' she made in her neighbourhood. There were a number of incidents where Pam left her door wide open when leaving the house, and there are concerns around her safety on roads and in kitchens as she has little awareness of risks to her safety. She has a strong desire for friendship and can be too kind, once being found with very few clothes and household items as she had given them all away. She also suffers from delusions and hallucinations which can be incredibly distressing to her, causing her to scream and lash out at what she is seeing and hearing. This has caused some members of her local community to react negatively towards her. Pam loves to be outdoors and has been her best when she attended an allotment club that allowed her to make friends and learn to grow food in a supportive and understanding environment. Pam has recently been diagnosed with diabetes and requires support to maintain her physical health. She needs a long-term placement where she can make good friends and receive supervision to ensure her safety.

Figure 11: Range of new residential packages agreed recently

Note – names have been changed

Figure 12: Main diagnosis and additional complexities in new packages agreed recently



9.6. Housing with Care

We have a number of housing with care places that are used for older working age people with severe and enduring mental health needs who are relatively settled and able to live with some independence, but will continue to need a level of monitoring and support for the long term, and where the level of need is too great for community-based support. For these clients, high quality housing with care offers them some independence in their own flat, but supervision and support as needed and the option to increase the level of care, including domiciliary care, as they get older should they need this.

In Coventry we currently lack sufficient specialist mental health housing with care places, so would be interested in commissioning a scheme where staff have enhanced mental health training and are able to support people whose mental health may fluctuate. This should include night staff.

We would expect provision to be asset-based, promoting independence and maintaining skills and interests in clients wherever possible. The scheme would be intended as a long-term home for the client, so we would expect the provision to be able to support people as their physical needs became greater.

We would be particularly interested in provision that could support people with specific needs such as early onset dementia, dual diagnosis or a combination of mental health issues and learning disability. However, while supporting people with dementia would be an advantage, it is acknowledged that this may require different skills and environment, so early onset dementia is dealt with separately in this plan.

We anticipate requiring around 15 additional mental health housing with care places over the next five years. This could be as a small standalone unit or, preferably, well integrated into a larger scheme. An indicative price for this kind of provision would be £16.25 per hour.

Example pen picture - Brenda

Brenda is 62 and previously worked as a shop assistant, enjoying socialising with colleagues outside work. Colleagues and customers noticed her personal hygiene and timekeeping deteriorating, and she often became upset and angry saying people thought she was stealing from the shop, though there was no evidence of this. Brenda stopped socialising, and then stopped coming into work altogether. Unable to contact her, her manager visited and found her home in a state of disrepair, full of rubbish and unsanitary, and Brenda unable to communicate. She was admitted to hospital and received medication and therapy and has improved significantly. However, she agrees returning to living alone would not suit her, and she still requires support to remain well and care for herself and her home. She also worries about her physical care needs increasing in the future and has no close family able to support her. She would like a long-term place where she can live independently but be supported and have a community around her.

9.7. Housing with Care for people with early onset dementia

While most dementia is outside the scope of this working age mental health plan, we are seeing an increasing number of people aged 30 to 65 with early onset dementia who require support. People with early onset dementia may struggle in mainstream mental health accommodation with people their own age due to their dementia symptoms. However, the majority of specialist dementia provision is aimed at an older demographic. People with dementia often have a reference point of when they were a child or young adult, so if there is a significant age gap between residents, cultural reference points and reminiscence work will be challenging, and it may be more difficult for them to make friends and enjoy group activities.

In younger people dementia is often particularly unexpected and they may still be working or have dependents. This needs to be considered when designing support for this group.

We would like to commission dedicated housing with care provision for people with early onset dementia. The accommodation and support must be tailored to meet the specific needs of younger people with dementia, such as providing a highly dementia-friendly physical environment. The environment should be well-designed with green space, shared areas including kitchens and lounges, and individual self-contained flats with relevant safety features. Good use should be made of assistive technology to support residents to live well and independently for as long as possible, and consideration given to the likely circumstances and needs of younger people with dementia.

Staff will need to be trained in supporting people with dementia, including with behaviour that challenges. This must include recognition of delirium and other indicators of physical illness or discomfort in people living with dementia, and support with their mental wellbeing.

Individualised activity and support plans for each resident should be used to ensure they are kept engaged and maintain their independence for as long as possible. This includes taking comprehensive histories from the resident, family and friends and using this to help unlock their dementia and make the world make more sense to them. As well as increasing the wellbeing of the client, it can have a significant impact on behaviour that challenges.

We would aim for the provision to be the client's long-term home, so it would be important that it was able to accommodate people with more advanced dementia, as well as increasing physical needs. Ideally the scheme would be equipped to include people with Korsakoff's dementia.

There is a wealth of research internationally and more locally about successful schemes for people with dementia, so we would encourage prospective providers to be creative in developing this provision.

We anticipate requiring around 10 additional early onset housing with care places over the next five years. This could be as a small standalone unit or, preferably, well integrated into a larger scheme. An indicative price for this kind of provision would be £16.25 per hour.

Example pen picture - Lynn

Lynn is 56 and was working as a teacher when she was diagnosed with early onset vascular dementia six years ago. Initially she remained mobile and independent, still enjoying music and socialising with her friends and family. Recently however, following a UTI, her condition has deteriorated and her husband has become unable to support her at home. She often becomes agitated and can be verbally aggressive. She has begun hallucinating and talking to herself, and this can interfere with her daily routines. She also requires help shopping, using transport and dressing. She had a stroke two years ago which led to reduced mobility. On her better days she sings along to 1980s pop music she remembers from her youth, and though she doesn't know their names, her whole demeaner changes when she sees her grandchildren, providing a glimpse into her earlier life as a young primary school teacher.

Case study – De Hogeweyk Dementia Village, Netherlands

Opened in 2010, De Hogeweyk is a small community for people living with dementia. It aims to provide as normal a life as possible, rather than an unfamiliar hospital or care home environment. People live in a small group of like-minded people where they can develop friendships.

The accommodation is built around the edge of the plot with a series of streets, squares and a park in the middle. Accommodation for 152 residents is organised into 23 households of 6 or 7 residents. Each household has a kitchen, dining area and living area, with single occupancy bedrooms. Residents eat together and are encouraged to help with food preparation for their household.

Households are grouped according to lifestyles so residents have things in common and similar values. Each household has a dedicated staff team. Residents have to go outside of the household to reach communal facilities such as shops, cafes, a pub and a theatre, and to attend communal activities.

While this is a much larger facility than we are looking for in early onset dementia provision, principles of the model can be applied on a smaller scale – indeed De Hogeweyk started as a wing of a traditional care home. A local example with similar principles, though not specifically for early onset dementia, is Arden Grove in Coventry.

For more information please see: http://www.cpa.org.uk/information/reviews/CPA-International-Case-Study-4-Housing-and-Dementia-Care-in-the-Netherlands.pdf

Dementia-friendly environments

Guidance on self-assessment and designing a dementia-friendly environment can be found at: https://www.kingsfund.org.uk/projects/enhancing-healing-environment/ehe-design-dementia

Some examples of what we would expect to see include:

- Use of safety features and assistive technology to avoid household risks and enable people to be independent for longer (alarms, window restrictors, cooker shut offs etc).
- Minimising falls, distress and disorientation risk by using adequate, even lighting, avoiding large mirrors and shiny floors, avoiding uneven walking surfaces and having clearly defined grab rails in corridors and bathrooms.
- Features such as reminiscence pictures of familiar items and events from a period they connect with, or themed corridors or areas can help people navigate the unfamiliar environment. Different coloured doors with landmarks and pictures can help people locate their flat and communal areas.
- Consideration must be given to helping people keep their independence and dignity. This includes adapted cutlery and crockery in plain, primary colours, and bathrooms with contrasting coloured doors, toilet and grab rails visible from the bed.

9.8. Respite and emergency beds

We often require short-term beds at very short notice. This may be because a placement has broken down, someone is leaving hospital or because a family carer needs respite. In these cases we need a bed we can access at short notice (including evenings and weekends) where staff are able to support people with a range of different needs, who may be coming out of crisis.

We would like to commission beds, ideally as part of a number of other provisions, which could support people for a period of between one night and twelve weeks. We will consult on an approach which enables providers to join a framework where vacant beds can be offered for short-term, immediate access to provide a specified assessment and step-up or step-down programme while a suitable longer-term placement is found or it is confirmed that the client can return to the community.

This would need sufficient staffing to support someone who may have high needs or be unsettled due to the move. They would need to provide a safe and welcoming environment for someone staying short-term, though this could be in a room or a self-contained flat or studio. Night staff would be required to ensure the provision was able to support people with more severe needs.

We anticipate requiring around 5 places over the next five years. Pricing structure for this kind of provision would be negotiable due to the different types of provision that would be suitable and the varying needs of clients. We plan to engage with providers to understand requirements from the health and social care system to make this approach effective.

Example pen picture - Jim

Jim is 26 and has bipolar disorder. He lives with his mother, step-father and 13 year old brother, with whom he usually has a good relationship. Though they have had some difficult times, the family want to stay living together, and with support from his social worker, community support and a local voluntary organisation, the family generally cope well. On Thursday evening the duty social worker received a call from Jim's mother saying he had physically threatened her. He was later apologetic, but they both felt they needed a break from each other as tensions have been rising recently and he was worried he might take it further next time. It was agreed that Jim should stay in short-term respite provision for two weeks, during which time his medication will be reviewed. Jim will need to be in the respite provision by the weekend.

Example pen picture - Alice

Alice has a history of eating disorders and significant anxiety and depression. She has recently completed the hospital portion of her most recent treatment plan, and is very keen to be discharged from hospital, as the environment adds to her anxiety and depression and makes her feel "like a sick person". There is also pressure to discharge her to enable her bed to be used for another patient. A potential supported living placement has been identified for her but will not be available for another month, and her independent living skills and level of ongoing risk in a less intensively supported environment need to be assessed first. She therefore needs a short-term placement where she can continue her recovery in a supportive but less institutionalised environment.

9.9. Summary of projected need

Table 3 summarises the projected needs described in this document, providing an indication of the levels of services we may wish to develop in the next five years. Developing these provisions will enable us to better meet existing need, offer Coventry people placed out of city the chance to return where appropriate, and to support the projected increased numbers of people requiring support in coming years.

Table 3: Summary of projected need

Type of provision	Estimated places needed	Indicative hourly or weekly cost (2020/21 prices)
Supported living	40	£13.78- £17.20
Staircase supported living for young people	15	£13.78- £17.20 with initial flexibility
Support for high risk individuals	25	£800-£1,500
Support for individuals with complex needs	30	£13.78- £17.20
Residential	On merit	£650-£1,000
Nursing	On merit	£1,000-£1,900
Housing with care	15	£16.25
Housing with care for people with early onset dementia	10	£16.25
Respite and emergency beds	5	Flexible depending on support offered

10. Outline proposal for development of the market

Table 4 provides an indication of the type of commissioning activity we currently estimate needing to carry out to meet the demand described in this document. However, commissioning will take place in the context of wider system changes, including those coming out of the Mental Health Transformation programme, which will affect our need for services. Estimated demand is based on current projections, which may change as the long-term impacts of the Covid-19 pandemic become clearer. The outline plan below sets out indicative timescales for implementing a combination of commissioning new provision and reviewing and improving existing provision. Where needed this may involve decommissioning any existing provision that is not able to reach the required standards to ensure provision across the market remains relevant to local need.

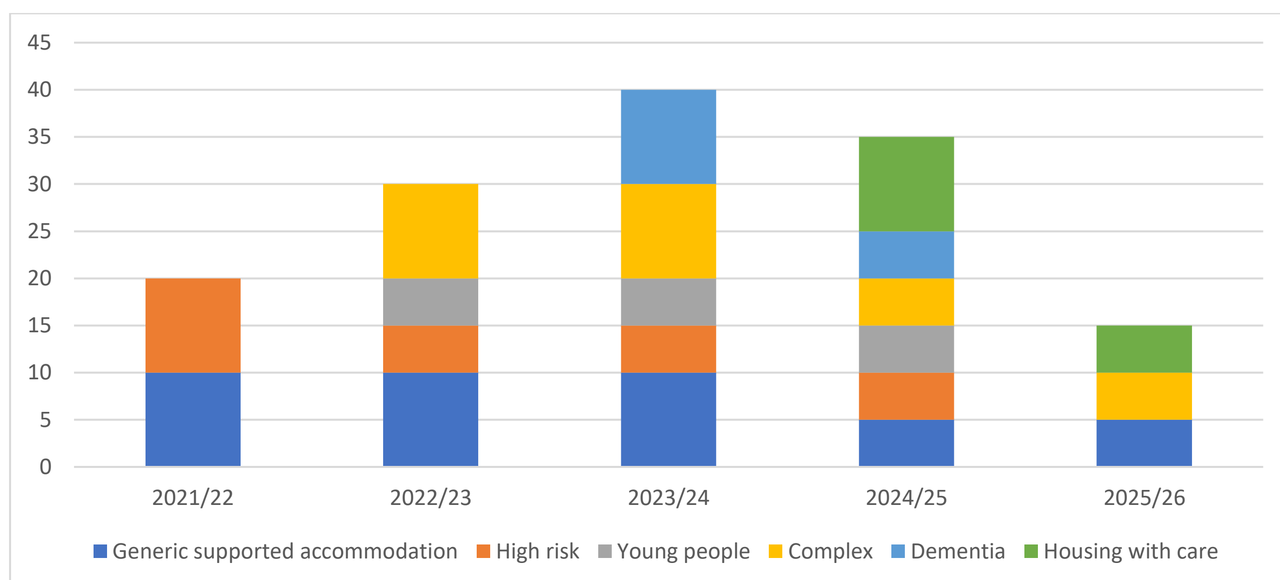
Table 4: Indicative outline five year plan for developing the market

Year	Key priorities	Anticipated achievements at year end
2021-22	Forensic and other high-risk beds	10 additional beds
	Generic supported accommodation beds	10 additional beds
	Emergency, respite and step up/down beds	Framework developed and launched
	Additional provision as required for identified clients	Requirements met
	Providers supported with post-Covid service recovery and development	All providers reviewed by Commissioning and supported to improve where needed
2022-23	Supported living for young people	5 additional beds
	Support for people with complex needs	10 additional beds
	Forensic and high-risk beds	5 additional beds
	Generic supported accommodation beds	10 additional beds
	Emergency, respite and step up/down beds	All providers have been invited; framework working well
	Additional provision as required for identified clients	Requirements met
	QA approach shared with providers and self-assessment encouraged	Support to providers to understand and meet requirements
2023-24	Early onset dementia beds	10 additional beds
	Supported living for young people	5 additional beds
	Support for people with complex needs	10 additional beds
	Forensic and high-risk beds	5 additional beds
	Generic supported accommodation beds	10 additional beds
	Additional provision as required for identified clients	Requirements met
	Review quality and use of provision	Providers not meeting required standard supported to improve
2024-25	Mental health housing with care beds	10 additional beds
	Early onset dementia beds	5 additional beds
	Supported living for young people	5 additional beds
	Support for people with complex needs	5 additional beds
	Forensic and high-risk beds	5 additional beds
	Generic supported accommodation beds	5 additional beds
	Additional provision as required for identified clients	Requirements met
	Review quality and use of provision	Providers not meeting required standard supported to improve
2025-26	Mental health housing with care beds	5 additional beds
	Support for people with complex needs	5 additional beds
	Generic supported accommodation beds	5 additional beds
	Additional provision as required for identified clients	Requirements met

	Review quality and use of provision and potentially decommission if required	Providers not meeting required standard no longer used by the council

Figure 13 summarises anticipated activity each year.

Table 13: Indicative five year plan for developing the market



In Coventry we have already begun developing additional high-quality provision for people with mental health needs. Table 5 provides examples of schemes that have recently opened or are being developed currently.

Table 5: Recent and potential upcoming developments

Description	**Timescale**	**Beds**
5 bedded women's reablement flats on Middleborough Road, aimed at move on within two years via a structured programme. This unit is currently full with one resident having successfully moved on to independent living in the community.	Completed 2019/2020	5
4 bedded men's reablement flats on Holyhead Road, aimed at move on within two years. Can support residents with a forensic background. This unit is currently full.	Completed 2019/2020	4
18 bedded supported accommodation replacing and expanding on a previous supported accommodation provision. Set across two units based on intensity of need. Individual flats with some two-bedded. Able to support some residents with forensic background within their mix of clients. This unit is well used and currently has two vacancies.	Completed 2019/2020	18
11 bedded women's reablement unit able to support women with additional vulnerabilities or experience of abuse.	Completed 2021/2022	11
5 bedded women's residential unit developed with specific long-term clients in mind, with a view to offering a long-term home and freeing up beds elsewhere in the system.	Completed 2021/22	5

14 bedded rehabilitation and move on unit aimed at accommodating people with severe and enduring mental illness. Potential to support people some clients with a combination of learning disability and mental health. Potential to allocate two beds as respite beds.	Initial stages of development – estimated opening 2022/2023	14
Newbuild 14 bedded supported accommodation unit for people with severe and enduring mental illness. This will include provision suitable for people with a forensic history and will include several accessible rooms.	Currently being built – estimated opening 2022/2023	14
18 supported accommodation units across two schemes, with one focusing on learning disabilities and one on mental health primarily.	Estimated opening 2022/2023	9
6 specialist high acuity residential beds. This would be aimed at individuals with a combination of learning disabilities and mental health issues with very high levels of support needs.	Estimated opening 2022/2023	6