Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Transforming Mental Health Inpatient Services in Shropshire, Telford and Wrekin 2024 - 2027

Contents

Introduction

Introduction

The NHS Long term plan was published in 2019 setting out national plans to transform mental health services. Inpatient mental health services are experiencing continued rises in demand and acuity following the COVID-19 pandemic and as a result of the cost-of-living crisis currently impaction on households.

This strategy sets out our journey to deliver the Acute Inpatient Mental Health care for adults and older adults vision focussing on:

- Personalised care
- Timely and purposeful admissions
- Providing therapeutic hospital stays
- Timely and effective discharge
- Joined up care across sour health and care system
- Services to actively identify and address health inequalities
- Develop the acute inpatient mental health workforce
- Continuous improvement of the inpatient pathway

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 Shropshire, Telford & Wrekin.

Our current service already delivers care aligned to these priorities however there is more work to be done, the Mental Health, Learning Disability and Autism Inpatient Quality Transformation programme presents a considerable opportunity to ensure that our services are delivering high quality care across all these priorities.

Introduction

This strategy serves as a roadmap for the Integrated Care Board (ICB) and its partner provider, Midlands Partnership University NHS Foundation Trust (MPFT) 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

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

While NHS providers deliver some of the inpatient provision within the ICB footprint, a small non-NHS community crisis and rehabilitation bed base 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.

Our Approach

Our Approach

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, primary care, 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.

Strategic bed modelling: This has been undertaken focusing on managing our inpatient demand, strengthening consistency of practice for bed requests, length of stay for inpatient beds to strengthen inpatient tasks and delivery of discharge, understanding the hidden acute inpatient demand and to inform the required bed base going forward. The outputs will inform the direction of travel within this strategy.

Population Health

Geographical and Social Context

The Shropshire, Telford and Wrekin area includes both affluent and deprived rural countryside and some urban conurbations.

Deprivation: While the overall rate of deprivation across STW is in line with the national average this masks considerable variation:
England: 21.67 Index of Multiple Deprivation (IMD) 2019 score
STW: 19.94 IMD 2019 score
There are also 60,700 people living in Core 20 areas (12% of the population).

Income: Average gross weekly pay for full-time workers in considerably lower than the national average:
England: £683.40
Shropshire: £660.20
Telford & Wrekin: £658.70

Unemployment: Unemployment is lower than the England average across the ICB and the area has a lower than average number of long-term jobseeker benefit claimants.

Homelessness: Homelessness is generally lower than the West Midland average in Telford & Wrekin, but higher in Shropshire.
Rough sleeping rate per 100,000:
West Midlands: 4.3
Shropshire: 6.4
Telford & Wrekin: 5.3

Ageing population: The ICB has an aging population, with an under-representation of working age adults compared to the England average, and an over representation of the 50 and older age groups.

Ethnicity: The 2021 Census indicates that the local population is considerably less ethnically diverse than the England average:
England: 81% Whites, 9.6% Asian / Asian British
STW: 93.6% White, 2.8% Asian / Asian British

Mental Health Inequalities at population level

Depression: Data from the Quality Outcomes Framework (QOF) suggests a higher-than-average rates of depression across STW, this is the sixth highest ICB rate nationally:

- **England:** 13.2
- **STW:** 15.6

Severe mental illness (SMI): The QOF data shows lower-than-average rates of inpatient stays in secondary mental health services.

Mortality rates in people with SMI: Excess under-75 mortality rates in adults with SMI are high across Shropshire (this appears to be driven by high rates of cancer mortality) and in line with the England average in Telford & Wrekin:

- **England:** 385.9%
- **Shropshire:** 474.2%
- **Telford & Wrekin:** 384.5%

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

Mental Health Inequities at population level

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 STW than the England average. There is a general trend towards much higher rates of detention in more deprived groups, and the same is true for STW:

England: 40 per 100,000 in the least deprived group and 148 in the most deprived group

STW: 36 per 100,000 in the least deprived group and 79 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 of detention in STW vary considerably across groups, very small numbers mean that rates of detentions of the Black and "Other" ethnic groups are recorded as zero. For the groups where data was available, rates were lower than the England average. However, these differences between groups still represent considerable unexplained variation which requires much greater understanding.

Our Learning so far

Learning from local data analysis

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 1,697 episodes of inpatient care provided by MPFT. This represented the data of 1,243 individual patients, 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. 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, have a record of previous admissions and have flags – indicating restrictive practice, seclusion and incidents.

Learning from local data analysis

Deprivation: Patients in the more deprived group had a greater number of previous referrals to adult services, were more likely to have a historical record of contact with CAMHS and were more likely to have a historical record of contact with forensic services. More deprived patients had a higher rate of restrictive practice flags on their records and were more likely to have previous admissions.

Age: Younger patients had more records of previous admissions, a greater proportion of restrictive practice, a greater proportion of seclusion flags and a greater proportion of incident flags. Younger patients had a higher average number of previous recorded contacts with adult services, were more likely to have a historical record of contact with CAMHS and were more likely to have a historical record of contact with forensic services. Older patients 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

Developing this strategy in the pre-election period resulted in the postponement of dedicated public engagement events. However, we have drawn on feedback from our initial launch session with stakeholders and 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

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 stakeholders

Our Inpatient Quality Transformation Launch event held in May 2024, included attendees from our workforce, NHS and Social Care partners, VCSE and service users and carers.

Key themes explored included:

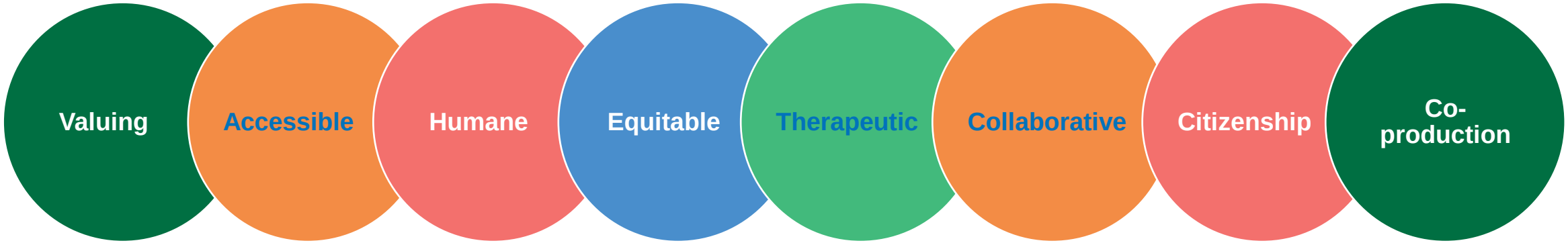
Review of the strategy was undertaken by our lived experience workforce who have offered valuable feedback to ensure the implementation of this programme of work aligns to the experiences of those using services. We will continue to learn and work with those with lived experience not only across out inpatient provision but across all services to ensure we take a whole pathway approach.

The findings from the event including 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.

Future Sessions

To assist with development of our plan a range of staff and stakeholders will be engaged as part of the Culture of Care Programme to support **a self-assessment against the nationally coproduced I/We statements**. Workshops will allow an opportunity for honest reflection and high-quality discussion on what is working well, and where improvements are needed. Outputs from the sessions may inform areas of improvement as part of the wider programme of work

I/We Themes:



Learning from our Audit Activity

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 wards at the Redwoods site. 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, **25 patients** were identified across the Redwoods site for MPFT adult acute and older adults wards.

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.**

An action plan has been developed prioritising key areas of focus as part of our implementation plan for year 1.

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 our Audit Activity

LDA audit:

In total **10 patients** were identified at the Redwoods site for MPFT on adult acute ward.

No patients were identified from the older adult wards at MPFT

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.

An action plan has been developed prioritising key areas of focus as part of our implementation plan for year 1.

Key themes from the audit:

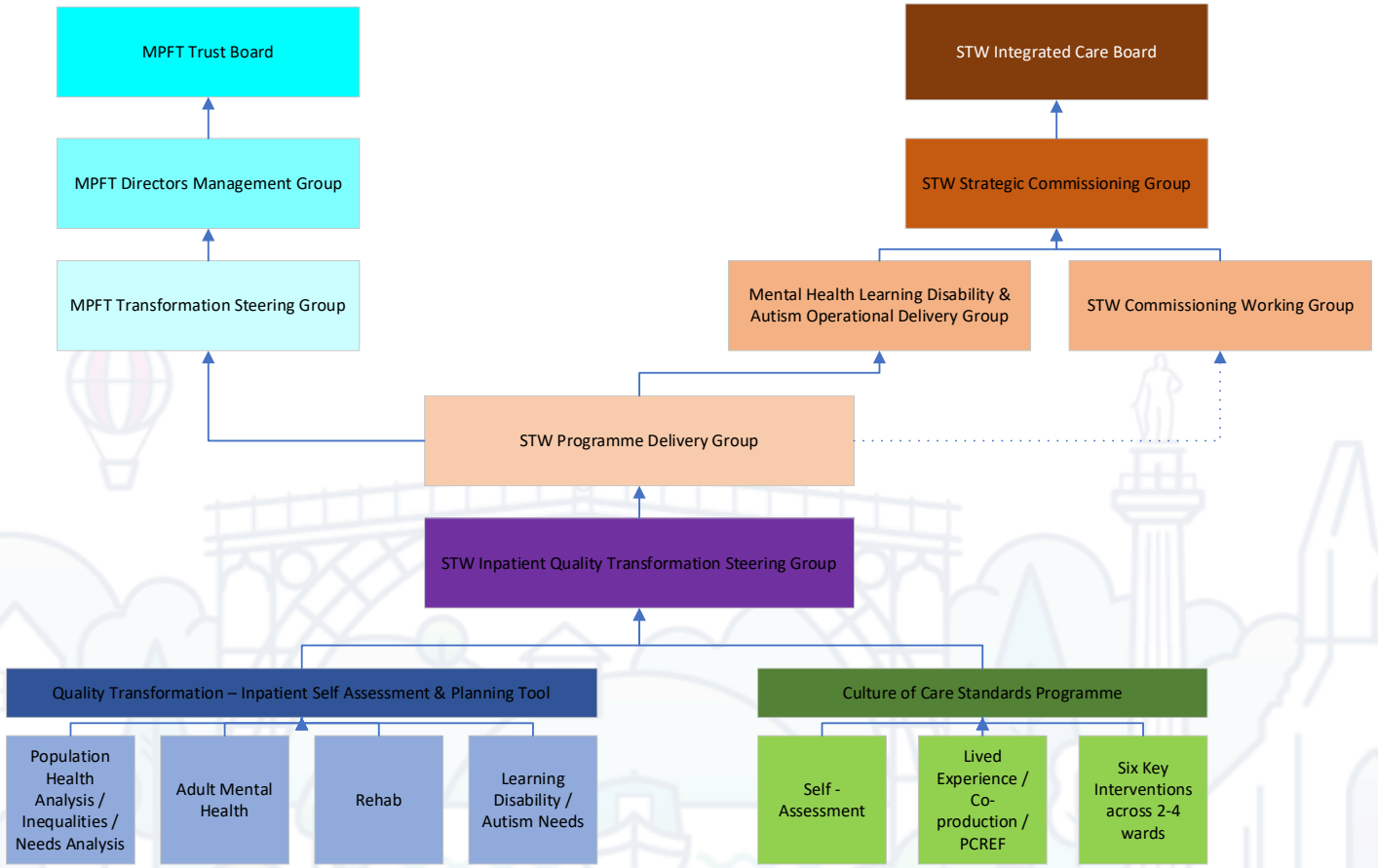
- ✓ Strong evidence of timely assessment on admission as well as admission being purposeful
- ✓ The purpose of admission was discussed with carers and uploaded to the EPR
- × **Inconsistencies in care planning, including patient involvement in care planning and providing a copy of the care plan**
- ×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

Our Commitments

Governance

We will have strong system wide governance in place feeding into MPFT as the main provider and the ICB. This will ensure we can meet our ambition for a whole system approach whilst ensuring organisational consistency within MPFT.

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 Health and Wellbeing Boards for both Shropshire and Telford and Wrekin.



Valuing – Co-Production

We will use the findings identified through population health analysis to inform our approach and activities including local profiles of people utilising inpatient services utilising a co-production and lived experience approach.

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 to ensure equity of approach for those that are placed out of area.**

The Triangle of Care is currently used across MPFT. 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 – Lived Experience

MPFT is embedding peer recovery and lived experience roles. Through the implementation of this strategy, we will continue this work and extend the provision in our acute wards, 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 ICB, MPFT and partners 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.

Learning from the introduction of our peer support workforce into community teams as part of the **Adult Community Mental Health Transformation Programme** will ensure the organisation is more prepared and ready for a wider lived experience workforce.

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

Accessible

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

Utilisation of the outputs from the Bed Base review undertaken to demonstrate demand and capacity planning/bed modelling and implications for models of care that deliver care closer to home is reflected in year one of our delivery plan. Key themes around potential interventions have been identified.

Managing Inpatient Demand

- Develop the in-area crisis offer to strengthen the current CRHT provision
- Explore opportunities to strengthen relationships and joint working
- Review current primary and prevention provision
- Complement work undertaken as part of community mental health transformation through assessment of demand and capacity

Strengthen consistency of practice for bed requests

- Ensure process for requesting inpatient bed is in line with best practice guidance
- Explore excluding bed availability from admissions assessment
- Understand differences between weekday and weekend admissions
- Improve rigour applied to assessment of patients from other areas
- Strengthen engagement with Mental Health Liaison and CRHT teams
- Strengthen clinical prioritisation to ensure consistency
- Strengthen the bed management team to introduce greater clinical seniority

Strengthening Inpatient Tasks

- Develop proposals to embed purposeful admission across STW footprint
- Improve processes through development of coproduced standard operational procedures
- Strengthen interfaces with CMH Services and CRHT to explore meaningful admissions and discharge planning

Accessible

Delivery of Discharge Plans

- Explore the option to implement a formulation meeting post 72-hours of admission with system partners
- Understand the opportunity to codevelop a CRFD checklist
- Understand the requirements and implement Multi Agency Discharge Events (MADE)

Understanding Hidden Demand

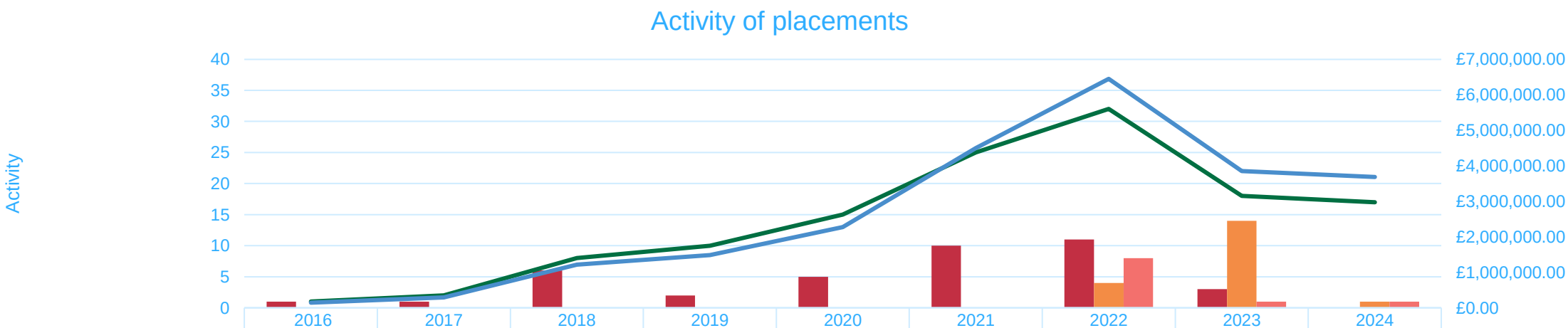
- Look at options to increase in-patient capacity to reduce delays for access
- Embed monitoring and demand and capacity modelling for Health Based Place of Safety, PICU and CRHT

Bed Base

- Understand the outputs from projected future demand
- Align demand and capacity planning with CMH Services
- Utilise demand and capacity modelling to inform planning

Accessible

We will adopt an approach to **whole system working** that supports people in crisis which ensures integration with the Adult Community Mental Health programme and Rehabilitation approaches. We have invested in a **Community Rehabilitation Pathway** since 2021, through effective MDT approaches that have supported the consideration and development of community-based alternatives we have reduced the number of inappropriate Out of Area referrals and started to repatriate those who are currently in inappropriate Out of Area placements as shown below. The continuation of this work is crucial to the delivery of this strategy and our objective to reduce **reliance on out of area placements**.



	2016	2017	2018	2019	2020	2021	2022	2023	2024
Moved to HDR	1	1	6	2	5	10	11	3	0
Repatriated	0	0	0	0	0	0	4	14	1
OOA Prevented	0	0	0	0	0	0	8	1	1
Cumulative numbers	1	2	8	10	15	25	32	18	17
Annual Cost cumuliative	£144,652.56	£295,025.12	£1,218,414.60	£1,484,958.80	£2,274,349.48	£4,502,358.64	£6,451,382.08	£3,849,311.44	£3,686,494.24

Accessible

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.

Humane

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.**

Our wards practice in accordance with the **Safewards Model** which enables us to evidence our safeward environments and monitor restrictive practice.

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 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 system wide commitment to the reduction of healthcare inequalities. 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 system wide commitment to the reduction of healthcare inequalities.

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.

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.

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.

Collaborative

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 Recovery College across MPFT is testament to this.

We will continue to work on the development and embedding of Mental Health specific long term accommodation strategies with both Shropshire & Telford & Wrekin Local Authorities further building on the work undertaken as part of the Adult Community Mental Health Programme. These strategies will prevent inpatient admissions, support timely discharge and enable effective flow through our Mental Health Rehabilitation Pathway.

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.

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.

We will develop and embed joined up care pathways across community and in-patient settings, and a shared vision across commissioners, providers, and stakeholders.

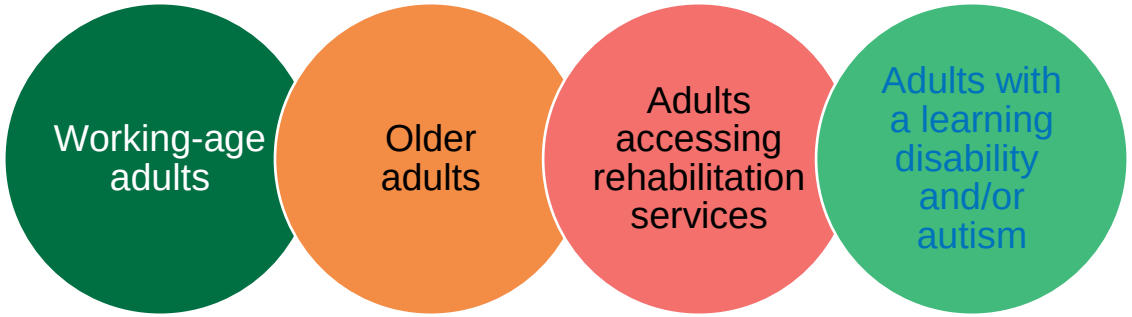
As a system, we have previously undertaken extensive mapping to identify the range of organisations and assets that support and represent the needs of the diverse communities we serve. We will use this knowledge to deliver a comprehensive programme of engagement into autumn 2024 that will shape our approach 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

Our demand and capacity planning has identified **alternative models of care**. 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.**

Bringing Our Commitments to Life

Personalised care and shared decision making

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 will be undertaken with inpatient ward managers and matrons to inform a self-assessment against the 'I/We standards. This will also inform part of our programme for our Community Roadshows to benchmark of where we currently are and to inform our programme of work to improve services.

Personalised care and shared decision making

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 **interpretation** and **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.

Purposeful admissions

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**.

Quality improvements and workforce development will be a key area of focus involving all ward staff to move from an observation culture towards **more therapeutic engagement**.

Purposeful admissions

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 **Community Rehabilitation Service which has** significantly reduced the number of out-of-area placements through robust **MDT consideration of alternatives** and the **development of enhanced community services** to address gaps in support.

Therapeutic and trauma-informed care

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

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

- **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

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.**
- 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 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**.

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**.

- 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

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 the number of adults and young people with autism who do not have a learning disability that 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

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**. 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 system wide commitment to the reduction of healthcare inequalities** focusing on addressing the wider determinants of (mental) health.

Key Enablers

Culture of Care

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.

Initial baseline audits have been undertaken against the Culture of Care Standards and an action plan has been developed to inform our key focus areas for implementation.

Culture of Care

Improved patient experience: Prioritising patient experience and recovery to improve the quality of care for patients in inpatient units. The ICB and partners will ensure our inpatient strategy focuses on creating a safe, supportive, and recovery-oriented environment for patients. By listening to our patients and their experiences we will know that our services are improving.

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

- **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 Improvements

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:** MPFT are participating in the first cohort of the Culture of Care programme signifying 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 trust are working with a shared framework for improvement. • **Action learning sets:** Inclusion in action learning sets within the Culture of Care programme facilitates invaluable knowledge sharing. Learning from each others' successes and challenges helps identify and implement best practices across inpatient services. • **Existing CI practices:** MPFT have already adopted CI approaches which 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.

Bed Modelling

Our Objectives

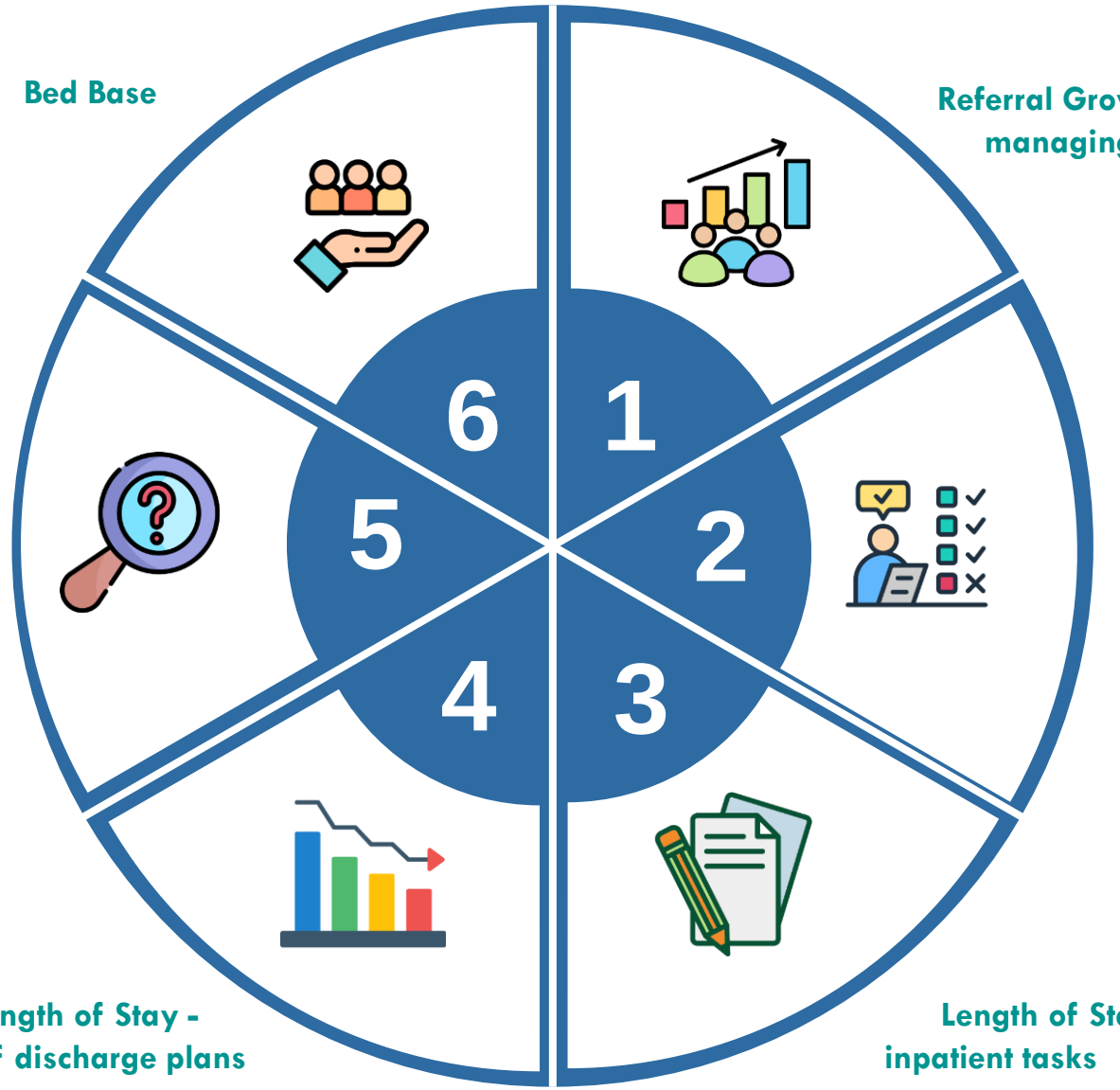
We have commissioned a Strategic Bed review to model our inpatient demand and capacity across Shropshire, Telford and Wrekin focussing on 3 key objective areas:

Objectives	
Develop a demand and capacity model	Project demand for inpatient bed days in STW compared with available capacity: • For the remainder of 2023/24 • For the subsequent three-year period, to the end of 2026/27 • Broken down by service e.g. Adult, Older Adult, Dementia etc. • Factor interventions into the model to determine any remaining capacity shortfall • Assess options for embedding the tool onto MPFT's digital infrastructure to support operational decision making • Summarise any remaining bed requirement, stratified as appropriate e.g. by service, gender
Out of Area Placements	Provide a view on the potential requirement arising from any shortfall in bed capacity the Trust can provide in the Shropshire and Telford & Wrekin Care Group
Interventions	Identify interventions that can: • reduce inpatient bed demand • reduce the length of stay of inpatient admissions • reduce the number of inpatient admissions

Our Deliverables

Phase 1 – Demand and Capacity	Phase 2 - Interventions	Phase 3 – Operational Tool	Phase 4 -Review process to agree any increase to in county bed base
• A view of inpatient bed demand and capacity (STW) • Based on historic Trust averages and other similar assumptions • Including any shortfall • Split as appropriate by service, patient gender etc	• Analysis of interventions to reduce inpatient bed demand • Including impact on number of admissions and expected length of stay • Include any key considerations, assumptions and challenges • Re-profiling of future demand and capacity • Provision of a fully documented Inpatient Demand and Capacity model (STW)	• Options for the embedding of outputs from the demand and capacity modelling to be accessible to relevant Care Group staff	• Identify potential need for further inpatient beds in county • Completion of Capital Business Case as required.

Key Themes



1. Referral Growth - managing inpatient demand
2. Conversion Rates - strengthening consistency of practice for bed requests
3. Length of Stay - strengthening inpatient tasks
4. Length of Stay - delivery of discharge plans
5. Understanding the hidden acute inpatient demand
6. Bed Base

Implementation

Implementation – Delivery Plan Year 1

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

A
Public engagement (months 1-6)

- 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.

B
Patient and staff surveys (months 2-4)

- 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.

C
Health inequalities analysis (months 3-5)

- 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.

Implementation – Delivery Plan Year 1

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

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

- Implementation of phase 2 deliverables from bed modelling - **interventions**
- Implement phase 3 deliverables from bed modelling - **embedding operational tool.**

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.

Implementation – Delivery Plan Year 1

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

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 operational tool -** Options for the embedding of outputs from the demand and capacity modelling to be accessible to relevant Care Group staff
- **Workforce gap analysis report** with strategies to address identified gaps
- **Audit Action plan** is in place with key focus areas to prioritise
- **Progress report** on the implementation of Culture of Care interventions
- **Evaluation plan** in place, understanding our baseline position

Implementation – Delivery Plan Year 2

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.
- **Bed modelling trajectory** to evidence impact of bed modelling interventions in year 1, to understand the effect of bed growth and requirements for additional in area beds

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.
- **Potential capital bid** based on the bed modelling trajectory if interventions do not provide a significant improvement on the current position.

Implementation – Delivery Plan Year 3

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.

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.

Utilising Investment

Utilising Investment

This section outlines the investment plan for transforming inpatient mental health services in Shropshire, Telford & 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

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 involvement and gather feedback on the proposed strategy, preferred models of care, and lived experiences.

Bed Modelling and scenario planning:

- Introduce recommendations and measure actuals against the bed modelling to measure the impact and understand future bed requirements.
- Understand the implications of changes to the criminal just system around ‘Fixed Term Recall’, ensuring that any hidden demand is included within our bed modelling.
- Ensure Continuity of Care Pathway or out of area PICU remain robust where alternative solutions are sought.

Workforce development:

- The development of a robust hospital bed management pathway headed up by a senior clinical leader to support patient flow and implement the Inpatient Quality Transformation.
- A tailored service for older adults with functional mental health needs and co-morbid conditions such as frailty and long-term conditions. Focusing on community hospital avoidance for Dementia and older functional adults.

Year 1

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

Crisis prevention and support (Crisis SDF):

- Exploration of the use of caseload management tools e.g. MaST to identify individuals at high risk of mental health crisis. To support 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.
- Peer-led intervention model to support with home treatment and reduction in length of stay through in reach, focusing on marginalised groups.

Community Rehabilitation Pathway (Reengineered MHIS):

- Continued development of a Mental Health Rehabilitation community team to reduce admission to local and out of area beds.

We will continue to follow the financial governance in place across the system to ensure the most efficient and sustainable use of resources.

Year 2

Year 2 focus: Bed acquisition and alternatives

Commissioning beds and crisis alternatives:

- Building on the work undertaken in year 1 on bed modelling, 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. Explore partnerships with voluntary, community and social enterprise organisations, housing organisations, and independent providers. This is based on the recommendations from bed modelling report.
- Improve the ward environment for service users with learning disabilities and/or autism and young adults – addressing specific needs within these populations.

Year 3

Year 3 focus: Sustainability through partnership

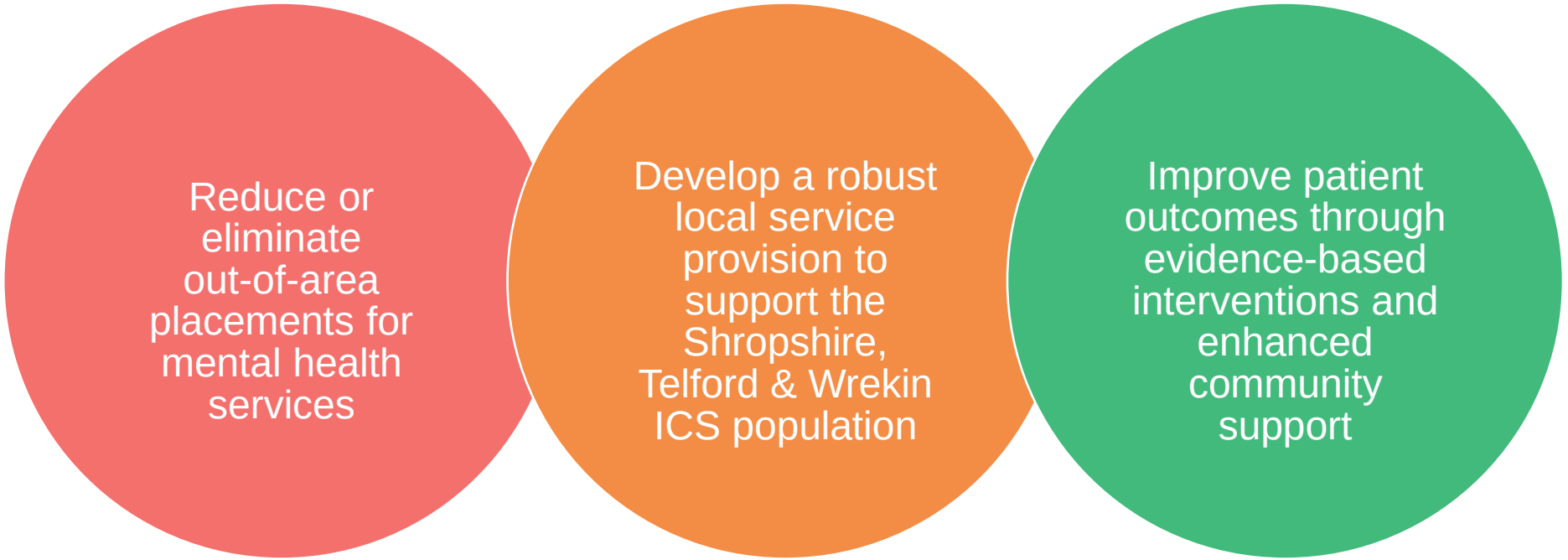
Funding bids for service development:

- 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.

Our Impact

Objectives

Our strategy aims to achieve several key objectives:



Proposed measurement framework

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 Improving 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.
- Utilise data intelligently to align comments/compliments/complaints with survey findings to **identify themes in patient outcomes.**

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

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 **measure 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.

Risk Management

Risk Management

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.

Risk Management

Risk area	Mitigation
• **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.	• **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.