NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Transforming adult mental health inpatient services in Staffordshire and Stoke-on-Trent

2024-27

Contents

Introduction (1 of 3)

This strategy serves as a roadmap for the Integrated Care Board (ICB) and its partner providers, Midlands Partnership University NHS Foundation Trust (MPFT) and North Staffordshire Combined Healthcare NHS Trust (NSCHT) to develop a well-coordinated and responsive inpatient mental health service. **By focusing on optimising bed use, developing integrated care pathways, and prioritising patient wellbeing, the strategy aims to improve access to effective care and ensure positive outcomes for individuals experiencing mental health challenges.**

While this strategy outlines a positive vision, several key challenges need to be addressed:

Demand and capacity management: It can be complex to balance the often-fluctuating demand for inpatient beds with available resources. The strategy explores innovative approaches to managing bed occupancy rates and potentially reducing reliance on inpatient care – through robust community support mechanisms and reducing (with a view to ultimately eliminating) the use of out-of-area placements

Workforce shortages: The national shortage of mental health professionals can impact service delivery. The strategy identifies opportunities to attract and retain qualified staff – potentially through training initiatives and career development programmes – while offering a range of therapeutic interventions to service users

Integration with system partners: Effective collaboration with system partners is crucial for smooth transitions between hospital and community settings. The strategy explores ways to strengthen partnerships and ensure a coordinated approach to care

Financial sustainability: Ensuring the long-term financial viability of inpatient services is essential. The strategy considers cost-effective service models that deliver high-quality care while optimising resource allocation.

Introduction (2 of 3)

The strategy encompasses a range of inpatient bed types catering to diverse needs:

While NHS providers deliver most of the inpatient provision within the ICB footprint, independent sector provision is also part of the local offer.

Considering how we make better use of this capacity will be a focus of the strategy as we seek to reduce and ultimately eliminate out-of-area placements.

Introduction (3 of 3)

Areas for consideration within the strategy:

Population demographics: The strategy will consider the specific demographics of our local population – including age distribution, prevalence of mental health conditions, and potential disparities in access to services. This data-driven approach will ensure the service model caters to the unique needs of the community.

National policy: Alignment with national directives for mental health service provision, such as the NHS Long Term Plan's focus on community-based care, will be a key consideration. The strategy seeks to find a balance that leverages the strengths of inpatient care, while promoting community-based interventions whenever appropriate.

Collaboration and stakeholder engagement: The success of the strategy hinges on fostering strong partnerships with mental health providers, local authorities, voluntary sector organisations, and critically, service users and their families. This collaborative approach will ensure a comprehensive and coordinated service that reflects the diverse needs and perspectives of all stakeholders.

Focus on reasonable adjustments and support: This strategy specifically addresses the needs of patients with learning disabilities (LD) and autism spectrum disorder (ASD) who may require inpatient mental health services.

This ICB strategy is not a static document. It will involve ongoing data analysis, service evaluation, and stakeholder engagement to ensure **continuous improvement** and **responsiveness to evolving needs**.

By working collaboratively, the ICB and its partner providers can strive to deliver a **robust, effective, and future-proof** inpatient mental health service that meets the needs of the people of Staffordshire and Stoke-on-Trent.

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Our population health

Geographical and social context

Staffordshire and Stoke-on-Trent (SSoT) ICB covers a diverse population, including some of the most deprived urban areas in the country and affluent rural countryside.

Deprivation: While the overall rate across SSoT is in line with the national average, this masks considerable variation:

- **England:** 21.67 Index of Multiple Deprivation (IMD) 2019 score
- **SSoT:** 20.64 IMD 2019 score

There are also large numbers of people living in Core 20 areas – 217,000 people (19% of the population).

Income: Average gross weekly pay for full-time workers in considerably lower than the national average:

- **England:** £645.80
- **Staffordshire:** £630.70
- **Stoke-on-Trent:** £568.20

Unemployment: While in line with the England average across the ICB, the number of long-term jobseeker benefit claimants in Stoke-on-Trent is higher than average.

Homelessness: Generally lower than the England average in Staffordshire, but higher than the England average in Stoke-on-Trent.

Ageing population: The ICB has an ageing population, with an under-representation of working-age adults compared to the England average, and an over-representation of people aged 55 and over.

Ethnicity: The 2021 Census indicates that the local population is considerably less ethnically diverse than the England average:

- **England:** 81% White, 9.6% Asian / Asian British
- **SSoT:** 91.31% White, 4.8% Asian / Asian British

Mental health inequalities at population level
(1 of 2)

Depression: Data from the Quality Outcomes Framework (QOF) suggests a higher-than-average rates of depression across SSoT:

- **England:** 12.7
- **Staffordshire:** 13.4
- **Stoke-on-Trent:** 17.9

Severe mental illness (SMI): The QOF data again points to a higher burden of disease in Stoke-on-Trent, with lower-than-average rates in Staffordshire.

Mortality rates in people with SMI: Excess under-75 mortality rates in adults with SMI are high across SSoT, which appear to be driven by high rates of cancer mortality:

- **England:** 385.9%
- **Staffordshire:** 419.2%

Premature mortality in people with SMI: Similarly, rates in Stoke-on-Trent is high, with cancer being a particular area of concern – but this is in line with high rates of premature mortality across the general population of Stoke-on-Trent.

These findings highlight the importance of **physical healthcare** for the severe mental illness population.

Mental health inequalities at population level
(2 of 2)

In May 2023, the NHS published data on **detentions under the Mental Health Act 1983** for the whole country and every ICB. This was in response to research showing disparities in the use of the Mental Health Act across ethnic groups, with no explanation for the variation. The data measures rates of detention, including people who were detained (or 'sectioned') in hospital for assessment or treatment under the act. As well as providing the data by ethnicity, information by sex, deprivation and age was also included. The detention rate is the number of detentions under the act in healthcare services for every 100,000 people in the general population.

In terms of deprivation: Rates are lower across every deprivation decile in SSoT than the England average, with the exception of the 'third less deprived' group. There is a general trend towards higher rates of detention in more deprived groups than less deprived (for both England and SSoT):

- **England:** 40 per 100,000 in the least deprived group, 148 per 100,000 in the most deprived group
- **SSoT:** 36 per 100,000 in the least deprived group, 125 per 100,000 in the most deprived group

In terms of ethnic groups: National data shows that Black people were most likely to be detained under the Mental Health Act during 2021/22:

- **England:** 342 detentions per 100,000 Black people
- **England:** 72 per 100,000 White people

While rates in SSoT vary considerably across groups, and all other ethnic groups have a higher rate of detention than the White population, the very high rates seen nationally are not reflected in the local data. Although the rate of detentions in Black populations in SSoT is less than half the national rate, this does still represent considerable unexplained difference, which requires much greater understanding.

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Our learning so far

Learning from local data analysis (1 of 2)

In developing this strategy, we have drawn from a wealth of information that exists across our Integrated Care System (ICS) to understand the needs of our local population, what is working well, and where we need to do more to deliver high quality recovery-focused services that empower individuals and promote health equity through a trauma-informed approach.

We have undertaken focused activities to review current practice against the Commissioning Framework for mental health inpatient services, and drawn from a range of associated research, reports and performance data to ensure a holistic view.

To supplement the understanding gained from national data sources, local data was extracted and analysed. The dataset contained 2,795 episodes of inpatient care provided by MPFT and 3,150 from NSCHT. This represented the data of 1,931 individual patients from MPFT and 2,219 from NSCHT, everyone admitted to the in-scope wards between January 2021 and December 2023.

The data was broken down by sex, ethnicity, age and deprivation, with the following themes:

Sex: Female patients were more likely to have had previous recorded contact with adult mental health services and children and young people mental health services, while male patients were more likely to have had recorded contact with forensic services. Males were more likely to be formally admitted and have a flag indicating seclusion on their records, while females were more likely to have flags indicating both incidents and restrictive practice on their records.

Ethnicity: Patients with ethnic minority backgrounds were more likely to be formally admitted and have flags – indicating restrictive practice, seclusion and incidents.

Learning from local data analysis (2 of 2)

Deprivation: Patients in the more deprived groups had a much greater number of previous referrals to adult services, and a greater proportion had a previous forensics referral. More deprived patients had a higher rate of incident flags on their records.

Age: Younger patients had more records of previous admissions, a greater proportion of restrictive practice flags, and a greater proportion of incident flags. Older people were more likely to be formally admitted.

Based on the results of this analysis, there are several avenues for further work:

- While there are clear differences in this data, very little is known about the **life experiences** of patients before they became inpatients, and therefore the factors driving these differences. A much broader view of case-mix and patient history will provide a greater understanding as to the underlying causes of the differences seen here
- Higher quality data regarding **demographic characteristics** such as sexuality is vital to understand the experiences of minority groups. Data relating to sexuality, gender identity, veteran status and disability was not presented here due to either very small numbers or lack of recording
- Information about **physical health** is lacking and would provide much greater insight into the overall health of inpatients.

Learning from our communities (1 of 2)

Developing this strategy in the pre-election period resulted in the postponement of dedicated public engagement events. However, we have drawn on a range of other engagement and co-production activity to inform our approach – which we commit to continuing as an iterative process for the duration of this strategy and beyond.

Public consultation undertaken in 2023 in respect of alternatives to inpatient treatment reflected people's **desire to receive care and support closer to home and in the community – wherever possible**. This was balanced against concern for the impact on carers and families, and whether community services could fully meet need.

Over the last three years, our system has transformed adult community mental health services – receiving positive recognition at a regional and national level. But we know there is more to do as **we continue to embed these changes and reflect on feedback**, such as the 2023 Community Mental Health Survey. This includes **improving approaches to person-centred care** – such as reasonable adjustments associated with neurodiversity.

We understand much of the change required to improve inpatient quality sits outside of the inpatient setting. This is why our Year 1 Delivery Plan includes a series of 'deep dives' focused on our patient and service user journey (from pre-admission, during treatment, to post-admission):

- ✓ They will be multi-agency
- ✓ They will include the input and perspective of those with lived experiences
- ✓ They will be explored through the lens of health inequality.

Learning from our communities (2 of 2)

Our three-year inpatient population health analysis demonstrated that health inequalities identified within mental health services nationally are present within our own system.

Action is required to **understand the reasons** for this, in order for us to take the appropriate steps to address them.

A **patient experience survey** exploring the relationship between protected characteristics and experiences of care and support will also inform the approach.

Our services are not delivered in a static environment, and **must constantly adapt** in response to changes in population need, support and service provision available across the Integrated Care Partnership.

The **deep dives** will support us to understand the impact of developments through community mental health transformation and beyond to ensure our pathways provide continuity and support and align with the objectives of the Inpatient Quality Transformation Programme.

Learning from our workforce (1 of 3)

A recent S117 survey received 107 responses from practitioners working across the ICS in a range of disciplines.

Key themes explored included:

The findings from the survey and the views of our workforce strongly align with the aims of the Inpatient Quality Transformation Programme. They include improving the range of community support and crisis alternatives and the need to improve services for specific cohorts, for example crisis alternatives for older adults.

Learning from our workforce (2 of 3)

Survey responses also reflected a need to ensure a holistic approach to care through inpatient and community settings through effective **multi-disciplinary team (MDT) approaches**. These incorporate a broad range of statutory and voluntary, community and social enterprise (VCSE) partners across a range of domains – including housing, substance misuse, and employment.

This feedback was further developed through a **system-wide workshop** for Staffordshire and Stoke-on-Trent, held in June 2024.

This strategy has developed while the local authorities have been leading the system S117 activity. However, **the significant interdependencies and shared objectives between the S117 activity and the Inpatient Quality Transformation Programme are now understood**, and will be reflected and managed through programme design and governance.

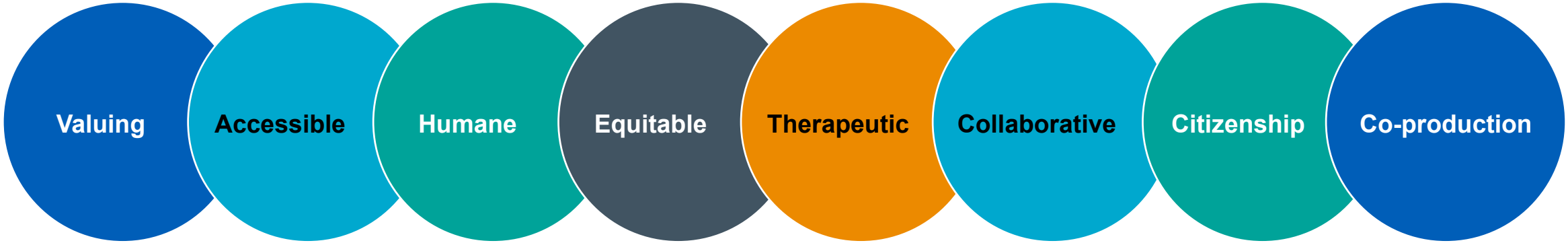
Opportunities for improvement were identified, which broadly align to five key themes:

1. **Process**
2. **Workforce development**
3. **Market development**
4. **Data**
5. **Improved joint working**

Learning from our workforce (3 of 3)

To assist in the development of this strategy, a range of staff from across our inpatient settings were involved in **workshops to support a self-assessment against nationally, co-produced 'I/We statements'**. These workshops offered an opportunity for honest reflection and high-quality discussion on what is working well, and where improvements are needed.

I/We themes:



The workshops identified variance across the thematic areas and the cohorts covered by this programme (adults, older adults, rehabilitation, and people with a learning disability and/or autism). **The average score across the self-assessment was three, with areas of strength identified within valuing, humane and therapeutic.**

The varying approaches within each trust will result in some differences, for example in relation to the role of lived experience and peer workers within inpatient settings. Self-assessment of the 'We' statements by our workforce must be set against assessment of the 'I' statements by service users and those with lived experience. This will form a key strand of activity during Year 1 of the programme.

Learning from audit activity (1 of 2)

An in-depth audit against the Commissioning Framework for Mental Health Inpatient Services was undertaken on a targeted sample of patients from across all in-scope MPFT and NSCHT wards. The sample included patients discharged in the 12 months to April 2024 to better understand current practice and identify areas for future development. **Two audits were completed – one for the general patient population and one for patients with a learning disability and/or autism (LDA)**. The audit format was adapted for the LDA audit.

General inpatient audit:

In total, **70 patients** were identified across MPFT and NSCHT from adult acute, PICU wards, and the rehabilitation ward at NSCHT.

Note that as the audit activity focused on evidence of adherence to standards within clinical records, a lack of evidence identified doesn't necessarily mean that the activity did not happen. However, **the importance of accurate record keeping is not underestimated, and will be a key determinant of how we measure the progress and impact of this strategy**.

Key themes from the audit:

- ✓ Strong evidence that care planning is undertaken based on assessment and that plans are available in the Electronic Patient Record (EPR)
- × Less evidence of patient involvement in the development of care plans or patients having a copy of their care plan
- × Less evidence of holistic assessment, records of advanced decisions, and reasonable adjustments
- ✓ Evidence relating to purposeful admissions shows standards are consistently met
- × Inconsistent recording of purpose of admission being discussed with patients and carers
- × Inconsistent application of factors related to discharge planning such as beginning within 72hrs
- ✓ Discharge was facilitated promptly and consistently followed up within 72hrs
- ✓ Limited evidence of a lack of community-based support being associated with delays for patients that were clinically ready for discharge.

Learning from audit activity (2 of 2)

LDA audit:

In total **24 patients** were identified.

- At MPFT and NSCHT, patients were identified on adult acute and PICU wards
- No patients were identified from the older adult wards at NSCHT or MPFT
- No LDA patients were identified from the rehabilitation ward at NSCHT.

The **recording of and ability to identify patients with a learning disability and/or autism** across inpatient wards has already been identified as an area for improvement.

Key themes from the audit:

- ✓ Strong evidence of timely assessment on admission as well as admission being purposeful
- ✓ The purpose of admission was discussed with carers and uploaded to the EPR
- × Inconsistencies in care planning, including patient involvement in care planning and providing a copy of the care plan
- × At times, staff with additional training to better support LDA patients were not available
- ✓ Factors that could delay discharge were considered
- × Discharge planning did not always occur within the recommended 72hr window after admission
- ✓ Follow-up within 72hrs of discharge occurred in most cases
- × There were minimal records related to patients clinically ready for discharge but whose discharge had been delayed.

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Our commitments

What good looks like in
Staffordshire and Stoke-on-Trent

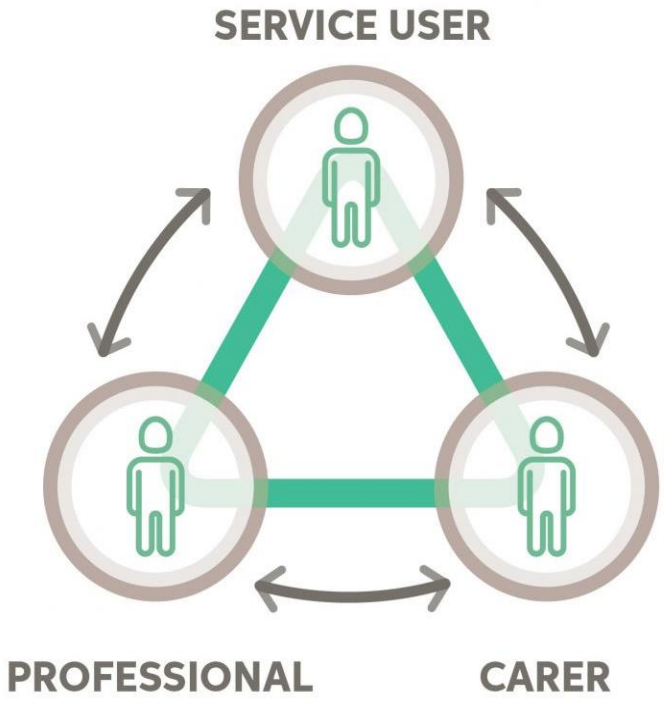
Valuing, co-production and lived experience (1 of 2)

We are committed to involving and integrating people with lived experience into mental health services – recognising the profound impact this has on service design, delivery and outcomes.

We will continue to value the contributions of those with lived experience and ensure meaningful involvement through a range of methods and tailored communication approaches. **We will ensure the principles and approaches to 'valuing' translate through activity as part of the Host and Home Commissioner pilot to ensure equity of approach for those that are placed out of area.**

The **Triangle of Care** is currently used across both MPFT and NSCHT. This comprehensive framework enhances collaboration and partnership between mental health professionals, service users and carers, ensuring all three parties are actively involved and have a voice in the care process.

Through this strategy, **we will work to ensure consistency in the use of Triangle of Care** and explore opportunities to formally commit to an overarching framework for the ICS, such as **4Pi** (Principles, Purpose, Presence, Process and Impact).



Valuing, co-production and lived experience (2 of 2)

Both trusts currently use peer recovery and lived experience roles in different ways. It is important for organisations to retain flexibility in approach, but we will work to ensure that where approaches may differ, the impact, outcomes and satisfaction of those with lived experience is equitable across providers and communities.

The **Culture of Care programme** will be a key enabler, with opportunities for sharing and responding to good practice, for example through action learning sets.

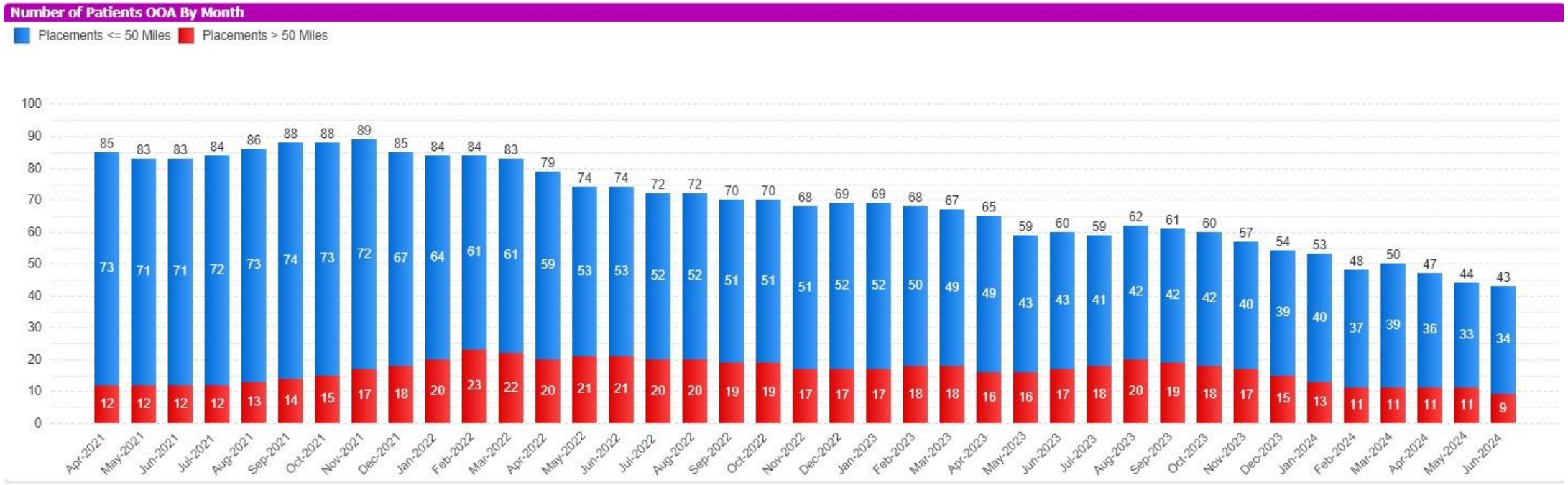
The trusts have worked collaboratively to successfully deliver the **Adult Community Mental Health Transformation Programme** which included the development of person-centred care planning. Further development and embedding of person-centred care plans within inpatient settings is a key component of this strategy, and critical to understanding and valuing the needs and wishes of service users.

Our approach will be informed by the data and learning arising from our **population health analysis**.

Accessible (1 of 2)

We are committed to ensuring our services are needs-led and accessible to all who need them.

As a system, we manage demand for acute beds well within existing capacity, with relatively few out-of-area placements – but we have identified **female PICU beds as an ongoing challenge**. Historically, we have experienced greater pressures in **Level 2 rehabilitation**. **We have reduced the total demand for these placements by almost 50% in the last three years through effective MDT approaches** that have supported the consideration and development of community-based alternatives.



Accessible (2 of 2)

We are committed to delivering a further reduction in out-of-area placements through strategic commissioning approaches. These include the Home and Host Commissioner pilot to ensure better use of independent capacity within the ICB footprint, with participation in regional planning and commissioning approaches where appropriate.

We recognise that the needs of adults with a learning disability and/or who are autistic must be a central consideration. We must go further in understanding and delivering a **consistent approach to reasonable adjustments,** that would mean a greater proportion of this population (for whom out-of-area placements continue to be high) are able to have their needs met locally.

Within this, a focus on **person-centred care** will ensure that individual needs are considered, making clear that a consistent approach to delivering appropriate reasonable adjustments does not mean treating adults with a learning disability and/or autism as a homogenous group.

The **demand and capacity planning work** scheduled for Year 1 of the programme will be instrumental in ensuring we plan for and deliver provision that is reflective of the needs of our local population.

Humane (1 of 2)

We are committed to delivering inpatient services that are person-centred and least restrictive. We have co-produced existing restrictive practice reduction strategies, and the impact of such strategies has been evident through reductions in the use of physical restraint and rapid tranquilisation.

Our providers have **invested in delivering trauma and psychologically informed training models** to staff that have been developed with the support of those with lived experience and their families. Models include the Institute of Conflict Management DMI training, Crisis Prevention Institute (CPI) safety interventions training and the Association for Psychological Therapies RAID training.

We will build on our success and seek to go further as we recognise inconsistencies in current approaches and opportunities for greater collaboration between our providers to share learnings. This will act as a key enabler as we roll out and successfully embed the Culture of Care programme.

Through a holistic and co-produced approach, we will ensure a multi-dimensional view of care – for example **consideration of environmental factors from the perspective of least-restrictive, trauma-informed and reasonable adjustments**.

Humane (2 of 2)

As part of our planning and delivery of improved commissioning approaches, including through our Host and Home Commissioner Pilot, **we will ensure these principles and commitment translate across independent sector provision** – including a move away from blanket restrictions to controlled access and egress systems determined by individual clinical assessment.

We will take the **learning** from successful MDT approaches used in the management and oversight of rehabilitation placements. We will apply this, as appropriate, to the **management of out-of-area acute placements**, which are fewer in number but of no less importance.

Equitable

We are committed to commissioning and delivering services where everyone counts, are treated with dignity and are safe – irrespective of where they live, their background, age, ethnicity, sex, gender, sexuality, disability of health conditions.

In establishing the underpinning evidence base for this strategy, we have committed considerable to resource to identify any inequalities in our current inpatient services and pathways. **We have a deeper understanding of local demographics and the varying needs of the populations across the ICB geography** – supported by the concurrent development of the ICS Health Inequalities Strategy. We also understand where there are gaps in our knowledge, for example being able to accurately report on the number of individuals with a learning disability and/or who are autistic across our inpatient wards. We are already taking action to address this.

A deep-dive into our inpatient population over the last three years has offered important insights but also raised more questions. **While we now understand where inequalities may exist, we do not always understand the reasons for this.** Only when we truly understand the reasons for inequality will we be able to take the appropriate action to address it. This must happen as part of a whole system approach and the established governance arrangements of which this programme is a part, ensures alignment across mental health, learning disability and autism services.

Our first step is engaging those with lived experience to seek their views and insight, along with that of our workforce. We will work collaboratively and use these insights to shape the subsequent programme of activity.

This will integrate and align with other relevant programmes as appropriate – for example implementation of Patient Carer Race Equality Framework and delivering the ICS Health Inequalities Strategy.

Therapeutic

Therapeutic care in mental health inpatient settings should be comprehensive, patient-centred and holistic. We are committed to delivering evidence-based services that demonstrate therapeutic benefit and support and sustain therapeutic relationships.

There is significant variance across our inpatient services in terms of the approach to therapeutic and trauma-informed care. While areas of good practice exist, more needs to be done to standardise approaches – including a focus on the patient journey to ensure **continuity through inpatient and community services**. We are committed to working systemically and in partnership to deliver **a co-produced model of therapeutic care that can sufficiently flex to the needs of individuals**, including consideration of protected characteristics.

Workforce is critical to delivering our commitments.
A full review of current MDT approaches will inform longer-term workforce planning and be reflected in each annual planning round over the life of this strategy.

Key principles for our approach, of which the Culture of Care Programme will be a key enabler:

- **Thorough assessment and person-centred care plans** that outline individual therapeutic goals, interventions and timelines
- An **appropriately skilled and experienced multi-disciplinary team** with the capacity to deliver therapeutic care that is subject to regular review
- A **supportive environment** that provides both physical safety and emotional support with appropriate spaces for therapy, recreation and individual reflection
- **Providing patients and their support network with appropriate information** about their condition and treatment options and encouraging them to take an active role in their treatment and recovery process
- Ensuring **integrative care that balances physical health needs with holistic approaches** that promote relaxation and broader wellbeing.

Collaborative (1 of 2)

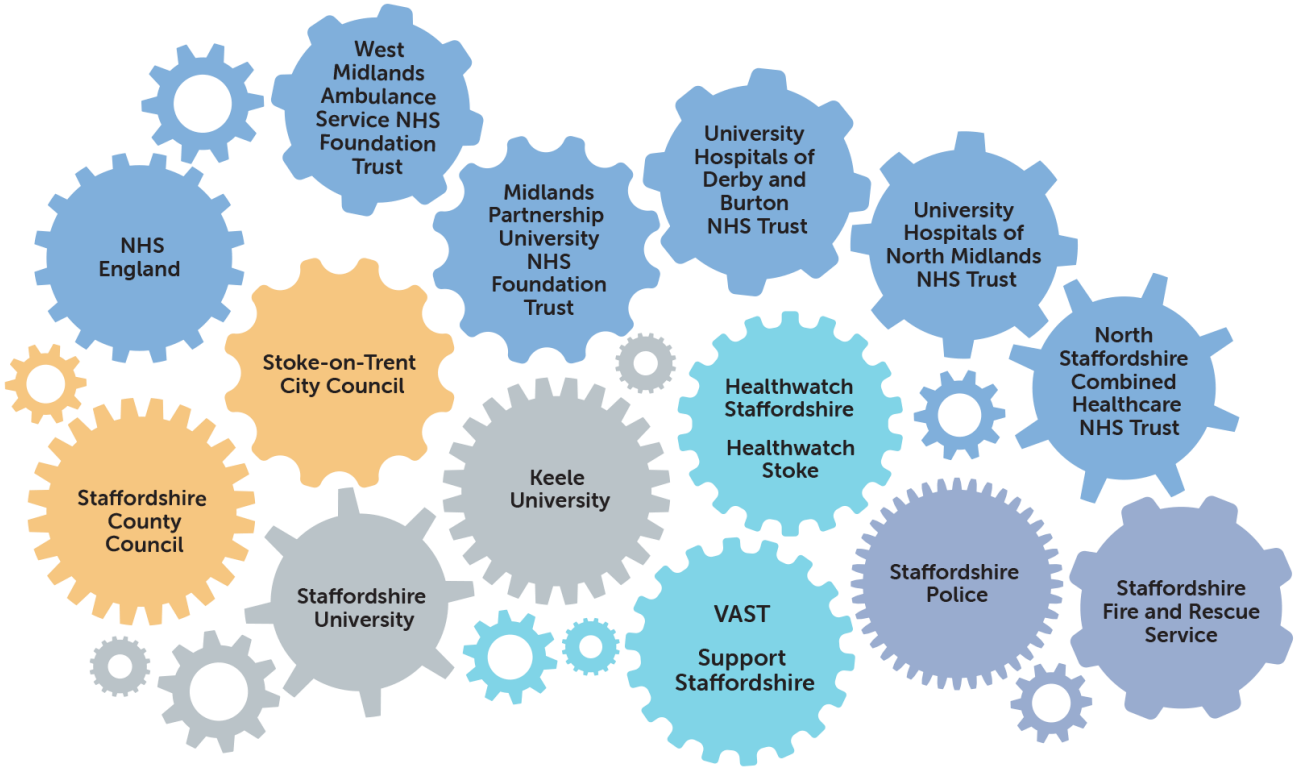
We will work in partnership across our system to ensure a range of appropriate and effective services that can support people within their local communities to ensure no-one is inappropriately admitted to hospital or experiences a delayed discharge.

We are committed to working with the people we provide care for and those that care for them – equipping our workforce with the skills and tools to do this consistently and effectively.

The successful development of the Wellbeing Colleges across MPFT and NSCHT is testament to this.

The system working group established to oversee its development has an immediate reporting line to the Staffordshire and Stoke-on-Trent Mental Health, Learning Disability and Autism Delivery Group. This includes representation from the ICB, MPFT, NSCHT, NHS England, Stoke-on-Trent City Council, Staffordshire County Council and a range of voluntary and community partners.

This has helped to ensure effective alignment and management of interdependencies with existing programmes of work.



Collaborative (2 of 2)

Our system is participating in the **Midlands regional task and finish group** that has been established to support the development of this strategy and the delivery of the associated programme of work. This includes links with relevant Provider Collaboratives, and opportunities to explore regional working where appropriate – for example in relation to commissioning approaches to more specialist provision.

Collaboration is about far more than governance arrangements and we have identified the need for both a **'top-down' and 'bottom-up' approach to developing and delivering our strategic objectives**.

While existing governance supports collaboration, some partners are not currently represented or engaged as this strategy necessitates – including the full range of housing and accommodation providers.

As we move from initial strategy formulation to more detailed development and delivery, we will address this to ensure a more effective approach to the development of **long-term accommodation strategies** that will both prevent inpatient admissions and support with timely discharge.

Citizenship

We will make sure that mental health services support the active participation and social inclusion of adults with a mental health need within their local community. We will continue to respect the value of lived experience in service improvement and continue to invite people who have previously been underrepresented to have a voice.

Through our detailed analysis of inpatient admissions over the last three years, **we have improved our understanding of those individuals and groups who may be most at risk of or vulnerable to restrictive practice and othering**. Our Delivery Plan for Year 1 includes extensive activity to develop our understanding through public engagement, patient and staff surveys, plus further exploration of health inequalities data. With this enhanced understanding, we will be well placed to work collaboratively with those with lived experience, including (as part of the Culture of Care programme) to develop and implement plans to mitigate these risks during Year 2.

As a system, we have previously undertaken extensive mapping to identify the range of organisations and assets that support and represent the needs of the diverse communities we serve. We will use this knowledge to deliver a comprehensive programme of engagement into autumn 2024 that will shape our approach to citizenship within this dynamic strategy. We know **the landscape of our communities and supporting infrastructure is constantly shifting – the engagement programme will provide an important opportunity to update our knowledge and understanding**. This will be supported through the life of the programme by our governance arrangements which ensure appropriate representation and connectivity across the system.

Through our demand and capacity scenario planning, we will focus on **alternative models of care**, informed by deep dives into the patient journey. These models will focus on reducing inpatient admissions and ensuring effective pathways across community and inpatient settings – achieving a collective vision shared by commissioners, providers, stakeholders and citizens that **promotes autonomy and improves quality of life.**

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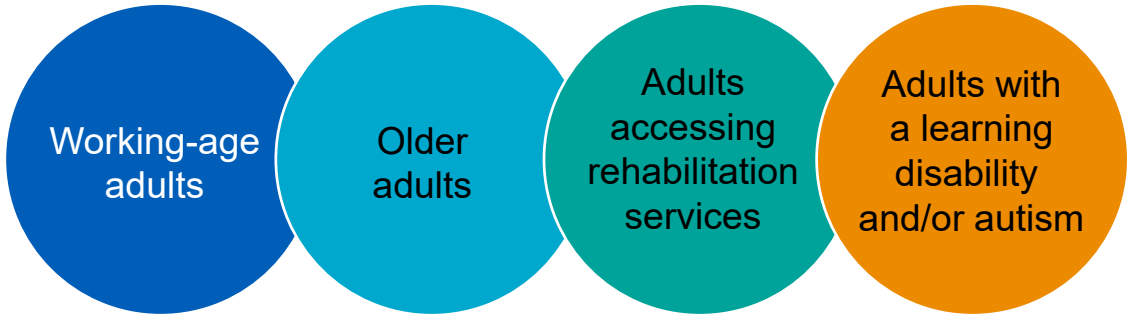
Bringing our commitments to life

Personalised care and shared decision making
(1 of 2)

In developing this programme and through our data analysis, we recognised the need to explore each thematic area of activity from the differing needs and perspectives of those who may fall within any of these cohorts:



This segmentation will be a feature of our approach, but will not detract from our understanding that delivering truly personalised care means treating every person as an individual regardless of any specific group characteristic.

Audit activity undertaken to inform the development of this strategy highlighted **inconsistencies in the extent to which personalised care and shared decision making was evidenced within patient records**.

Workshops undertaken with inpatient ward managers and matrons to inform a self-assessment against the 'I/We standards provided greater evidence of person-centred care and shared decision making. **Examples included:**

- Consistent use of multiple **communication methods**
- Individualised **wellbeing support** mechanisms
- Use of the **Power-Threat-Meaning framework** to support individual psychological formulations and person-centred care planning
- Activity planning that takes account of **personal preferences**, including those linked to culture and religious beliefs
- Well-embedded **patient advocacy services** and links to carers advocacy groups
- A range of opportunities to **capture, record and respond** to the voice and views of patients.

Personalised care and shared decision making

(2 of 2)

Areas for further development have been identified in terms of greater consistency in:

The role of and access to **lived experience within inpatient settings**

Application of **formal mechanisms to ensure involvement of carers**

Access to **translation services**.

Co-production of new, person-centred care plans was a key strength within the Adult Community Transformation Programme, and an area we will build on to deliver the Adult Inpatient Quality Transformation Programme.

Although MPFT and NSCHT adopted different approaches to the development of person-centred care plans as part of community transformation – including the extent to which this was rolled-out across inpatient settings – collaborative system working will ensure **consistent application of the underpinning principles and that differing approaches do not result in differences in the quality of care or outcomes**.

Through the Host and Home Commissioner Pilot, **we will work with independent providers to ensure that the principles and practice associated with personalised care and shared decision making are upheld**.

Purposeful admissions (1 of 2)

To shape and determine purposeful admissions, we need a clear understanding of the offer of both community and inpatient services. **For an inpatient admission to be purposeful, it must be able to do and deliver something which cannot take place in the community.**

The continual evolution of the relationship, interface and pathways between community and inpatient services has supported us to reach a point where **in most cases, audit activity demonstrates a clear purpose of admission**.

The introduction of **'Red to Green'** has also had a positive impact in terms of ensuring that inpatient stays continue to be purposeful during the admission, **but further work is required to successfully embed the approach across all wards.**

Purposeful admissions (2 of 2)

The focus moving forward will be on making sure that the purpose of admission can only be responded to effectively with inpatient treatment. There will be many facets to our approach. **As we review and develop our models of care, we hope to identify opportunities to strengthen current community provision so we can respond appropriately to the increasing levels of acuity that have been observed in our inpatient settings.**

This includes not only the need for appropriate and sufficient crisis alternatives, but also further development of early intervention. As part of this strategy, we are also scoping the feasibility of using predictive analytics within Community Mental Health Teams to support earlier identification of those at greater risk of reaching crisis – facilitating timely Intervention to manage this risk.

We will identify and transfer relevant learning from our **Complex Care** service which has significantly reduced the number of out-of-area rehabilitation placements through robust **MDT consideration** of alternatives and the **development of enhanced community services** to address gaps in support.

Therapeutic and trauma-informed care (1 of 3)

The Adult Community Mental Health Transformation Programme delivered a range of positive changes that have impacted on therapeutic and trauma-informed care.

This has included **improvements to person-centred care planning and care pathways**, supported by wider developments including NHS Talking Therapies, and improved interfaces with primary care (such as through the Additional Roles Reimbursement Scheme)

Continuity of care is a focus for this strategy – ensuring joined-up **support is provided as part of a continuum across community and inpatient services**

Inpatient admissions must be **purposeful, of therapeutic benefit, and ideally short in duration** – the therapeutic framework and interventions offered must align to this

Therapeutic and trauma-informed care (2 of 3)

Initial mapping has explored the range of therapeutic interventions and approaches currently delivered across our inpatient settings. **This highlighted examples of good practice, including group activities that are co-produced and co-delivered with lived experience peers** – but also a fragmented approach

Investments to upskill staff have not always been accompanied by the resource needed to successfully embed

There are differences in the levels and nature of **input from psychological professions**, and challenges identified in terms of the capacity of ward staff to deliver therapeutic interventions

Safer staffing also presents challenges to releasing the necessary capacity and achieving the level of therapeutic skill-mix desired.

Therapeutic and trauma-informed care (3 of 3)

- **We will build on initial mapping and undertake a gap analysis to determine where and how resource should be focused.** This will provide a **framework that considers the full range of therapeutic interventions required and how trauma-informed approaches can support this**
- The gap analysis and framework will be considered as part of the planned wider review of the MDT and to understand who is best placed to deliver what forms of therapeutic intervention – recognising that **all members of the MDT have a role to play**
- The **relationship and interdependencies** between therapeutic and trauma-informed care and our work to further reduce restrictive practice are also noted
- In considering our approach, we have **identified opportunities** to build on current psychologically-informed training models (such as RAID – Reinforce Appropriate, Implode Disruptive) to ensure the impact of such training is maximised and sustained.

Proactive discharge planning and effective post-discharge support (1 of 2)

In developing this strategy, we considered and engaged with the work of the Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS) and Partners in Care and Health on **'Achieving excellence in person-centred discharge from inpatient mental health settings'**.

- We will **explore local application and development of this framework**, the principles of which align with much of the feedback received during recent S117 system workshops
- In accordance with the principles of the framework, we will use this strategy to **promote and ensure parity for discharge from mental health settings within system planning and investment** – such as through the discharge grant and as part of wider spending plans for the Better Care Fund
- We have **identified a range of positive practice** that is currently supporting proactive discharge – including 'Red to Green' and the management of step-down approaches for out-of-area rehabilitation
- We continue to observe an **increase in average length of stay**, and face challenges with the number of **patients who remain on wards once clinically ready for discharge**.

Proactive discharge planning and effective post-discharge support (2 of 2)

While we recognise increasing acuity is a factor, **as a system we have identified the need for better joined-up and enhanced partnership working to fully understand and address the current barriers to planning and delivering proactive discharge**.

- There is a desire amongst health and local authority partners to **pilot additional social work capacity within inpatient settings**, with the funding and mechanisms to achieve this currently being worked through.
- The **system-wide S117 activity will be a key enabler** – with use of tools such as the S117 Maturity Matrix supporting planning (effective planning is also required for those not eligible for S117 after care)
- We will build on **examples of good practice such as enhanced training and support for accommodation providers** as part of a broader accommodation strategy, recognising the complexities of this across the ICB footprint
- We will ensure that our positive progress in reducing restrictive practice within inpatient settings is built on when considering discharge planning and the **application of least-restrictive principles within the community**.

Care that advances health equality (1 of 2)

The development of this strategy has included a significant focus on understanding where health inequalities are present within our existing inpatient services. A range of activities will be undertaken during Year 1 to inform and impact our approach to advancing health equality, including:

Patient and staff surveys focusing on protected characteristics and the impact on individual experiences of care and support. These will be conducted sequentially, so findings from patient surveys (including out-of-area patients) will inform the areas explored with staff. The findings will determine subsequent activity

A co-produced programme of environmental and practice audits and observations, making use of experts by experience, to determine actions required to improve reasonable adjustments and cultural competence. Recognising that offering reasonable adjustments in community settings can prevent admissions, the scope will extend beyond inpatient services where appropriate

A focus on reasonable adjustments and workforce development will be critical in addressing recent trends where an increasing number of adults and young people with autism who do not have a learning disability are admitted out-of-area. The planned deep dives into the patient journey will also hear experiences of young people with autism transitioning to adult services

Participation in the next phase of the National Mental Health Act Quality Improvement Programme delivered by the Virginia Mason Institute and The Public Service Consultants, in partnership with NHS England. Taking place from July 2024 to February 2025, this will build on learning from the pilot programme with an overarching focus on improving equity of experience for groups experiencing significant inequalities under the Mental Health Act.

Care that advances health equality (2 of 2)

Scoping **opportunities to maximise the skills and impact of the workforce**, for example where there are trained learning disability nurses in general mental health nursing roles

Improving the **quality of data capture and recording across a range of characteristics**. Particular emphasis will be placed on capturing improved information on adults with a learning disability and/or autism needs – where there is an identified gap at present

Further development and **embedding of trauma-informed approaches** which recognise and address the impact of trauma, especially in communities with high levels of violence, discrimination and historical oppression

Ensuring activity within the programme is **aligned to the implementation of the ICS Health Inequalities Strategy** and those elements that focus on addressing the wider determinants of (mental) health.

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Our enablers

Culture of Care (1 of 2)

The Culture of Care programme is a significant enabler for the Inpatient Quality Transformation Programme and delivery of this strategy in several ways:

Shared vision and values: Promoting a national vision for improved mental health inpatient care, emphasising compassion, dignity, and recovery. This aligns with the goals of the ICB's quality transformation programme and inpatient strategy

Staff empowerment and development: Focusing on staff development and empowerment. This includes training on trauma-informed care, communication skills, and de-escalation techniques. This aligns perfectly with the need for a skilled and well-supported workforce within the ICB's inpatient facilities. Well-trained staff can create a more positive and therapeutic environment for patients – ultimately leading to better outcomes

Reduction in restrictive practices: Emphasising minimising the use of restrictive practices (seclusion and restraint) on patients. This aligns with the national aim of reducing reliance on such measures. By focusing on de-escalation strategies and building trusting relationships, the programme can help create a safer and more therapeutic environment for both patients and staff.

Culture of Care (2 of 2)

Improved patient experience: Prioritising patient experience and recovery. This aligns with the core goal of the ICB's quality transformation programme – to improve the quality of care for patients in inpatient units. By adopting the programme's principles, the ICB and partners can ensure our inpatient strategy focuses on creating a safe, supportive, and recovery-oriented environment for patients

Collaboration and learning: Fostering collaboration and knowledge sharing between healthcare providers. This aligns with the need for the ICB to collaborate with various stakeholders, including patient groups, staff representatives, and potentially other mental health trusts within Midland's region

Building a sustainable model: Focusing on long-term sustainability by creating a culture that values staff wellbeing alongside patient care. This aligns with the need for our inpatient strategy to be sustainable and ensure a positive working environment for staff to attract and retain talent. A happy and well-supported workforce is more likely to deliver high-quality care.

Workforce

The adult mental health workforce plays a critical role in enabling the Inpatient Quality Transformation Programme and delivery of our strategy. Here is a breakdown of their impact and the challenges to consider.

Enablers

- **Therapeutic relationships:** A compassionate and caring workforce is essential to build trust with patients. Strong therapeutic relationships contribute to better treatment outcomes, patient engagement, and overall recovery. Staff who feel valued and supported are more likely to provide empathetic care – creating a positive environment for healing.
- **Safer staffing:** While it is a key focus and has some positives, safer 'staffing' doesn't always account for the diverse skillsets needed on a ward. Mental health teams require professionals beyond nurses such as occupational therapists, psychologists, social workers, lived experience experts and activity coordinators – who typically contribute to safer staffing numbers. Their interventions are crucial for patient recovery but might not directly impact these metrics – potentially limiting the number of these vital roles on wards.

Challenges

- **Inequity of provision:** Discrepancies in staffing ratios between local mental health trusts create an uneven quality of care for patients across the region. This can lead to poorer outcomes for patients in understaffed facilities. The programme must address disparities to ensure equitable access to high-quality mental health care.
- **Workforce gaps:** The current workforce may not be sufficient to achieve the ICB's ambitious transformation goals. Gaps may exist in specific professions, skillsets, or geographic areas. Filling these gaps requires targeted funding to attract and retain qualified personnel. Additionally, upskilling existing staff through training programmes can further enhance their capacity to deliver on the new strategy.

Continuous improvement

Continuous improvement (CI) is a fundamental enabler for the Inpatient Quality Transformation Programme and delivery of our strategy. Here's how CI fosters positive change:

Strengths

- **Culture of Care programme:** The fact that both local mental health trusts are participating in the first cohort of the Culture of Care programme signifies a strong commitment to CI. The programme emphasises data-driven decision making, staff empowerment, and collaborative problem-solving. This aligns perfectly with the goals of the inpatient transformation programme and ensures the ICB and MH trusts are working with a shared framework for improvement.
- **Action learning sets:** Inclusion in the same action learning sets within the Culture of Care programme facilitates invaluable knowledge sharing between the MH trusts. Learning from each others' successes and challenges helps identify and implement best practices across inpatient services.
- **Existing CI practices:** The fact that both MH trusts have already adopted CI approaches indicates a foundation for future improvement. This existing expertise will be leveraged to drive the transformation programme forward.
- **Collaboration with independent providers:** Integrating independent providers into the CI cycle will introduce fresh perspectives and innovative solutions. Shared learning with them can help identify areas for improvement, and potentially reduce reliance on out-of-area placements for patients.

Host and Home Commissioner (1 of 2)

The Independent Sector and the Host Commissioner programme can be significant enablers for the Inpatient Quality Transformation Programme and delivery of our strategy. Here's how they contribute:

Improved quality and safety in independent providers: Staffordshire and Stoke-on-Trent ICB's pilot of the Host Commissioner programme focuses on improving quality, safety, and care within independent mental health providers. This directly aligns with our system goal of delivering high-quality inpatient services across the entire system. By ensuring independent providers meet high standards, our system can expand its network of reliable care facilities.

Reducing out-of-area placements: Currently, patients from our ICS occupy 35% of independent provider beds within the system. Making the best the use of these beds for local patients is crucial for reducing out-of-area placements. The Host Commissioner programme can achieve this through:

- **Improved communication and collaboration:** The programme fosters better communication between the ICB and independent providers. This can streamline the placement process – ensuring local patients have priority access to available beds
- **Quality assurance:** By ensuring high standards in independent facilities, the ICB can build trust in the Independent Sector – making it a more viable alternative for local patients, and potentially reducing the need for out-of-area placements.

Host and Home Commissioner (2 of 2)

Addressing bed shortages: The ICB has identified a need for additional beds, particularly in female PICU (Psychiatric Intensive Care Unit) and rehab units. Partnering with the Independent Sector offers an opportunity to address this shortage, as the ICB can:

- **Develop targeted proposals:** Work with independent providers to develop proposals specifically targeted towards independent providers with expertise in operating female PICU and rehab units – which has been highlighted as a need for our system.

Repatriation of out-of-area patients: By expanding capacity within the ICS, particularly in female PICU and rehab units, the ICS can facilitate the repatriation of patients currently placed out-of-area. This repatriation would offer several benefits:

- **Continuity of care:** Patients can receive care closer to their homes and families, which can improve their wellbeing and recovery
- **Improved patient experience:** Being closer to home can significantly improve a patient's experience during treatment
- **Reduced costs:** Repatriation can potentially reduce the overall cost of care for the ICB.

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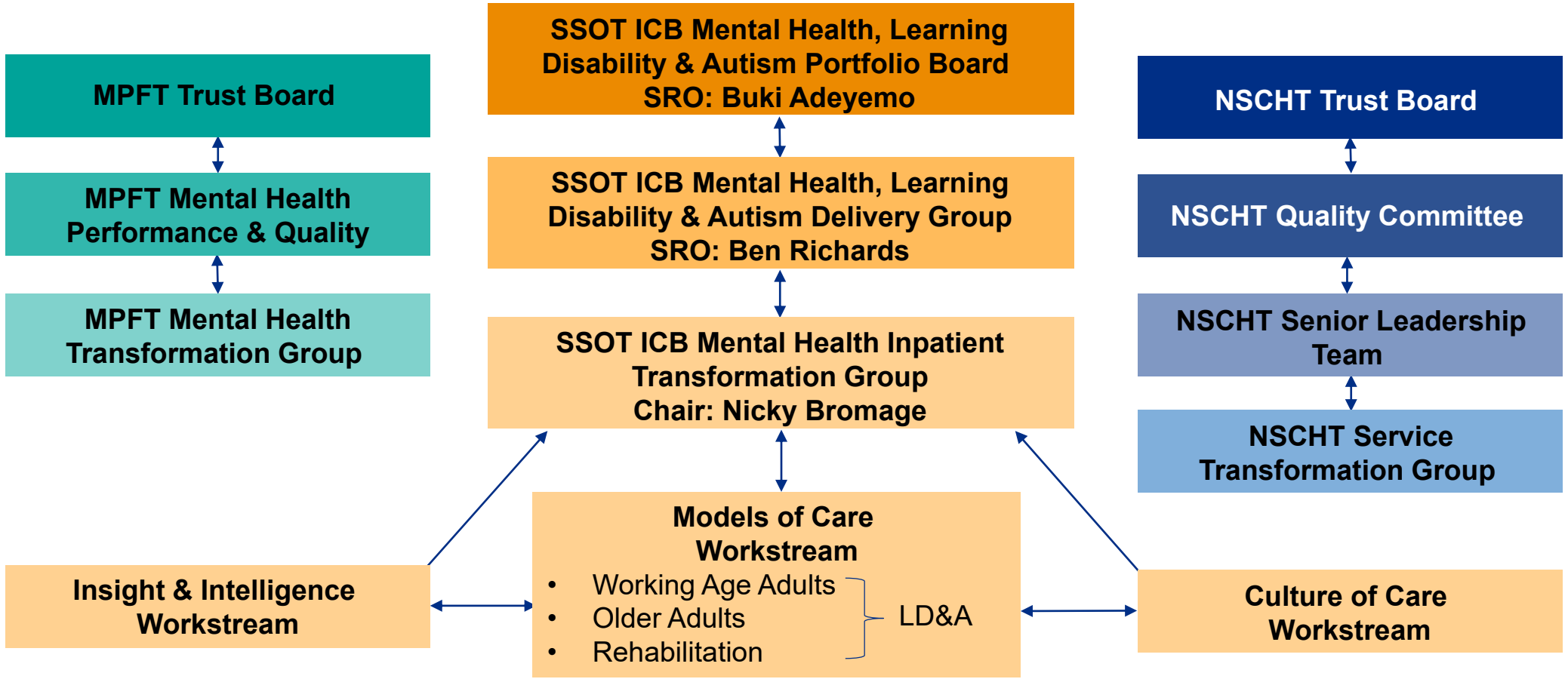
Governance

Governance
continued

The immediate governance arrangements for the programme are illustrated below. The identified workstreams may be subject to change as the programme evolves. Outside of this structure, the programme has links with wider system governance – including the Joint Commissioning Boards and Health and Wellbeing Boards for both Staffordshire and Stoke-on-Trent.



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Delivery Plan

Year 1 Delivery Plan: Analysis and review (1 of 3)

Year 1 goal: Conduct a comprehensive analysis of the current state of adult mental health inpatient services to inform a strategic plan for transformation

Activities:

A Public engagement (months 1-6)	B Patient and staff surveys (months 2-4)	C Health inequalities analysis (months 3-5)
• Conduct focus groups and surveys with service users, families, and carers to **gather feedback on experiences, needs, and priorities** • Organise public engagement sessions to **raise awareness** of the programme and gather community input.	• Develop and distribute surveys to patients and staff to **assess and identify areas for improvement**, and **capture workforce needs** • Analyse survey data to **identify trends and develop action plans** based on the findings.	• Analyse data to **identify and understand existing inequalities** in access to and quality of inpatient services for different population groups • Develop strategies **to address these inequalities** and **ensure equitable access** to high-quality care.

Year 1 Delivery Plan: Analysis and review (2 of 3)

Year 1 goal: Conduct a comprehensive analysis of the current state of adult mental health inpatient services to inform a strategic plan for transformation

Activities:

D
Bed modelling and scenario planning (months 4-6)

- Develop a detailed model to **forecast inpatient bed requirements** based on projected population growth, patterns of service use, and anticipated changes in service delivery
- Conduct scenario planning exercises to **assess the impact of different service models** on bed needs – to be informed by multi-agency patient journey deep dives.

E
Workforce gap analysis (months 5-7)

- Analyse current staffing levels across all disciplines and **compare them to projected needs** based on bed modelling and service transformation plans
- Identify existing workforce gaps and **develop strategies to address them**, including recruitment, training, and retention initiatives.

F
Commence Culture of Care interventions (months 6-12)

- Partner with the national Culture of Care programme to **identify and implement relevant interventions for staff**, focusing on building compassion, communication skills, and de-escalation techniques
- Develop a train-the-trainer programme to **ensure long-term sustainability** of Culture of Care principles within the workforce.

Year 1 Delivery Plan: Analysis and review (3 of 3)

Year 1 goal: Conduct a comprehensive analysis of the current state of adult mental health inpatient services to inform a strategic plan for transformation

Activities:

G
Outcome of Host and Home Commissioner pilot (months 8-12)

- Monitor and evaluate the effectiveness of the Host/Home Commissioner programme in **improving quality and safety standards** within independent providers
- Analyse the impact of the pilot on **reducing out-of-area placements** and **explore opportunities for further collaboration** with the Independent Sector.

Deliverables:

- **Public engagement report** summarising key findings and recommendations
- **Patient and staff survey reports** with action plans for improvement
- **Health inequalities analysis report** with targeted strategies for addressing inequities
- **Bed modelling report** with scenario planning results and recommendations
- **Workforce gap analysis report** with strategies to address identified gaps
- **Progress report** on the implementation of Culture of Care interventions
- **Evaluation report** on the Host and Home Commissioner pilot and its impact on service quality and out-of-area placements.

Year 2 Delivery Plan: Transformation

Year 2 goal: Implement a comprehensive strategy to transform inpatient services based on the findings from Year 1

Activities:

- **Develop a detailed service transformation plan** informed by the Year 1 analysis and stakeholder engagement
- **Implement service redesign initiatives** based on the chosen model (for example, establishing specialised units, creating new pathways for admission and discharge)
- **Continue rolling out Culture of Care interventions** and expand the programme to all staff
- **Address identified workforce gaps** through targeted recruitment, training, and development programmes
- **Monitor and evaluate the impact of service transformation** on key performance indicators such as patient outcomes, length of stay, and staff satisfaction
- **Analyse data from Year 1** to inform targeted interventions to address specific patient populations and service needs.

Deliverables:

- **Detailed service transformation plan** with clear timelines and milestones
- **Progress reports** on the implementation of service redesign initiatives
- **Ongoing monitoring and evaluation reports** on Culture of Care implementation and impact
- **Workforce development strategies** and action plans
- **Quarterly reports** on key performance indicators and service utilisation patterns.

Year 3 Delivery Plan: Consolidation

Year 3 goal: Embed the changes implemented in Years 1 and 2, and ensure their sustainability

Activities:

- **Continue to monitor and evaluate the impact of service transformation** on patient outcomes and service efficiency
- **Refine and adjust service models** based on ongoing data analysis and feedback from stakeholders
- **Identify opportunities for continuous improvement** and implement new initiatives to further enhance service quality
- **Foster a culture of innovation and continuous learning** within the workforce
- **Ensure ongoing collaboration** with the Independent Sector and the Host Commissioner programme.

Deliverables:

- **Final evaluation report** on the Inpatient Quality Transformation Programme
- **Recommendations** for further service improvement and ongoing monitoring
- **Strategies** for sustaining the positive outcomes achieved through the programme.

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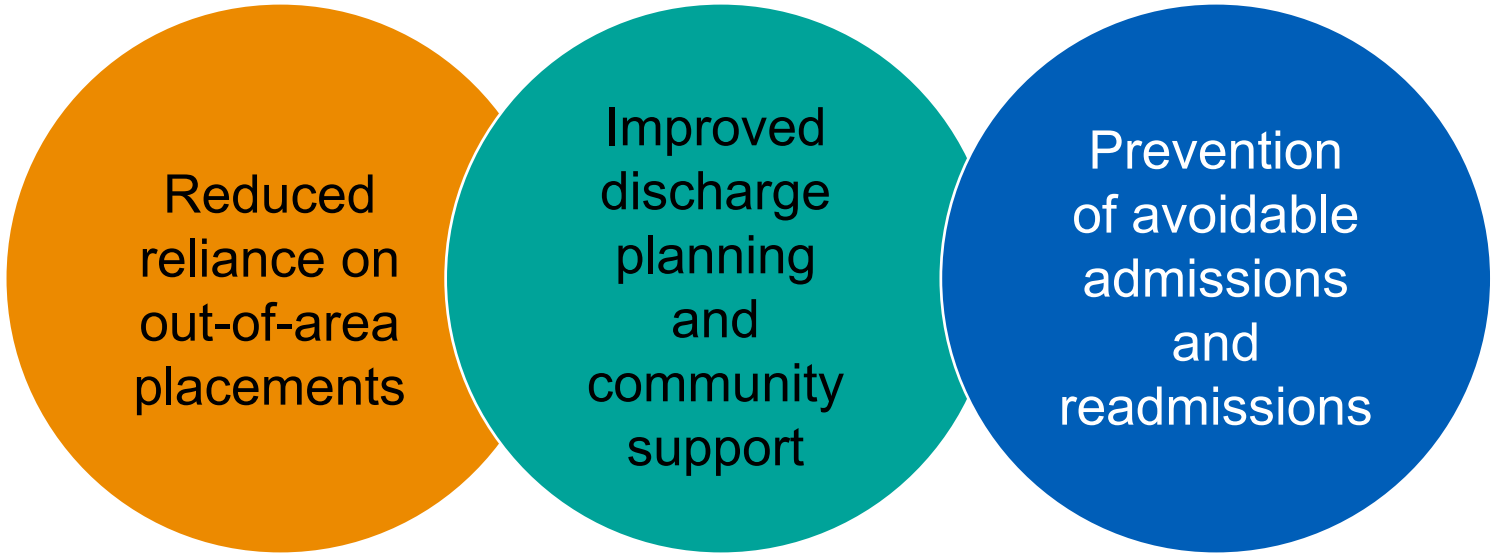
Investment Plan

Investment

This section outlines the investment plan for transforming inpatient mental health services in Staffordshire and Stoke-on-Trent over a three-year period. The aim is to create a more accessible, efficient, and recovery-oriented system, by focusing on:



The investment plan for Years 2 and 3 is indicative at this stage – recognising that some elements may be subject to change depending on the outcomes of Year 1 activity.

Year 1: Laying the foundations (1 of 2)

Year 1 focus: Data, engagement, and workforce – utilisation of service development funding (SDF).

Public engagement and needs assessment:

- Funding will be allocated to conduct public consultations and gather feedback on the proposed strategy, preferred models of care, and lived experiences.

Bed modelling and scenario planning:

- Investment will support the Strategy Unit in developing a comprehensive bed model for the region. This will inform future strategies for acquiring beds, and ensure our resources are used as efficiently as possible.

Workforce development:

- Funding will be dedicated to establishing 'lived experience roles' within inpatient services. These roles will integrate service user perspectives into service delivery, and foster a culture of care
- Resources will also be directed towards creating roles to support patient discharge from inpatient units, ensuring a smooth transition back to the community
- Funding for reasonable adjustment schemes will allow for personalised support for service users with learning disabilities and/or autism on inpatient wards
- Further investment will be made in the workforce to strengthen approaches to therapeutic and trauma-informed care.

Year 1: Laying the foundations (2 of 2)

Year 1 focus: Data, engagement, and workforce – utilisation of service development funding (SDF)

Crisis prevention and support:

- Investments will be made in the management and supervision tool (MaST) to identify individuals at high risk of mental health crisis. This enables proactive interventions to prevent avoidable admissions
- Collaborative schemes will be developed with the relevant local authorities and in partnership with voluntary, community and social enterprise organisations where appropriate, to explore crisis alternatives for marginalised communities – reducing reliance on inpatient care.

Evaluation and research:

- Funding will be allocated to establish an Inpatient Quality Transformation Evaluation and Research Support function. This will ensure ongoing monitoring and evaluation of the transformation programme's effectiveness, and inform future improvements.

Year 2: Implementation and system expansion

Year 2 focus: Bed acquisition and alternatives

Commissioning beds and crisis alternatives:

- Year 2 will see the development of commissioning models to reduce the need for out of area placements and improve the range of alternative crisis support services. This will be achieved through partnerships with voluntary, community and social enterprise organisations, housing organisations, and independent providers. This is based on the recommendations from the Year 1 bed modelling report
- Dedicated bed allocation schemes will be implemented for service users with learning disabilities and/or autism and young adults – addressing specific needs within these populations.

Year 3: Collaborative innovation

Year 3 focus: Sustainability through partnership

Funding bids for service development:

- Approaches for further innovation will be explored with an emphasis on sustainability through collaborative working across the partnership. Details of the approach will be developed during Year 2, but may include an open bidding process whereby partners are encouraged to submit proposals for innovative service developments and projects aligned with the strategic plan
- Proposals would be expected to use the learning from the programme to demonstrate impact against admission avoidance, reducing length of stay, facilitating quicker discharge, and preventing readmissions – ultimately reducing the need for inpatient beds.

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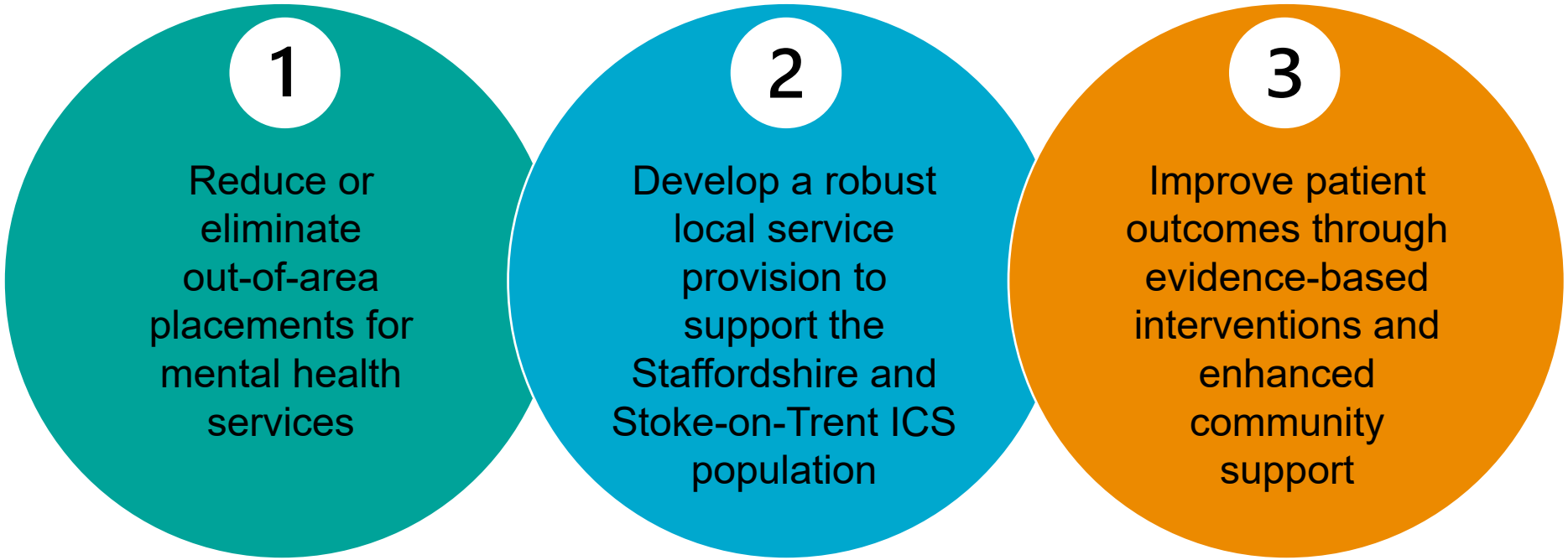
Measuring impact

Core objectives

Our strategy aims to achieve several key objectives:



Proposed measurement framework (1 of 2)

To assess the impact of our transformation programme, we will employ a comprehensive measurement framework encompassing various quantitative and qualitative data points:

1 Reduce out-of-area placements

- Monitor the **percentage of patients requiring out-of-area placements** compared to the baseline established in Year 1
- Track the **cost savings** associated with reduced reliance on out-of-area placements.

2 Develop local provision

- Measure the **increase in inpatient bed capacity** within the ICB region, including beds commissioned from independent providers
- Track the **utilisation rate of new beds** to assess their effectiveness in serving the local population
- Monitor the **development and expansion of community support services** through partnerships with voluntary, community and social enterprise organisations.

3 Improve patient outcomes

- Implement standardised **Patient Reported Outcome Measures (PROMs)** to track patient-reported changes in mental health symptoms before and after admission
- Analyse the average **length of stay** for different patient populations to identify areas for improvement in discharge planning and community support
- Track **readmission rates** within a defined timeframe (e.g. 30 days) to assess the effectiveness of discharge planning and post-discharge support
- Conduct regular **patient satisfaction surveys** to gather feedback on the quality of care, communication, and overall care experience within inpatient facilities
- Analysis of inpatient admissions demonstrates a positive trajectory in addressing health inequalities and how they present within our data set.

4 Implement Culture of Care recommendations

- Measure **staff satisfaction** through surveys to assess the impact of implemented Culture of Care initiatives
- Track the **number of reported incidents and complaints** to gauge improvements in patient safety and staff wellbeing
- Conduct staff surveys to assess the extent to which **staff feel empowered and equipped** to deliver high-quality care.

Proposed measurement framework (2 of 2)

5
Adhere to evidence-based practices

- Regularly **audit patient care records** to ensure alignment with National Institute for Health and Care Excellence (NICE) guidelines and best practices for specific mental health conditions
- **Track the implementation** of various evidence-based therapeutic interventions within inpatient units.

6
Effective Workforce Strategy

- Monitor progress in **filling identified staffing gaps** based on the Workforce Plan established in Year 1
- Track staff **training and development opportunities** offered within the programme
- Conduct staff surveys to **assess confidence and competence** in delivering planned therapeutic interventions.

7
Staff and patient satisfaction

- Conduct regular staff satisfaction surveys to **gauge overall morale**, sense of purpose, and job satisfaction within inpatient services
- Administer patient satisfaction surveys to **assess experience with care delivery**, communication, and overall service provision.

8
Additional impacts

- Evaluate the **financial impact** of the strategy by comparing costs associated with improved local service provision against the cost savings from reduced out-of-area placements
- Include **qualitative data** such as service user and staff feedback through focus groups or interviews to gain deeper insights into the programme's impact on experiences and recovery journeys
- Continuously monitor the effectiveness of implemented strategies and make adjustments as needed to ensure the **long-term sustainability** of the programme's positive impact.

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Managing risk

Managing risk (1 of 2)

The scale and complexity of this programme requires a robust approach to identifying and managing risk. Detailed and dynamic risk registers form part of the programme management and governance arrangements. The high-level risks and mitigations are summarised over the next two slides:

Risk area	Mitigation
• **Unknown impact of any political and policy change** following the 2024 General Election, which may influence the requirements of this programme and/or how they are delivered • **Lack of capital funding** to progress the environmental improvements associated with a range of domains – including accessible, humane, therapeutic and equitable • **Achieving the required level of flexibility within workforce planning** to respond to therapeutic requirements in the context of a financially challenged system.	• This dynamic strategy includes **various scoping activities** in Year 1 – offering the flexibility to build-in and respond to any changes as required • **Working in partnership with Independent Sector providers** and where possible seek to influence, inform and respond to Capital Strategy developments and spending reviews • A comprehensive **review of current MDT approaches** to identify opportunities to work differently within current resource limitations.

Managing risk (2 of 2)

Risk area	Mitigation
• **The strategic direction of Independent Sector providers** operating within the footprint of the ICB does not align with our population needs • **Financial challenges** experienced by multiple system partners impact the ability to work in a truly collaborative way • **Pace of regional working** on areas such as demand and capacity planning may not align with our system activity • **Provider-level risk around access to data and analytics** required to inform the programme due to a significant Electronic Patient Record upgrade falling within the first two years of the programme.	• **Working relationships and strategic planning opportunities** strengthened via Host and Home Commissioner arrangements, including regular meetings • **A system commitment** to working in the best interests of service users and recognition that a focus on reducing inpatient admissions through community alternatives provides opportunity for improved outcomes and financial efficiencies across partner organisations • **Activity is being planned concurrently** to ensure alignment of project plans and milestones. Effective coordination through regional task and finish group • **Chief Digital Information Officer and Digital Transformation leads represented at different levels** within the programme governance structure – ensuring full awareness of the requirements and enabling effective planning and mitigation ahead of the upgrade.