Cheshire and Merseyside

NHS Cheshire and Merseyside Mental Health, Learning Disability & Autism Quality Transformation Programme

Self-Assessment and 3 Year Plan

Date: June 2024

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This plan has been prepared in collaboration with a wide range of stakeholders including people with lived experience across Cheshire and Merseyside and has been signed off by both NHS Trusts and ICB executives.

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Introduction

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Cheshire and Merseyside have embraced the MHLDA Quality Transformation and have been fully committed to co-producing a strategic plan to localise and realign mental health inpatient services over a 3-year period so that inpatient provision better fits the needs of the population, makes more effective use of the funds available, and protects and improves the lives of citizens in our locality. It is hoped that the plan will not only improve the experience and outcomes of care and support for the people accessing mental health inpatient services, but also support people to strengthen their relationships, sense of belonging and connection to local services.

Cheshire and Merseyside ICB acknowledge that whilst mental health or learning disability inpatient care is necessary for some and should be accessible for all, it does not always offer the best outcomes for people, especially when people are placed outside of a local pathway of care. It is known there are increased risks for people placed out of area and concerns regarding quality assurance through spot purchase provision. Out of area inpatient care comes at a significant financial cost to the system, and due to the dislocation of support networks and communities, a significant personal and social cost to people and their families. It is therefore essential that this programme focusses on the quality of the inpatient therapeutic offer to optimise experience and outcomes of care, but also to improve the flow through inpatient services, so there is local inpatient capacity for those that need it.

The completion of this self-assessment has involved multiple stakeholders and a series of face to face and online events to agree the vision and plan. Stakeholders have included ICB place commissioners, ICB quality leads, Chief Operating officers of NHS provider organisations and senior clinical and operational staff. Representatives from local authorities, adult social care, housing, support and Voluntary, Charity, Faith and Social Enterprise (VCFSE) organisations have been invited to contribute to the assessment and inpatient providers have engaged with people with lived experience and used complaints, compliments and feedback to inform the self-rating against the ‘I and we statements’. An inpatient services questionnaire, aligned to the ‘I’ statements, was sent to all inpatient units and those placed out of area. The questionnaire was available in electronic and printable versions, however response rates were varied, with minimal responses gained from those placed out of area. A plan to capture feedback in a variety of ways from all people receiving mental health inpatient care remains a priority for Cheshire and Merseyside; especially from marginalised communities, people with protected characteristics, people within our learning disability settings, and those placed out of area., Cheshire and Merseyside are committed to being able to confidently rate the services against the ‘I’ statements to inform the development and delivery of the 3 year plan and embedding lived experience will be a programme priority for year one.

The success of this programme and achievement of the agreed aspirations in this strategic plan will not only require transformation within adult inpatient mental health services, but continued transformation and strengthening of community services to offer timely and responsive, individualised, evidence-based care and support in the least restrictive setting for a person’s needs. The continued collaboration with community partners is key, as is ongoing focus to ensure the community mental health offer is accessible and appropriate for all people regardless of socio-economic, gender, race or other protected characteristic.

The Cheshire and Merseyside 3-year plan to re-align and recommission mental health inpatient services is focussed on 3 main areas:

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1. **A good quality inpatient offer**- ensuring that when someone requires an admission it is purposive, evidence-based, trauma-informed and the offer of intervention is individualised, diverse and provided by a workforce with sufficient, skills, competencies and expertise to meet the needs of the person. Robust mechanisms will be in place to ensure that people, their carers and families are fully involved in shared decision making and co-produced care planning.
2. **Flow through inpatient services-** ensuring that people are able to access the right care, support and intervention for their needs quickly and in the least restrictive setting. There is emphasis on ensuring that people aren't waiting for specific inpatient care either in the community, emergency department or other parts of the system and are not waiting to be discharged from hospital when they are clinically ready. Waits across the system cause harm to people and increase inefficiencies, therefore efforts will be made to embed the 'easy in, easy out principle' and ensure transitions are seamless.
3. **Community alternatives-** continued development and collaboration to provide strong community alternatives to inpatient provision to optimise the time people can spend at home and in their communities, through early intervention, prevention, and dedicated support and active system collaboration to facilitate discharge from hospital at the earliest opportunity.

A main aim of this programme of work is to eliminate people being admitted to an inpatient unit that is outside a local pathway of care and there will be robust mechanisms and system oversight of all 'out of area' or spot purchase inpatient provision. There will be a live and centralised list of all out of area placements, and a record of purpose of admission, estimated discharge date and what is required to support people to step out of hospital or be within a local pathway of care. There will be system scrutiny and consistent processes to ensure there is effective oversight and quality assurance.

Key enablers to the success of the 3 year plan 1/4

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Co-production with people with lived experience

Cheshire and Merseyside ICB and ICS are committed to ensuring that all service developments linked to this programme are co-produced and co-delivered with lived experience at the heart of all we do. We strive to gather voices of people that are representative of our local communities and are working to ensure that voices of people who have previously been underrepresented in service development are heard. As noted, we have created and shared an online survey for rating against the 'I statements' for all people who are in inpatient settings and will ensure developments and opportunities for informing the programme are communicated widely, via various means, including using our communities and VCFSE's. There is some dedicated resource within the budget for the programme team for paid lived experience input and work has commenced with Patient and Carer Experience Teams in the Trusts to widen opportunities for engagement and provide support. Within the plans there is also a commitment to developing peer support across all services.

Alignment to wider Cheshire and Merseyside strategies

This self-assessment aligns to Cheshire and Merseyside strategies, policies and guidance including but not limited to:

- Mersey Care Strategic Framework 23-28 and Operational Plan
- Cheshire and Wirral Partnership Strategy- Imaging the Future
- CWP Trust Autism Strategy
- Mersey Care Learning Disability Guidelines
- Cheshire and Merseyside Health and Care Partnership (ICP) Interim Strategy
- Cheshire and Merseyside Joint Strategic Needs Assessments (JSNA's)
- Place Learning Disability Plans and Autism strategies
- Place Mental Health and Well- being strategies

As strategies are reviewed and refreshed, the self -assessment aspirations and objectives will be incorporated. This programme will also align with other programmes of work including the Adult Mental Health Community Transformation, Transforming Care programme, Mental Health Crisis Care programme and Children and Young People's mental health programme, inclusive of the children and young people's inpatient model of care development being led by the Lead Provider Collaborative.

Key enablers to the success of the 3 year plan 2/4

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Data and Business Intelligence

Whilst there are areas within this self-assessment already supported by well established data collections and flows and business intelligence tools, there are some areas which require further development. For example, although we are able to profile the people using different types of inpatient services using data sourced from the MHSDS, some of our independent sector providers do not flow to the MHSDS so we need to take action to ensure that this dataset provides a complete and accurate reflection of local activity. Some further focussed work is also needed to improve the visibility of patients in rehabilitation provision, in particular out of area placements, to fully understand their needs. Addressing these gaps in reporting will be a priority in year one.

It is crucial that strategic plans are intelligence informed, therefore, having high quality and timely data is key to ensuring that we are meeting the needs of our patients and local populations. Improving data quality is, therefore, also a priority area of work. Data flow and data quality is embedded into this programme of work as it has been identified as an enabler. Specific deliverables relating to data and intelligence will be identified via the programme.

JSNA's are being utilised to understand population health and support needs and to implement recommendations from the independent 'rapid review' launched by the Government in 2023, intended to improve the way that local and national data is gathered and information is used in relation to monitoring and improving patient safety in mental health inpatient care settings and pathways, including for people with a learning disability and autistic people.

A new clause has been included in the NHS Standard Contract for 2024/25 which requires all mental health providers to have implemented the Patient and carer race equality framework (PCREF) by March 2025. The PCREF was launched in 2023 for all mental health providers in England to improve access, experiences and outcomes for people from racialised communities, and the new clause means that the framework is mandatory as per contractual obligations. Providers are expected to continue to improve the capture and flow of data to national datasets to help identify and overcome inequalities in access, experience and outcomes and partnership working will be critical in addressing the underlying determinants of health inequalities across inpatient mental health services.

Relevant and meaningful system wide metrics will be defined and developed to support each aspect of the plan, including monitoring outcomes and any unintended consequences of new initiatives and these will inform areas for improvement and prioritisation of work.

There has been significant work already with NHS Provider Trusts to embed the utilisation and reporting of Patient Reported Outcome Measures (PROMs) in line with the Mental Health Community Framework. There will be a focus to extend this into inpatient settings to ascertain whether people are receiving care that meets their individual needs, to systematically measure the experience of care and support, and identify areas for development.

In year one, efforts will be focussed on improving data quality and reporting to improve oversight and inform plans for years 2 and 3. By year 3, we will have a comprehensive understanding of our population needs, the demand on our mental health inpatient services and the capacity requirements which will inform strategic and financial planning.

Population data

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Cheshire & Merseyside Adult Population and Prevalence data, sourced from Population & Person Insight Model (model.nhs.uk), Oct 21 – Sep 22

Place / ICB	Total Population (18+)	SMI - Prevalence per 1,000 population (18+)	SMI - Prevalence % (18+)	LD - Prevalence per 1,000 population (18+)	LD - Prevalence % (18+)
Cheshire East	0.6M	12.3	1.2%	12.3	0.5%
Cheshire West					
Halton	0.1M	16.4	1.7%	15.5	1.7%
Knowsley	0.1M	19.8	2.0%	10.5	1.1%
Liverpool	0.5M	22.4	2.2%	8.2	0.8%
Sefton	0.2M	18.6	1.9%	9.6	1.0%
St. Helens	0.2M	18.1	1.8%	11.6	1.2%
Warrington	0.2M	14.5	1.5%	17.1	1.8%
Wirral	0.3M	16.6	1.7%	6.0	0.6%
Total	**2.2M**	**16.9**	**1.7%**	**8.5**	**0.9%**

Note: Population data is derived from the Personal Demographic Service (PDS); Cheshire East and Cheshire West data is combined; Sefton includes South Sefton and Southport & Ormskirk.

Place / ICB	SMI Register
Cheshire East	6,558
Cheshire West	
Halton	1,261
Knowsley	2,036
Liverpool	7,194
Sefton	3,387
St. Helens	2,047
Warrington	1,675
Wirral	3,326
Total	**27,484**

Cheshire & Merseyside SMI Register, 2023/24 Q3

Note: Numbers reflect the total number of people on the GP SMI register on the last day of the reporting period, reported via the SDCS data collection; Cheshire & Merseyside's SMI register is lower that the expected GP SMI register based on 2021/22 QoF figures and ONS population projections, with the expected number being 30,988; Cheshire East and Cheshire West data is combined; Sefton includes South Sefton and Southport & Ormskirk.

Key enablers to the success of the 3 year plan 3/4

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Workforce

This self-assessment and 3-year plan incorporate a specific focus on workforce and aligns with existing work in Cheshire and Merseyside to implement the priorities of the NHS Long Term Workforce Plan and subsequent ICB strategic drivers. This includes the development and initial implementation of a Cheshire and Merseyside strategic framework for aligning service model design and workforce planning in mental health which starts with a focus on the identified needs of the population accessing services, the models of care needed to meet these needs and to enable this the required skills and competencies that in turn inform the workforce profile required. Utilising the dedicated workforce development capacity within Cheshire and Merseyside Mental Health Transformation Programme Team, the plan will align with the wider work to inspire, attract, grow, develop, retain, diversify and support the workforce. This will be essential in improving the therapeutic offer in both inpatient and community services, more collaborative working with Local Authorities, Adult Social Care, Voluntary, Charity, Faith and Social Enterprise (VCFSE) organisations and housing to wrap around a person with mental health needs or needs associated with their Learning Disability or Autism. The plan also focuses on workforce well-being through the development of clinical networks, support, supervision and peer reflection structures across Cheshire and Merseyside.

Improved collaboration

This plan identifies areas for greater system and provider collaboration, to improve quality, maximise learning opportunities and make best use of resource. Opportunities for provider collaboration have been highlighted in the plan, where economies of scale and consistency in clinical pathways would be beneficial, and these will be explored in Year 1. In addition, collaborative commissioning models will be explored in Years 1 and 2, including formal provider collaborative models, pooled budgets and agreement to re-invest any efficiencies to strengthen community services.

The further development and implementation of an ICB Housing strategy is also key to this plan and clear local processes for accessing housing and identifying strategic needs are already underway. Cheshire and Merseyside Health Care Partnership have extended the scope of their system wide housing project to incorporate the strategic housing requirements of people with needs associated with their mental health, learning disability or autism.

Leadership

Strong strategic, clinical, commissioning and operational oversight of the different inpatient pathways across Cheshire and Merseyside will be essential to the achievement of the aspirations identified in this plan and will support:

- Implementation of the published NHSE Guidance for each inpatient service type, NHSE key discharge initiatives, NICE guidance and GIRFT recommendations
- Reporting of CRFD and agreement of escalation processes to address barriers and delays to discharge from hospital
- Identification of Quality Improvement initiatives across Cheshire and Merseyside to improve flow and the quality of inpatient care
- Development of consistent and robust transition processes for young people in Cheshire and Merseyside
- Working as a system and having a mutual aid approach to the developments and challenges

Key enablers to the success of the 3 year plan 4/4

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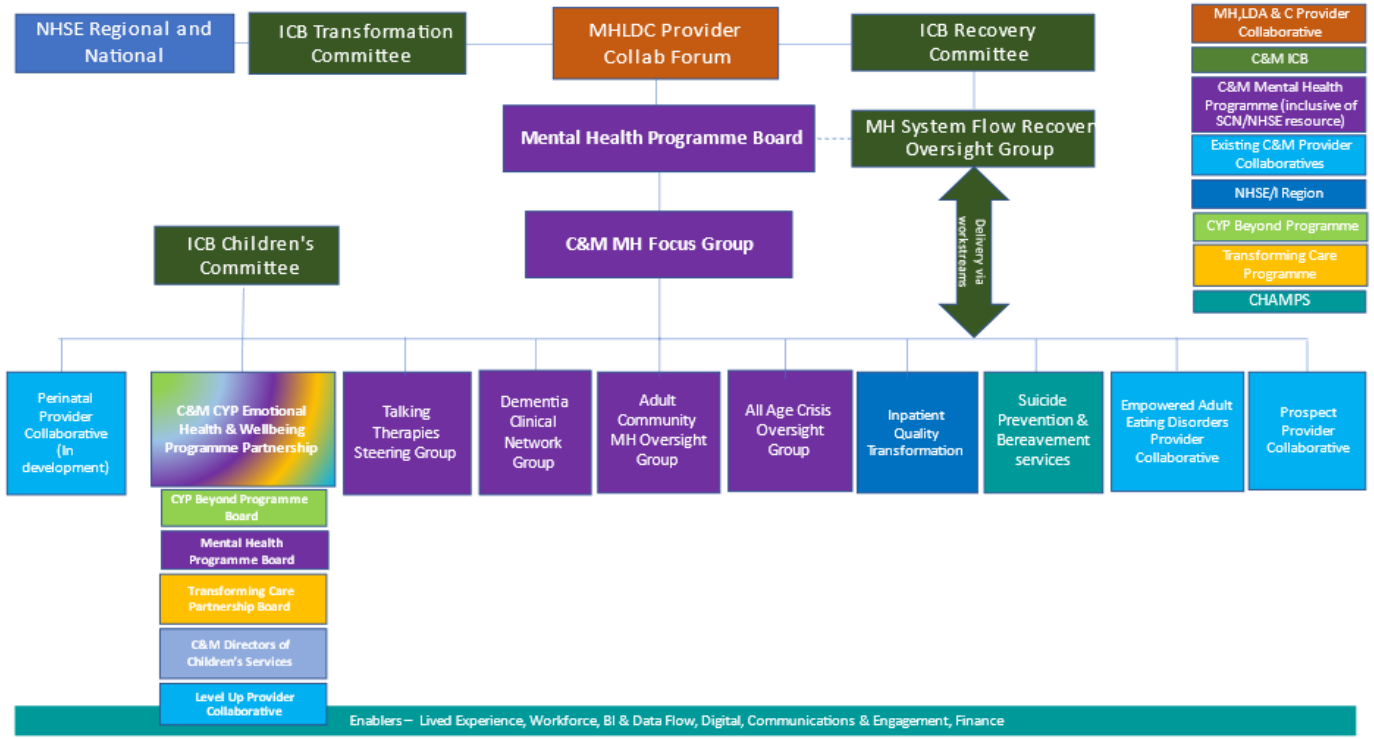
Governance

The responsibility for the leadership of the Inpatient Quality Transformation Programme in Cheshire and Merseyside will sit with the Mental Health Programme Team. The implementation and oversight of this plan and associated investment will be via the Quality Transformation Steering Group and this will report and take direction from the Cheshire and Merseyside Mental Health System Flow Recovery Programme. Information will also be reported through the Cheshire and Merseyside Programme Board and a communications strategy will be developed in Year one to provide updates and opportunities for engagement to all stakeholders.

Figure One: Mental Health System Flow (Recovery) Programme Governance Map



Engagement in the North West Regional Quality Transformation oversight group will ensure Cheshire and Merseyside's plan is in line with National and Regional NHSE directives and will enable the escalation of issues. The governance structure will also embed lived experience.

The objective of the Mental Health System Flow Programme is to improve mental health system flow for adults with mental health conditions, this will result in a better experience and outcomes for people with mental health needs as they will receive the right care or support, in the right place, at the right time from the right professional.

The aims of the programme are aligned to the Inpatient Quality Transformation Programme and include:

- Reduced waits for mental health inpatient beds for people in community setting. The ambition is that no person in the community is waiting for a mental health inpatient bed.
- A reduction in numbers of people being accommodated in Emergency Departments (EDs) in Cheshire and Merseyside waiting for discharge into the community or a mental health inpatient bed. Eradication of clinically inappropriate 48+ hour waits for mental health patients in EDs.
- A reduction in number of people in mental health inpatient beds who are Clinically Ready For Discharge (CRFD). The Cheshire and Merseyside ambition is that no more that 5% occupied bed days filled by people who are CRFD.
- No inappropriate out of area placements for acute mental inpatient placements.
- Expenditure on appropriate acute mental health inpatient placements in the independent sector is reduced.
- Expenditure on out of area rehabilitation placements is reduced.

The 3-year plan and alignment of SDF funding

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The system wide engagement across Cheshire and Merseyside in this Self-Assessment enabled the identification of some priorities for this programme and the SDF investment. It was agreed that the investment would be provided on a fair share basis to the NHS Trusts, noting that some of the investment would be pooled for shared initiatives that would enable collaboration and minimise any unwarranted variance.

In year one the investment will be focussed on:

- Demand and capacity modelling for all inpatient care across Cheshire and Merseyside within and outside of the NHS providers to enable inpatient and community services to be commissioned based on population health data, taking into account current trends and testing scenarios based upon improving flow and community alternatives. This will include improving the quality and accessibility of data on the needs of all people accessing mental health, learning disability and autism care and support services and identifying underserved groups which developments can then target.
- Implementation of the Safe Care programme across Cheshire and Wirral Partnership NHS FT and Mersey Care NHS FT, which is a digital solution to ensure wards are safe and therapeutic and therefore offering best quality care. This will be used to ascertain the staffing capacity and mix needed to offer optimum care and to deploy resources as necessary reducing inefficiencies. With anticipated outputs of greater intelligence, this work will positively impact on the flow through inpatient services and improve the therapeutic offer and development of inpatient roles and career pathways.
- Dedicated project management to support the re-design of the Learning Disability and Autism inpatient provision across Cheshire and Merseyside, scoping out the needs of all people in hospital, including those placed out of area and how to best use existing resource for optimum outcomes for all.
- Investment aligned to fully implement the 10 high impact initiatives across all inpatient services to ensure people are only in hospital for as long as they need to be.
- Strengthening of ward to Board Peer support
- Evaluation of the funded initiatives by Q4 of year one to ascertain the spending plan for years two and three.

In year two: there will be a focus on redesigning the inpatient pathways and developing community alternatives to enable step up and step down from inpatient provision and financial modelling to scope out any formal provider collaboration or reinvestment from savings.

In year three: focus will be on the re-commissioning of local pathways of care, ensuring they are commissioned appropriately according to population health needs, address inequalities and offer timely and evidence based high quality care and support.

In addition, there will be an ongoing review and dedicated plan within each of the specific inpatient development plans to improve co-production and the engagement of those with lived experience in the development and delivery of services, as this was consistently reported as an area for development in the survey against the ‘I and We statements’.

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Cheshire and Merseyside's commitment to the principles underpinning the Inpatient Quality Transformation Programme

Valuing

Cheshire and Merseyside ICS and ICB will ensure that the people accessing or working in inpatient services feel valued and cared for and benefit from a culture that lives its values. We are committed to hearing all the voices of people who may need to call on mental health services and their families and will commission and provide services that promote inclusion, strengthen individual rights and promote citizenship. Through our programme we will challenge stigma and work in ways that prevent othering, respecting all people as citizens and valued members of the community, and providing support to all people as and when they need us.

Cheshire and Merseyside ICB recognise that co-production and engagement with people with lived and living experience is vital to the success of this programme of work and achievement of the aspiration. An inpatient survey against the 'I and We' statements has been developed and shared across all inpatient services in Cheshire and Merseyside, including block contract and spot purchase inpatient provision in the Independent Sector. The feedback received to date has been included in the ratings against the 'I and We' statements table for each section of this plan. It is recognised that this will need to be an ongoing process and work is underway to set up a sustainable mechanism and embed this in practice.

Different means of capturing feedback from those with lived experience and their supporters and loved ones, will be utilised wherever they may be receiving inpatient care for their mental health needs. This is inclusive of autistic people, people with a learning disability, people who may have dementia, literacy needs or where English is not their first language. Improved data on the needs and demographics of those accessing each type of inpatient care will enable a more targeted communications approach and ensure all voices are being heard.

There will be an expectation that any plans to develop learning disability or mental health services, including for autistic people across Cheshire and Merseyside will be co-produced and the services co-delivered.

Accessible

Cheshire and Merseyside ICB and ICS will commission and provide services that are inclusive and accessible to all, offering early and preventative intervention, to enable a person to function and maintain their optimum health and well-being, and spend the maximum amount of time within their community. If inpatient care is needed this will be appropriate, purposeful, timely and therapeutic.

The ICB and system partners are commitment to improve the data and oversight of all people accessing mental health and learning disability inpatient services both within and outside of the NHS. This will enable the current provision to be analysed against the prevalence data and any inequalities identified. Having defined metrics for each section of the assessment will enable progress against the aspirations to be monitored and will inform the modelling of the local inpatient and community pathways of care that will be commissioned in year 3.

A Cheshire and Merseyside governance structure has been developed to drive the programme and support the implementation of the Commissioning framework and commissioner guidance for each type of inpatient setting. This will include ensuring reasonable adjustments are in place to facilitate appropriate access and engagement in interventions for all. The Green Light Toolkit will be utilised to offer autistic people and people with a learning disability appropriate care and support within mental health settings and Care and Treatment Reviews will be utilised to identify and address individual needs to expedite recovery and discharge from hospital.

There has been significant progress already made in terms of developing community mental health, learning disability and autism services to reduce reliance on inpatient care, including wider system work with VCSFE, Individual Placement Support, Housing, Local Authorities, and Primary Care. Aligning this work and building upon the successes of the mental health Community Transformation and the work of the Transforming Care Partnership will be key to the programme's success.

Humane

Cheshire and Merseyside ICB are committed to commissioning inpatient services that are least restrictive, person-centred, caring and compassionate. As part of NHSE North West region, we have already identified unintentional harms caused to people who remain in hospital longer than they need to be and the ICB and ICS have a plan to report on all people who are clinically ready for discharge and use this data to develop more step up and step-down provision in the community, using a population health commissioning approach. The 10 high impact initiatives are also being embedded into practice, which includes a focus on purposeful admissions, estimating a person's discharge date and. planning for discharge on day one of an inpatient admission, escalating barriers to discharge via Multi-Agency Discharge Event (MADE) meetings. Careful consideration will also be given to our hospital environments and the impact these have on the wellbeing of people experiencing inpatient services and the staff working within them. Best practice and commissioning guidance is being utilised to provide the most accessible, comfortable and therapeutic inpatient environments.

All types of mental health, learning disability and autism inpatient care across Cheshire and Merseyside is offered via a multi-disciplinary and multi-agency teams. The workforce will have the right expertise, knowledge, competencies, skills, and values, and will be supported and offered supervision to maintain high standards of care and compassion, whilst maintaining their own health and well-being.

The 3-year plan for Cheshire and Merseyside inpatient services includes increased oversight and quality assurance of the whole inpatient care pathway; including establishing robust processes for ensuring least restrictive options have been explored prior to a hospital admission. This includes support and intervention as an alternative to a hospital admission being offered in the community via crisis resolution or home treatment teams, learning disability intensive support teams and community rehabilitation services.

Equitable

Cheshire and Merseyside ICB will commission and deliver services that are equitable and where people are treated with dignity and they are respected as individuals. We are committed to providing personalised care that respects a person's human rights and promotes shared decision making at all times. The whole Cheshire and Merseyside system will work together to identify and address inequalities and priority will be given to ensure underserved groups can access appropriate and effective intervention and support both in the community and in hospital. We are committed to ensuring everyone is valued irrespective of where they live, their background, age, ethnicity, sex, gender, sexuality, disability, or health conditions and will ensure all the environments where mental health, learning disability and autism support are offered are inclusive and accessible.

The alignment to the ICB system flow programme and development of SHREWD real-time reporting for mental health, will allow for improved data and insight into the demands in the system and reasons why. This, along with improved data via PCREF, and using population health data, will help us to understand groups that may be over-represented in inpatient settings and reasons why.

It is recognised that qualitative information will also be key to understanding the needs and wants of people from Cheshire and Merseyside in any inpatient unit, and in addition to the I and we statement surveys that have been developed, a plan to improve the consistency and robustness of reviews will enable us to ask what different groups of people want from mental health, learning disability or autism support.

Therapeutic

Cheshire and Merseyside are committed to commissioning and providing good quality, evidence based and timely mental health, learning disability and autism intervention and support, recognising the importance of therapeutic relationships and continuity of care. Our offer of care and support will be trauma informed and promote feelings of safety, by ensuring therapeutic relationships are based on trust, respect and compassion. Using a strength's based and holistic approach our inpatient services will make sure a person's mental and physical health and any co-occurring conditions or social needs are considered and acted upon.

Quality is of utmost importance and the wider work under the Inpatient Quality Transformation including the culture of care standards, quality reporting and seeking regional support if an area is challenged, will be embedded into all operational and clinical processes and there will be clear routes for escalation via the governance infrastructure. All providers of mental health, learning disability and autism services will be commissioned to demonstrate therapeutic benefit, including continuous improvement of the inpatient pathway, co-producing service developments, making best use of data and using quality improvement methodology

Within the Mental Health, Learning Disability and Autism Inpatient Commissioning Framework there are key principles that are embedded in the service developments in Cheshire and Merseyside, including 'all means all', developments being co-produced and co-delivered, interventions offered in the community first and foremost through wider system working, trauma informed practice and continuity of care. There have been regional workshops/discussions re the role of the key worker as part of the community transformation and special emphasis in the North West regarding the development of services not inadvertently creating 'hand-offs' or resulting in people having to move from one service to another. We are committed to ensuring that care and support wraps around the person and their families or supporters.

Co-production/Lived experience embedded

This Cheshire and Merseyside plan holds people accessing mental health, learning disability and autism services at the centre, recognising that people require holistic support that addresses their social, emotional, and practical needs and all care and support should wrap around the person and their supporters, and be offered through shared decision making and planning. Through maximising community assets, the plan promotes citizenship and enables people to remain attached to their communities, providing a sense of belonging and reducing potential feelings of isolation and stigma. The plan incorporates how any care and support offered will be respectful and relevant to the person's background, cultural needs and experiences and reasonable adjustments will be utilised to ensure that no-one is excluded from accessing support for their identified needs on the basis of diagnosis, gender or any protected characteristic. Reporting mechanisms to ascertain how an individual's physical and mental health needs, sensory or communication needs, and cultural, gender, sexuality or faith requirements/preferences are being addressed and/ or reasonably catered for, will be developed alongside the increased use of personalised health budgets to facilitate discharge from any mental health inpatient care setting.

The culture of care standards and culture of care programme are incorporated within the Mental Health, Learning Disability and Autism Inpatient Quality Transformation Programme and this plan will interlink with the work that is being led nationally with Cheshire and Wirral Partnership and Mersey Care NHS Foundation Trusts.

Collaborative

Cheshire and Merseyside ICB and ICS will work in partnership to ensure that locally, there is a range of services to support people within their local communities and that all admissions to hospital are appropriate and purposeful. There will be system ownership of any delays to accessing inpatient care or people being delayed when clinically optimised or ready via the system wide MADE meetings.

Cheshire and Merseyside ICB are committed to increasing peer support and access to independent advocacy and will ensure that the views and advanced choices of people accessing mental health, learning disability or autism services are respected. Priority will be given to investing in the support and development of the workforce, so they are able to form caring, compassionate and safe therapeutic relationships and feel like they have the skills, competencies, capacity and tools to provide the evidence- based care required.

This plan has been developed with system partners and people with lived experience and has been shared across Provider Trusts, Commissioner Groups and Partnership Boards. Ensuring this plan is reflected in broader strategies across organisations will be a priority for year one, along with ensuring that all efforts are aligned. The plans have also been shared with regional colleagues and neighbouring ICBs to ascertain areas for collaboration and where solutions may be of better quality and more sustainable at scale.

There have been efforts to ensure that the specific inpatient focussed parts of the programme are not duplicating existing work or increasing the burden of demands on all stakeholders. This will continue to be monitored as Governance structures are embedded and throughout the programme's implementation.

The success of the aspirations related to the inpatient quality transformation will require dedicated leadership and system support. There are already identified leads within the providers, the ICB are exploring a strategic commissioning lead for the different inpatient specialties and there is a lead Clinical Director overseeing the Quality Transformation for Cheshire and Merseyside with dedicated project management support.

Citizenship

Cheshire and Merseyside will commission and deliver mental health, learning disability and autism services that support the active participation of people in their community and social inclusion. Building on the successes of the mental health community transformation and transforming care partnerships there will be increased opportunities for community connectedness through VCFSE organisations and peer support.

We acknowledge that the people who have been inpatient for needs related to their mental health, learning disability or autism, may have lost their sense of belonging to their local community, especially if they have been in hospital for a long time or have been receiving care out of area. The programme of work will promote and validate the citizenship of these people by working as a system to improve the local pathway of care and maintain community and social connections, including increasing the opportunities available to access employment, education, leisure activities and appropriate housing.

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Adult Mental Health Plan

Adult Mental Health: Current State Description (as of March 2024)

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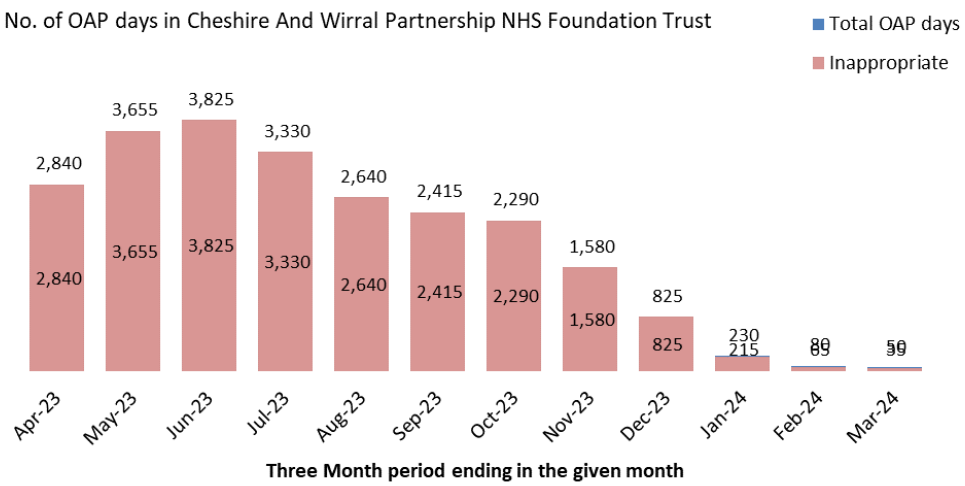
Cheshire and Wirral Partnership NHS Foundation Trust (CWP) and Mersey Care NHS Foundation Trust provide Adult and older adult mental health acute inpatient services, inclusive of older adult organic wards and Psychiatric Intensive Care (PICU) provision. Cheshire and Wirral Partnership provide adult mental health inpatient provision over three sites in Macclesfield, Clatterbridge (Wirral) and Chester, serving Cheshire East, Cheshire West and Wirral places and Mersey Care provide services out of 13 inpatient sites based in Liverpool, Sefton, Knowsley & St. Helens and Warrington & Halton.

Snapshot data was provided in March 2024:

NHS Trust	Adult acute beds	Older adult organic beds	PICU	Specialist beds
CWP	125	39	17	---
MCFT	334	32	12	71

Over recent years there hasn't been sufficient inpatient capacity in CWP to meet local demand and therefore 13 additional beds were opened in a vacant CWP ward, funded by CWP which is above the core contract with the ICB. In addition, the 4 PICU beds that were historically sold by CWP for income generation have been occupied by CWP patients due to the level of demand at an additional cost to CWP. CWP has also utilised inpatient beds via the North West Bed Bureau and through a direct contract with Cygnet, in total this is an additional 26 acute adult beds. These additional beds are not being reported as "out of area" via national submissions as continuity principles are being met. CWP have also utilised spot purchase acute mental health inpatient beds in the independent sector which are reported as inappropriate out of area placements (as per NHSE definition), however, there has been a significant reduction demonstrated in National data taken from NHS future collaboration platform:



This demonstrates the extensive work on the acute care pathway at CWP to date which has had dedicated trust wide support with executive leadership and oversight, which has included the creation of a data dashboard with key lines of enquiry to understand the factors influencing bed capacity and flow.

Mersey Care NHS Foundation Trust (MCFT) have maintained zero inappropriate out of area mental health acute care placements over the past year and have an extensive programme of work to optimise the therapeutic offer for people needing mental health acute care and to continue to ensure there is local bed capacity for those that need it. The work aligns to Mersey Care's 'Super Six' strategic intentions of operational and clinical excellence, highly engaged and supported staff, whole person, redesign to improve value, technology and data transforming care and realising the benefits of research and innovation.

Cheshire and Merseyside have seen a reduction in flow since 2017 based upon admission and discharge data, however, as noted this is not inclusive of CWP admissions outside of the main provider. Out of all admissions to adult mental health inpatient services in the last year excluding data reporting issues, 48% accessed an inpatient bed through the crisis resolution home treatment team, whilst 20% were admitted through the emergency department. It was also noted that out of the 4370 admissions 14% had no previous contact with mental health services. Both CWP and Mersey Care have identified this as an issue and are actively working to understand and improve any community access issues.

The average length of stay (LOS) across adult, older adult and PICU wards in Cheshire and Merseyside has remained higher than the national average. There has been a gradual increase over previous years and, in the past year, Cheshire and Merseyside reported that 31% of their inpatients were discharged after an inpatient stay of over 60 days and 19% over 90 days. It has been identified that this is due to both people taking longer to reach a point where their needs can be appropriately met in the community and for those who are clinically ready for discharge, to be discharged because of internal and external barriers. There has been an increase in people who are clinically ready for discharge in Cheshire and Merseyside, the number at any one time is still significant and sits between 50 and 80 people and lengthy delays are often incurred as reported via the North West NHS England sitrep. This clearly impacts on bed availability and the pressures experienced by mental health acute services. MADE meetings are happening across Cheshire and Merseyside and system barriers are being escalated, however it is noted that housing is a significant barrier and system support with this is required.

It is recognised that there needs to be further focus and system support to improve flow, not only to reduce the risk of harm to people who are unable to be discharged from hospital despite being clinically ready, but to increase local bed capacity for those who may need or are waiting for an inpatient admission. The data has shown a gradual increase in the number of people waiting for over 4 and 12 hours for an emergency inpatient admission in the community and emergency departments in Cheshire and Merseyside.

Work to implement the National Acute Care Guidance is happening across Cheshire and Merseyside and this includes focussing on the diversity and breadth of the therapeutic offer within inpatient services, and what workforce is required to provide this. There are ongoing significant workforce challenges across inpatient mental health services; including high numbers of vacancies and variance across Cheshire and Merseyside with regards to the make-up of inpatient multidisciplinary teams and the offer of peer support.

Although the primary focus on this part of the self-assessment is on adult inpatient mental health provision and improving the quality via improving the therapeutic offer, consideration has also been given to community mental health services (inclusive of the broader system offer eg, VCFSE, LA's, Housing etc), first response and crisis pathways, and step up/step down provision, as development of these is crucial to reduce reliance on adult acute inpatient care.

Adult Mental Health: Our ICB Vision Statement

NHS
Cheshire and Merseyside

By the end of year 3 we will aspire to meet an adult's needs impacting on their mental health at the right time, in the right place and with the right offer of intervention and support. We will have a focus on earlier intervention and prevention in the community and reduce the reliance on inpatient bed-based care. When an individual does require care in an inpatient setting, we will ensure that there is a clear individualised purpose for the admission, that discharge planning commences at the point of admission and that inpatient units have the skills and resources to deliver the range of therapeutic interventions to support individuals to achieve their identified goals.

This will include reducing risks of harm to people requiring adult acute mental health care by:

- 0 people being admitted to an inappropriate out of area placement where continuity principles cannot be applied
- Reducing the time people wait for an emergency acute mental health inpatient admission in Emergency Departments or the community
- Reducing the number of days lost for people in the community by improving the quality of care and therapeutic offer within inpatient services, including the diversity in multi-disciplinary teams, staffing capacity and skills of the workforce
- Reducing the number of days lost for people in the community when they are clinically ready for discharge by system focus/support to address internal and external barriers and delays to discharge, including the development of housing or community offers, eg spread of models such as CHART in Crosby and CWP's Mental Health Intensive Support Team (MHIST).
- Improved engagement with people with lived, and living, experience to identify gaps in provision, especially for any marginalised groups, and to embed co-production and co-delivery in all service development and improvement work at all levels

Specific key enablers for achieving this vision

(in addition to the key enablers described in the introduction)

NHS
Cheshire and Merseyside

- Implementation of the NHSE Acute Care Guidance and 10 high impact initiatives including continued use of MADE's and Super MADE's to escalate issues impacting on quality or increasing harm by delaying discharge from hospital
- Implementation of the Cheshire and Merseyside mental health strategic workforce planning framework to determine the workforce profile required
- Development of reporting mechanisms to ascertain how an individual's physical and mental health needs, any reasonable adjustments, eg sensory or communication needs, and cultural, gender, sexuality or faith requirements/preferences are being addressed and/ or reasonably catered for, when accessing adult mental health services
- Collaborative working with wider clinical teams and system partners including substance misuse services, neurodevelopmental services, housing, VCFSE and community mental health services to ensure a person's needs can be fully met by the whole Cheshire and Merseyside system
- Collectively prioritise investment opportunities to embed peer support workers and lived experience engagement from ward to Board
- Continue to create alternatives to Emergency Departments for people experiencing mental health crisis, building on the success of existing crisis services as an alternative means of meeting people's needs outside of hospital
- Improve estates and ward environments including PICU, especially in relation to sensory stimulus for neurodivergent groups to promote recovery and support transitions between inpatient services
- The consistent utilisation and reporting of PROMs to ascertain whether people are receiving care that meets their individual needs, to systematically measure the experience of care and identify areas for development
- Improved insights into adult mental health inpatient demand from demand and capacity modelling and dedicated research to improve early intervention and preventative support (eg, reduced admissions of those not known to mental health services)
- The development of strategic housing needs for those accessing adult mental health care and clearer routes for accessing housing, homelessness support and Personalised Health Budgets to facilitate discharge

Adult mental health ratings against the 'I & We statements'

Total Score	16

Rating Guidance	
1	Limited evidence that principles are embedded. Scope for improvement is identifiable
2	Emerging and growing evidence of principles within the system, but they are not embedded, and improvement work can be identified.
3	Evidence of principles within the system, but not consistent/embedded. Plan in place, or in active development to embed.
4	Strong evidence that the principled are evident within the system, but do not yet feel fully embedded into culture and business as usual
5	Strong evidence that the principles are fully embedded within, and across the system and are part of business as usual.

Principle			Rating	Rationale
A	Valuing	Preventing 'othering' and fostering a sense of belonging	2	There is evidence of feedback from concerns/complaints, compliments, community meetings and friends and family tests that people accessing mental health services in Cheshire and Merseyside, and their families and carers are valued and listened to. Extensive efforts are made to seek feedback, not only from people who access services, but those that work in them, and workforce well-being is a priority. There is further work needed to seek out the voice of those with lived and living experience to champion improvements within inpatient services and establishing mechanisms for this is an area for development within the first 6 months. There is a commitment to ensuring that people are admitted close to home and to inpatient provision that is part of a local pathway of care. Mersey Care NHS FT have not admitted anyone out of area in over a year and CWP have made progress to reduce this in recent months. This ensures that people needing adult mental health care from Cheshire and Merseyside are supported to remain within their community, valuing their citizenship and sense of belonging and being supported to maintain social ties. There are ambitions to develop a stronger peer support workforce, which will further reduce stigma, and lived experience leadership and involvement from ward to Board. Of the inpatients who completed the Inpatient Questionnaire: • 80% agreed or strongly agreed that they are made to feel valued and that their wishes and needs are respected. • 75% agreed or strongly agreed that they feel listened to and that their voice is heard • 71% agreed or strongly agreed that they feel a sense of belonging and part of their own community Constructive feedback suggest that time restrictions and staff shortages can lead to reduced interaction, appointment times and that there is a lack of activities at times.
B	Accessible	Early intervention & timely support Choice	3	Across the ICB there are a range of alternatives to admission including community support offers such as crisis cafes, crisis beds and joint working with VCFSE via the mental health alliances. There is evidence of the benefits of early intervention through the development of crisis lines and the support of crisis resolution home treatment teams. Across the ICB there are aspirations to develop an understanding of those who have a mental health admission who are not known to services, and how services before this point can be strengthened. There is also a desire to further understand the populations (ethnicity, demography or other intersections), who may be within services, but who may struggle to access support for their escalating mental health needs and who are overrepresented within inpatient settings, to ensure mental health care across Cheshire and Merseyside is accessible to all. Of the inpatients who completed the Inpatient Questionnaire: • 76% agreed or strongly agreed that they are able to access services based on their need and that they do not feel excluded or stigmatised due to their diagnosis. The majority of feedback suggests that they are able to access multiple services based upon their need however, constructive feedback suggest that a minority of inpatients find that some the activities are unclear.

C	Humane	Least coercive Compassionate and caring	3	There is evidence of a consistent approach to reducing restrictive practices across inpatient services, supported by compassionate leadership, planning for discharge at the point of admission and embedding the key discharge initiatives (100 day discharge challenge initiatives). Across the ICB, there are people within the acute mental health wards who are delayed due to lack of appropriate housing provision and therefore, further work is required with wider system partners to develop solutions for those who are homeless and/or live complex lives, with a similar focus on this as is afforded to those within an acute hospital environment (parity of esteem). Of the inpatients who completed the Inpatient Questionnaire: • 84% agree or strongly agree that first and foremost, they are treated like a human being • 71% agree or strongly agree that the environment is considerate of their individual strengths and needs • 76% agree or strongly agree that staff speak to them using their preferred method of communication • 76% agree or strongly agree that they are supported to plan and prepare for important changes, such as transitions between services or discharge home Feedback suggests that, although they are supported by staff, transfers and discharges can be slow.
D	Equitable	Personalised Needs led Culturally safe	3	Services are designed to best meet the needs of people and while acknowledging that people are acutely unwell, they are still able to make valuable contributions to their care and treatment. Task and finish groups have been developed in some areas to focus on personalised care planning, but it is acknowledged that the voice of lived and living experience requires strengthening when it comes to continuous improvement activities. It is acknowledged that across the ICB inequalities exist within the system and that certain communities are overrepresented within our inpatient settings and the use of the mental health act. Such inequalities also exist when considering local pathways that impact on discharge from hospital and require the same focus that exists within Acute hospital settings. Of the inpatients who completed the Inpatient Questionnaire: • 70% agreed or strongly agreed that they feel valued and respected for who they are • 76% agreed or strongly agreed that they can be themselves around peers and staff • 77% agreed or strongly agreed that they are not discriminated against for who they are or the choices they make • 67% feel that difference is understood, respected and celebrated
E	Therapeutic	Holistic Strengths based Trauma informed	3	Across Cheshire and Merseyside, workforce challenges are apparent, limiting the range of support and interventions that can be offered. Providers are working with the mental health alliances who know their communities and at times, are better placed to provide the support (debt advice, wellbeing interventions, accessing employment and education). There is evidence of the principles of trauma informed care and positive behavioural support within inpatient services being embedded and evidence of meaningful and therapeutic engagement from all members of the multi-disciplinary team. There has been recent inpatient investment to further strengthen the MDT offer within inpatient services to support the needs of the whole person. Across the ICB there are plans to assess and improve environments to ensure that they are therapeutic and appropriate for people who are neurodivergent. Of the inpatients who completed the Inpatient Questionnaire: • 63% agree or strongly agree that they are able to access a range of support that meets their needs • 71% agree or strongly agree that they have the time and space to form trusting relationships with the people involved in their care Feedback suggests that the majority of inpatients have formed good relationships with their care teams however, staff are always busy and more time with staff would be appreciated

F	Collaborative	People in partnership Skilled workforce System working	2	There is a national challenge in the recruitment of registered professionals and the impact of this is evident across the ICB. Workforce analysis has been conducted so as to understand the key gaps to enable safe and effective care however, currently there are resource issues and recruitment challenges. The workforce is tired but their efforts and commitment to doing a good job is recognised and valued. Staff retention is a key focus throughout the ICB and as part of this, there is a focus on listening to staff experience so that support can be offered, and solutions developed. Of the inpatients who completed the Inpatient Questionnaire: • 75% agree or strongly agree that they have a voice and feel that their views and choices are respected • 77% agree or strongly agree that they are able to access independent advocacy if they want to • 67% agree or strongly agree that they are able to make use of peer supporters as they wish Feedback suggests that some inpatients have been informed of what is available to them on discharge, while others have not. Those that have used independent advocacy have felt that the service has been helpful.
G	Support People as Citizens	Social inclusion Active participation	2	Work is ongoing with regards to addressing identified gaps in areas such as independent advocacy and alternatives to admission. Across the ICB there is evidence of strong commitment to collaborative working with the VCFSE sector, system partners, community mental health alliance and those with lived/living experience within continuous improvements initiatives. The extensive work completed as part of the community mental health transformation needs to continue to be built upon to ensure that the implementation of improvements (supporting timely discharge, preventing unnecessary delays and ensuring that all alternatives to admission are exhausted prior to coming into hospital) are co-produced and evaluated by those with lived/living experience. Of the inpatients who completed the Inpatient Questionnaire: • 72% agree or strongly agree that they feel supported to access things that matter to them • 71% agree or strongly agree that they feel that their hopes dreams and plans for the future are heard • 71% agree or strongly agree that they feel a sense of belonging with the community that they identify with Feedback suggests that a minority of inpatients do not have many hopes for the future and could benefit from more time to talk things through with staff.
H	Co-production / Lived experience embedded	Nothing about us without us	2	This is work in progress and further work is needed to establish a framework to enable people with lived experience to be supported to contribute to service developments, continuous improvement and provide feedback, recognising this through compensation for their time and expertise. There is good evidence of this within community mental health transformation however, there is a need to build on this approach within the inpatient programme. A number of Inpatient QI workstreams have been developed, including how volunteers and people with lived experience can be embedded. In some areas, there is engagement with AQUA to support training and development in QI methodology for volunteers and people with lived experience. Of the inpatients who completed the Inpatient Questionnaire: • 70% agree or strongly agree that they are aware of and supported to attend meetings in their area that are aimed at improving services • 57% agree or strongly agree that they know who the patient experience representatives are in their area and how to contact them • 60% agree or strongly agree that they can contribute their lived experience to changes being made in their area • 54% agree or strongly agree that they have a role in the development of services in their area on the basis of their lived experience • 52% agree or strongly agree that they are compensated for their time and can access support where needed to make sure they are not left in a difficult position because of their contributions Feedback suggests that some have been to meetings in the area and find the meetings useful. Other inpatients have suggested that, although they attend ward meetings, they are not yet in a position to contribute to other lived experience meetings in their area.

Adult mental health 3 year plan

NHS
Cheshire and Merseyside

Year 1

- Embed work to implement the mental health acute care guidance and 10 high impact challenges into the system flow programme
- Continue to address all barriers to discharge as a system when someone is clinically optimised, through improved data reporting and development of strategic housing plan and equitable access to housing
- Invest in formal demand and capacity modelling for inpatient care
- Invest in Safe Care Programme to increase staffing capacity so the therapeutic offer is improved (as highlighted by people with lived experience)
- Dedicated focus to increase lived experience involvement in service development and delivery of care through peer support (as identified through the self ratings completed by people with lived experience).
- Increased data quality and reporting to monitor progress and identify areas for prioritisation

Year 2

- Evaluation of year one investment to inform programme priorities
- Identify gaps in community and inpatient(including step up and step down) provision based on modelling and improved data needed to maintain flow
- Engage VCFSE and housing colleagues re potential service development opportunities
- Explore financial modelling including provider collaboration to ensure service developments are sustainable
- Co-produce a redesigned plan for a local pathway of inpatient and community care for adults with mental heath needs, based on evidence, feedback and population health data

Year 3

- Implementation of re-designed pathway of inpatient and community care and robust evaluation
- Plan for future investment ensuring best use of available resource and that the principles of the inpatient quality transformation are embedded throughout.

NHS
Cheshire and Merseyside

Rehabilitation plan

Rehabilitation: Current State Description

NHS
Cheshire and Merseyside

Cheshire and Merseyside have block contract inpatient mental health rehabilitation provision in Cheshire and Wirral Partnership, Mersey Care and Alternative Futures Group and rehabilitation inpatient provision is also spot purchased in the independent sector.

Snapshot data on inpatient rehabilitation activity

- A snapshot data request was made to providers and place commissioners to understand rehabilitation inpatient activity on a census date of 31/1/2024.
- Block contract inpatient activity was reported as:
- Rosewood Unit and Maple Unit provided by CWP are level 2 units and have 33 beds between them (26 male and 7 female), however this is inclusive of 4 forensic step-down beds that are commissioned differently.
- Heys Court and Rathbone Rehabilitation Centre provided by Mersey Care are level 1 units and have 41 beds between them (20 female and 21 male).
- Alternative Futures Group (AFG) have 3 level 1 rehabilitation inpatient units placed across Cheshire and Merseyside and bed use varies, however, at the time of completing the self-assessment the following beds were being used by Cheshire and Merseyside ICB; 18 beds in Lea Court (6 female and 12 male), 20 beds in Meadow Park (9 female, 11 male) and 18 in Weaver Lodge (5 female and 13 male).

This totals 130 people in block contract inpatient rehabilitation services from Cheshire and Merseyside (47 females and 83 males). 117 of these people have a primary need of psychosis, 2 male inpatients have learning disability or autism, 11 people are noted to have complex emotional needs and 90% of this cohort are recorded as being of White British ethnicity. The length of time people had been inpatient on the unit varied. 59% of the cohort had been in the inpatient setting up to 12 months, 23% had been inpatient for 1-2 years, 9% had between 3 and 5 years and 9% had been inpatient over 5 years. It was identified that there are issues with flow through the block contract inpatient rehabilitation services and in the snapshot data 58 (45%) of the 130 people in the block contract inpatient rehabilitation provision were identified as being clinically ready for discharge. The reason for the barriers to discharge mostly related to identification and funding of community placements.

The snapshot data also included people who are receiving level 2 inpatient rehabilitation outside of the block contract provision, via a spot purchase commissioning arrangement. There were 90 people from Cheshire and Merseyside in spot purchase rehabilitation placements on the census date, 69% of these people were in placements within Cheshire & Merseyside, 4% in the wider North West region and 27% (24 people) were in placements outside of the North West. 66% of these people had been in hospital for over a year and 10% of people had been inpatient for over 5 years.

Identified areas for improvement

NHS
Cheshire and Merseyside

There continues to be variance in how inpatient rehabilitation is accessed, commissioned and reviewed in Cheshire and Merseyside, and there hasn't been ICB central oversight of inpatient rehabilitation activity or costs that sit outside of the block contract provision. This has presented challenges in assuring that people have a clear purpose of admission, are receiving good quality and evidence-based intervention that is reviewed regularly, and that the best use is being made of available resource. There is now ICB agreement that the reduction in out of area inpatient rehabilitation is a key priority as part of the Cheshire and Merseyside system flow programme and improved data and oversight will be key to this.

There has been a complex care dashboard developed in the North West, which not only looks at the people who are in NHS inpatient rehabilitation provision, but also those that become stranded and super-stranded in adult mental health services. This can be broken down into known health inequalities including ethnicity, social deprivation, diagnosis, age, and gender. There remain issues with some data quality, including limited information on sexuality, and this is being addressed at a system level. There is a plan to expand existing data sets to also understand the needs and types of populations in out of area (non-block contract) inpatient rehabilitation, to ensure the rehabilitation offer is equitable and accessible for all. This will be monitored to ensure underserved groups are able to access developed community rehabilitation services, are not waiting longer for rehabilitation, staying in hospital for a longer time, being placed out of area or receiving more restrictive care.

Work is underway to improve flow through inpatient rehabilitation services, embedding the 10 high impact initiatives, system flow reporting and reporting of all barriers that may be delaying discharge, with an aspiration that over the next 3 years there will be a reduction in the number of inpatient rehabilitation beds commissioned. It is recognised that inpatient provision comes at a significant financial cost to the system and personal cost to the people accessing it and their families, especially when they are placed outside of the local pathway of care, dislocated from their families and communities, or when they are in hospital for longer than they need to be, because there isn't a viable or accessible community offer.

Community rehabilitation has a key role in scaffolding and supporting community services so more people with severe and enduring mental health needs can live outside of hospital. They work collaboratively with wider community mental and physical health teams, local authorities, housing and support providers and VCFSE. The community mental health transformation in Cheshire and Merseyside has seen the development of community rehabilitation services in CWP and Mersey Care with system stakeholders and the benefits are starting to be realised.

In addition, the development of dedicated pathways for people with complex emotional needs or a diagnosis of personality disorder are ensuring that this group has access to evidence-based psychological and trauma informed interventions in the community to reduce and stop distressing symptoms that impact on a person's functioning, which can be enough to enable them to regain skills without needing specific intensive rehabilitation in the community or within an inpatient setting. This has already been demonstrated through the Mersey Care model. Further development of these services will be a key enabler to reducing reliance on inpatient care.

Rehabilitation: Our ICB Vision Statement

NHS
Cheshire and Merseyside

- Over the next 3 years Cheshire and Merseyside will have fewer people in inpatient rehabilitation placements and more people being supported to live and thrive in the community. Rehabilitation will be community based by default and inpatient by exception, will be person-centred, provided collaboratively and will have a whole system focus. There will be warranted variance in the provision of rehabilitation to take account of population need, to address health inequalities and reach marginalised groups and rehabilitation will be delivered by a diverse, skilled and multi-agency workforce.
- If a person has a mental health rehabilitation need that can only be met within an inpatient setting, they will not be excluded on the basis of diagnosis, the admission will be prompt, purposive and intervention driven, there will be agreed and consistent processes for accessing inpatient rehabilitation and clear delegated responsibility within Cheshire and Merseyside for oversight of the whole rehabilitation pathway.
- People's purpose of admission will be reviewed regularly with the community rehabilitation service and discharge facilitated when a person's rehabilitation need can be met in the community. There will be established mechanisms for system support and escalation to ensure that people are not in hospital longer than they need to be and identification of gaps in community provision such as housing or support, which will inform strategic and financial planning.
- Community rehabilitation services will also ensure oversight and regular review of supported living placements or significant packages of care, to facilitate people being able continue to move to more independent living whilst receiving ongoing support and intervention for any rehabilitation needs. This dedicated focus in the community for those with severe mental health and rehabilitation needs, will ensure that best use is being made of available resource, there will be increased flow through the whole pathway and increased local inpatient and commissioned community capacity for those people who require it.
- All commissioned inpatient rehabilitation placements will be part of a locally designed and agreed pathway of care, will be evidence-based, co-produced and co-delivered. National guidance will be implemented to improve quality and data and outcome tools used and regularly reviewed by the ICB to monitor the effectiveness of the model and inform developments.

The realisation of the aspirations for the rehabilitation pathway in Cheshire and Merseyside will require new and innovative ways of working, and there is specific focus on ensuring staff are trained and supported to provide the interventions needed. There have been links with universities to develop rehabilitation training in parts of the ICB geography and plans to expand this. There is also a commitment to develop peer support roles and for multi-disciplinary teams to be diverse, reflect the population they are serving and be multi-agency. The community transformation across the ICB has already facilitated much better system working and it is key that this work continues to develop in the community, but also as part of an in-reach into inpatient rehabilitation to smooth transitions in and out of hospital. This will also include the further development of personalised care and support planning across all services.

Rehabilitation- ratings against the ‘I and We statements’

Total Score	27

Rating Guidance	
1	Limited evidence that principles are embedded. Scope for improvement is identifiable
2	Emerging and growing evidence of principles within the system, but they are not embedded and improvement work can be identified.
3	Evidence of principles within the system, but not consistent/embedded. Plan in place, or in active development to embed.
4	Strong evidence that the principled are evident within the system, but do not yet feel fully embedded into culture and business as usual
5	Strong evidence that the principles are fully embedded within, and across the system and are part of business as usual.

Principle			Rating	Rationale
A	Valuing	Preventing ‘othering’ and fostering a sense of belonging	3	There is evidence of feedback from people who use our services, ranging from feedback from concerns/complaints, compliments, community meetings on the ward, plus friends and family tests to demonstrate how valued people feel. Across the ICB mental health rehabilitation services are designed to empower people to develop their own goals with the support of staff and significant others involved in their care. Each person has individualised goals agreed as part of the access assessment and there are mechanisms in place to review these regularly. Inpatient services are based on the 'needs of the person' and whether rehabilitation services can add value rather than rigid inclusion / exclusion criteria. The in-patient pathway aims to keep the admission as short as possible with community re-integration being the focus. There are active links with community resources with the aim to maintain social ties and promote patients to integrate back into the community. This also promotes a sense of belonging and citizenship. Individuals are placed as close to home wherever possible, and this continues to be a major focus for further work. More recently, staffing and system challenges in some areas have made it difficult to practice these principles consistently. The large number of people who are CRFD due to housing challenges add to the pressures faced. Work is required to establish a baseline of people's experiences (in line with I and We statements) and this is planned within the first 6 months of the programme. Of the inpatients who completed the Inpatient Questionnaire: 84% agreed or strongly agreed that they are made to feel valued as a person 88% agreed or strongly agreed that they feel listen to and that their voice is heard 64% agree or strongly agree that they feel a sense of belonging and part of their own community Feedback suggests that staff are always on had to listed and treat inpatients with respect and dignity, with an approach that helps to build confidence.

B	Accessible	Early intervention & timely support Choice	4	Within CWP NHS FT, a well-established intensive community rehabilitation team (MhiST) is in place, who also lead on access to all rehab services allowing for the consideration of the least restrictive options to be considered first. They also in-reach to acute wards to inform discharge planning and work with people in the community as an alternative to a hospital admission. Mersey Care NHS FT are currently developing their community rehabilitation team (CERT), which will support a person's recovery without the need for hospital admission or reduce the time a person spends in hospital. Mersey Care have also developed a clinical model for people with a diagnosis of personality disorder which has significantly reduced admissions and time spent in hospital for this cohort. CWP are developing their Complex Needs Service offer currently. Alternative Futures Group have worked to increase accessibility and ensure that goals for admission are recorded to ensure purposive admission and that people are only in hospital for as long as they need to be. All block contract inpatient units are needs led rather than diagnostically driven and ensure that admission to hospital is appropriate and therapeutic. People being referred and their families/carers are offered choices with regards to their admission to hospital, and efforts are made to ensure that access is timely. Of the inpatients who completed the Inpatient Questionnaire: • 84% agree or strongly agree that they are able to access services based on their need and don't feel excluded or stigmatised due to their diagnosis Feedback suggests that inpatients are happy with the service they receive
C	Humane	Least coercive Compassionate and caring	3	A consistent approach is taken across the ICB in relation to reducing restrictive practices across inpatient services. Community rehabilitation is prioritised wherever possible, and admissions are kept as short as clinically indicated. In some areas of the ICB peer reviews are being utilised for people who are inpatient who aren't progressing as planned and these support clinicians to make appropriate clinical decisions. Processes are in place to plan for discharge on admission and mitigate any known barriers or delays. Challenges to discharge are apparent across the ICB due to a lack of appropriate housing provision and although work has commenced in some areas to address this, further work is required with wider system partners to develop housing and support offers that meet the often severe and co-occurring needs of this cohort. Restrictive interventions are reported on frequently to identify any themes and inform any improvement work and all providers have embedded the 6 C's to ensure care that is compassionate. Of the inpatients who completed the Inpatient Questionnaire: • 88% agree or strongly agree that first and foremost, they are treated like human beings • 80% agree or strongly agree that that the environment is considerate of their individual strengths and needs • 76% agree or strongly agree that staff speak with them, not to them and use their preferred method of communication. • 76% agree or strongly agree that they are supported to plan and prepare for important changes, such as transitions between services or discharge home Feedback suggests that the majority of inpatients feel safe, are treated with respect and that this approach is aiding their recovery. A minority suggest that they feel 'fobbed off' to another member of staff.

D	Equitable	Personalised Needs led Culturally safe	3	All rehabilitation services across the ICB are designed to meet the needs of people as individuals. They are personalised in a way that also includes reasonable adjustments and supports cultural sensitivities. In some areas, this includes the involvement of equality and diversity teams. In other areas, task and finish groups have been established to focus on personalised care planning. People, and wherever possible, their carers and families are fully involved in all aspects of their care and treatment and shared decision making encouraged. It is acknowledged that there are inequalities that exist within the wider system pathways that impact on people's discharge from hospital. This requires the same focus that is afforded to those within an Acute hospital (parity of esteem). Of the inpatients who completed the Inpatient Questionnaire: • 76% agree or strongly agree that they feel valued and respected for who they are • 84% agree or strongly agree that they can be themselves around peers and staff • 80% agree or strongly agree that they are not discriminated against for who they are and the choices they make • 80% agree or strongly agree that they feel that difference is understood, respected, and celebrated Feedback suggests that inpatients are not feeling discriminated against and can be themselves around most staff. One respondent suggests that they have heard night staff talking about other patients.
E	Therapeutic	Holistic Strengths based Trauma informed	3	Rehabilitation delivered is evidence-based, trauma informed and person-centred. Care plans address a range of needs, all of which are based on individual goals, and are reviewed regularly with people accessing services to ensure that they remain relevant and are strengths based. Care plans are purposive but also support the whole person including their social, psychological, and physical needs. Therapeutic relationships are prioritised that are respectful and instil hope. Across the ICB there is evidence of rehabilitation specific training to ensure the MDT has the right values, skills and knowledge, however further work is needed. In some areas, investment has been made to strengthen the AHP and psychology workforce to support a 'whole person' approach. Further work is required around environmental factors and work has commenced around assessing environments to ensure that they meet the needs of neurodivergent groups. Of the inpatients who completed the Inpatient Questionnaire: • 80% agree or strongly agree that they are able to access a range of support that meets their needs • 80% agree or strongly agree that they have the time and space to firm trusting relationships with the people involved in their care Feedback suggests that inpatients are happy with the level of therapeutic care.

F	Collaborative	People in partnership Skilled workforce System working	3	As noted, rehabilitation intervention is collaborative with the person, their families and carers and takes account of their individual needs and preferences. In addition, across the ICB it is recognised that there are opportunities for collaboration that will strengthen the rehabilitation offer and address known workforce challenges. There have been discussions re collaborating in the development and delivery of rehabilitation specific training and in developing the community rehabilitation services. Within CWP NHS FT, the rehabilitation strategy is being refreshed to reflect the workforce challenge but also to bolster the community rehabilitation offering as much as possible, with the whole CWP rehabilitation footprint working closely to share good practice and provide peer support. At Alternative Futures Group, 1:1 process, community meetings, daily meetings and reviews give the patients a voice to share views/wishes, minutes of meetings, community networks, CQC reports, advocacy information, resources, rights and responsibility information, complaints and comments are displayed, and suggestion boxes are in place to enable the patients to feel heard. Across the ICB there is work being undertaken to focus on retention of staff, listening to their experience so as to provide the required levels of support and progression opportunities. It is hoped that this will also optimise therapeutic relationships and interventions. Of the inpatients who completed the Inpatient Questionnaire: • 72% agree or strongly agree that they have a voice and that their views and choices are respected • 72% agree or strongly agree that they are able to access independent advocacy if they want to • 68% agree or strongly agree that they are able to make use of peer supporters if they wish Feedback suggests that all of their views have been explored by staff. A small minority suggests that they feel that friendships with peers are frowned upon by staff.

G	Support People as Citizens	Social inclusion Active participation	3	Access to independent advocacy is available throughout the ICB and this is being developed further with strategies developed to re-embed this back into practice (after identifying a gap in some areas, post-COVID). Work continues to ensure people are placed as near to home as possible for rehabilitation and community connection and inclusion is prioritised. Across the ICB, there is evidence of collaboration within local systems to prevent unnecessary delays wherever possible and alternatives to admission are always considered. Community activities and participation are prioritised to promote social inclusion; however, it is acknowledged that more can be done in this area. Of the inpatients who completed the Inpatient Questionnaire: • 80% agree or strongly agree that they feel supported to access the things that matter to them • 68% agree or strongly agree that they're hopes, dreams and plans for the future are heard • 68% agree or strongly agree that they feel a sense of belonging with the community they identify with Feedback suggests that inpatients are receiving the support that they require in this area.
H	Co-production / Lived experience embedded	Nothing about us without us	2	Further work is planned within this area to build upon the lived experience representation achieved so far. Within Mersey Care NHS FT, a framework is in development to enable those with lived experience to be supported to contribute to service developments and continuous improvement, with some QI workstreams already in place. Within CWP NHS FT, there are a number of volunteer roles within the units, with many of those volunteers having lived experience. There are good examples across the ICB of lived experience representation (both voluntary and paid roles) within community rehabilitation teams and there is the aim to take similar approaches within inpatient services. This is particularly relevant for underrepresented voices, which are common within this cohort. Of the inpatients who completed the Inpatient Questionnaire: • 80% agree or strongly agree that they are aware and supported to attend meetings in their area that are aimed at improving services • 64% agree or strongly agree that they know who the patient experience representatives are in their area and how to contact them • 68% agree or strongly agree that they can contribute their lived experience of using services to changes being made in their area • 60% agree or strongly agree that they have a role in the development of services in their area on the basis of their lived experience • 60% agree or strongly agree that they are compensated for their time and can access support where needed to make sure they are not left in a difficult position because of their contributions Feedback suggests that inpatients responded to these questions in relation to support from staff in their environment.

Rehabilitation 3 year plan

NHS
Cheshire and Merseyside

Year 1

Design and implement processes across Cheshire and Merseyside for accessing all inpatient mental health rehabilitation, including assessment, shared decision making looking to least restriction, setting a purpose of admission or intervention, regular reviews and facilitating transitions out of hospital.

- Embed work to implement the mental rehabilitation guidance and 10 high impact challenges
- Continue to address all barriers to discharge as a system when someone is clinically optimised, through improved data reporting and development of strategic housing plan and equitable access to housing
- Invest in formal demand and capacity modelling for rehabilitation inpatient care in and outside of main NHS providers
- Development of systemwide rehabilitation forum inclusive of VCFSE, LA, Housing, NHS Provider Trust (inpatient and community) and IS colleagues.
- Dedicated focus to increase lived experience involvement in service development and delivery of care through peer support (as identified through the self ratings completed by people with lived experience).
- Increased data quality and reporting of all rehabilitation activity and costs
- Consistent community offer for those with complex emotional needs or who have experienced significant trauma

Year 2

- Evaluation of year one investment to inform programme priorities
- Identify gaps in community and inpatient(including step up and step down) provision based on modelling and improved data needed to maintain flow
- Work collaboratively with the local authorities and adult social care throughout Cheshire and Merseyside and explore different commissioning models, recognising that a shift from inpatient care to community care may require a shift in resource to ensure people are able to have their needs met in the least restrictive setting
- Co-produce a redesigned plan for a local pathway of inpatient and community care for rehabilitation based on evidence, feedback and population health data

Year 3

- Implementation of re-designed pathway of inpatient and community care and robust evaluation
- Plan for future investment ensuring best use of available resource and that the principles of the inpatient quality transformation are embedded throughout.

NHS
Cheshire and Merseyside

Learning Disability Plan

Learning disability: Current State Description (at time of completion: March 2024)

NHS
Cheshire and Merseyside

There are currently 3 assessment and treatment units for adults with learning disabilities, including autistic adults with learning disabilities across Cheshire and Merseyside:

- Greenways inpatient unit in Macclesfield provided by CWP NHS FT, which has 12 inpatient beds (inclusive of 4 additional beds commissioned by GM)
- Eastway inpatients unit in Chester provided by CWP NHS FT which has 9 beds
- Byron inpatient unit provided by Mersey Care which has 10 beds for Merseyside

These inpatient services are part of a pathway of care for adults with learning disabilities inclusive of those autistic people with learning disabilities.

In March 2017 there were 110 people with a Learning Disability or Learning Disability and Autism in inpatient settings in Cheshire and Merseyside. In December 2023 this had reduced to 61 people across all Mental Health inpatient settings, with 35 of this cohort being in secure inpatient services and 26 in ICB commissioned placements.

At the same time there were 5 inpatients in Byron Unit, and 10 people between Eastway and Greenways. There are ongoing issues impacting on bed capacity including challenges with recruitment and staffing capacity, and although the bed occupancy is lower, people being admitted have higher complexity of need and require more intensive support and a more specialist therapeutic offer. Further focus is needed to maximise the Learning Disability workforce to ensure the sustainability of Learning Disability and Autism inpatient services across Cheshire and Merseyside.

In March 2024 12 of the people who were in hospital with learning disabilities and learning disabilities and autism were placed in ICB commissioned inpatient settings outside of the main providers for rehabilitation or other mental health needs. Out of these 12, 6 were in active treatment and 6 were clinically ready for discharge. Similarly, in March 2024, out of the 15 in the main provider inpatient provision in CWP and Mersey Care only 3 were in active treatment and 12 people were clinically ready for discharge. There are therefore ongoing challenges with the flow through inpatient units and the availability of community services, and this is illustrated through hospital admissions with an extended length of stay.

Cheshire and Merseyside ICB have the longest total length of stay in the North West and the total length of stay for adults with learning disabilities has doubled over recent years. There has also been an increase in the inpatient episode length of stay since 2017 with the average as of December 2023 being at about 1,200 days. Whilst recognising that the acuity and complexity of the group of people accessing inpatient care has increased, therefore people are likely to take longer to reach a level where they are clinically ready for discharge, they also often have significant aftercare needs and it can take a considerable time to identify or develop a package of care and support to enable a successful discharge. This results in people being required to stay longer in hospital than is clinically needed, inadvertently placing them at risk of harm and reducing local bed capacity and staffing resource for those that need it.

It has been demonstrated that the development and spread of the Dynamic Support database and Intensive Support Function have been beneficial in reducing reliance on inpatient care in Cheshire and Merseyside through providing a rapid intensive response to a person's escalating need and strengthening the community offer by being able to work with increased complexity outside of hospital. There is, however, unwarranted variance in the provision and coverage of such services and further analysis is needed to understand the impact of this. In addition, a gap analysis is required looking at community learning disability teams, intensive support functions, respite and step up and step-down provision from inpatient services to inform the future vision for Learning Disability Inpatient.

Learning disability: Our ICB Vision Statement

NHS
Cheshire and Merseyside

By the end of year 3 we will aspire to further reduce the numbers of people with learning disability inclusive of autistic people with a learning disability in hospital placements across Cheshire and Merseyside and ensure that all hospital admissions are to inpatient units that are part of a local pathway of care. This requires the re-design and re-commissioning of the current inpatient provision in Cheshire and Wirral Partnership and Mersey Care, the strengthening of the intensive support function and development of a community rehabilitation offer across Cheshire and Merseyside and more opportunities for provider collaboration including with Greater Manchester.

This will enable this group of people with learning disability and mental health needs to:

- wherever possible remain in the community and at home through rapid intensive support to address any escalating mental health needs
- access step up provision or respite in a timely way as and when required,
- access appropriate admission to hospital if necessary and to the best inpatient provision to meet their individual needs eg, ensuring the Green Light Toolkit is utilised in mental health inpatient services if that is the most appropriate inpatient placement and would offer best outcomes for the individual
- have a clear co-produced purpose of admission and expected date of discharge agreed with them, their carer's, families, and advocates, and pre and post admission CTRs fully utilised
- access good quality evidence-based care and intervention from a diverse multi-disciplinary and multi-agency offer both in the community and in inpatient settings
- have their aftercare needs identified on admission and discharge plans implemented as soon as the person is clinically ready
- receive support to overcome any delays and barriers to discharge through a clear process for senior system escalation
- be supported to step down out of hospital or transition back to community living at a pace that works for them

This will require building on the existing work completed through the North West ODN and Cheshire and Merseyside Transforming Care Partnership and they will play a key roles in continued oversight and development planning for this specific inpatient plan.

Lived experience feedback via the confirm and challenge forum

NHS
Cheshire and Merseyside

The self-assessment questions were taken to the Cheshire and Merseyside Confirm and Challenge forum, which is attended by self-advocates and experts by experience, they identified the following priorities for the future of inpatient services for adults with learning disabilities with or without autism in Cheshire and Merseyside:

- Involving people with lived experience throughout (Ask, Listen, Do; Nothing about is without us)
- Respecting people in services, informing service development and people with learning disabilities who are part of the delivery of services
- Getting the culture of care right
- Ensuring admissions to hospital are appropriate, close to home or in the Northwest, and are only as a last resort
- People are orientated to the surrounding area of the inpatient unit (eg, a pre-admission visit)
- People are inpatient for as short a time as possible and then supported in the community
- Time is taken to understand individual circumstances and what is important to each person
- Information is accessible
- There are enough staff who are appropriately trained to meet people's need
- Consultation is available from skilled practitioners to the whole system to ensure appropriate assessments and treatment plans
- People receive individualised, person-centred care
- Follow-ups after discharge and understanding my progress
- Good transport links to inpatient services so that family can visit and clear processes and communication so that people can claim travel expenses back

These comments have been embedded into our project planning and there will be continued involvement from the group in the Programme.

Specific key enablers for achieving this vision

(in addition to the key enablers described in the introduction)

NHS
Cheshire and Merseyside

In addition to the key enablers that run through all of the sections of the self- assessment as described in the Introduction, further specific focus to achieve the vision will include:

- Strong clinical and operational focus, oversight, and leadership of the whole adult learning disability pathway across Cheshire and Merseyside, including the implementation of the NHSE Guidance for inpatient services for adults with learning disabilities and autism, NHSE key discharge initiatives and HOPES model.
- Dedicated project management to support the re-design of the Learning Disability and Autism inpatient provision across Cheshire and Merseyside, scoping out the needs of those placed out of area and how to best use existing resource for optimum outcomes for all.
- Exploration of the development of a Cheshire and Merseyside Centre of Excellence to attract skilled and experience workforce and facilitate the sharing of knowledge and expertise. This would also support the identification of Quality Improvement initiatives across Cheshire and Merseyside to improve flow, the quality of inpatient care and the development of a clinical network to share best practice.
- Development of consistent and robust transition processes for young people in Cheshire and Merseyside
- Development of processes and mechanisms to be used consistently across Cheshire and Merseyside to maximise co-production and shared decision making in individual care planning and in the development and delivery of services eg, exploring the spreading of the function of the lived experience feedback roles
- To collaborate to ensure consistency in the capacity and clinical offer of the intensive support function across Cheshire and Merseyside and develop a community rehabilitation offer as an alternative to a rehabilitation inpatient admission and to facilitate discharge from inpatient services at the earliest opportunity
- Work collaboratively with the local authorities and adult social care throughout Cheshire and Merseyside and explore different commissioning models, including pooled budgets, recognising that a shift from inpatient care to community care may at least initially drive-up costs and increase financial pressures across the system
- Development of Cheshire and Merseyside process for clinical peer support to provide second clinical opinions on complex cases and generate effective treatment and intervention plans to expedite discharge
- Further development and implementation of an ICB Housing strategy including the inclusion of step up and step down care, and clear local processes for accessing housing
- To complete demand and capacity modelling of inpatient services using UNBRA to facilitate strategic and financial planning and building on the work completed by the North West ODN on modelling
- To continue to improve centralised data using AT and MHSDS data sets, in addition to local data derived from completion of the Dynamic Support Database
- Identification and utilisation of Research to improve insights into Learning Disability inpatient demand from dedicated research to improve early intervention and preventative support, admission criteria into Learning Disability Inpatient services and clinical decision making and practices that reduce the known health inequalities people with learning disabilities face
- Continued system wide work, including with housing and VCFSE to facilitate citizenship and community connectedness

Learning disability ratings against the ‘I and We statements’

NHS
Cheshire and Merseyside

Feedback has been obtained from people with learning disabilities placed within our Adult Mental Health and Rehabilitation settings, direct feedback from inpatients within our Learning Disability settings is more challenging, and usually gained from the family /and/or carers perspective. CWP NHS FT are currently piloting a method to enable us to gain feedback from the person themselves. using observations and based upon the ‘I statements’. If effective, this will be rolled out throughout Cheshire and Merseyside.

Total Score	27

Rating Guidance	
1	Limited evidence that principles are embedded. Scope for improvement is identifiable
2	Emerging and growing evidence of principles within the system, but they are not embedded and improvement work can be identified.
3	Evidence of principles within the system, but not consistent/embedded. Plan in place, or in active development to embed.
4	Strong evidence that the principled are evident within the system, but do not yet feel fully embedded into culture and business as usual
5	Strong evidence that the principles are fully embedded within, and across the system and are part of business as usual.

Principle			Rating	Rationale
A	Valuing	Preventing ‘othering’ and fostering a sense of belonging	4	Throughout the ICB there is good evidence of proactively involving people, their families, and carers. They are supported to have a voice throughout their inpatient journey and we have evidence of positive feedback regarding valuing people, ensuring their wants and needs are considered, and putting a range of reasonable adjustments and adaptions in place. This provides with people with the opportunity for meaningful engagement and participation to support decision making in their health care journey and individual treatment plans. There is a strong culture and practice of person-centred care and striving to 'get to know' people to enable support to focus on strengths, needs and preferred communication methods. Further development is required to further embed creative ways of capturing feedback from people with lived experience to robustly ensure that we fully understand the 'I' perspective. Areas of the ICB have embedded the 'Green Light' toolkit and are embedding LD and Autism champions. Further work is required to develop the wider workforce with regards to LD awareness and reasonable adjustments. Of those with learning disabilities, who are currently placed within adult acute MH and rehabilitation wards and responded to the inpatient questionnaire: • 66% agreed or strongly agreed that they are made to feel valued as a person and that their individual wishes and needs are respected. • 66% agreed or strongly agreed that they feel listened to and that their voice is heard.

B	Accessible	Early intervention & timely support Choice	3	Service provision has improved regarding avoidance of inappropriate admissions, with reduction in admissions to LD inpatient beds and increased appropriate admissions to mainstream mental health, with proactive supporting in line with the Green Light toolkit, and there is robust evidence of this. Aims of admission are outlined from the outset and clarity in roles and responsibilities are stated for all involved. Therapeutic goals and interventions remain dynamic and responsive to support the person throughout their journey and facilitating choice (where practically possible) is evident. Further work and development is required to ensure the robustness of the intensive support offer to meet the current demand, needs and gaps, including those in the wider system. Also, a review of the LD inpatient model and alternatives to admission is required. This will ensure that people are supported in the right therapeutic environment to meet their needs, for example, reducing admissions (where a bed is used as a place of safety) and reduce delayed discharges. This work will require collaboration with the wider system and local authorities to enable LD inpatient pathways to be fully effective. Of those with learning disabilities, who are currently placed within adult acute MH and rehabilitation wards and responded to the inpatient questionnaire: • 66% agree or strongly agree that they are able to access services based on their need and they don't feel excluded or stigmatised due to their diagnosis Feedback suggests that inpatients are made to feel at home and are supported well by the staff. Constructive feedback suggests that inpatients would like staff to listen more.
C	Humane	Least coercive Compassionate and caring	3	The ICB is unwavering in their commitment to ensure the least restrictive approach is taken to supporting people and remains a dynamic and responsive process, where alternative therapeutic interventions are implemented: sensory integration, trauma informed PBS for example. The LD inpatient model and clinical pathway ensures discharge planning and treatment options are discussed at preadmission and continued throughout. Respect and compassionate care are demonstrated in both culture and practice, as outlined within the 6Cs, organisational strategies and processes. Important networks are encouraged, supported and maintained, communication passports are in place to ensure people's means of communication is understood, facilitated, and supported, along with embedded person-centred approaches 'How to Support Me'. Further work relating to delayed discharges and the community infrastructure is required to ensure people are not detained, and thus restricted for longer than is necessary. Of those with learning disabilities, who are currently placed within adult acute MH and rehabilitation wards and responded to the inpatient questionnaire: • 66% agree or strongly agree that first and foremost, they are treated as a human being • 66% agree or strongly agree that the environment is considerate of their individual strengths and needs • 66% agree or strongly agree that staff speak with them, not to them and use their preferred method of communication • 66% agree or strongly agree that they are supported to plan and prepare for important changes, such as transitions between services or discharge home Feedback suggests that inpatients feel safe and have someone to talk to when they need it.

E	Therapeutic	Holistic Strengths based Trauma informed	4	The LD inpatient clinical model has a strong emphasis on the delivery of trauma informed positive behaviour support and therapeutic interventions which maximise a person's potential. Clear aims of admission are outlined, comprehensive assessment processes are conducted throughout a person's inpatient stay and regular, holistic reviews are conducted, ensuring maximum opportunities for involvement throughout. Combined, this approach promotes a feeling of safety for both the person and staff. Robust data collection and analysis allows for the identification of what is going well and what could be improved so it is important that we continue to list to what the data is telling us. At a trust level, Mersey Care NHS Foundation Trust will soon be moving to a new LD inpatient environment and further work is planned to re-launch the clinical model, taking a full co-production approach Of those with learning disabilities, who are currently placed within adult acute MH and rehabilitation wards and responded to the inpatient questionnaire: • 66% agree or strongly agree that they are able to access a range of support that meets their needs • 66% agree or strongly agree that they have the time and space to form trusting relationships with the people involved in their care No feedback was recorded.
F	Collaborative	People in partnership Skilled workforce System working	3	The ICB demonstrates an absolute commitment to collaborative systems working and staff have access to a range of support mechanisms at service and trust levels. These include reflective practice, Heart of Care (developing non-registered workforce), supervision including restorative practice, staff huddles, Ask Listen Do forums and training. Wider support is also available around workforce wellbeing and organisational development. The ICB fosters a robust multi-disciplinary approach with clear DSR processes in place across the system to ensure collaboration to reduce inappropriate admissions and delayed discharges. There is ongoing work with regards to specialist advocacy and ensuring that quality advocacy is available to all is a key focus of the ICB. There is a broader workforce challenge (indicative of a much wider system issue) which impacts service delivery. Dynamic and responsive steps are being taken in an attempt to mitigate this risk, but it is recognised that some aspects are outside of trusts' control. Of those with learning disabilities, who are currently placed within adult acute MH and rehabilitation wards and responded to the inpatient questionnaire: • 66% agree or strongly agree that they have a voice and feel that their views and choices are respected • 33% agree or strongly agree that they are able to access independent advocacy if they want to • 66% agree or strongly agree that they are able to make use of peer supporters as they wish No feedback was recorded.

G	Support People as Citizens	Social inclusion Active participation	4	Our person-centred care approach means that we seek to understand what is important to and for people throughout their inpatient stay. This includes meaningful relationships and networks, and we support people to maintain these wherever possible. We are proactive in the facilitation of regular engagement and involvement in the local community during the admission and while preparing for discharge and community LD teams work in partnership to support this. This helps the person to build upon and improve experiences, which we actively support. In providing such support, it is essential that we have a robust understanding of capacity, decision making and best interest so that we can provide appropriate support. It is recognised that there are limitations around availability, choice, and access due to wider system issues however, we continue to strive to ensure that people are supported as citizens and that their hopes and aspirations are sought, heard and realised. Further work may be required to review the approach in mainstream mental health beds to ensure that a similar approach is taken to fully hear the voice of the person. Of those with learning disabilities, who are currently placed within adult acute MH and rehabilitation wards and responded to the inpatient questionnaire: • 66% agree or strongly agree that they feel supported to access the things that matter to them • 66% agree or strongly agree that their hopes, dreams, and plans for the future are heard • 66% agree or strongly agree that they feel a sense of belonging with the community they identify with
H	Co-production / Lived experience embedded	Nothing about us without us	3	Experience of co-production within the ICB varies between trusts. Mersey Care NHS FT has developed a co-produced & co-written learning disability and autism strategic plan which is due to be launched in April/May 2024. This has included implementation of a Learning Disability and Autism co-production group to support development and roll out of the strategic plan. Within CWP NHS FT, a dynamic approach is has been taken to ensure that the voices of people accessing our services are of paramount importance in our service design and delivery and thus we strive to ensure they are sought in meaningful ways and are heard ‘loud and clear’. There is a focused and creative approach currently being undertaken to ensure that we also seek and hear the voice of people more directly who may have been underrepresented previously. Proactive involvement in recruitment of staff and involvement in review meetings is routinely facilitated and supported. Throughout the ICB a proactive approach to seeking peoples' input is taken and Ask, Listen, Do is evident, as is engagement with advocacy groups, sharing learning regarding patient stories, from incidents and situations and influencing environmental changes. There is clearly a desire to improve further in this area with paid lived experience roles a high consideration across the ICB. Of those with learning disabilities, who are currently placed within adult acute MH and rehabilitation wards and responded to the inpatient questionnaire: • 66% agree or strongly agree that they are aware of and supported to attend meetings in their area that are aimed at improving services • 66% agree or strongly agree that they know who the patient experience representatives are in there are and how to contact them • 66% agree or strongly agree that they can contribute their lived experience of using services to changes being made in their area • 66% agree or strongly agree that they have a role in the development of services in their area on the basis of their lived experience • 66% agree or strongly agree that they are compensated for their time and can access support where needed to make sure they are not left in a difficult position because of their contributions

Learning Disability 3 year plan

NHS
Cheshire and Merseyside

Year 1

- Ensure implementation of the 12 point discharge challenge, 10 high impact initiatives and continue to report on CRFD and barriers to discharge across all inpatient settings in and out of area, to improve flow and identify opportunities for earlier intervention with CLDT, ISF, crisis teams or step up/step down services or housing.
- Continue to use DSD and track admission avoidance, to identify themes and gaps
- Evaluation of the Green Light Toolkit to improve the quality of care and improve data reporting on people in mental health provision
- Develop a NW consistent process for admission and discharge to learning disability inpatient services
- Investment in dedicated project management to support the re-design of the Learning Disability and Autism inpatient provision across Cheshire and Merseyside, scoping out the needs of those placed out of area and how to best use existing resource for optimum outcomes for all.
- Dedicated focus to improve lived experience involvement and consistent reporting against the I statements

Year 2

- Evaluation of year one investment to inform programme priorities
- Identify gaps in community and inpatient(including step up and step down) provision based on modelling and improved data needed to maintain flow
- Engage VCFSE and housing colleagues re potential service development opportunities
- Explore financial modelling including provider collaboration to ensure service developments are sustainable
- Co-produce a redesigned plan for a local pathway of inpatient and community care for adults with learning disabilities, based on evidence, feedback and population health data
- Implementation of any identified research

Year 3

- Implementation of re-designed pathway of inpatient and community care and robust evaluation
- Plan for future investment ensuring best use of available resource and that the principles of the inpatient quality transformation are embedded throughout.

NHS
Cheshire and Merseyside

Plan for provision for autistic people

Autism: Current State Description (at time of completion: March 2024)

Cheshire and Merseyside

There are no specific inpatient units for autistic people in Cheshire and Merseyside and autistic adults can access any inpatient setting for their mental health need, with appropriate reasonable adjustments and individual considerations to care and treatment plans, including the use of the Green Light Toolkit. For the purpose of this self-assessment autistic adults with learning disabilities who are in learning disability assessment and treatment units or inpatient rehabilitation placements, have been included in the learning disability inpatient section. Autistic adults who access acute adult mental health inpatient services are included in the adult mental health section and autistic adults in inpatient mental health rehabilitation have been included in the rehabilitation section. This section therefore explores what should be available for all autistic people accessing any mental health or learning disability inpatient service, what is needed to improve the quality of the therapeutic intervention and required in the community to reduce reliance on inpatient care for autistic adults in Cheshire and Merseyside.

The proportion of the population being diagnosed as autistic in Cheshire and Merseyside has grown significantly over recent years and that rate of growth is accelerating, with rising diagnostic rates for both children and adults. It is known that autistic adults are more likely than non-autistic adults to experience mental ill health and are more likely to require mental health services. The numbers of people diagnosed as autistic in mental health inpatient settings is increasing nationally; data collected by NHS England shows that there was an increase of 7.3% in the numbers of autistic inpatients (both with and without a learning disability) in mental health hospitals between March 2017 and August 2023 and an increase of 51.3% in the numbers of autistic inpatients without a learning disability in the same timeframe. In Cheshire and Merseyside from March 2017 to November 2023 there was a 29% increase in the numbers of autistic adults without a learning disability in mental health beds across all mental health inpatient services, recognising that this is probably an under-representation of the full number, as many people are waiting for diagnosis and there are some known data quality issues with reporting through the AT data set.

In Cheshire and Merseyside in February 2024 there were 34 autistic adults without a learning disability in a mental health inpatient bed, which is 37% of the LDA inpatient group. Average length of stay is recorded as over a year and appropriate community provision and support has been sighted as a reason for increased demand on inpatient services and a barrier to discharge.

There is variance in what mental health provision is available to autistic adults across Cheshire and Merseyside and what additional specialist autism resource can support and scaffold wider health and community services, to be able to provide autism informed care. There has been a significant increase in demand for autism diagnostic assessments, which outstrips commissioned specialist autism services' capacity and leaves minimal resource for post diagnostic or additional intervention that would support an autistic person's mental health recovery. Therefore, more work is required across all mental health services to ensure they are accessible to autistic adults and have the skills, expertise, and capacity to meet their mental health needs. Providing early intervention, before mental health symptoms may worsen should reduce the need for more intensive and more costly inpatient care and offer improved health outcomes and experience of care for autistic adults.

In addition to place based autism strategies, both Mersey Care and Cheshire and Wirral Partnership are working strategically to improve the offer of mental health care to their autistic populations. Across Cheshire and Merseyside there is already a focus on improving acute inpatient care for autistic adults through increased numbers of autism ambassadors and champions, training and formal education opportunities and development of inpatient ward areas to enable spaces where sensory stimulation is reduced. Oliver McGowan Training is being rolled out across organisations and in CWP CANDDID developed a PGCert programme for Neuro developmental disorders at the University of Chester and 34 people have completed the PgCert with a further cohort on the course at present and there are 72 Autism Ambassadors working across the Trust.

Both Mersey Care and CWP have also implemented the use of reasonable adjustment flags within the electronic inpatient record and this is allowing community and inpatient staff to provide more personalised care and intervention and reasonable adjustments. It also enables audit to ensure people are accessing Care and Treatment Reviews as appropriate.

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Autism: Our ICB Vision Statement

By the end of year 3 we will aspire to effectively meet the needs of autistic adults in mental health services by ensuring that appropriately adjusted and tailored mental health provision is available in Cheshire and Merseyside, that is informed by local and national statistical data.

Provision of mental health and learning disability services for autistic people will be underpinned by research, national and NICE guidance and will align to place based and provider trust Autism Strategies along with the Autism Act. The plan will implement the principles as outlined in the Meeting the needs of autistic adults in mental health services national guidance, ensuring that all services are accessible and acceptable to autistic adults, there is access to meaningful activity, timely access to autism assessments when clinically indicated, availability and access to a range of evidence-based interventions and appropriately trained and skilled practitioners, and dedicated focus to reduce restrictive practice and proportionately manage risk. In addition, autistic adults will be supported to transition through services as and when required and receive early intervention and appropriate crisis support and intervention to prevent a deterioration in their mental health.

The workforce will feel more confident and competent to meet the needs of autistic people through training and access to support and expertise from specialist autism practitioners, champions, ambassadors and peer support, and links with VCFSE groups specifically for autistic people will promote citizenship and a sense of identity and belonging.

There will be Cheshire and Merseyside oversight of the needs of autistic adults, through improved data quality to inform demand and capacity in community and inpatient mental health commissioned provision, and mechanisms for highlighting strategic needs to inform financial planning and service developments.

Through this programme Autistic people's needs will be viewed holistically, recognising the premature mortality associated with autism, social impacts such as difficulties maintaining employment and facing homelessness, and the impacts social issues can have on an autistic person's mental and physical health and well being.

Specific key enablers for achieving this vision

(in addition to the key enablers described in the introduction)

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In addition, to the key enablers that run through all of the sections of the self- assessment as described in the cover report, further specific focus to achieve the vision will include:

- Strong clinical and operational focus, oversight, and leadership of the whole adult autism pathway across Cheshire and Merseyside, including the implementation of the NHSE Guidance Meeting the needs of autistic adults in mental health services, ensuring the Green Light Tool Kit is being utilised effectively across inpatient settings to enable reasonable adjustments to be applied, and that data is flowing and being used to inform service developments for autistic people.
- The development of a Cheshire and Merseyside community of practice to ensure oversight of any issues with diagnostic overshadowing or people being excluded from services because of their autism to be addressed and escalated as appropriate, for best practice to be shared and opportunities for research or implementation of new evidence to be applied.
- Development of consistent and robust transition processes for young people in Cheshire and Merseyside
- Investment and planning to maximise the therapeutic benefit of interventions and inpatient environments including consideration of sensory sensitivities, communication difficulties, anxiety about uncertainty or unpredictable care, executive functioning difficulties and masking and the impacts of this.
- Exploration of a potential Cheshire and Merseyside Centre of Excellence to attract skilled and experience workforce and facilitate the sharing of knowledge and expertise
- To increase specialist autism advice and consultation to the wider health and social care system to upskill staff and consult on clinical intervention to maximise positive outcomes and flow through inpatient services.
- To explore the inclusion of autistic peer support workers within inpatient mental health settings and further develop further develop autism champion and ambassador roles
- Development of processes and mechanisms to be used consistently across Cheshire and Merseyside to maximise co-production and shared decision making in individual care planning and in the development and delivery of services.
- Review community clinical pathways across Cheshire and Merseyside, identify any unwarranted variance and agree a consistent model for meeting the mental health needs of autistic adults, including the provision of supported living placements, housing and packages of care
- To complete demand and capacity modelling of inpatient services to facilitate strategic and financial planning
- To continue to improve centralised data for this group using AT and MHSDS data sets

Adult mental health ratings against the ‘I & We statements’

Cheshire and Merseyside

Total Score	20

Rating Guidance	
1	Limited evidence that principles are embedded. Scope for improvement is identifiable
2	Emerging and growing evidence of principles within the system, but they are not embedded, and improvement work can be identified.
3	Evidence of principles within the system, but not consistent/embedded. Plan in place, or in active development to embed.
4	Strong evidence that the principled are evident within the system, but do not yet feel fully embedded into culture and business as usual
5	Strong evidence that the principles are fully embedded within, and across the system and are part of business as usual.

Principle			Rating	Rationale
A	Valuing	Preventing ‘othering’ and fostering a sense of belonging	2	In addition to the information provided in the AMH submission - information is collated from people with neurodiverse conditions. However, it is recognised that it would be highly beneficial to disaggregate feedback and data for Autistic people to ensure that we are responding to specific needs of the population. This is happening in some teams/ services but is not consistent. Over the past year there has been specific developments in autism services to refresh the delivery of patient /service user feedback forums utilising the framework of ASK LISTEN DO. At CWP, a 6-monthly Ask Listen Do report is published on the website which highlights the work being done in response to feedback from autistic people and those with learning disabilities. 100% of those with autism and other neurodevelopmental conditions, who are currently placed within adult acute MH and rehabilitation wards and responded to the inpatient questionnaire, strongly agreed that: • they felt valued as a person • their individual wishes and needs are respected • they feel a sense of belonging. Feedback suggests that these inpatients feel valued, listened to and that staff are knowledgeable and compassionate to their needs.

B	Accessible	Early intervention & timely support Choice	3	In addition to the information provided within the AMH submission - over the past 12 months there have been significant developments within parts of the system to enhance the community provision in the form of an Intensive Support Function within St Helen & Knowsley, Warrington & Halton as a means of reducing avoidable admissions and supporting people in the community. It is recognised that such developments will require further investment and enhancement to ensure parity across the 6 places. In addition, the Autism Mental Health Support Team has been rolled out across the trust to support colleagues, providing consultation and training to effectively meet the needs of Autistic people. At CWP, there is a tiered programme of skills development aimed at improving the knowledge and skills of all staff in relation to neurodiversity and use of reasonable adjustments, with a recent staff survey showing an improvement in awareness and confidence over a baseline survey last year. A Trust-wide Autism Clinical Specialist and Training Lead post supports a network of Autism Ambassadors and Autism Champions who are local points of contact to lead on advice and support to better meet the needs of autistic people. 100% of those with autism and other neurodevelopmental conditions, who are currently placed within adult acute MH and rehabilitation wards and responded to the inpatient questionnaire, strongly agreed that: • they were able to access services based upon their needs • they did not feel excluded or stigmatised due to their diagnosis Feedback suggests that there is support available when required.
C	Humane	Least coercive Compassionate and caring	3	In addition to the information within the MH submission - it is recognised that further work is required to understand viable future service models/pathways for Autistic people to ensure the least restrictive approach, models which focus on admission avoidance and build wider capacity in the community to effectively support people who are Autistic. At CWP, specific pieces of work have been undertaken to support least restrictive practice in inpatients (use of Patient Safety Pods) and improve skills on acute wards. A SOP for transition between CYP inpatients and adult inpatients has been developed with a specific focus on improving this for autistic people. We are working to develop low stimulation sensory environments in MH wards with 2 due to complete in 2024 (Springview site in Wirral and Alderley site at Soss Moss). 100% of those with autism and other neurodevelopmental conditions, who are currently placed within adult acute MH and rehabilitation wards and responded to the inpatient questionnaire, strongly agreed that: • first and foremost, they are treated like a human being the environment is considerate of their individual strengths and needs • Staff speak to them using their preferred method of communication • they are supported to plan and prepare for important changes, such as transitions between services and discharge. Feedback suggests that these inpatients feel safe and always have someone to talk to, should they need this.

F	Collaborative	People in partnership Skilled workforce System working	2	Across both organisations, further work is required to understand the current skill and gap with regards to the MH workforce and the capacity to deliver reasonably adjusted services to Autistic people. at CWP, an annual staff survey supports an assessment of how staff self-rate their skills and knowledge. Both trusts are committed to enabling staff to access relevant training, with the need for a key focus on rolling out mandatory Autism awareness training. At CWP a 4-tier approach is taken with Oliver McGowan training covering Levels 1&2; Level 3 includes both bespoke training offer by the Trust-wide Autism Clinical Specialist and Training Lead (targeting teams and/ or individual patient issues) and the Postgraduate Certificate in Neurodevelopmental Conditions; Level 4 is a master levels programme. As highlighted in the AMH submission there are a number of gaps with regards to the ability to ensure a skilled and trained workforce. 100% of those with autism and other neurodevelopmental conditions, who are currently placed within adult acute MH and rehabilitation wards and responded to the inpatient questionnaire, strongly agreed that: • they have a voice and feel that their choices and views are respected • they are able to access advocacy if they want to 50% of respondents, strongly disagreed that: • they are able to make use of peer supporters as they wish The remaining 50% strongly agreed with this question. Feedback suggests that they have been well informed of all of the services available to them.
G	Support People as Citizens	Social inclusion Active participation	2	Please refer to the AMH submission as this is identified as a gap for Mersey Care. At CWP, our Individual Placement and Support service support autistic individuals (with MH needs) to find employment. We work with 3 Autism Hubs in the community (3rd sector) to provide safe, social inclusion areas for autistic people with a range of activities and support. This includes providing assessment clinics in the autism hub spaces (where possible) and supporting groups at the hubs. 100% of those with autism and other neurodevelopmental conditions, who are currently placed within adult acute MH and rehabilitation wards and responded to the inpatient questionnaire, strongly agreed that: • they are supported to access the things that matter to them • their hopes, dreams and plans for the future are heard • they feel a sense of belonging with the community that they identify with Feedback suggests that activities such as daily gym visits have been helpful.

H	Co-production / Lived experience embedded	Nothing about us without us	2	In addition to the AMH submission - the Autism services have embedded service user/self-advocate forums (embedding the Ask Listen Do framework). Further work is required across autism and MH services to develop a framework for coproduction including the development of such roles for people with lived experience of autism to contribute to research and service development. At CWP, there are a range of participation and engagement offers for autistic people which are in place such as an annual stakeholder conference, individuals and groups involved in developing resources such as reasonable adjustment checklists and guidance, autistic people involved in the design of new builds/ food menus etc. Experts by experience are regularly involved in staff recruitment interviews. Autistic people are involved in delivering training to CSWs as part of the Heart of Care programme. However, there is still significant work to be done to broaden participation and engagement. We are developing peer support roles within our adult autism team at present. 100% of those with autism and other neurodevelopmental conditions, who are currently placed within adult acute MH and rehabilitation wards and responded to the inpatient questionnaire, strongly agreed that: • they are aware of and supported to attend meetings in their area that are aimed at improving services • they know who the patient experience representatives are and how to contact them 50% strongly agree that: • they are able to contribute their lived experience of using services to changes being made in their area • they have a role in the development of services in their area on the basis of their lived experience 50% responded neutrally to these questions.

Autism 3 year plan

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Year 1

Ensure implementation of national and NICE guidance and emerging evidence from research to optimise the experience and outcomes of mental health and learning disability care for autistic people.

- Evaluation of the Green Light Toolkit and reasonable adjustment flags and recording of the autism diagnosis to improve the quality of personalised care and improve data reporting on autistic people in mental health provision
- Develop a Cheshire and Merseyside community of practice/clinical network to collaborate on service development and ensure service offers are equitable based on local population need
- Investment in dedicated project management to support the re-design of the Learning Disability and Autism inpatient provision across Cheshire and Merseyside, scoping out the needs of those placed out of area and how to best use existing resource for optimum outcomes for all.
- Dedicated focus to improve lived experience involvement and consistent reporting against the I statements especially for those placed out of area

Year 2

- Evaluation of year one investment to inform programme priorities
- Identify gaps in community and inpatient(including step up and step down) provision based on modelling and improved data needed to maintain flow
- Engage VCFSE and housing colleagues to ensure easily accessible support for autistic adults with social needs and promote citizenship
- Explore financial modelling including provider collaboration to ensure service developments are sustainable
- Co-produce a redesigned plan for a local pathway of inpatient and community care for autistic adults based on evidence, feedback and population health data
- Implementation of any identified research

Year 3

- Implementation of re-designed pathway of inpatient and community care and robust evaluation
- Plan for future investment ensuring best use of available resource and that the principles of the inpatient quality transformation are embedded throughout.

Appendices

Appendix 1: I and We statements

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I statements - Valuing

- I am valued as a person and my individual needs and wishes are respected
- I feel listed to and that my voice is heard
- I have a sense of belonging and feel part of my own community

We statements

- We will ensure that the people who experience inpatient services and the staff who work within them, feel valued and cared for, benefiting from a culture that lives its values
- We will work to ensure we can hear the voice of people who may need to call on mental health services and their families, we employ a range of communication methods to reflect individual preferences and needs
- We will commission and provide services that are part of a local pathway of care which promotes inclusion, strengthens individuals' rights, and is orientated towards citizenship
- We will work with people in ways that prevent othering, foster a sense of belonging, reduce stigma, and enable people to maintain their social ties
- We respect people as citizens and valued members of the community. We are here for all our people when they need us, irrespective of where they live, their background, age, ethnicity, gender, sexuality, disability, or health conditions

I statements-Humane

- I am first and foremost treated as a human being
- I am cared for in an environment that is considerate of my individual strengths and needs
- I am supported by staff who talk with me, not to me, using a way of communication that is preferred by me
- I am supported to plan and prepare for important changes such as transitions between services, or discharge home

We statements

- We are unwavering in our commitment to commission inpatient services that are least restrictive and where people are not confined in conditions of greater security than required
- We will plan discharge with each person at the very start of their admission, mitigating the risk of delays and ensuring that transitions between services are carefully considered
- We are person-centred in our approach and staff are supported to respond to people's distress with compassion
- We will pay attention to our hospital environment and the impact it has on the wellbeing of people experiencing inpatient services and the staff working within them

I statements -Accessible

- I can access services based on my need and I do not feel excluded or stigmatised by my diagnosis

We statements

- We provide services that are needs led, accessible to all who need them and are proactive in facilitating choice
- We will ensure that admissions are appropriate, purposeful, therapeutic, and timely
- We will employ interventions designed to avoid unnecessary admission to hospital but when inpatient care is appropriate, it will not be impeded, not regarded as the ‘last resort’

I statements - Equitable

- I feel valued and respected for who I am
- I can be myself around peers and staff
- I am not discriminated against for who I am and the choices I make
- I feel difference is understood, respected and celebrated

We statements

- We will commission and deliver services where everyone counts, are treated with dignity and are safe. Where a person’s identity is not contested, their individuality is recognised and who they are and what they need is respected
- We will work with people (and those who know and love them) to identify ‘what matters to them’ and make sure that the care they receive is personalised, needs led and respects their human rights
- We will work with people to make sure we share decision making, acknowledging that even when people are acutely unwell, they are experts in their own lives and have valuable contributions to make about the support they need
- We will be relentless in our pursuit to identify and address inequalities that exist within our local pathway. We are committed to ensuring everyone is valued irrespective of where they live, their background, age, ethnicity, sex, gender, sexuality, disability, or health conditions
- We ensure our environments are inclusive and accessible for everyone. We are thoughtful about people’s cultural needs and people with disabilities. We pay close attention to people’s individual sensory needs, particularly for autistic people and trauma survivors

I statements –Support people as citizens

- I am supported to access the things that matter to me
- I feel my hopes, dreams and plans for the future are heard
- I have a sense of belonging with the community I identify with

We statements

- We will actively work to promote the social inclusion of adults, children and young people with mental health need
- We will ensure that mental health services, by their design and activities, support the active participation of people in their local community
- We respect everyone's rights and responsibilities as citizens, supporting them to make real their hopes and aspirations, to contribute and to lead fulfilling lives

I statements – co production/lived experience embedded

- I am aware and supported to attend meetings in my area that are aimed at improving services
- I know who the patient experience representatives are in my area and how to contact them
- I can contribute my lived experience of using services to changes being made in my area
- I have a role in the development of services in my area on the basis of my lived experience
- I am compensated for my time and can access support where needed to make sure I am not left in a difficult position because of my contributions

We statements

- We respect the value of lived experience in service improvement
- We ensure that people with experience of services are invited to attend meetings and discussions around the changes that impact the way we deliver services
- We strive to gather voices of people that are representative of our local communities and the people using a range of services that we commission
- We make additional efforts to include the voices of people who have previously been underrepresented in our voice and engagement work
- We will identify ways for people to be compensated for their time and receive necessary support that is determined by their needs

I statements - Therapeutic

- I will be ablet o access a range of support that meets my need
- I feel I have the time and space to form trusting relationships with the people involved in my care

We statements

- We know that therapeutic relationships are the strongest predictor of good clinical outcomes and so we will support staff to prioritise building relationships with people and enable continuity of care
- We recognise that many people who are admitted to inpatient services will have experienced trauma at some point in their lives. Therefore, we will place emphasis on creating physical and emotional environments that promote feelings of safety and therapeutic relationships that are based on trust, respect and compassion
- We will invest in inpatient services that demonstrate a holistic, strengths based, integrated approach to care and make sure that mental and physical health conditions are considered, managed and monitored
- We will undertake assessments, interventions, and treatments that are evidence-based and delivered in a timely way
- We are committed to delivering services that demonstrate therapeutic benefit. This includes continuous improvement of the inpatient pathway, co-producing service developments, making best use of data and using quality improvement methodology
- We will develop a workforce that is in line with national workforce profiles and has the right skills and knowledge to ensure people have access to a full range of multi-disciplinary interventions and treatments

I statements- Collaborative

- I have a voice and I feel my views and choices are respected
- I am able to access independent advocacy if I want to
- I can make use of peer supporters as I wish

We statements

- We respect the views and advanced choices of the people we serve and the contribution of people who know and care for them
- We will invest in peer support and facilitate easy access to independent advocacy
- We understand that safe and high quality inpatient mental health care relies on staff being able to ‘be with’ and work in partnership with people in a high state of distress. We will provide support for our staff to enable them to do this compassionately, safely and respectfully
- We are committed to providing the right resources for all staff to ensure their time is protected to care, and that they can respond appropriately to the therapeutic aspects of their work
- We will work in partnership across our system to ensure that locally, there is a range of services to support people within their local communities
- We are committed to the working together so that no-one is inappropriately admitted to hospital or experiences a delayed discharge

Appendix 2: 10 high impact initiatives

Mental health discharge initiatives

1. Identify the purpose of the admission, set an expected date of discharge (EDD) for when this purpose will be achieved, and communicate this with the person, family/carers and any teams involved in the person's care post-discharge, e.g. community mental health team (CMHT) or crisis resolution home treatment team (CRHTT).
2. Complete care formulation and care planning at the earliest opportunity with the person, and within a maximum of 72 hours of admission.
3. Identify any potential barriers to discharge early on in admission and take action to address these. Where appropriate action cannot be taken, escalate this to the ICB Discharge Lead.
4. Conduct daily reviews, such as the 'Red to Green' approach, to ensure each day is adding therapeutic benefit for the person and is in line with the purpose of admission.
5. Hold Multi Agency Discharge Events (MADE) with key partners on a regular basis, to review complex cases.
6. Ensure partnership working and early engagement with the person, family/carers and teams involved in the person's post-discharge support; agree a joint action plan with key responsibilities, for example for social care, housing, primary care, CMHT, CRHTT, etc.
7. Apply 7-day working to enable people who are clinically ready for discharge to be discharged over weekends and bank holidays, and allow people who require admission timely access to local beds
8. "Identify common reasons and solutions to people being delayed in hospital, e.g. housing support/ accommodation. Start by reviewing:
    1. Those who are clinically ready for discharge but occupying beds
    2. Adults and older adults with a long length of stay (over 60/90 days for adult/older adult admissions)."
9. Communicate notice of discharge at least 48 hours prior to the person being discharged, to the person, their family/carers and any ongoing support services.
10. Follow up to be carried out with the person by the CMHT or CRHTT at the earliest opportunity and within a maximum of 72 hours of discharge, to ensure the right discharge support is in place