Bedfordshire, Luton and Milton Keynes Mental Health, Learning Disabilities and Autism In-Patient Quality Transformation Plan 2024-2027

By Michael Farrington, Bedfordshire, Luton and Milton Keynes Mental Health Programme Manager

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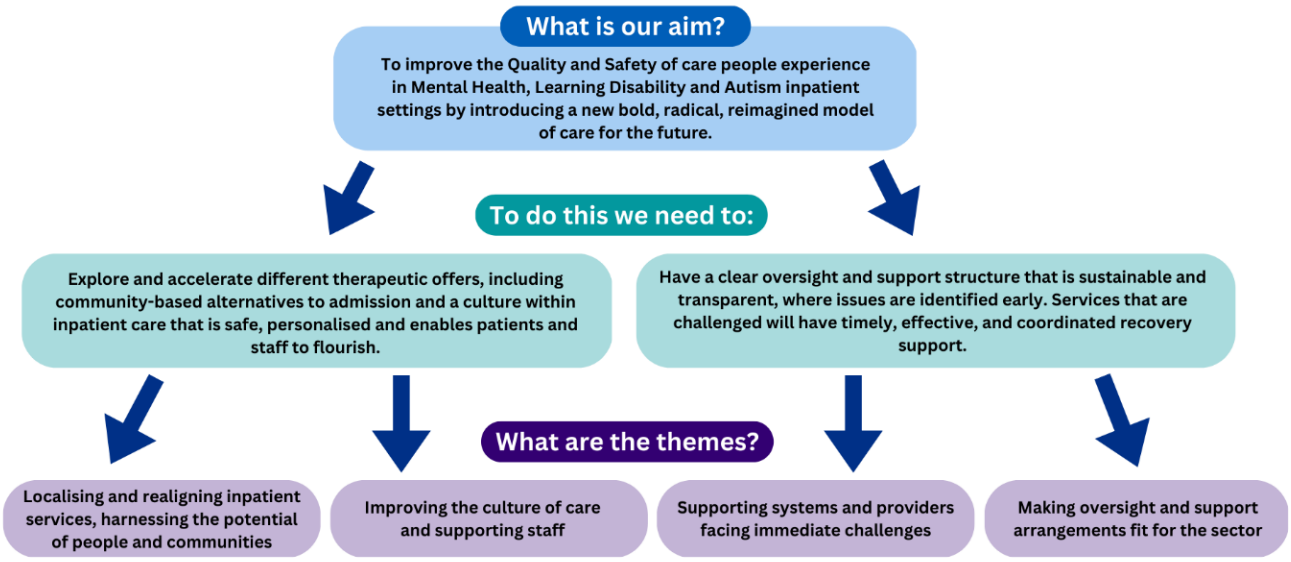
Our local vision

We have developed our Bedfordshire, Luton and Milton Keynes Mental Health, Learning Disabilities and Autism In-Patient Quality Transformation Plan as part of our transformation programme as this is an exciting development to improve the quality and safety of care people experience in mental health, learning disabilities and autism in-patient settings by implementing a new reimagined model of care. Our Bedfordshire, Luton and Milton Keynes vision for our 3 year plan which has been developed by service users and carers is as follows;

'By the end of year 3, our vision is to have implemented improvements to the quality and safety of care people experience across our mental health services which includes our mental health inpatients settings through a new bold, radical and reimagined model of care across Bedfordshire, Luton and Milton Keynes. Central to the development and implementation of our BLMK vision is that it will be co-produced by people with lived experience of inpatient services, and their families; nurses, psychiatrists, psychologists, allied health professionals and other staff who work in inpatient settings or at various levels of the different organisations including wider partners such as Local Authority and voluntary sector organisations. Service users want to feel safe on the ward, they want to be listened to and included in their treatment and care, when they are going to go home, the support they will receive and ultimately helped to feel that they can have a fulfilling life despite their diagnosis. Our local plans ambitions is to meet the needs of our local residents by providing care and support close to home and to address inequalities.'

The National Mental Health, Learning Disabilities and Autism In-Patient Quality Transformation Programme

Our Bedfordshire, Luton and Milton Keynes Mental Health, Learning Disabilities and Autism In-Patient Quality Transformation Programme is part of the national NHS England programme which has the following aims and themes:



There has been the development of a commissioning framework to advance the system wide requirement to ensure that services are local, inclusive and deliver safe, personalised, and therapeutic care. The framework is to enable and support systems to develop local plans for change, 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 their locality. The programme has engaged with hundreds of people across the country, at all levels, including staff, people with lived experience, third sector partners and sector leaders from workshops, interviews, evidence reviews and lived experience networks.

Whilst the primary focus of the commissioning framework is on inpatient provision, it is known that creating improved models and pathways will be dependent to a large degree, on the capacity and capability of the local community, its assets, and strengths. Therefore, our Bedfordshire, Luton and Milton Keynes Mental Health, Learning Disabilities and Autism In-Patient Quality Transformation Programme will be aligned to our on-going community mental health programme. The following diagram illustrates what we have been implementing over the last five years:

Across Bedfordshire, Luton and Milton Keynes, we will continue to develop mental health pathways which have a focus on integrated models of care and meet the needs of our local communities, building on their strengths and assets.

The Case for Change

The national Mental Health, Learning Disabilities and Autism In-Patient Quality Transformation Programme emphasizes that without a concerted effort to localise and realign inpatient services then people may continue to find themselves:

- **Stranded** in hospital when they are ready to leave, often for many months or years.
- **Sent away** to services at distance from home and the people who care about them
- **Subject** to overly restrictive practice, including the use of long-term segregation
- **Susceptible** to poor and abusive care
- **Stigmatised** and discriminated against and at risk of criminalisation

Therefore, our Bedfordshire, Luton and Milton Keynes Mental Health, Learning Disabilities and Autism In-Patient Quality Transformation Plan focuses on improving the quality and safety of our in-patient services as well as how we can provide services that are close to people's homes.

Knowing the needs of our local population across Bedfordshire, Luton and Milton Keynes and addressing mental health inequalities

BLMK has an increasingly ethnically diverse population, with a large Asian and 'Other White' population compared to England. The ethnicity breakdown varies across BLMK, with the percentage of people from ethnic groups other than 'White British' ranging from 16% in Central Bedfordshire to 68% in Luton (Census 2021). In Luton 37% of the population is Asian, 13% is 'Other White' and 10% is Black. Milton Keynes also has a larger Asian population (12%), with 10% from Black ethnic groups. In Bedford Borough the largest population apart from 'White British' is 'Other White' (10%). Across England, health and wellbeing outcomes are different for ethnic groups. For example, those who identify as White Gypsy or Irish Traveller have worse health across a range of indicators. Some health issues such as diabetes, heart disease and kidney disease are more prominent in people from South East Asia.

Mental health issues are more prominent among black populations. For many years, there have been concerns that people from minoritised ethnic groups have poorer access to, experience of and outcomes from mental health services, including talking therapies compared with people from White British groups. Therefore our new reimagined model will focus on addressing inequalities in our local area. We will also be focusing on supporting people from our more deprived neighbourhoods as they tend to have a shorter life expectancy and spend more of their life in ill health.

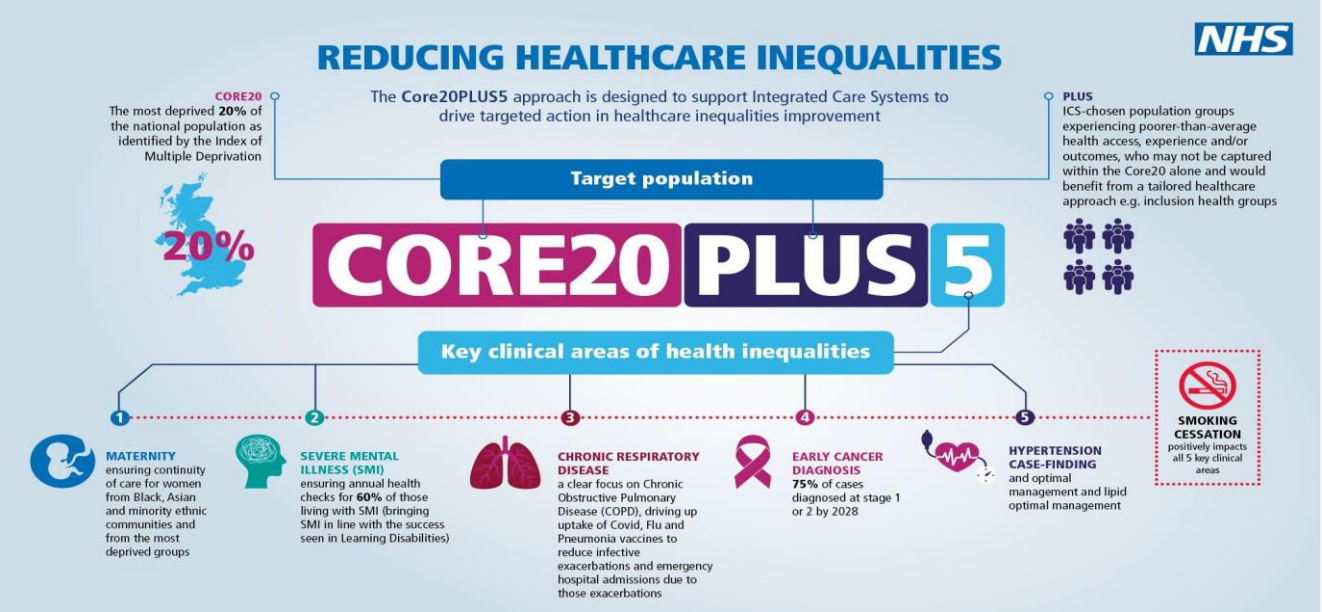
Central Bedfordshire is the most affluent place with 2% of neighbourhoods (3 lower super output areas or LSOAs, which are small geographical areas of about 1,500 people) in the 20% most deprived neighbourhoods in England. Those small pockets of significant deprivation are important drivers of inequality in Central Bedfordshire. This proportion rises to 12% of neighbourhoods (18 LSOAs) in Milton Keynes and 14% (14 LSOAs) in Bedford Borough.

Luton has the highest levels of deprivation, with 24% of neighbourhoods (29 LSOAs) among the 20% most deprived neighbourhoods in England. Many factors contribute to deprivation including worse educational outcomes, low income, mental ill-health and lack of suitable housing.

Children's mental health is linked to parental financial pressures, overcrowded housing, lack of safe green spaces and racism. Young people from deprived backgrounds are more likely to have their referral deemed "unsuitable", have shorter contact time within a mental health appointment and be re-referred to mental health services within a year despite completing their treatment plans. Therefore, with evidence that 75% of mental health problems develop before the age of 24 this continued to be an area of focus across BLMK about supporting the mental health needs of children and young people, adults and older adults living in areas of deprivation.

Addressing mental health inequalities is a key priority across Bedfordshire, Luton and Milton Keynes and there are several areas that our BLMK Mental Health, Learning Disabilities and Autism In-Patient Quality Transformation Plan will be focusing on as follows;

- There will be a focus on embedding anti-racism through the Patient and Carer Race Equality Framework. This will particularly focus on leadership and governance, national organisational competencies and patient and carer feedback mechanisms.
- We will be focusing on detentions under the Mental Health Act and in particular where there is a higher percentage of people who are detained from a particular ethnic group compared to the proportion of people from that ethnic group in the population (BLMK data - 'Black/Black British' - 10.8% of detained population against 6.8% of actual population, 'Mixed'- 8% of detained population against 3.9% of the actual population). There is currently consideration to join the main phase of the 'Putting into practice the principles of the Mental Health Act reforms: A national QI programme'. The programme will provide expert QI coaching to 37 NHS trust-run inpatient services in England throughout 2024/25, with the aim of improving the equity of experience for people from ethnically diverse backgrounds and people with a learning disability & autistic people when detained under the Mental Health Act in hospitals across England, including improving the cultural appropriateness of care they receive.
- One of the areas of focus will be improving the physical health of people with severe mental illness across the pathway which is a key area of focus to address mental health inequalities (Core20Plus5). Uptake of the annual physical health checks will support with this with BLMK currently showing as being at 53% with an ambition to achieve 60% by the end of March 2025. The following diagram illustrates Core20Plus5 for adults and children and young people:



Continuing to deliver the NHS Long Term Plan commitments for acute mental health inpatient services

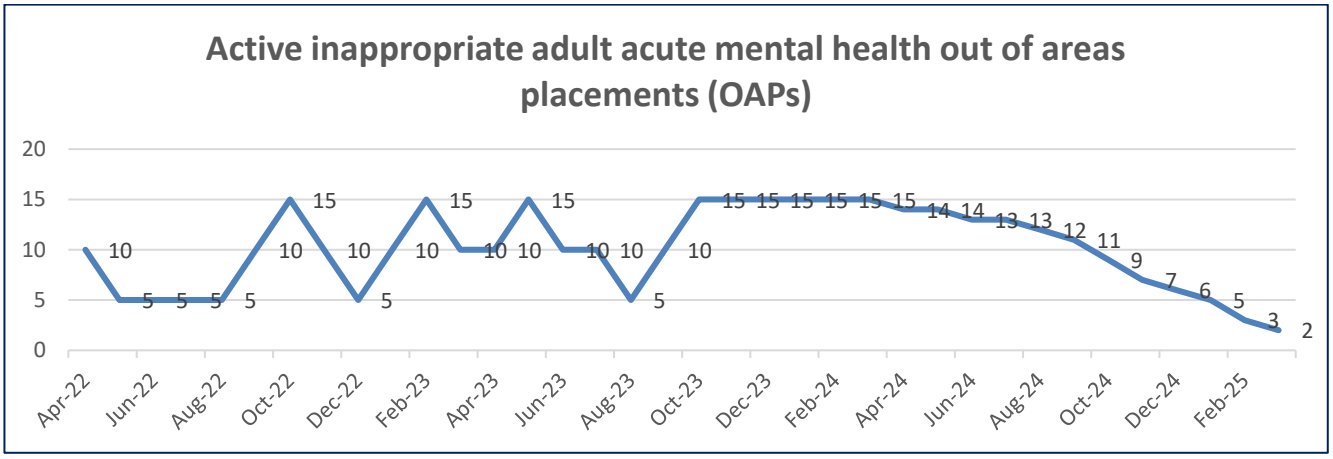
Since 2019, across Bedfordshire, Luton and Milton Keynes, we have been focusing on delivering the following NHS Long Term Plan commitments for acute mental health inpatient services and we will continue to implement these as part of this plan:

- Eliminate all inappropriate adult acute mental health out of area placements.
- Improve the therapeutic offer from inpatient mental health services by enhancing access to therapeutic interventions and activities.
- Increase the level and mix of staff on acute mental health inpatient wards, including improving access to peer support workers, psychologists, occupational therapists, social workers, housing experts and other relevant professionals during admission.
- Reduce avoidable long lengths of stay in adult acute mental health inpatient settings (including for people with a learning disability and autistic people), so that people are not staying in hospital any longer than necessary.
- Reduce the number of people with a learning disability and autistic people in mental health settings, so that by March 2024, there are no more than 30 adults with a learning disability and/or autism in an inpatient setting, per one million adults.
- Ensure that all inpatient care commissioned by the NHS meet the Learning Disability Improvement Standards.

As part of our 3 year Bedfordshire, Luton and Milton Keynes Mental Health, Learning Disabilities and Autism In-Patient Quality Transformation Plan we will be continuing to focus on the above. Data from November 2023 was showing BLMK as having 15 people out of area and our plan is to reduce this to 2 people by the end of March 2025.This is a particular area of focus for Bedfordshire and Luton with the follows actions to be taken:

- There are a number of change ideas that are being considered relating to Bedfordshire and Luton patient flow to reduce active inappropriate adult acute mental health out of area placements which include the following:
- Long stays – Clinical Peer Review Model
- Social Work and Occupational Therapy capacity review
- Approaches to supporting admissions who are unknown to services
- Review of Crisis Resolution and Home Treatment Teams and wider crisis alternatives
- A focus on step down provision
- A focus on improving purposeful admission and quality of inpatient care which will lead to shorter length of stays and improve outcomes
- A focus on addressing bottlenecks which prevent people being discharged from hospital when they are clinically well enough e.g., housing support/accommodation

The following graph illustrates our plan to reduce inappropriate out of area placements during 2024-25 with a longer term ambition to eliminate inappropriate out of area placements altogether:



<u>An overview of how we have developed our Bedfordshire, Luton and Milton Keynes Mental Health, Learning Disabilities and Autism In-Patient Quality Transformation Plan</u>

To develop our plan, we have involved service users, carers and staff in the design of the plan. Co-production is a fundamental part of our BLMK Mental Health, Learning Disabilities and Autism In-Patient Quality Transformation Programme and we will continue to ensure that people with lived experience and their carers' are central to the delivery of our plan. Across BLMK we have held two workshops on the 26th and 27th of March 2024 which involved people with lived experience and staff from the two mental health trusts, East London NHS Foundation Trust (ELFT) and Central North West London NHS Foundation Trust (CNWL). The workshop held on the 26th of March 2024 particularly focused on acute inpatient mental health care for adults and older adults and also improving mental health care for people with learning disabilities and autistic people. The following are some photographs from the workshop held on the 26th of March 2024:

The workshop held on the 27th of March 2024 particularly focused on acute inpatient mental health care for adults and older adults and also improving adult mental health rehabilitation inpatient services. The following are some photographs from the workshop held on the 27th of March 2024:

In addition to these two workshops, a service user and carers forum called a BLMK working together group provided input into the development of the plan with the following a summary of particular areas that service users and carers have highlighted that need focusing on:

- Development of Peer Support Workers (People with lived experience) within mental health in-patient services
- Improving 'induction' for patients when admitted to a mental health in-patient unit so that they are aware of what to expect and what activities are available
- Increase service user's access to gardens, sensory rooms, gyms and other activities
- Increasing activities to reduce boredom for service users, especially in evenings and weekends
- Developing staff so that they are able to support service users when they are upset, to give them time to talk and 'hand holding'
- Developing trauma informed care and personalised care, ensuring that service users only have to tell their story once and staff valuing service users. Also, staff not being aggressive to people
- Developing staff so that they have human values, care, respect, kindness and treating patients the way you would want to be treated if you were a patient.
- Ensuring that staff are held to account over their behaviour and attitudes. Regular surveys to be held to identify difficulties around staff attitudes. Performance reviews on quality of care.
- Improving security and safety on mental health in-patient services so that service users are not scared and frightened of both other patients and staff.
- Improving transitions at weekends so that there is a smooth experience for service users.
- Improving training for primary care staff on engaging with LGBTQ+ individuals
- Improving staff understanding of Autism and other conditions. Increase staff training around communication, sensory needs and time to process instructions especially when a person is in distress.
- Develop a survival pack, picture cards/written instructions on what is going to happen in the next few days (Including noise cancelling headphones)
- Improved access to sensory rooms
- Ability to change lighting conditions (dimmer switches)
- Supporting patients who have sensory issues around food and eating with others
- Staff to have an increased understanding of patients feelings around anxiety and sensory overload
- Insulation needs to be considered in all the wards as the noise can be difficult for patients
- Specifically Autistic Trained staff to work with service users with Autism

All these areas have been included as actions to be taken forward in this BLMK Mental Health, Learning Disabilities and Autism In-Patient Quality Transformation Programme Plan.

We have also discussed our proposed plan at our BLMK Mental Health Programme Board and our BLMK Community Mental Health Transformation Group which has Local Authority representation including social care and public health and VCSE representation.

‘What good looks like’

The NHS commissioning framework sets out ‘what good looks like’ which is illustrated in the following diagram which focuses on ‘I’ and ‘We’ statements.

These are the indicators or signposts for commissioners on how they can work together with people, families, staff, and other stakeholders to achieve the vision of ‘what good looks like’ in mental health inpatient care. Good mental health inpatient services are**:**

Valuing

I Statements:
• I am valued as a person, and my individual needs and wishes are respected.
• I feel listened 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, benefitting 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 their community. We are here for all our people when they need us, irrespective of where they live, their background, age, ethnicity, sex, gender, sexuality, disability, or health conditions.

We have self-assessed ourselves against ‘Valuing’ as follows:

Acute mental health in-patient services

In Milton Keynes from the point of admission we work in a person centred way ensuring that patients' views are captured within their admission care plan. There are a variety of opportunities for patients to engage and contribute to life and improvement on the ward; community meetings, patient forums and external organisations (e.g. healthwatch) are invited in to value the patient voice. Staff are trained to provide a trauma informed approach and this is the approach adopted by the whole MDT. Staff have been part of an anti-racism forum and undertaking bystander training. Racism, gender identity and how people can be disadvantaged or abused by their identity are talked about openly in different forums including reflective practice and case formulation. There is access to outside space including space for sports activities, gardening and a sensory garden. There are a range of therapeutic and occupational activities and access to a well-equipped sensory room for use by all patients.

Within Bedfordshire and Luton all patients admitted to our Units will start their discharge planning on the day of admission, this is done in partnership with the patient. We use a patient-centred recovery model where patients are engaged in every step of their care and treatment. Our aim is to engage with all parties, including carers, community providers etc, working with the patient to ensure continuity of care, focussing on their own resources but most importantly what support they need to be able to return to their community safely. A focus on physical health is equally important to our patients and we have onsite Sports Therapists as well as providing a range of physical activities including gardening and exercise groups. Sensory spaces are available on our Units and our Autism and LD Staff support people in both our Acute Hospital and MH Hospital Units when admitted. Staff are trained in trauma informed care using the ROOTs tool and are part of an established Anti-Racism Steering Group. Our People Participation Leads visit the Units on a regular basis and there are a number of QI projects underway which include staff and patients. The Trust has a Service User Led Accreditation Programme which assesses Units from the perspective of a patient.

Mental health rehabilitation in-patient services

In Milton Keynes, patients want to come to Cherrywood and that is noticable in the unit, from the point of admission we work in a person centred way ensuring that patients' choices are integral to life in Cherrywood. Cherrywood aims to emulate homelife as much as possible, providing opportunities for patients to acquire, improve and develop necessary living skills to live and contribute to society. Patients are able to live together as a community, negotiating and contributing to life with others and improvements on the ward; community meetings, patient forums and are invited in to value the patient voice. Staff are trained to provide a trauma informed approach and this is the approach adopted by the whole MDT. Staff have been part of an anti-racism forum and undertaken bystander training. Racism, gender identity and how people can be disadvantaged or abused by their identity are talked about openly in different forums including reflective practice and case formulation. Patients are encouraged to access the local community and when ready venture further afield, to where the community that they are familiar with, moving to, originally lived. Staff and patients work with local VCSE groups. There are a range of therapeutic and occupational activities aimed to promote recovery and rehabilitation.

Within Bedfordshire and Luton, Cedar House is a unit which promotes recovery as part of its rehabilitation services. The community living there contributes to the development of the service through community meetings and Dialog+ is used to enable patients to develop their

own recovery goals. The unit is supported by a MDT. All staff are trained in trauma informed care and provide a high level of support when enabling people to move on to more independent services.

Learning Disabilities

The new policy guidance for DSR/CTR/CETRs (January 2023) aims to empower and support people and their families to be listened to and to be equal partners in their care and treatment pathway. The principles of CTR/CETRs are based on co-production, person centredness and human rights. Two of these principles include person and family centred and nothing about us without us. The principles and standards provide a solid framework that ensures people are valued and this is implemented and monitored in BLMK for all adults with a learning disability and autistic people who are admitted or at risk of admission.

Autism

The new policy guidance for DSR/CTR/CETRs (January 2023) aims to empower and support people and their families to be listened to and to be equal partners in their care and treatment pathway. The principles of CTR/CETRs are based on co-production, person centeredness and human rights. Two of these principles include person and family centred and nothing about us without us. The principles and standards provide a solid framework that ensures people are valued and this is implemented and monitored in BLMK for all adults with a learning disability and autistic people who are admitted or at risk of admission. ELFT commissioned Autism Bedfordshire to deliver Autism training to the workforce across community mental health services.

Accessible

I Statements:
• 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, nor regarded as the ‘last resort’.

We have self-assessed ourselves against ‘Accessible’ as follows:

Acute mental health in-patient services

In Milton Keynes, for patients with complex emotional needs, we recognise that inpatient admission is not always the most therapeutic response to someone being in crisis and explore appropriate and timely alternatives with patients in the form of system wide care plans which are co-produced. Where an admission cannot be avoided, planned admission as per the system wide care plan will take place. There is a robust CRHTT who can see patients up to four times a day, empowering people with alternative interventions, timely crisis support. When on the ward, review of therapeutic days using 'Red / Green' tool is underway

to ensure that days on the ward are therapeutically optimised and it can be seen clearly when patients are ready for discharge. There is a peer support workers discharge group which can be accessed prior to and immediately post discharge.

Within Bedfordshire and Luton care and support is person centred and Units, CRHT and Community Teams work together with the patient to get the most appropriate support in the least restrictive way. Where possible we support people at home, through our CRHT in addition there are Crisis Cafes that are open each evening. When an admission cannot be avoided, we work with the patient and their family/carers to agree the purpose for the admission and give an estimated date of discharge. To support flow across the system we have a number of community beds provided locally. We have a framework of bed management meetings and a Discharge Team which work to identify discharge challenges on admission and support the patient to get these addressed.

Mental Health Rehabilitation In-Patient Services

In Milton Keynes the Operational Policy is currently being reviewed in line with the national quality standards with current patients, peer support workers and experts by experience and these are also being used to generate discussion in community meetings including a recently recruited peer support worker. Recovery and rehabilitation is integral to all aspects of mental health services within Milton Keynes. Cherrywood provides a service to meet the needs where particular rehabilitation needs are required. The routes into the service are described within the operational policy and include stepping down from acute admissions ward and also from specialised hospital out of area. Inclusion criteria is as wide as possible and the nature of the unit allows some moving of patients to increase numbers of male or females if required. Patients referred to Cherrywood are invited to spend the day on the unit and engage in normal activities to experience what a day is like and to be part of an assessment. An assessment is carried out using DIALOG (To capture the patient and carers views)

Within Bedfordshire and Luton, we use Dialog+ as the tool for capturing patient identified outcomes as part of their recovery journey. We have an Assessment and Rehabilitation Team which is taking a focussed approach identifying good quality community and provision. Our Operational Policy and model for our Rehabilitation Beds is currently under review.

Learning Disabilities

The Intensive Support Team (IST) will in-reach into MH inpatient services and support people with a learning disability. IST will work with the mental health workforce to provide training that enables the team to support people with a learning disability in a person centred way. IST will screen for physical health and analyse ahead of considering mental health needs. The DSR identifies when a person's health and care needs are increasing or complex, and may require a multi-agency response, monitoring or prioritised for additional support to meet their presenting need. The DSR enables the identification of people early to apply interventions that may prevent the need for a CTR but if required, will trigger a community CTR at the most appropriate time to support the person/family. ELFT have an accessible website containing easy read information and an app that creates easy read information in relation to medication.

Autism

Autism practitioner posts have been commissioned to work within Bedford CMHT and Milton Keynes MH hub. The posts will carry a caseload supporting autistic people with complex needs and support the workforce, offering advice that will improve the skillset. The DSR identifies when an autistic persons health and care needs are increasing or complex, and may require a multi-agency response, monitoring or prioritised for additional support to meet their presenting need. The DSR enables the identification of people early to apply interventions that may prevent the need for a CTR but if required, will trigger a community CTR at the most appropriate time to support the person/family.

Humane

I Statements:
• 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.

We have self-assessed ourselves against 'Humane' as follows:

Acute mental health in-patient services

In Milton Keynes we provide a least restrictive environment with all staff trained in the use of therapeutic management of violence and aggression. The use of restrictive interventions are monitored and audited locally by the team and Trust wide. Each patient can expect personalised care planning using a trauma informed approach. Reflective practice for staff and debriefing occurs following the use of an intervention so as to explore alternative strategies. The use of blanket restrictive practices is not permitted within the wards and this is frequently reviewed and discussed. The use of and access to outside space and sec 17 leave is monitored and encouraged. Discharge planning commences from the point of admission in partnership with the patient and people that are important to them.

Within Bedfordshire and Luton each admission is person centred, care plans are developed with the patient and their family if appropriate. Discharge planning commences on admission with consideration of someone's social care needs and support as well as on going treatment. Prior to admission, individual needs are considered to identify the most appropriate unit for admission. Use of blanket restrictive practices are not permitted, Safety

Huddles for both staff and patients are undertaken on a daily basis as a minimum. Reflective practice and debrief is used post any incident to explore alternative strategies to support individuals. Lifeskill Recovery Works are in place on twilight shifts to increase opportunities for activities outside of normal working hours, outdoor spaces are available for each Unit and people are encouraged to use the space as well as for those patients who are detained, a proactive approach to using s17 leave for community visits/home leave.

Mental health rehabilitation in-patient services

In Milton Keynes discharge planning commences from the point of admission in partnership with the patient and people that are important to them. The recovery goal is to develop skills and support packages that include families and carers for a successful return to community living with needs collaborative degrees of support. The site is community-based, with a focus on developing practical activities of daily living skills in a domestic environment close to a person's home and within the community.

Within Bedfordshire and Luton, we have a Discharge Hub which starts discharge planning within 72hrs of admission, undertaking a thorough assessment of social care needs. Dialog+ is used as the tool for supporting individuals to identify their own recovery journeys. There is a programme underway which aims to improve the community asset in supporting people to live well in their communities which includes all system partners.

Learning Disabilities

The CTR/CETR framework that is applied in BLMK have no regulatory powers however are empowered on behalf of the person/family to ask questions based on human rights and least restrictive framework. The review team have a role in constructively challenging inappropriate or ineffective practice and supporting a cultural change and shift to a community care model. The KLOES that support the CTR/CETR framework covers several areas and includes - what is my current care like? What is my daily life like? Is there a plan in place for my future? The AT (Assuring Transformation) database records the use of restrictive practice and reports performance data into the BLMK LDA Transformation Board. ELFT report on restrictive practice through the NHSE benchmarking standards.

Autism

ELFT report on restrictive practice via the NHSE Benchmarking tool. The CTR/CETR framework that is applied in BLMK have no regulatory powers however are empowered on behalf of the person/family to ask questions based on human rights and least restrictive framework. The review team have a role in constructively challenging inappropriate or ineffective practice and supporting a cultural change and shift to a community care model. The KLOES that support the CTR/CETR framework covers several areas and includes - what is my current care like? What is my daily life like? Is there a plan in place for my future? The AT (Assuring Transformation) database records the use of restrictive practice and reports performance data into the BLMK LDA Transformation Board.

Equitable

I Statements:

• 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.
• I feel that my cultural needs and preferences are respected by all the staff who support me.

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 will strive to achieve parity of esteem, valuing mental health equally to physical heath, enabling people living with a mental health condition to have an equal chance of a long and fulfilling life.
• 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.

We have self-assessed ourselves against 'Equitable' as follows:

Acute mental health in-patient services

In Milton Keynes patients have collaboratively written, personalised care plans inclusive of family and an MDT of which a sample are audited weekly and key workers supported to achieve improvements in areas that need work. Think Family has been a focus within mental health services in Milton Keynes for several years. There are carer / family surgeries facilitated by the ward matrons. Families are invited to be part of ward rounds and this is monitored through the audit process and reported in the Inpatient COG. Therapeutic and occupational activities are designed to be as inclusive as possible. Where a patient may be too unwell to benefit from being with others, a bespoke programme will be provided with the aim of encouraging joint participation as soon as possible. The wards are sensitive to gender identity and staff are able to speak freely if they are unclear about how to implement the policy.

Within Bedfordshire and Luton we work with the service user and where appropriate their carer/family and providers of care in developing their care plan based on their individual needs and these are reviewed with the patient as a minimum on a weekly basis. Families/Carers/Advocacy/Care Providers are invited to Ward Rounds when required, therapy and activities are discussed and agreed as part of the care plan development. Drug and Alcohol Providers attend the Units weekly to offer support and help people to access local services.

Mental health rehabilitation in-patient services

In Milton Keynes during the initial review period the key worker will coordinate evidence based standardised assessment tools. A progress review will occur around 7 weeks from admission at which point a report will be produced with possible outcomes that could include; a review of care plans and continue with the rehabilitation pathway, new care plans and setting new goals, or rehabilitation goals are met or recovery potential met and the service user is ready to move on. Patients have collaboratively written, personalised care plans inclusive of family and MDT. Think Family has been a focus within mental health services in Milton Keynes for several years. There are carer / family surgeries facilitated by the ward matron. Families are invited to be part of ward rounds. Therapeutic and occupational activities are designed to be as inclusive as possible. The ward is sensitive to gender identity and staff are able to speak freely if they are unclear about how to implement the policy. There is a female only lounge.

Within Bedfordshire and Luton we have a Recovery College and Occupational Therapy offer. There is an MDT which meets with the patients and carers where appropriate to review care and support and enable people to move forward on their recovery journey. Families are seen as an important part of recovery and engaged in care and support, service development and community events that take place on the ward.

Learning Disabilities

Care planning is person centred and captures people's aspirations and hopes. Responses are personalised, understanding and compassionate of individual need. There was a recent case where the person identified as a male however wanted to be in a female ward. MDT recognised and understood the reasons having reviewed the background, history and trauma. The MDT supported this to happen with the appropriate risk management plan in place. Inpatient staff are trained in delivering trauma informed care and the approach is adopted by the MDT, Diverse Cultures team and the 'We Deserve Better' publication, BLMK self-assessment and recommendations. The Patient Carer and Race Equalities framework, SPLD with support of PPL have established workshops.

Autism

Autism OT working within the BLMK Transforming Care team has been commissioned and is being recruited. This post will support people who are in hospital, planning discharge or at risk of admission. CNWL co-designed a new sensory garden, sensory room installation, portable sensory items, staff training and recruitment of a peer support worker for the Campbell Centre. CNWL also co-hosted autism awareness events in Milton Keynes alongside Talkback. Care planning is person centred and captures people's aspirations and hopes. Responses are personalised, understanding and compassionate of individual need. There was a recent case where the person identified as a male however wanted to be in a female ward. MDT recognised and understood the reasons having reviewed the background, history and trauma. The MDT supported this to happen with the appropriate risk management plan in place.

Therapeutic

I Statements:
• I will be able to 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, 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.

We have self-assessed ourselves against 'Therapeutic' as follows:

Acute mental health in-patient services

In Milton Keynes we have monitored trauma informed approach training across the staff groups and report on this weekly. Additionally some staff have attended KUF training. Care plans incorporate physical, mental health and social issues using trauma informed approaches and multi-disciplinary wherever possible, seeking expertise from others where needs lie such as Autism and Learning Disability.

Within Bedfordshire and Luton staff have received Trauma Informed Care/Approach training, using the ROOTs training. Care planning is developed using Dialog+ which is a strengths based outcome measure. Regular physical health training is provided to staff. Autism and LD practitioners provide training, including Oliver McGowan training and provide support for patients who have autism or LD when admitted.

Mental health rehabilitation in-patient services

In Milton Keynes Cherrywood is a 7 bedded house in a residential street. It's low-staffed, with staff who have specialist risk assessment skills through experience and evidence-based practice. Staff access a range of Trauma Informed Approach training which is monitored and some staff have attended KUF training. Staff have also completed training in LD and Autism as well as the Oliver McGowan training. Care plans incorporate physical, mental health and

social issues using trauma informed approaches and multi-disciplinary wherever possible, seeking expertise from others where needs lie such as autism and/or learning disability.

Within Bedfordshire and Luton, we have Cedar House which provides 16 beds, it has nurses on duty 24 hours a day as part of a wider MDT. The team access a wide range of training to support both the physical health and mental health needs of their patient community. This service is currently under review.

Learning Disabilities

People with a learning disability and autistic people who are admitted to hospital are offered a CETR/CTR within 6 weeks of admission and every 6 months throughout their time in hospital. The inpatient CTR/CETRs are focused on the safety, care and future planning for people who are admitted and remain in hospital. The focus of the review is to understand the reasons for extended hospital stays, barriers to progression and discharge and whether the correct or more effective treatments are being provided. Physical health along with people's mental health is a key focus within the CTR/CETR process. The role of the SAWRs also identify gaps in care in relation to people's physical health and wellbeing. The 8 weekly QoV include the 'sit and see' element of a CTR/CETR and considers the person's environment as part of that assessment.

Autism

Autistic people who are admitted into hospital are offered a CETR/CTR within 6 weeks of admission and every 6 months throughout their time in hospital. The inpatient CTR/CETRs are focused on the safety, care and future planning for people who are admitted and remain in hospital. The focus of the review is to understand the reasons for extended hospital stays, barriers to progression and discharge and whether the correct or more effective treatments are being provided. Physical health along with people's mental health is a key focus within the CTR/CETR process.The role of the SAWRs also identify gaps in care in relation to peoples physical health and wellbeing. The 8 weekly QoV include the 'sit and see' element of a CTR/CETR and considers the persons environment as part of that assessment.

Collaborative

I Statements:
• 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 support 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 our 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.

We have self-assessed ourselves against 'Collaborative' as follows:

Acute mental health in-patient services

In Milton Keynes we have a team of peer support workers that are employed and work in partnership across the wards. Healthwatch have been commissioned to work specifically with the female ward to provide advocacy and a local voice. Patients have access to regular patient forums and issues raised and response to these are displayed in posters across the unit. There are daily (Monday to Friday) mental health system patient flow meetings at 16:00 attended by the bed manager, inpatient, CRHTT, HLT and community mental health teams and local authority colleagues. Milton Keynes mental health attend weekly system calls with ICB partners which are increased where indicted. There are several daily Trust wide bed calls as well as weekly director level weekly reviews of system wide flow.

Within Bedfordshire and Luton we have People Participation Leads that attend Units and engage with patients to understand their experience of services. There are You Said, We Did Boards on each ward which capture patient feedback and our response to them. We have patient representation as part of our In Patient Rebuild Programme and a number of QI projects on the Units. As part of managing the patient flow we have a framework of Bed Management Meetings with local system partners as well as having held a number of MADE Events to engage the wider system.

Mental health rehabilitation in-patient services

In Milton Keynes we have recently recruited a peer support worker on the ward. Patients have access to regular patient forums and issues raised and response to these are displayed in posters across the unit. Everything on the ward is done with patients. The expectation is discussed with patients before admission and it is expected that patients engage together with support with staff to coexist and develop skills. Patients are able to access community events including the recovery college and VCSE supported forum, initially with support from a range of multidisciplinary staff including OT, peer support workers but with the aim of striving to do this independently.

Within Bedfordshire and Luton, patients are encouraged to be involved in all aspects of care and service delivery. Service Users are part of all interview panels and within our Recovery College workshops are co-produced and delivered with service users. Access to communities is an essential part of our programme and people are supported on an individual basis depending on their need to support.

Learning Disabilities

The 12 point discharge plan and CTR/CETR code and toolkit is used and provides discharge standards and a stepped model for discharge to support the discharge planning process and improve people's experience. Inpatients can access or be referred into the local advocacy services. Training around Trauma is offered to the ELFT workforce.

Autism

The 12 point discharge plan and CTR/CETR code and toolkit is used and provides discharge standards and a stepped model for discharge to support the discharge planning process and improve people's experience. Inpatients can access or be referred into the local advocacy services. Training around Trauma is offered to the ELFT workforce. Autism Bedfordshire delivers the key worker scheme for people aged 18-25. Collaborative working with VCSEs to coproduce and deliver local projects that offers pre and post diagnostic support, reduces inequalities and connects with the wider system, for example social prescribing that supports people's wellbeing.

Support people as citizens

I Statements:
• 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.

We have self-assessed ourselves against 'Support people as citizens' as follows:

Acute mental health in-patient services

In Milton Keynes patients are actively encouraged to maintain contact with their family and local activities through the use of sec 17 leave, escorted and unescorted leave. Invites to the peer support worker facilitated discharge groups commence prior to and after discharge, with engagement to the recovery college. Discharge planning commences at the point of admission and may alter depending on the patient's wishes and needs. The tenancy sustainment officer enables access to housing and prevents delayed discharges, they have access to shared info/database and homeless assessments can be carried out with patients before discharge; assisting with sign ups and support to temporary accommodation – avoiding waiting as previously this would have resulted in delayed discharge for the NFA patients. There's a continuous care after the discharge element (sustainment), joint working with housing colleagues, mental health, ARC, ASC, DWP and any other services that the patient may need; help with referrals to support networks; supporting with any housing

issues, tenancy issues, mutual exchange, repairs or deep cleans which can sometimes delay discharge – these can all be addressed quickly.

Within Bedfordshire and Luton all patients admitted into our Units are encouraged to maintain community activities wherever possible, the use of leave away from the ward is supported. All patients are aware of the Recovery College and supported to access when required. There is a discharge team which support patients with all aspects of their discharge, as well as Drug and Alcohol Providers, People Participation and some Community Initiatives such as Pet Therapy reaching into services.

Mental health rehabilitation in-patient services

In Milton Keynes patients are actively encouraged to maintain contact with their family and local activity through the use of sec 17 leave if detained under the MHA, escorted, unescorted leave. Patients have regular use of the local leisure centre with the aim of improving physical health but also to encourage the embedding of healthy lifestyle patterns prior to discharge. Patients are also able to access the recovery college. Discharge planning commences at the point of admission and may alter depending on the patient's wishes and needs for example this could include a return to their own home or they may need somewhere with some additional support.

Within Bedfordshire and Luton, patients are supported to access their local community, including social events. The MDT and Recovery College promote a wide range of workshops and sessions to support recovery. There are physical health leads/PE instructors on the Wards to help to transition to healthy living approaches on discharge as well as Lifetime Recovery Workers to aid integration into services.

Learning Disabilities

People with learning disabilities are involved in the crisis care pathway review and there are specific voice groups that support this area and also capture the views and experiences of people who have been in mainstream mental health inpatient services. All the information and intelligence gathered is used to inform ongoing quality improvement and strategic commissioning that is linked to the BLMK LDA strategy. More access and awareness around the benefits of social prescribers, creating better access to personalised support around wellbeing, physical exercise, employment, LDAHC. Improved partnership working with VCSEs focusing on social and leisure opportunities. Key worker scheme in place supporting 18 - 25 year olds.

Autism

There are autism people participation leads that have a working together groups across Bedfordshire and Luton and capture the experiences and feedback from local people. This information and intelligence is use to support ongoing quality improvement work, reduce inequalities and strategic commissioning priorities that have been co-produced with local people and families. A project has been set up to develop a peer support model for BLMK following the outcome of the BLMK Autism Pathway Review. This is further supported by the LDA strategy that was co-produced.

Co-Production/lived experience embedded

I Statements:

- 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

We have self-assessed ourselves against 'Co-production' as follows:

Acute mental health in-patient services

In Milton Keynes we work hard to make sure that the patients are at the heart of everything and enabled to contribute to ward developments, improvements and culture. Either current or previous patients are part of recruitment processes and service users and carers are always included in the selection of senior posts. We involve patients in all QI work. We have an expert by experience co-delivering a teaching programme. We have an extremely proactive patient, carer and community engagement coordinator who leads on weekly drop in's and displays actions taken as a result as well as engaging with the local community. Healthwatch have been commissioned to carry out weekly visits over a year to hear patients experience.

Within Bedfordshire and Luton, Service Users are involved in the recruitment of all posts within ELFT. Service Users are involved in all of our QI projects, they co-produce our Recovery College workshops and are involved in all service review/redesigns including the In-Patient Rebuild. Service User Accreditations are undertaken and led by Service Users. Service Users Co Chair our Community Meetings on each Unit. Healthwatch provide us with quarterly feedback from Service Users.

Mental health rehabilitation in-patient services

In both Milton Keynes and Bedfordshire and Luton, we work hard to make sure that the patients are at the heart of everything and enabled to contribute to ward developments,

improvements and culture. Either current or previous patients are part of recruitment processes and service users and carers are always included in the selection of senior posts. We involve patients in all QI work.

Learning Disabilities

In January 2023, the ICB coordinated the co-production of a Learning Disability and Autism Strategy, which sets out strategic priorities for BLMK over the next three years. The voices of people with lived experience is very much at the heart of the strategy. The multi-agency Learning Disabilities & Autism Transformation Board will be taking the strategy forward. There are People Participation Leads for learning disabilities who facilitate local voice groups for people with learning disabilities, families and carers.

Autism

Autism awareness conference funded for June and October 2022. A 130 seated event in Milton Keynes, designed in partnership with Talkback MK; to understand service user stories and how we can work together to improve services in CNWL. In January 2023, the ICB coordinated the co-production of a Learning Disability and Autism Strategy, which sets out strategic priorities for BLMK over the next three years. The voices of people with lived experience is very much at the heart of the strategy. The multi-agency Learning Disabilities & Autism Transformation Board will be taking the strategy forward. There are Autism People Participation Leads in ELFT who facilitate local voice groups for autistic people, families and carers.

As part of our Bedfordshire, Luton and Milton Keynes Mental Health, Learning Disabilities and Autism In-Patient Quality Transformation Plan we will be focusing on delivering ‘what good looks like’ by continuing to deliver on the ‘I’ and the ‘We’ statements.

Themes to deliver as part of our 3-year local plan

The Patient and Carer Race Equality Framework

NHS England has launched its first ever anti-racism framework, the Patient and Carer Race Equality Framework (PCREF), for all Mental Health Trusts and service providers to embed across England. The PCREF is a mandatory framework to ensure Trusts and providers are responsible for co-producing and implementing concrete actions to reduce racial inequality within their services and will become part of CQC’s and EHRC's inspection processes. The framework focuses on improving the experiences of care in mental health services for ethnically and culturally diverse communities.

The PCREF has been piloted over the last three years, initially by four Trusts (South London and Maudsley NHS Foundation Trust, Birmingham and Solihull Mental Health NHS Foundation Trust, East London NHS Foundation Trust and Greater Manchester Mental Health NHS Foundation Trust).

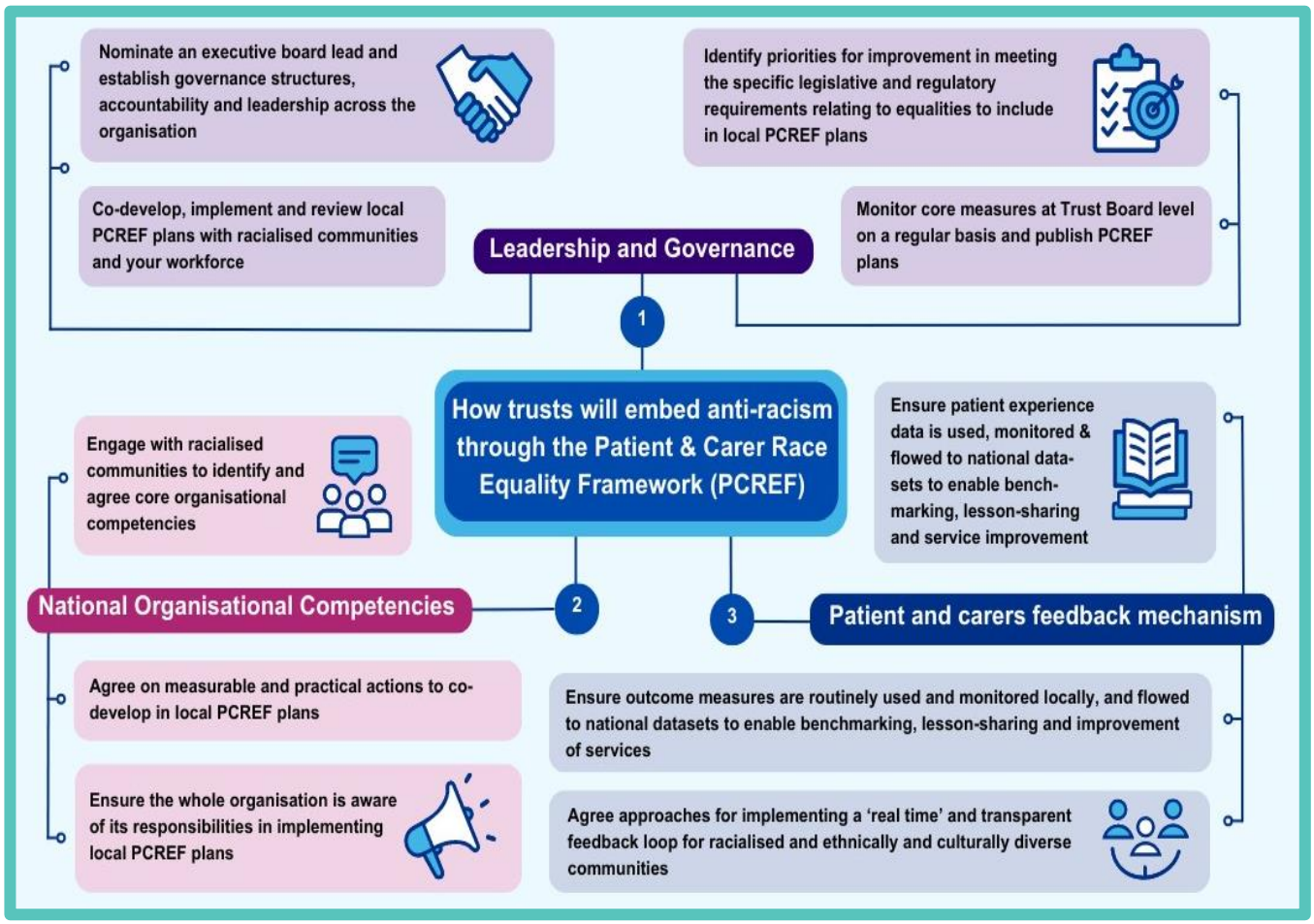
Having just marked 75 years of the NHS, NHS England has reflected on how far the mental health sector has come, from locking people away in Victorian asylums, to focusing more on care in the community, as close to home as possible. But despite amazing progress, inequalities are still high across the sector, and people from ethnic minority groups still face racism and discrimination. Mental health services need to take responsibility for ending local health inequalities – and be held accountable nationally.

Ethnically and culturally diverse groups still face barriers to access, and their experience of mental health services is likely to be worse than for the rest of the population. We know that despite higher prevalence of mental health issues, Black adults for instance have the lowest mental health treatment rate of any ethnic group, at 6% (compared to 13% in the White British group).

The new framework empowers trusts to use their data in a transparent way to inform and improve services for culturally diverse communities. It will be mandatory, and Trusts will need to report on how:

- They have improved their governance, accountability, and leadership across the organisation.
- They improve their data collection around ethnicity.
- Examine what their data tells them about their population and use that information to improve services to better meet needs.
- They will also need to publish the data they collect in regard to ethnicity, as well as their co-produced plans to address local health inequalities.
- They have improved their interaction with ethnic minority groups.

Patient and carers will be actively involved at every level of trusts governance structures, including in decision making, and consulted more about their care and the services they access. Leaders and staff will get more familiar with the needs of the communities they serve from a racial/cultural perspective and improve their governance structures to include better representation of ethnic minorities and improve services accordingly.



Next Steps: Ensure the rollout of the framework as part of the implementation of the Bedfordshire, Luton and Milton Keynes Mental Health, Learning Disabilities and Autism In-Patient Quality Transformation Programme with strong leadership support and staff and patient engagement. The PCREF must be shared with patient, carer and community networks to achieve the highest level of participation possible.

Trauma-Informed Care

What is trauma-informed care?

Trauma-informed care is a whole system approach that means both the prevalence and impact of trauma (and adversity) is recognised, understood and responded to in a way that causes **no further harm.**

In inpatient care, a critical part of this means becoming harm aware and being thoughtful and reflective about ways to avoid harm.

It means focusing on consistent and trusting relationships that help trauma survivors to feel safe and heal from their experiences

THE 4 R'S OF TRAUMA-INFORMED CARE

Realise - All people at all levels have a basic realisation about trauma, how it can affect individuals, families and communities.

Recognise - People within organisations are able to recognise trauma, and how it can affect individuals, families and communities.
Respond - Organisations respond by practising a trauma-informed approach.
Resist re-traumatisation - Organisational practises may compound trauma. Trauma informed organisations avoid this.

We will continue to progress with implementing a whole system approach to trauma-informed care across BLMK as part of implementing our plan.

The Culture of Care Standards

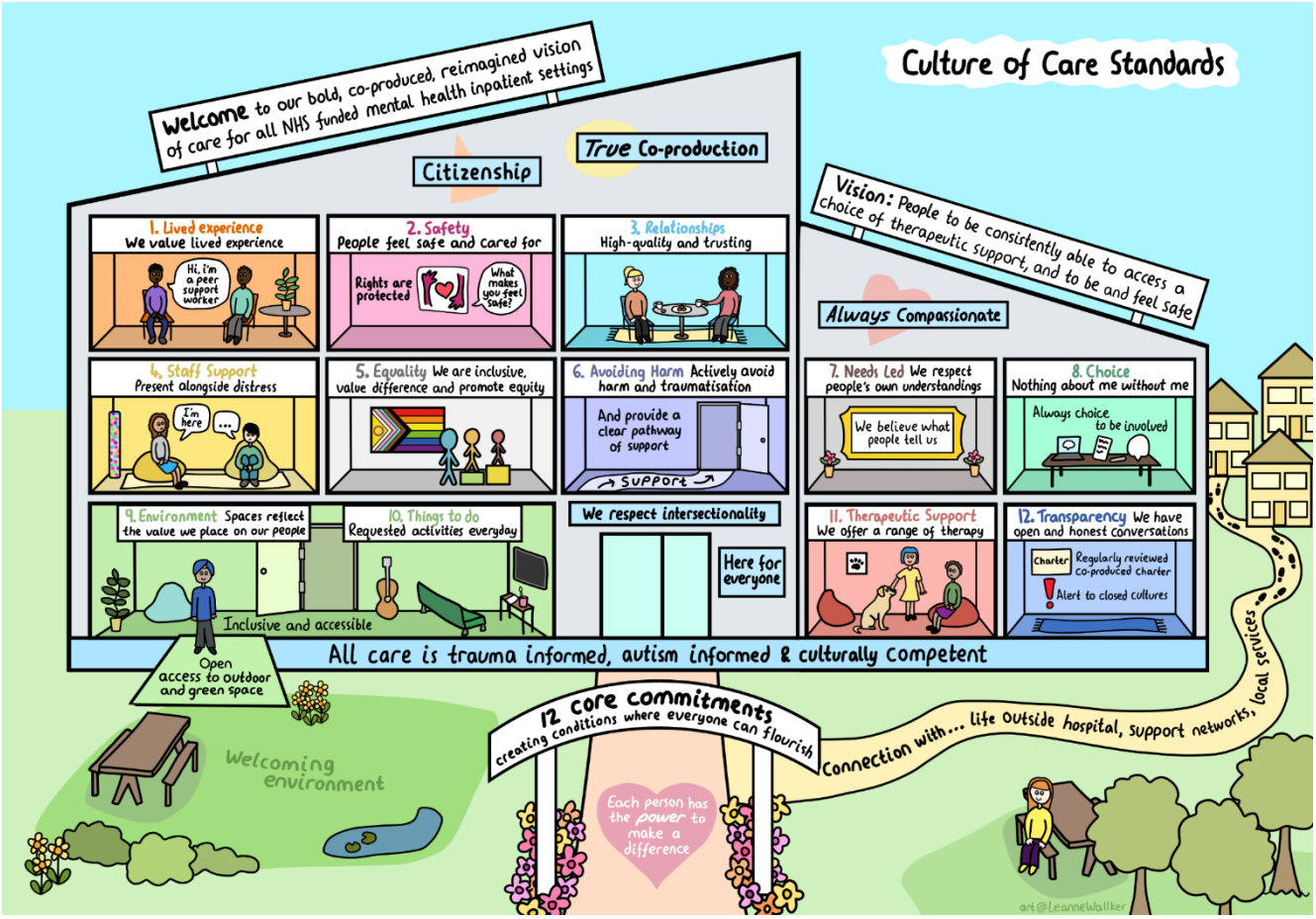
The culture of care standards for mental health inpatient care have been developed by NHS England to support all providers to realise the culture of care within inpatient settings everyone wants to experience – people who need this care and their families, and the staff who provide this care. They apply across the life course to all NHS-funded mental health inpatient service types, including those for people with a learning disability and autistic people, as well as specialised mental health inpatient services such as mother and baby units, secure services, and children and young people's mental health inpatient services. The aim of the culture of care is to support patients and their families to flourish, and staff to flourish; to be proud to work in inpatient care and supported to deliver the care they came into their profession to give. There will be the initial implementation of the culture of care standards in a selected number of in-patient services within the two mental health trusts, CNWL and ELFT, which will then be expanded across all of the in-patient services. Being in hospital is a form of restriction in and of itself, and it is our moral and legislative duty to provide the least restrictive experience possible within inpatient settings with a clear focus on balancing the right to liberty with therapeutic benefit.

To support the culture of care vision there has been the development of 12 overarching core commitments, each of which has a set of associated standards. Work to improve the culture of care on inpatient wards – creating the conditions where patients and staff can flourish – should focus on these core commitments:

- **Lived experience**: We value lived experience, including in paid roles, at all levels – design, delivery, governance and oversight
- **Safety**: People on our wards feel safe and cared for
- **Relationships**: High-quality, rights-based care starts with trusting relationships and the understanding that connecting with people is how we help everyone feel safe
- **Staff support**: We support all staff so that they can be present alongside people in their distress.
- **Equality**: We are inclusive and value difference; we take action to promote equity in access, treatment and outcomes
- **Avoiding harm**: We actively seek to avoid harm and traumatisation, and acknowledge harm when it occurs
- **Needs led**: We respect people's own understanding of their distress
- **Choice**: Nothing about me without me – We support the fundamental right for patients and (as appropriate) their support network to be engaged in all aspects of their care
- **Environment**: Our inpatient spaces reflect the value we place on our people
- **Things to do on the ward**: We have a wide range of patient requested activities everyday

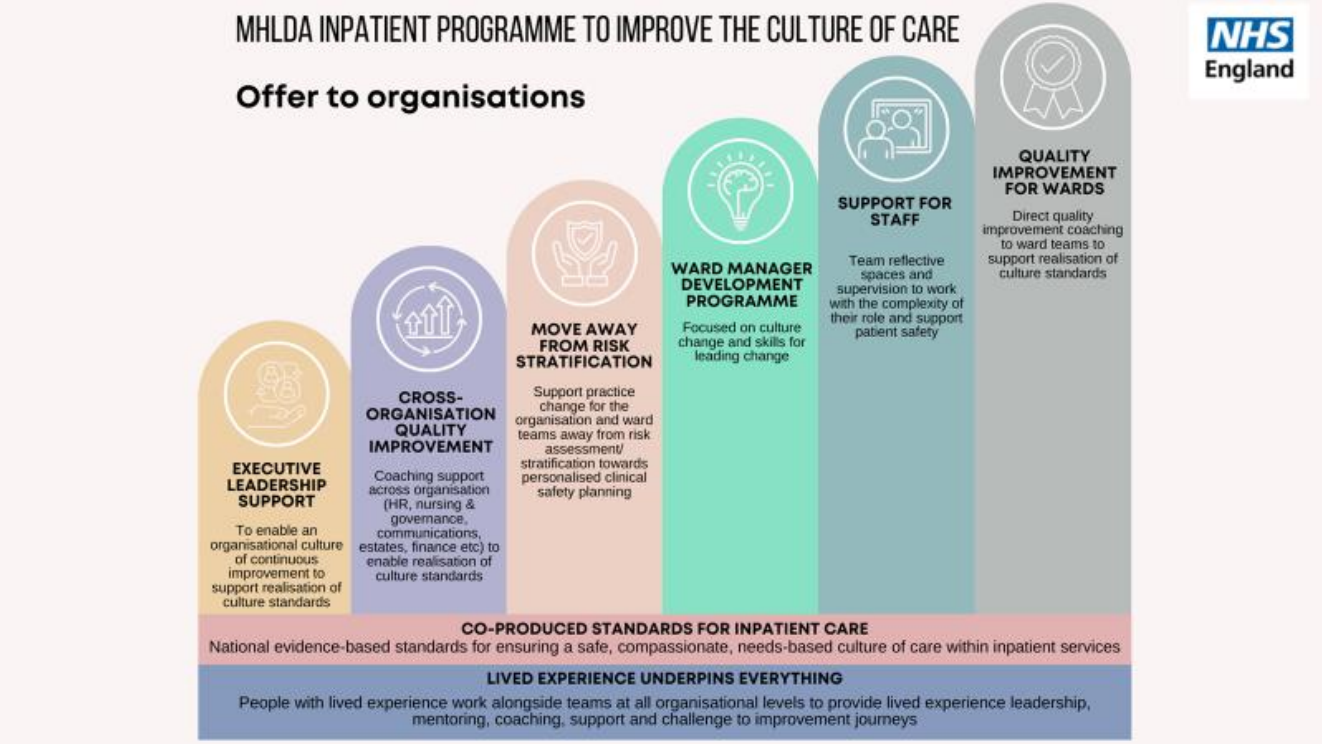
- **Therapeutic support**: We offer people a range of therapy and support that gives them hope things can get better
- **Transparency**: We have open and honest conversations with patients and each other, and name the difficult things

In addition, the standards are aligned to 3 key approaches – trauma-informed, autism-informed and culturally competent care – to support the ambition for equality focused inpatient care. The following diagram illustrates the vision relating to the culture of care standards



The following diagram illustrates the NHS England 'offer' to support with implementation which focuses on:

- Executive Leadership Support
- Cross-Organisation Quality Improvement
- Move Away from Risk Stratificaiton
- Ward Manager Development Programme
- Support for Staff
- Quality Improvement for Wards



As part of our BLMK 3-year plan we will be implementing these different elements.

Sexual Safety as part of Bedfordshire, Luton and Milton Keynes Mental Health In-Patient Quality Transformation Plan

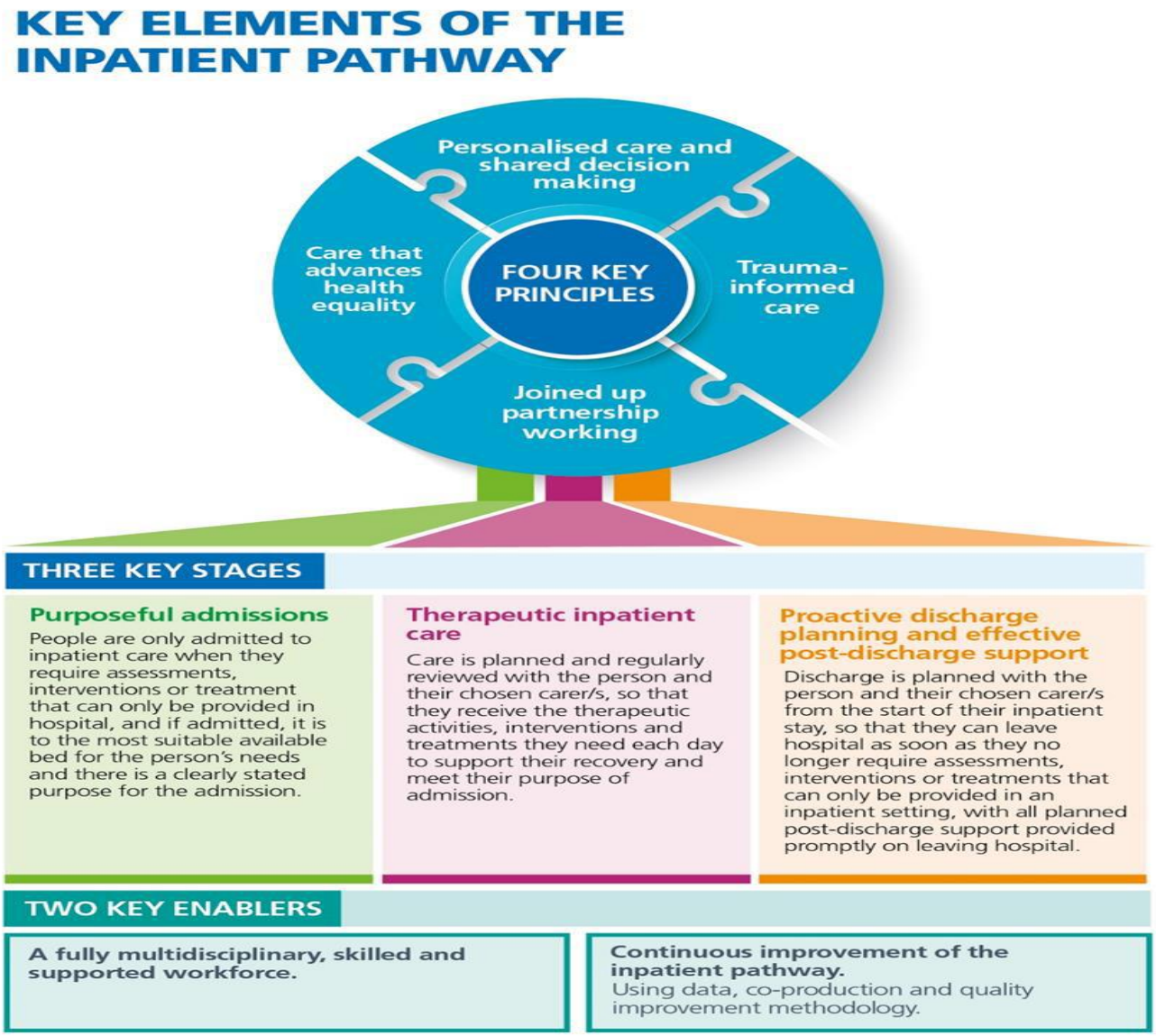
As part of our Bedfordshire, Luton and Milton Keynes Mental Health, Learning Disability and Autism In-Patient Quality Transformation Plan, we will be focusing on implementing the 10 key actions of the Sexual Safety in Healthcare Charter which includes taking a zero-tolerance approach to any unwanted, inappropriate or harmful sexual behaviours within the workplace. The recent results from the NHS Staff Survey and the National Education and Training Survey revealed that 58,000 staff reported unwarranted sexual approaches from patients or other members of the public last year – that's 1 in every 12 NHS workers. 1 in 26 reported experiencing similar harassment from work colleagues. Analysis of the surveys shows that there is variation in the degree of prevalence, with some settings experiencing higher trends – for example, ambulance and mental health trusts, and women – experiencing these crimes at a disproportionate rate. Therefore, across Bedfordshire, Luton and Milton Keynes we will focus on implementing the following 10 key actions including taking a zero-tolerance approach to any unwanted, inappropriate or harmful sexual behaviours within the workplace as follows:

- We will actively work to eradicate sexual harassment and abuse in the workplace.
- We will promote a culture that fosters openness and transparency, and does not tolerate unwanted, harmful and/or inappropriate sexual behaviours.
- We will take an intersectional approach to the sexual safety of our workforce, recognising certain groups will experience sexual harassment and abuse at a disproportionate rate.
- We will provide appropriate support for those in our workforce who experience unwanted, inappropriate and/or harmful sexual behaviours.
- We will clearly communicate standards of behaviour. This includes expected action for those who witness inappropriate, unwanted and/or harmful sexual behaviour.

- We will ensure appropriate, specific, and clear policies are in place. They will include appropriate and timely action against alleged perpetrators.
- We will ensure appropriate, specific, and clear training is in place.
- We will ensure appropriate reporting mechanisms are in place for those experiencing these behaviours.
- We will take all reports seriously and appropriate and timely action will be taken in all cases.
- We will capture and share data on prevalence and staff experience transparently.

Acute In-Patient Mental Health Care for Adults and Older Adults

The Acute In-Patient Mental Health Care for Adults and Older Adults guidance sets out the key elements of the pathway as follows:



Key Stage 1

From the point of presentation to within 72 hours of admission

- Holistic assessment conducted to understand the person's needs. This assessment should build on information contained within the person's electronic patient record (EPR), including any recorded advanced choices and reasonable adjustments.
- Decision reached, considering as fully as possible the person's preferences, including any advanced choice documents (ACDs), those of their chosen carer/s, and the views of relevant partner services, that the person's needs can only be met in an inpatient setting and cannot be supported in the community. For people with a learning disability and autistic people, a care, education, and treatment review C(E)TR should take place pre-admission to support this decision (or if this is not possible, within 28 days of admission).
- Purpose of admission discussed and agreed with the person and their chosen carer/s and uploaded to the person's electronic patient record (EPR).
- Prompt access facilitated to the most suitable hospital provision available for the person's needs.
- Formulation review completed to gain an in-depth understanding of the person, the circumstances leading up to their admission and what will help them to recover. This, together with recorded ACDs and the findings of a C(E)TR (for people with a learning disability and autistic people), should be used as the basis to co-develop a personalised care plan with the person and their chosen carer/s, which should then be uploaded to the person's EPR.
- Discharge planning begun with the person and their chosen carer/s, including identifying any factors that could delay discharge (e.g., housing, social care), agreeing an estimated date of discharge (EDD) and an intended discharge destination, and uploading these to the person's EPR.
- Interventions and treatment for physical and mental health conditions commenced or maintained, and a physical health check completed.

Key Stage 2

During the hospital stay

- Daily reviews (e.g., using the Red to Green approach) completed to check the person is receiving prompt access to the assessments, interventions and treatment they require, in line with their purpose of admission and care plan. Assessments, intervention, and treatment should be adapted to meet reasonable adjustments and the needs of people from groups who experience health inequalities.
- Purpose of admission, care plan, discharge plan and EDD reviewed and updated regularly with the person and their chosen carer/s. If the purpose of admission is close to being met, additional focus should be given to discharge planning.
- Any factors that could delay discharge, (e.g., the need for step down provision, home adaptations, housing, supported living or care home placement) reviewed every two to three days and proactively addressed with partner services.
- Monitoring visits completed by commissioners every eight weeks for adults with a learning disability and autistic people, and every six weeks for young people aged up to 25, who have an Education, Health, and Care (EHC) plan.

Key Stage 3

At and following discharge

- Person centred discharge plan refined with the person and their chosen carer/s. The plan should set out who is responsible for providing the assessments, interventions, and treatments that the person will receive after leaving hospital and when the person can expect this support.
- Discharge facilitated promptly once a decision is reached that the person is clinically ready for discharge (CRFD) (i.e., the person does not require any further assessments, interventions and/or treatments, which can only be provided in the current inpatient setting), and that it is possible to discharge them (i.e. because the planned discharge support is available at that time). If a person is CRFD, but it is not possible to discharge them, they should continue receiving interventions, activities and support in hospital so that they remain CRFD and can be discharged as soon as planned support is in place.
- At least 48 hours' notice of the decision to discharge given to the person, their chosen carer/s and any services (e.g., community based mental health and learning disability teams, Crisis Resolution Home Treatment Teams (CRHTTs), housing services, social services) that will be involved in the persons ongoing care.
- Risk assessment updated and uploaded to the person's EPR which includes information on how any risks to self or others will be managed once the person is discharged.
- Follow up meeting arranged pre-discharge, including providing written details of when, where and who the follow up will take place with.
- Clear information provided to the person and their chosen carer/s about how to access crisis support after discharge (including direct contact details for CRHTT)
- Prompt access provided to all planned post discharge support including in the person's discharge plan. The person should also be supported to develop advanced choice documents and a crisis plan.
- Follow up completed (face to face wherever possible) within 72 hours of discharge for all adults discharged (NB this has been included in the NHS Standard Contract since 2020/21). If the follow up indicates additional support is required, action is taken promptly to put this in place.
- Relevant information relating to a person's discharge (which may include a copy of the person's discharge plan) shared with the services involved in the person's ongoing care and treatment. Discharge summary shared with the persons GP and other relevant parties, where appropriate, within a week of discharge.
- Multi-Agency Discharge Events used where there are complex discharges requiring agreement across multiple partners and follow locally agreed escalation procedures where there are concerns about delayed discharges.

In year 1, across Bedfordshire and Luton as part of implementing the key elements of the inpatient pathway (Purposeful admissions, therapeutic inpatient care, proactive discharge planning and effective post-discharge support) there is an ambition to reduce private sector bed usage to zero. There are a number of schemes that are being considered to be taken forward which include the development of a High Intensity User Scheme (Admission avoidance) and a Crisis House (Admission avoidance). In year 1 in Milton Keynes there will be a focus on improving patient flow by supporting patients with moving on from supported accommodation by providing both financial and practical support to enable patients to move towards successful independence in the community. The pilot will support 4 mental health

service users initially, currently in funded supported accommodation placements, to move into self-contained independent accommodation. The project will provide financial support for a 2 year period alongside a programme of holistic practical and emotional support. The programme, in summary is set out as follows:

Financial – housing benefit top up for 2 years, to enable Service User's to afford independent accommodation in a competitive Milton Keynes market. This will be funded via CNWL but accessed via the MKC housing team.

Vocational – via CNWL's Individual Placement and Support Team to provide support to gain employment, where necessary through first accessing pre-employment training/ development. The aim is to have clients in paid employment within 18-24 months.

Case Management - via the CNWL placements team – support activities of daily living, including practical tasks of maintaining accommodation alongside support to maintain emotional wellbeing and good mental health. The team will access support from health and care colleagues as required.
Clients will be:
• Under 35 and in a funded placement
• Committed to working towards paid employment, so are able to take over rent top-up at the end of the 2-year period

Outcomes: Clients will secure stable accommodation, which they are able to maintain after the 2-year financial support ends. Clients are able to maximise their recovery and live the most independent high quality of life possible as measured against 4 recovery areas.

Reducing restrictive practices

One of the themes that the national transformation programme is focusing on is reducing restrictive practices which is an area of focus within our BLMK 3 year plan. The national priorities are as follows:

- Support Providers and Systems to realise the culture and practice change that the Use of Force Act and Mental Health Act intend
- Scope and support targeted interventions seeking to tackle Restrictive practices with particular focus on inequalities
- Support and embed learning from culture change and improvement approaches seeking to reduce restrictive practices such as HOPEs, Mental Health Safety Improvement Programme
- Ensure improved approaches to Early Warning Signs and oversight capture key indicators of restrictive practices and the risk of such practices
- Ensure all forms of restrictive practices are understood, captured and acted upon linking with key mechanisms such as the Patient Safety Framework

The Overall 3 year Bedfordshire, Luton and Milton Keynes Plan

The overall 3 year Bedfordshire, Luton and Milton Keynes part of the plan for acute mental health in-patient care for adults and older adults is as follows;

Year 1 – Action	Target date

Service user and carer priorities as follows: • Development of Peer Support Workers (People with lived experience) within mental health in-patient services • Improving 'induction' for patients when admitted to a mental health in-patient unit so that they are aware of what to expect and what activities are available • Increase service user's access to gardens, sensory rooms, gyms and other activities • Increasing activities to reduce boredom for service users, especially in evenings and weekends • Developing staff so that they are able to support service users when they are upset, to give them time to talk and 'hand holding' • Developing trauma informed care and personalised care, ensuring that service users only have to tell their story once and staff valuing service users. Also, staff not being aggressive to people • Developing staff so that they have human values, care, respect, kindness and treating patients the way you would want to be treated if you were a patient. • Ensuring that staff are held to account over their behaviour and attitudes. Regular surveys to be held to identify difficulties around staff attitudes. Performance reviews on quality of care. • Improving security and safety on mental health in-patient services so that service users are not scared and frightened of both other patients and staff. • Improving transitions at weekends so that there is a smooth experience for service users. • Improving training for primary care staff on engaging with LGBTQ+ individuals • Improving staff understanding of Autism and other conditions. Increase staff training around communication, sensory needs and time to process instructions especially when a person is in distress. • Develop a survival pack, picture cards/written instructions on what is going to happen in the next few days (Including noise cancelling headphones) • Improved access to sensory rooms • Ability to change lighting conditions (dimmer switches) • Supporting patients who have sensory issues around food and eating with others • Staff to have an increased understanding of patients feelings around anxiety and sensory overload • Insulation needs to be considered in all the wards as the noise can be difficult for patients • Specifically Autistic Trained staff to work with service users with Autism	March 2025
During the first year we will continue to focus on clearly defining and starting to implement improvements to the quality and safety of care	March 2025

people experience in mental health inpatient settings across BLMK through the introduction of a new bold, radical and reimagined model of care for the future. Central to its development and implementation of our local BLMK vision will be for it to be co-produced with people with lived experience of inpatient services and their families; nurses, psychiatrists, psychologists, allied health professionals and other staff who work in inpatient settings at various levels of the different organisations including wider partners such as Local Authority organisations and voluntary sector organisations. We will focus on developing a user-friendly overview of the programme which will articulate both our vision and outcomes. Our local plan's ambition is to meet the needs of our local residents and to address inequalities across BLMK. In the first year we will be focusing on strengthening our governance structure so as to support with implementing the programme.	
As part of implementing our local plan we will be focusing on eliminating out of area placements. Data from November 2023 was showing BLMK as having 15 people out of area with the plan to reduce this to 2 people by the end of March 2025. As part of improving flow and pathways we will be focusing on the mental health waiting times standards - Urgent and emergency mental health - 1. All age referrals to liaison psychiatry services from A and E contacts within 1 hr - Currently showing as 63% (March 2024) 2. All Age Very Urgent referrals to community crisis services contacts within 4hrs - Currently showing as being suppressed which is being investigated further. 3. All age urgent referrals to community crisis services contacts within 24 hrs - Currently showing as 73%. Non-urgent adult community-based mental health services waiting times standards - Longest waits still waiting data - 114 (median), 714 (90th percentile) - February 2024 and 34.6% of referrals with 2+ contacts recorded in four weeks in March 2024	March 2025
As part of increasing access to community mental health support we will be focusing on looking at inpatient admissions for people who have had no previous contact with community mental health services in the year prior to their admission, with a focus on inequalities of experience by ethnic minorities. Our latest data is showing 9% (Non-White British - 14%, White British - 5%). However, as community mental health services develop and we embed the 'transformed' models of care we expect that there will be a smaller and smaller proportion of people (across all ethnicities) who will have an inpatient admission without prior contact with community mental health services. We will be focusing on increasing access to our 'transformed' models of community mental health services and if successful for Milton Keynes we will be piloting community 24/7 provision.	March 2025
As part of focusing on the key elements of the inpatient pathway (Purposeful admissions, therapeutic inpatient care, proactive discharge planning an effective post-discharge support) we will be focusing on length of stay. The latest data is show this as being 9 for adult length of staff > 60 days (The ambition is 8) and for older adults length of stay > 90 days as being 9 (The ambition is 8). We will be particularly focusing on reviewing and implementing elements of the 3 key stages of the acute in-	March 2025

patient pathway which we need to progress locally: From the point of presentation to within 72 hours of admission: 1. Holistic assessment conducted to understand the person's needs. This assessment should build on information contained within the person's electronic patient record (EPR), including any recorded advanced choices and reasonable adjustments. 2. Decision reached, considering as fully as possible the person's preferences, including any advanced choice documents (ACDs), those of their chosen carer/s, and the views of relevant partner services, that the person's needs can only be met in an inpatient setting and cannot be supported in the community. For people with a learning disability and autistic people, a care, education, and treatment review C(E)TR should take place pre-admission to support this decision (or if this is not possible, within 28 days of admission). 3. Purpose of admission discussed and agreed with the person and their chosen carer/s and uploaded to the person's electronic patient record (EPR). 4. Prompt access facilitated to the most suitable hospital provision available for the person's needs. 5. Formulation review completed to gain an in-depth understanding of the person, the circumstances leading up to their admission and what will help them to recover. This, together with recorded ACDs and the findings of a C(E)TR (for people with a learning disability and autistic people), should be used as the basis to co-develop a personalised care plan with the person and their chosen carer/s, which should then be uploaded to the person's EPR. 6. Discharge planning begun with the person and their chosen carer/s, including identifying any factors that could delay discharge (e.g., housing, social care), agreeing an estimated date of discharge (EDD) and an intended discharge destination, and uploading these to the person's EPR. 7. Interventions and treatment for physical and mental health conditions commenced or maintained, and a physical health check completed. During the hospital stay: 1. Daily reviews (e.g., using the Red to Green approach) completed to check the person is receiving prompt access to the assessments, interventions and treatment they require, in line with their purpose of admission and care plan. Assessments, intervention, and treatment should be adapted to meet reasonable adjustments and the needs of people from groups who experience health inequalities. 2. Purpose of admission, care plan, discharge plan and EDD reviewed and updated regularly with the person and their chosen carer/s. If the purpose of admission is close to being met, additional focus should be given to discharge planning. 3. Any factors that could delay discharge, (e.g., the need for step down provision, home adaptations, housing, supported living or care home placement) reviewed every two to three days and proactively addressed with partner services. 4. Monitoring visits completed by commissioners every eight weeks for adults with a learning disability and autistic people, and every six weeks	

for young people aged up to 25, who have an Education, Health, and Care (EHC) plan. At and following discharge: 1. Person centred discharge plan refined with the person and their chosen carer/s. The plan should set out who is responsible for providing the assessments, interventions, and treatments that the person will receive after leaving hospital and when the person can expect this support. 2. Discharge facilitated promptly once a decision is reached that the person is clinically ready for discharge (CRFD) (i.e., the person does not require any further assessments, interventions and/or treatments, which can only be provided in the current inpatient setting), and that it is possible to discharge them (i.e. because the planned discharge support is available at that time). If a person is CRFD, but it is not possible to discharge them, they should continue receiving interventions, activities and support in hospital so that they remain CRFD and can be discharged as soon as planned support is in place. 3. At least 48 hours' notice of the decision to discharge given to the person, their chosen carer/s and any services (e.g., community based mental health and learning disability teams, Crisis Resolution Home Treatment Teams (CRHTTs), housing services, social services) that will be involved in the persons ongoing care. 4. Risk assessment updated and uploaded to the person's EPR which includes information on how any risks to self or others will be managed once the person is discharged. 5. Follow up meeting arranged pre-discharge, including providing written details of when, where and who the follow up will take place with. 6. Clear information provided to the person and their chosen carer/s about how to access crisis support after discharge (including direct contact details for CRHTT) 7. Prompt access provided to all planned post discharge support including in the person's discharge plan. The person should also be supported to develop advanced choice documents and a crisis plan. 8. Follow up completed (face to face wherever possible) within 72 hours of discharge for all adults discharged (NB this has been included in the NHS Standard Contract since 2020/21). If the follow up indicates additional support is required, action is taken promptly to put this in place. 9. Relevant information relating to a person's discharge (which may include a copy of the person's discharge plan) shared with the services involved in the person's ongoing care and treatment. Discharge summary shared with the persons GP and other relevant parties, where appropriate, within a week of discharge. 10. Multi-Agency Discharge Events used where there are complex discharges requiring agreement across multiple partners and follow locally agreed escalation procedures where there are concerns about delayed discharges.	
As part of implementing effective post-discharge support we will continue to focus on the follow up within 72 hrs of discharge. The latest data is showing this as being 91% (The ambition is 80%)	March 2025

One of the areas of focus will be improving the physical health of people with severe mental illness across the pathway which is a key area of focus to address mental health inequalities (Core20Plus5). Uptake of the annual physical health checks will support with this with BLMK currently showing as being at 53% with an ambition to achieve 60% by the end of March 2025. We will also be exploring how we can develop opportunities for patients to have a greater range of choice to access physical activities whilst being on an in-patient ward.	March 2025
There will be a focus on embedding anti-racism through the Patient and Carer Race Equality Framework. This will particularly focus on leadership and governance, national organisational competencies and patient and carer feedback mechanisms.	March 2025
We will start to implement the Culture of Care Standards. These core commitments are: 1. Lived experience: We value lived experience, including in paid roles, at all levels – design, delivery, governance and oversight 2. Safety: People on our wards feel safe and cared for 3. Relationships: High-quality, rights-based care starts with trusting relationships and the understanding that connecting with people is how we help everyone feel safe 4. Staff support: We support all staff so that they can be present alongside people in their distress. 5. Equality: We are inclusive and value difference; we take action to promote equity in access, treatment and outcomes 6. Avoiding harm: We actively seek to avoid harm and traumatisation, and acknowledge harm when it occurs 7. Needs led: We respect people's own understanding of their distress 8. Choice: Nothing about me without me – we support the fundamental right for patients and (as appropriate) their support network to be engaged in all aspects of their care 9. Environment: Our inpatient spaces reflect the value we place on our people 10. Things to do on the ward: We have a wide range of patient requested activities everyday 11. Therapeutic support: We offer people a range of therapy and support that gives them hope things can get better 12. Transparency: We have open and honest conversations with patients and each other, and name the difficult things	March 2025
We will start to implement the 10 key actions within the Sexual Safety in Healthcare Charter which was launched by NHS England in September 2023 which includes taking a zero-tolerance approach to any unwanted, inappropriate or harmful sexual behaviours within the workplace.	March 2025
We will be focusing on detentions under the Mental Health Act and in particular where there is a higher percentage of people who are detained from a particular ethnic group compared to the proportion of people from that ethnic group in the population (BLMK data - 'Black/Black British' - 10.8% of detained population against 6.8% of actual population, 'Mixed'- 8% of detained population against 3.9% of the actual population). There is currently consideration to join the main phase of the 'Putting into practice the principles of the Mental Health Act reforms: A national QI programme'.	March 2025

The programme will provide expert QI coaching to 37 NHS trust-run inpatient services in England throughout 2024/25, with the aim of improving the equity of experience for people from ethnically diverse backgrounds and people with a learning disability & autistic people when detained under the Mental Health Act in hospitals across England, including improving the cultural appropriateness of care they receive. We will also be continuing to implement Right Care Right Person which will be incorporated in our new local model.	
We will be focusing on improving the environment of our in-patient provision so as to improve quality and safety. In Bedfordshire and Luton there is currently work being progressed with the Section 136 provision.	March 2025
We are experiencing particular challenges with housing across Bedfordshire, Luton and Milton Keynes and this will continue to be an area of focus to improve the in-patient pathway. On the 15th of June a BLMK mental health supported accommodation pathway event was held to progress with improving the housing pathways. Luton and Milton Keynes have been identified as 'high need' areas in relation to rough sleeping and so there will continue to be a focus on improving mental health support for rough sleepers. In Milton Keynes there will be a focus on improving patient flow by supporting patients with moving on from supported accommodation by providing both financial and practical support to enable patients to move towards successful independence in the community. The pilot will support 4 mental health service users initially, currently in funded supported accommodation placements, to move into self-contained independent accommodation. The project will provide financial support for a 2 year period alongside a programme of holistic practical and emotional support. The programme, in summary is set out as follows: Financial – housing benefit top up for 2 years, to enable Service User's to afford independent accommodation in a competitive Milton Keynes market. This will be funded via CNWL but accessed via the MKC housing team. Vocational – via CNWL's Individual Placement and Support Team to provide support to gain employment, where necessary through first accessing pre-employment training/ development. The aim is to have clients in paid employment within 18-24 months. Case Management - via the CNWL placements team – support activities of daily living, including practical tasks of maintaining accommodation alongside support to maintain emotional wellbeing and good mental health. The team will access support from health and care colleagues as required. Clients will be: • Under 35 and in a funded placement • Committed to working towards paid employment, so are able to take over rent top-up at the end of the 2-year period Outcomes: Clients will secure stable accommodation, which they are able to maintain after the 2-year financial support ends Clients are able to maximise their recovery and live the most independent high quality of life possible as measured against 4 recovery areas.	March 2025

As part of implementing our reimagined model we will be particularly focusing on improving care and support for carers, young adults, older adults and people who use drugs and/or alcohol. 1. Carers - Our focus will be on improving support and communication with carers so as to prevent carer breakdown and to also improve effective post-discharge support for the patient so that carers feel supported in the community. 2. Young adults - We will be particularly focusing on improving support for young adults (18 to 25 age group) which includes: • young people who transition from children and young people's mental health services (CYPMHS) and are accepted by adult mental health services • those who do not meet the criteria for adult mental health services but have continuing needs and require care • People who may have tried to access CYPMH but been unable to do so • people presenting for the first time High risk groups that have been identified are children from care, SEND, physical illness, homeless, young offenders, self-harm and students. 3. Older adults - We will be focussing on improving support for older adults by addressing the following barriers that have been identified: Perception – In some cases older people may believe that psychological therapies are not relevant or helpful in addressing their problems – on occasion this may be a view supported by health and social care professionals who work alongside them. Some older people could be worried about the NHS having "enough resources" to treat them or think that lots of younger people might need help more. • Practical barriers – Mobility and sensory problems that are more common in older people may require special consideration by mental health services about the venue, timing, and format of service delivery. • Confidence – of staff, who can be less sure in working with older adults • Exclusions – Some services are established to particularly focus on working age adults and the needs of older people are not actively considered, nor sufficient efforts made to encourage increased access. In addition we will be improving care for adults who also experience memory difficulties. 4. People who use drugs and/or alcohol - People who use drugs and/or alcohol often do not attend hospitals or health and social care appointments due to experiences of being judged or negative attitudes from health and social care staff. This arguably contributes to the health inequalities seen among this population. Improved multi-agency working is clearly needed for people who use drugs and/or alcohol, with a move away from the notion that they and their needs can and should be met by only one part of the health and care system. Therefore, we will be focusing on addressing gaps in provision for people with co-occurring needs relating to mental health, drugs and alcohol and improving their care and experience.	March 2025
In Bedfordshire and Luton as part of implementing the key elements of the inpatient pathway (Purposeful admissions, therapeutic inpatient care, proactive discharge planning and effective post-discharge support) there is an ambition to reduce private sector bed usage to zero. There are a	March 2025

number of schemes that are being considered to be taken forward which include the development of a High Intensity User Scheme (Admission avoidance) and a Crisis House (Admission avoidance)	
There will be a particular focus on improving therapeutic in-patient care across BLMK. This will mean enabling our local residents to be consistently able to access a choice of therapeutic support, and to be and feel safe. We will also be working to ensure that inpatient care is trauma informed, autism informed and culturally competent. We will continue to explore opportunities to develop our multi-disciplinary teams such as expanding peer support and other roles such as psychology as well as the skill mix of the teams. We will also explore opportunities for new ways of working such as new digital technologies that could improve patient care and safety. One of the areas that we will be focusing on is improving staff health and well-being and continuing to develop their skills and knowledge through supervision and training opportunities. We will also have consistent and safe staffing levels. We understand the harm some of our practices can cause – for example, sectioning, restraint, seclusion and coercion – and that they can compound people's previous trauma, oppression and/or experience of racism. We will focus on using least restrictive practices and only use them as a last resort, proportionately and in line with the law. We will enable reflection between staff and patients about the way we use restrictive practices. We will focus on implementing an understanding across our staff that both action and inaction can be harmful, and seek never to neglect people and that we do not exclude based on diagnosis and we do not misuse the Mental Capacity Act (2005) to deny access to support. Our focus will be on reducing our use of restrictive practices for all patients, keeping under close review patient groups that we know are at greater risk of avoidable harm such as those subject to restraint inequality. These include trauma survivors, people who have been given a diagnosis of personality disorder, autistic people, people with a learning disability, people from racialised communities and people from LGBTQ+ communities. We will be continuing to take forward the NHS Long Term Workforce Plan objectives which focus on train, retain and reform. 1. Train - Increase education and training and increase apprenticeships and alternative routes into professional roles to deliver more doctors and nurses, and more of other professional groups and increasing new roles designed to meet patient's changing needs and support the ongoing transformation of care. 2. Retain - NHS Organisations ensure and keep more staff within the health service by better-supporting people throughout their careers and boosting flexibility and offering staff to work in ways that suit them and continue to improve the culture and leadership across NHS organisations. 3. Reform - Improving productivity by working and training differently, building broader teams with flexible skills and changing education and training to deliver more staff in roles and services where needed most. We will also ensure that staff have the right skills to take advantage of new technology that frees up clinician's time to care.	March 2025

Year 2 – Action	Target date
During the second year we will continue to focus on implementing improvements to the quality and safety of care people experience in mental health inpatient settings across BLMK through our new bold, radical and reimagined model of care. There will continue to be co-production with people with lived experience of inpatient services and their families; nurses, psychiatrists, psychologists, allied health professionals and other staff who work in inpatient settings at various levels of the different organisations including wider partners such as Local Authority organisations and voluntary sector organisations. Our local plan's ambition is to meet the needs of our local residents and to address inequalities across BLMK.	March 2026
As part of implementing our local plan we will continue to focus on eliminating out of area placements. As part of improving flow and pathways we will be focusing on the mental health waiting times standards - Urgent and emergency mental health - 1. All age referrals to liaison psychiatry services from A and E contacts within 1 hr 2. All Age Very Urgent referrals to community crisis services contacts within 4hrs 3. All age urgent referrals to community crisis services contacts within 24 hrs. Non-urgent adult community-based mental health services waiting times standards - Longest waits still waiting data as well as 2+ contacts recorded in four weeks	March 2026
As part of increasing access to community mental health support we will continue to focus on looking at inpatient admissions for people who have had no previous contact with community mental health services in the year prior to their admission, with a focus on inequalities of experience by ethnic minorities. As community mental health services develop and we embed the 'transformed' models of care we expect that there will be a smaller and smaller proportion of people (across all ethnicities) who will have an inpatient admission without prior contact with community mental health services. We will be focusing on increasing access to our 'transformed' models of community mental health services and if successful for Milton Keynes we will be piloting community 24/7 provision.	March 2026
As part of focusing on the key elements of the inpatient pathway (Purposeful admissions, therapeutic inpatient care, proactive discharge planning and effective post-discharge support) we will continue to focus on length of stay.	March 2026
As part of implementing effective post-discharge support we will continue to focus on the follow up within 72 hrs of discharge.	March 2026
One of the areas of focus will be improving the physical health of people with severe mental illness across the pathway which is a key area of focus to address mental health inequalities (Core20Plus5). Uptake of the annual physical health checks will support with this. We will also be exploring how we can develop opportunities for patients to have a greater range of choice to access physical activities whilst being on an in-patient ward.	March 2026
There will be a focus on embedding anti-racism through the Patient and Carer Race Equality Framework. This will particularly focus on leadership and governance, national organisational competencies and patient and carer feedback mechanisms.	March 2026

We will continue to implement the Culture of Care Standards. These core commitments are: 1. Lived experience: We value lived experience, including in paid roles, at all levels – design, delivery, governance and oversight 2. Safety: People on our wards feel safe and cared for 3. Relationships: High-quality, rights-based care starts with trusting relationships and the understanding that connecting with people is how we help everyone feel safe 4. Staff support: We support all staff so that they can be present alongside people in their distress. 5. Equality: We are inclusive and value difference; we take action to promote equity in access, treatment and outcomes 6. Avoiding harm: We actively seek to avoid harm and traumatisation, and acknowledge harm when it occurs 7. Needs led: We respect people's own understanding of their distress 8. Choice: Nothing about me without me – we support the fundamental right for patients and (as appropriate) their support network to be engaged in all aspects of their care 9. Environment: Our inpatient spaces reflect the value we place on our people 10. Things to do on the ward: We have a wide range of patient requested activities everyday 11. Therapeutic support: We offer people a range of therapy and support that gives them hope things can get better 12. Transparency: We have open and honest conversations with patients and each other, and name the difficult things	March 2026
We will continue to implement the 10 key actions within the Sexual Safety in Healthcare Charter which was launched by NHS England in September 2023 which includes taking a zero-tolerance approach to any unwanted, inappropriate or harmful sexual behaviours within the workplace.	March 2026
We will continue to focus on detentions under the Mental Health Act and in particular where there is a higher percentage of people who are detained from a particular ethnic group compared to the proportion of people from that ethnic group in the population. We will also be continuing to implement Right Care Right Person which will be incorporated in our new local model.	March 2026
We will be focusing on improving the environment of our in-patient provision so as to improve quality and safety.	March 2026
We will be continuing to focus on housing and the BLMK mental health supported accommodation pathway.	March 2026
As part of implementing our reimagined model we will be particularly focusing on improving care and support for carers, young adults, older adults and people who use drugs and/or alcohol. 1. Carers - Our focus will be on improving support and communication with carers so as to prevent carer breakdown and to also improve effective post-discharge support for the patient so that carers feel supported in the community. 2. Young adults - We will be particularly focusing on improving support for young adults (18 to 25 age group) which includes:	March 2026

• young people who transition from children and young people's mental health services (CYPMHS) and are accepted by adult mental health services • those who do not meet the criteria for adult mental health services but have continuing needs and require care • People who may have tried to access CYPMH but been unable to do so • people presenting for the first time High risk groups that have been identified are children from care, SEND, physical illness, homeless, young offenders, self-harm and students. 3. Older adults - We will be focussing on improving support for older adults by addressing the following barriers that have been identified: Perception – In some cases older people may believe that psychological therapies are not relevant or helpful in addressing their problems – on occasion this may be a view supported by health and social care professionals who work alongside them. Some older people could be worried about the NHS having "enough resources" to treat them or think that lots of younger people might need help more. • Practical barriers – Mobility and sensory problems that are more common in older people may require special consideration by mental health services about the venue, timing, and format of service delivery. • Confidence – of staff, who can be less sure in working with older people • Exclusions – Some services are established to particularly focus on working age adults and the needs of older people are not actively considered, nor sufficient efforts made to encourage increased access. In addition we will be improving care for adults who also experience memory difficulties. 4. People who use drugs and/or alcohol - People who use drugs and/or alcohol often do not attend hospitals or health and social care appointments due to experiences of being judged or negative attitudes from health and social care staff. This arguably contributes to the health inequalities seen among this population. Improved multi-agency working is clearly needed for people who use drugs and/or alcohol, with a move away from the notion that they and their needs can and should be met by only one part of the health and care system. Therefore, we will be focusing on addressing gaps in provision for people with co-occurring needs relating to mental health, drugs and alcohol and improving their care and experience.	
In Bedfordshire and Luton as part of implementing the key elements of the inpatient pathway (Purposeful admissions, therapeutic inpatient care, proactive discharge planning and effective post-discharge support) there is an ambition to reduce private sector bed usage to zero. There are a number of schemes that are being considered to be taken forward which include the development of a High Intensity User Scheme (Admission avoidance) and a Crisis House (Admission avoidance). In Milton Keynes, in year 2 there will be a focus on improving flow by working with existing placement providers to offer two dedicated beds for step down from TOPAS (older adult assessment service). These beds will be part of existing plans with MKCC to jointly commission. Funding will provide additional, specialist training to placement staff to care for older adults with severe mental illness with possible comorbid physical health conditions. This will improve flow from acute OA wards,	March 2026

reducing unnecessary delays to discharge. There may be the requirement also to fund voids (empty beds) at the beginning of the contract if patients are not ready to be discharged from TOPAS at the point of contract commencing.	
There will be a particular focus on improving therapeutic in-patient care across BLMK. This will mean enabling our local residents to be consistently able to access a choice of therapeutic support, and to be and feel safe. We will also be working to ensure that inpatient care is trauma informed, autism informed and culturally competent. We will continue to explore opportunities to develop our multi-disciplinary teams such as expanding peer support and other roles such as psychology as well as the skill mix of the teams. We will also explore opportunities for new ways of working such as new digital technologies that could improve patient care and safety. One of the areas that we will be focusing on is improving staff health and well-being and continuing to develop their skills and knowledge through supervision and training opportunities. We will also have consistent and safe staffing levels. We understand the harm some of our practices can cause – for example, sectioning, restraint, seclusion and coercion – and that they can compound people's previous trauma, oppression and/or experience of racism. We will focus on using the least restrictive practices and only use them as a last resort, proportionately and in line with the law. We will enable reflection between staff and patients about the way we use restrictive practices. We will focus on implementing an understanding across our staff that both action and inaction can be harmful, and seek never to neglect people and that we do not exclude based on diagnosis and we do not misuse the Mental Capacity Act (2005) to deny access to support. Our focus will be on reducing our use of restrictive practices for all patients, keeping under close review patient groups that we know are at greater risk of avoidable harm such as those subject to restraint inequality. These include trauma survivors, people who have been given a diagnosis of personality disorder, autistic people, people with a learning disability, people from racialised communities and people from LGBTQ+ communities. We will be continuing to take forward the NHS Long Term Workforce Plan objectives which focus on train, retain and reform. 1. Train - Increase education and training and increase apprenticeships and alternative routes into professional roles to deliver more doctors and nurses, and more of other professional groups and increasing new roles designed to meet patient's changing needs and support the ongoing transformation of care. 2. Retain - NHS Organisations ensure and keep more staff within the health service by better-supporting people throughout their careers and boosting flexibility and offering staff to work in ways that suit them and continue to improve the culture and leadership across NHS organisations. 3. Reform - Improving productivity by working and training differently, building broader teams with flexible skills and changing education and training to deliver more staff in roles and services where needed most. We will also ensure that staff have the right skills to take advantage of new technology that frees up clinician's time to care.	March 2026

Year 3 – Actions	Target date
During the third year we will continue to focus on implementing improvements to the quality and safety of care people experience in mental health inpatient settings across BLMK through the reimagined model of care.	March 2027
As part of implementing our local plan we will be focusing on eliminating out of area placements. As part of improving flow and pathways we will be focusing on the mental health waiting times standards - Urgent and emergency mental health - 1. All age referrals to liaison psychiatry services from A and E contacts within 1 hr 2. All Age Very Urgent referrals to community crisis services contacts within 4hrs 3. All age urgent referrals to community crisis services contacts within 24 hrs. Non-urgent adult community-based mental health services waiting times standards - Longest waits still waiting data and 2+ contacts recorded in four weeks in March 2024	March 2027
As part of increasing access to community mental health support we will be focusing on looking at inpatient admissions for people who have had no previous contact with community mental health services in the year prior to their admission, with a focus on inequalities of experience by ethnic minorities. As community mental health services develop and we embed the 'transformed' models of care we expect that there will be a smaller and smaller proportion of people (across all ethnicities) who will have an inpatient admission without prior contact with community mental health services.	March 2027
As part of focusing on the key elements of the inpatient pathway (Purposeful admissions, therapeutic inpatient care, proactive discharge planning and effective post-discharge support) we will be focusing on length of stay.	March 2027
As part of implementing effective post-discharge support we will continue to focus on the follow up within 72 hrs of discharge.	March 2027
One of the areas of focus will be improving the physical health of people with severe mental illness across the pathway which is a key area of focus to address mental health inequalities (Core20Plus5). Uptake of the annual physical health checks will support with this. We will also be exploring how we can develop opportunities for patients to have a greater range of choice to access physical activities whilst being on an in-patient ward.	March 2027
There will be a focus on embedding anti-racism through the Patient and Carer Race Equality Framework. This will particularly focus on leadership and governance, national organisational competencies and patient and carer feedback mechanisms.	March 2027
We will continue to implement the Culture of Care Standards. These core commitments are: 1. Lived experience: We value lived experience, including in paid roles, at all levels – design, delivery, governance and oversight 2. Safety: People on our wards feel safe and cared for 3. Relationships: High-quality, rights-based care starts with trusting relationships and the understanding that connecting with people is how we help everyone feel safe	March 2027

4. Staff support: We support all staff so that they can be present alongside people in their distress. 5. Equality: We are inclusive and value difference; we take action to promote equity in access, treatment and outcomes 6. Avoiding harm: We actively seek to avoid harm and traumatisation, and acknowledge harm when it occurs 7. Needs led: We respect people's own understanding of their distress 8. Choice: Nothing about me without me – we support the fundamental right for patients and (as appropriate) their support network to be engaged in all aspects of their care 9. Environment: Our inpatient spaces reflect the value we place on our people 10. Things to do on the ward: We have a wide range of patient requested activities everyday 11. Therapeutic support: We offer people a range of therapy and support that gives them hope things can get better 12. Transparency: We have open and honest conversations with patients and each other, and name the difficult things	
We will continue to implement the 10 key actions within the Sexual Safety in Healthcare Charter which was launched by NHS England in September 2023 which includes taking a zero-tolerance approach to any unwanted, inappropriate or harmful sexual behaviours within the workplace.	March 2027
We will continue to focus on detentions under the Mental Health Act and in particular where there is a higher percentage of people who are detained from a particular ethnic group compared to the proportion of people from that ethnic group in the population. We will also be continuing to implement Right Care Right Person which will be incorporated in our new local model.	March 2027
We will be focusing on improving the environment of our in-patient provision so as to improve quality and safety.	March 2027
We will continue to focus on improving our mental health pathway.	March 2027
As part of implementing our reimagined model we will be particularly focusing on improving care and support for carers, young adults, older adults and people who use drugs and/or alcohol. 1. Carers - Our focus will be on improving support and communication with carers so as to prevent carer breakdown and to also improve effective post-discharge support for the patient so that carers feel supported in the community. 2. Young adults - We will be particularly focusing on improving support for young adults (18 to 25 age group) which includes: • young people who transition from children and young people's mental health services (CYPMHS) and are accepted by adult mental health services • those who do not meet the criteria for adult mental health services but have continuing needs and require care • People who may have tried to access CYPMH but been unable to do so • people presenting for the first time High risk groups that have been identified are children from care, SEND, physical illness, homeless, young offenders, self-harm and students. 3. Older adults - We will be focussing on improving support for older adults by addressing the following barriers that have been identified: Perception	March 2027

– In some cases older people may believe that psychological therapies are not relevant or helpful in addressing their problems – on occasion this may be a view supported by health and social care professionals who work alongside them. Some older people could be worried about the NHS having “enough resources” to treat them or think that lots of younger people might need help more. • Practical barriers – Mobility and sensory problems that are more common in older people may require special consideration by mental health services about the venue, timing, and format of service delivery. • Confidence – of staff, who can be less sure in working with older people • Exclusions – Some services are established to particularly focus on working age adults and the needs of older people are not actively considered, nor sufficient efforts made to encourage increased access. In addition we will be improving care for adults who also experience memory difficulties. 4. People who use drugs and/or alcohol - People who use drugs and/or alcohol often do not attend hospitals or health and social care appointments due to experiences of being judged or negative attitudes from health and social care staff. This arguably contributes to the health inequalities seen among this population. Improved multi-agency working is clearly needed for people who use drugs and/or alcohol, with a move away from the notion that they and their needs can and should be met by only one part of the health and care system. Therefore, we will be focusing on addressing gaps in provision for people with co-occurring needs relating to mental health, drugs and alcohol and improving their care and experience.	
In Bedfordshire and Luton as part of implementing the key elements of the inpatient pathway (Purposeful admissions, therapeutic inpatient care, proactive discharge planning and effective post-discharge support) there is an ambition to reduce private sector bed usage to zero. There are a number of schemes that are being considered to be taken forward which include the development of a High Intensity User Scheme (Admission avoidance) and a Crisis House (Admission avoidance)	March 2027
There will be a particular focus on improving therapeutic in-patient care across BLMK. This will mean enabling our local residents to be consistently able to access a choice of therapeutic support, and to be and feel safe. We will also be working to ensure that inpatient care is trauma informed, autism informed and culturally competent. We will continue to explore opportunities to develop our multi-disciplinary teams such as expanding peer support and other roles such as psychology as well as the skill mix of the teams. We will also explore opportunities for new ways of working such as new digital technologies that could improve patient care and safety. One of the areas that we will be focusing on is improving staff health and well-being and continuing to develop their skills and knowledge through supervision and training opportunities. We will also have consistent and safe staffing levels. We understand the harm some of our practices can cause – for example, sectioning, restraint, seclusion and coercion – and that they can compound people’s previous trauma, oppression and/or experience of racism. We will focus to use the least restrictive practices and only use them as a last resort, proportionately and in line with the law. We will enable reflection between staff and	March 2027

patients about the way we use restrictive practices. We will focus on implementing an understanding across our staff that both action and inaction can be harmful, and seek never to neglect people and that we do not exclude based on diagnosis and we do not misuse the Mental Capacity Act (2005) to deny access to support. Our focus will be on reducing our use of restrictive practices for all patients, keeping under close review patient groups that we know are at greater risk of avoidable harm such as those subject to restraint inequality. These include trauma survivors, people who have been given a diagnosis of personality disorder, autistic people, people with a learning disability, people from racialised communities and people from LGBTQ+ communities. We will be continuing to take forward the NHS Long Term Workforce Plan objectives which focus on train, retain and reform. 1. Train - Increase education and training and increase apprenticeships and alternative routes into professional roles to deliver more doctors and nurses, and more of other professional groups and increasing new roles designed to meet patient's changing needs and support the ongoing transformation of care. 2. Retain - NHS Organisations ensure and keep more staff within the health service by better-supporting people throughout their careers and boosting flexibility and offering staff to work in ways that suit them and continue to improve the culture and leadership across NHS organisations. 3. Reform - Improving productivity by working and training differently, building broader teams with flexible skills and changing education and training to deliver more staff in roles and services where needed most. We will also ensure that staff have the right skills to take advantage of new technology that frees up clinician's time to care.	

Adult Mental Health Rehabilitation In-Patient Services

The Adult Mental Health Rehabilitation In-Patient Services guidance describes the principles of adult mental health rehabilitation inpatient services as being:

- Embedded in a local comprehensive mental healthcare service.
- Provide a recovery-orientated approach that has a shared ethos and agreed goal, sense of hope and optimism, and aims to reduce stigma.
- Deliver individualised, person-centred care through collaboration and shared decision-making with service users and their carers involved.
- Be offered in the least restrictive environment and aim to help people progress from more intensive support to greater independence through a rehabilitation pathway.
- Recognise that not everyone returns to the same level of independence they had before their illness and may require supported accommodation (such as residential care, supported housing or floating outreach) in the long term.

It describes the following areas for assessment, admission, care and treatment:

- Referrals made to hospitals should clearly state the reason for admission and what the mental health rehabilitation needs are to support an appropriate assessment by the inpatient team. Admissions should be planned, and undertaking pre-admission assessments is considered good practice.

- The purpose of admission, specific interventions required, anticipated length of stay and estimated date of discharge should be agreed collaboratively. This should be at the earliest opportunity and with the person, their family and carers, the inpatient multi-disciplinary team, community team and commissioner. This information should be clearly articulated to provide clarity of what is expected from the admission for all of those involved.
- All multidisciplinary ward rounds, Care Programme Approach meetings and Care Education and Treatment Reviews must be centred around the person and where possible enabling the person to lead their own meeting. The purpose of admission, specific interventions required, expected length of stay and estimated date of discharge should be regularly reviewed. Any changes to the original position should be clearly documented with reasons for the changes.
- The therapeutic offer should be holistic, needs led, trauma informed and diverse.
- Activities and leave from the ward should be planned individually and should consider functional skill development that is relevant to each person. Access should be seven days a week and not only during the day but also include evenings.
- Vocational and employment opportunities are very important, with an emphasis on appropriately knowledgeable and skilled staff educating and supporting people, thinking about new ideas and options.
- Returning to their previous occupation is not an option for many people using mental health rehabilitation services. Therefore, being able to think about how skills might be transferrable is something that is emphasised in terms of recovery.
- Co-facilitation of activities and groups by people and staff is described positively by those leading sessions and those attending. There are many examples of different groups on the wards that were regularly led by people themselves.
- Peer support should be encouraged, making friends in services is very important to people, and their families and carers.
- People who need it, must be able to access appropriate support in relation to substance misuse, whilst they are in a mental health rehabilitation service.
- Physical exercise options need to be individually planned and varied. They need to be available on and off the ward, accessing these in the local community is viewed positively.
- Primary and secondary health needs should be understood and met. Support while in hospital, and a better understanding of how to manage their physical healthcare in the community was valued.

‘Locked rehabilitation’

The Commissioning framework for mental health inpatient services highlights the following in relation to ‘locked rehabilitation’ which we will be focusing on as part of the delivery of our plan:

‘It is important to note that services described as ‘locked rehabilitation’ are not mental health rehabilitation services and that these locked services remain a concern, as illustrated by these quotes:

‘More than 50 years after the movement to close asylums and large institutions, we were concerned to find examples of outdated and sometimes institutionalised care. We are particularly concerned about the high number of people in ‘locked rehabilitation wards’….In

the 21st century a hospital should never be considered 'home' for people with a mental health condition' (CQC 2017)

'Too often, locked rehabilitation wards are in fact long stay wards that institutionalise rather than rehabilitate people and that such wards are against the least restrictive principle and potentially represents a breach of human rights'. (CQC 2020)

'I was put somewhere and left; I was forgotten about!' (A person in a mental health rehabilitation service).

Similarly, the Royal College of Psychiatrists has expressed its increasing concern about the use of locked rehabilitation wards, a term not recognised by the Rehabilitation or Social Psychiatry Faculty…'there remain concerns about the high number of wards continuing to identify as 'locked rehabilitation'. This goes against the least restrictive principle that mental health services should be using' (CQC 2020).

The case for change in relation to 'locked rehabilitation' services is clear and in future, the commissioning of services described as such should cease.'

Our local vision for adult mental health rehabilitation in-patient services

Our Bedfordshire, Luton and Milton Keynes vision for adult mental health rehabilitation in-patient services is:

'By the end of year 3 we will have strengthened our BLMK approach to recovery from mental ill health so that we maximise our local residents quality of life and social inclusion. We will be focusing on promoting individuals independence and autonomy in order to give individuals hope for the future which will lead to successful community living through appropriate support. We will be focusing on a joined-up rehabilitation pathway where adult mental health rehabilitation inpatient services are embedded within our local mental healthcare services. By the end of year 3, our vision is to have implemented improvements to the quality and safety of care people experience across our mental health services which includes our mental health inpatients settings through the new bold, radical and reimagined model of care across Bedfordshire, Luton and Milton Keynes. Central to its development and implementation of our BLMK vision is that it will be co-produced by people with lived experience of inpatient services, and their families; nurses, psychiatrists, psychologists, allied health professionals and other staff who work in inpatient settings or at various levels of the different organisations including wider partners such as Local Authority and voluntary sector organisations. Service users want to feel safe on the ward, they want to be listened to and included in their treatment and care, when they are going to go home, the support they will receive and ultimately helped to feel that they can have a fulfilling life despite their diagnosis. Our local plans ambitions is to meet the needs of our local residents by providing care and support close to home and address inequalities.'

Our 3 year transformation plan is as follows:

Year 1 Actions	**Target date**
We will be reviewing the principles of adult mental health rehabilitation inpatient services which are as follows and will be focusing on those that we need to particularly focus on: 1. Be embedded in a local comprehensive mental healthcare service.	March 2025

2. Provide a recovery-orientated approach that has a shared ethos and agreed goal, sense of hope and optimism, and aims to reduce stigma. 3. Deliver individualised, person-centred care through collaboration and shared decision-making with service users and their carers involved. 4. Be offered in the least restrictive environment and aim to help people progress from more intensive support to greater independence through a rehabilitation pathway. 5. Recognise that not everyone returns to the same level of independence they had before their illness and may require supported accommodation (such as residential care, supported housing or floating outreach) in the long term.	
We will particularly focus on our assessment and admission processes and will review the following areas: 1. Referrals made to hospitals should clearly state the reason for admission and what the mental health rehabilitation needs are to support an appropriate assessment by the inpatient team. 2. Admissions should be planned, and undertaking pre-admission assessments is considered good practice. 3. The purpose of admission, specific interventions required, anticipated length of stay and estimated date of discharge should be agreed collaboratively. This should be at the earliest opportunity and with the person, their family and carers, the inpatient multi-disciplinary team, community team and commissioner. This information should be clearly articulated to provide clarity of what is expected from the admission for all of those involved.	March 2025
We will particularly focus on the care and treatment that we provide and will be reviewing the following elements to identify opportunities that we need to develop further: 1. All multidisciplinary ward rounds, Care Programme Approach meetings and Care Education and Treatment Reviews must be centred around the person and where possible enabling the person to lead their own meeting. The purpose of admission, specific interventions required, expected length of stay and estimated date of discharge should be regularly reviewed. Any changes to the original position should be clearly documented with reasons for the changes. 2. The therapeutic offer should be holistic, needs led, trauma informed and diverse. 3. Activities and leave from the ward should be planned individually and should consider functional skill development that is relevant to each person. Access should be seven days a week and not only during the day but also include evenings. 4. Vocational and employment opportunities are very important, with an emphasis on appropriately knowledgeable and skilled staff educating and supporting people, thinking about new ideas and options. Returning to their previous occupation is not an option for many people using mental health rehabilitation services. Therefore, being able to think about how skills might be transferrable is something that is emphasised in terms of recovery.	March 2025

5. Co-facilitation of activities and groups by people and staff is described positively by those leading sessions and those attending. There are many examples of different groups on the wards that were regularly led by people themselves. 6. Peer support should be encouraged, making friends in services is very important to people, and their families and carers. 7. People who need it, must be able to access appropriate support in relation to substance misuse, whilst they are in a mental health rehabilitation service. 8. Physical exercise options need to be individually planned and varied. They need to be available on and off the ward, accessing these in the local community is viewed positively. 9. Primary and secondary health needs should be understood and met. Support while in hospital, and a better understanding of how to manage their physical healthcare in the community was valued.	

Year 2 Actions	**Target date**
We will continue to focus on implementing the principles of adult mental health rehabilitation inpatient services which are as follows and will be focusing on those that we need to particularly focus on: 1. Be embedded in a local comprehensive mental healthcare service. 2. Provide a recovery-orientated approach that has a shared ethos and agreed goal, sense of hope and optimism, and aims to reduce stigma. 3. Deliver individualised, person-centred care through collaboration and shared decision-making with service users and their carers involved. 4. Be offered in the least restrictive environment and aim to help people progress from more intensive support to greater independence through a rehabilitation pathway. 5. Recognise that not everyone returns to the same level of independence they had before their illness and may require supported accommodation (such as residential care, supported housing or floating outreach) in the long term.	March 2026
We will particularly focus on our assessment and admission processes and will review the following areas: 1. Referrals made to hospitals should clearly state the reason for admission and what the mental health rehabilitation needs are to support an appropriate assessment by the inpatient team. 2. Admissions should be planned, and undertaking pre-admission assessments is considered good practice. 3. The purpose of admission, specific interventions required, anticipated length of stay and estimated date of discharge should be agreed collaboratively. This should be at the earliest opportunity and with the person, their family and carers, the inpatient multi-disciplinary team, community team and commissioner. This information should be clearly articulated to provide clarity of what is expected from the admission for all of those involved.	March 2026
We will particularly focus on the care and treatment that we provide and will be reviewing the following elements to identify opportunities that we need to develop further:	March 2026

1. All multidisciplinary ward rounds, Care Programme Approach meetings and Care Education and Treatment Reviews must be centred around the person and where possible enabling the person to lead their own meeting. The purpose of admission, specific interventions required, expected length of stay and estimated date of discharge should be regularly reviewed. Any changes to the original position should be clearly documented with reasons for the changes. 2. The therapeutic offer should be holistic, needs led, trauma informed and diverse. 3. Activities and leave from the ward should be planned individually and should consider functional skill development that is relevant to each person. Access should be seven days a week and not only during the day but also include evenings. 4. Vocational and employment opportunities are very important, with an emphasis on appropriately knowledgeable and skilled staff educating and supporting people, thinking about new ideas and options. Returning to their previous occupation is not an option for many people using mental health rehabilitation services. Therefore, being able to think about how skills might be transferrable is something that is emphasised in terms of recovery. 5. Co-facilitation of activities and groups by people and staff is described positively by those leading sessions and those attending. There are many examples of different groups on the wards that were regularly led by people themselves. 6. Peer support should be encouraged, making friends in services is very important to people, and their families and carers. 7. People who need it, must be able to access appropriate support in relation to substance misuse, whilst they are in a mental health rehabilitation service. 8. Physical exercise options need to be individually planned and varied. They need to be available on and off the ward, accessing these in the local community is viewed positively. 9. Primary and secondary health needs should be understood and met. Support while in hospital, and a better understanding of how to manage their physical healthcare in the community was valued.	

Year 3 Actions	**Target date**
We will continue to focus on implementing the principles of adult mental health rehabilitation inpatient services which are as follows and will be focusing on those that we need to particularly focus on: 1. Be embedded in a local comprehensive mental healthcare service. 2. Provide a recovery-orientated approach that has a shared ethos and agreed goal, sense of hope and optimism, and aims to reduce stigma. 3. Deliver individualised, person-centred care through collaboration and shared decision-making with service users and their carers involved. 4. Be offered in the least restrictive environment and aim to help people progress from more intensive support to greater independence through a rehabilitation pathway.	March 2027

5. Recognise that not everyone returns to the same level of independence they had before their illness and may require supported accommodation (such as residential care, supported housing or floating outreach) in the long term.	
We will particularly focus on our assessment and admission processes and will review the following areas: 1. Referrals made to hospitals should clearly state the reason for admission and what the mental health rehabilitation needs are to support an appropriate assessment by the inpatient team. 2. Admissions should be planned, and undertaking pre-admission assessments is considered good practice. 3. The purpose of admission, specific interventions required, anticipated length of stay and estimated date of discharge should be agreed collaboratively. This should be at the earliest opportunity and with the person, their family and carers, the inpatient multi-disciplinary team, community team and commissioner. This information should be clearly articulated to provide clarity of what is expected from the admission for all of those involved.	March 2027
We will particularly focus on the care and treatment that we provide and will be reviewing the following elements to identify opportunities that we need to develop further: 1. All multidisciplinary ward rounds, Care Programme Approach meetings and Care Education and Treatment Reviews must be centred around the person and where possible enabling the person to lead their own meeting. The purpose of admission, specific interventions required, expected length of stay and estimated date of discharge should be regularly reviewed. Any changes to the original position should be clearly documented with reasons for the changes. 2. The therapeutic offer should be holistic, needs led, trauma informed and diverse. 3. Activities and leave from the ward should be planned individually and should consider functional skill development that is relevant to each person. Access should be seven days a week and not only during the day but also include evenings. 4. Vocational and employment opportunities are very important, with an emphasis on appropriately knowledgeable and skilled staff educating and supporting people, thinking about new ideas and options. Returning to their previous occupation is not an option for many people using mental health rehabilitation services. Therefore, being able to think about how skills might be transferrable is something that is emphasised in terms of recovery. 5. Co-facilitation of activities and groups by people and staff is described positively by those leading sessions and those attending. There are many examples of different groups on the wards that were regularly led by people themselves. 6. Peer support should be encouraged, making friends in services is very important to people, and their families and carers. 7. People who need it, must be able to access appropriate support in relation to substance misuse, whilst they are in a mental health rehabilitation service.	March 2027

8. Physical exercise options need to be individually planned and varied. They need to be available on and off the ward, accessing these in the local community is viewed positively. 9. Primary and secondary health needs should be understood and met. Support while in hospital, and a better understanding of how to manage their physical healthcare in the community was valued.	

Transforming acute mental health inpatient services for adults with a learning disability and autistic adults

The national guidance to support integrated care boards to commission acute mental health inpatient services for adults with a learning disability and autistic adults highlights that people with a learning disability and autistic people should not be admitted to a mental health hospital unless there is a suspected or identified mental health need requiring inpatient care and support. The draft mental health bill seeks to limit the grounds upon which people with a learning disability and autistic people can be detained in hospital under the Mental Health Act. It is known that people with a learning disability and autistic people have a higher risk of premature mortality often from preventable or treatable mental health and physical health conditions. It is also known that significant contributory factors for this are due to facing additional barriers to receiving health and social care services. It is therefore essential that there are no additional barriers or delays for people with a learning disability and autistic people accessing services for an identified or suspected mental health need, including inpatient services when these are clinically necessary. People with a learning disability and autistic people should have equitable access to such services.

The national guidance to support integrated care boards to commission acute mental health inpatient service for adults with a learning disability and autistic adults highlights that where an acute mental health inpatient admission may be required for an adult with a learning disability or an autistic adult that:

- services have been co-designed by people with lived experience and their families
- care, treatment and support plans are co-produced with people and their families, with appropriate advocacy support
- any admission is appropriately supported by relevant specialists, for a specific indication for a mental health assessment and/or intervention that can only be delivered in an inpatient setting
- any admission is for the minimum time possible, and with timely discharge enabled through effective multi-agency working
- reasonably adjusted, personalised care, support (including advocacy), assessment and intervention is provided
- the admission is, wherever possible, to a general adult/ older adult acute mental health inpatient service and, where this is not possible due to the needs of the person, to an acute mental health inpatient service specifically for adults with a learning disability and autistic adults.

It also highlights that care should be joined up across the health, education, care, and housing system with inpatient services working in a cohesive way with partner organisations, both during a person's inpatient stay and after discharge, so that people are supported to stay well and can further their recovery when they leave hospital. There should be a clear link between community and inpatient services. Before admission to hospital, people may have assessments through teams in the community (whether mental health, learning disability or

autism teams) – including crisis teams and intensive support teams where applicable. This will help to ensure their needs are understood, and they have clear and measurable objectives set for their admission to hospital and receive care in an appropriate environment. One of the key adjustments that can be supported is for community health teams, social care teams and community support providers to form part of the multidisciplinary team that supports someone during their inpatient stay. They can then support the person throughout their admission and after discharge, which enhances continuity of care. It can also enable the sharing of knowledge and transfer of skills between the inpatient mental health and community team.

Our local vision

The Bedfordshire, Luton and Milton Keynes vision is as follows;

"If i feel healthy, I feel positive, I feel happy" The BLMK Learning Disability and Autism Strategy 2023/26 was coproduced with local people and our purpose statement is to work in partnership to reduce inequalities for people with learning disabilities and autistic people by listening to people and increasing awareness of their needs. Our overall aim is to improve access, improve wellbeing outcomes to reduce premature deaths. The five asks include communicate compassionately, offer me reasonable adjustments, break down barriers, put me at the centre of my care and support, keep me well. There were focused groups held across BLMK throughout the spring/summer 2023. In addition to the extensive engagement work done as part of the Denny review, which along with the work of the collaborative, supported the co-production of the strategy identifying assets, needs and I and we statements that formulated a measurable delivery plan over the next three years. We continue to work in partnership to help reduce inequalities for people with learning disabilities and autistic people by working closely with and listening to people and increasing awareness of their needs. Our overall aim is to improve access, improve wellbeing outcomes and reduce premature deaths. As we implement these in this strategy, we will continue to work with and engage people with lived experience, families, carers and with system partners across BLMK.'

Our 3 year plan for learning disabilities is outlined as follows:

Year 1 Actions	**Target date**
Achieve BLMK inpatient performance trajectory target for (ICB adult inpatient beds) across LDA, no more than 12 admissions at any one time, reported monthly using AT data.	March 2025
Completing the Quality Oversight Visits for all adults (LDA) who are admitted in hospital (ICB beds) & include the sit & see element for the CTR/CETR, minimum every 8 weeks. Data to be added to the Assuring Transformation (AT) database and reports run weekly to monitor performance.	March 2025
Comply with the Dynamic support register and Care (Education) and Treatment Review policy and guide (January 2023) and trigger points for adults in non-secure inpatient provision. Report activity through the Assuring Transformation database and by exception, to the BLMK LDA board. Achieve 75% by September and 95% by March for all adults who meet the criteria.	March 2025

Ensure patients who are admitted in a MH acute hospital are offered physical health checks and supported through the KLOEs. BLMK to audit cases and follow up to see if the CTR/CETR recommendations, at point of discharge, are carried to ensure people with an LD have been supported to access their LDAHC if appropriate.	March 2025
Carry out RCA (Root Cause Analysis) for patients with LoS exceeding five years.	March 2025
Market Development - Identify gaps OOA admissions covering adults LDA in non-secure inpatient provision, intelligence to inform ongoing market development work and S117 programme for LDA in BLMK.	March 2025
Self-assess BLMK inpatient service provision (LDA) against: - Five key elements for discharge, supporting people with LDA to leave hospital - Joint guiding principles for ICS - LDA	March 2025
We will focus on our acute mental health inpatient provision developments being co-produced with adults with a learning disability and autistic adults as well as with their families	March 2025
We will focus on ensuring that care, treatment and support plans are co-produced with people and their families, with appropriate advocacy support and any admission is appropriately supported by relevant specialists, for a specific indication for a mental health assessment and/or intervention that can only be delivered in an inpatient setting. We will ensure that any admission is for the minimum time possible, and with timely discharge enabled through effective multi-agency working	March 2025
We will focus on ensuring that reasonable adjustments are implemented including exploring how the environment can be improved.	March 2025
There will be a focus on ensuring that care is joined up across the health, education, care, and housing system with inpatient services working in a cohesive way with partner organisations, both during a person's inpatient stay and after discharge, so that people are supported to stay well and can further their recovery when they leave hospital. There will also be a clear link between community and inpatient services such as with intensive support teams and community support providers.	March 2025
We will continue to focus on staff training such as Oliver McGowan training to improve the quality of care that is delivered	March 2025

Year 2 Actions	**Target date**
Carry out gap and need analysis equitable service across BLMK for community specialist healthcare supporting adults with a learning disability.	March 2026
Achieve BLMK inpatient performance trajectory target for (ICB adult inpatient beds) across LDA, no more than 12 admissions at any one time, reported monthly using AT data.	March 2026
Completing the Quality Oversight Visits for all adults (LDA) who are admitted in hospital (ICB beds) & include the sit & see element for	March 2026

the CTR/CETR, minimum every 8 weeks. Data to be added to the Assuring Transformation (AT) database and reports run weekly to monitor performance.	
Comply with the Dynamic support register and Care (Education) and Treatment Review policy and guide (January 2023) and trigger points for adults in non-secure inpatient provision. Report activity through the Assuring Transformation database and by exception, to the BLMK LDA board. Achieve 75% by September and 95% by March for all adults who meet the criteria.	March 2026
Develop plans for joint working with developments for acute mental health inpatient provision and look to co-produce this with adults with a learning disability and autistic adults as well as with their families	March 2026
Focus on ensuring that care, treatment and support plans are co-produced with people and their families, with appropriate advocacy support and any admission is appropriately supported by relevant specialists, for a specific indication for a mental health assessment and/or intervention that can only be delivered in an inpatient setting. We will ensure that any admission is for the minimum time possible, and with timely discharge enabled through effective multi-agency working	March 2026
We will focus on ensuring that reasonable adjustments are implemented including exploring how the environment can be improved.	March 2026
Develop plans that focus on joined up care across the health, education, care, and housing system with inpatient services with partner organisations, both during a person's inpatient stay and after discharge, so that people are supported to stay well and can further their recovery when they leave hospital. There will also be a clear link between community and inpatient services such as with intensive support teams and community support providers.	March 2026
We will continue to focus on staff training such as Oliver McGowan training to improve the quality of care that is delivered	March 2026
Market Development - Carry out a gap analysis for all OOA admissions covering adults LDA in non-secure inpatient provision, intelligence and information obtained will be used to inform the ongoing market development work and S117 programme for LDA in BLMK.	March 2026

Year 3 Actions	**Target date**
Develop services that will allow for an equitable service across BLMK for community specialist healthcare supporting adults with a learning disability.	March 2027
Achieve BLMK inpatient performance trajectory target for (ICB adult inpatient beds) across LDA, no more than 12 admissions at any one time, reported monthly using AT data.	March 2027
Completing the Quality Oversight Visits for all adults (LDA) who are admitted in hospital (ICB beds) & include the sit & see element for the CTR/CETR, minimum every 8 weeks. Data to be added to the	March 2027

Assuring Transformation (AT) database and reports run weekly to monitor performance.	
Comply with the Dynamic support register and Care (Education) and Treatment Review policy and guide (January 2023) and trigger points for adults in non-secure inpatient provision. Report activity through the Assuring Transformation database and by exception, to the BLMK LDA board. Achieve 75% by September and 95% by March for all adults who meet the criteria.	March 2027
Continue working on plans jointly on acute mental health inpatient provision developments being co-produced with adults with a learning disability and autistic adults as well as with their families	March 2027
We will focus on ensuring that care, treatment and support plans are co-produced with people and their families, with appropriate advocacy support and any admission is appropriately supported by relevant specialists, for a specific indication for a mental health assessment and/or intervention that can only be delivered in an inpatient setting. We will ensure that any admission is for the minimum time possible, and with timely discharge enabled through effective multi-agency working	March 2027
We will focus on ensuring that reasonable adjustments are implemented including exploring how the environment can be improved.	March 2027
There will be a focus on ensuring that care is joined up across the health, education, care, and housing system with inpatient services working in a cohesive way with partner organisations, both during a person's inpatient stay and after discharge, so that people are supported to stay well and can further their recovery when they leave hospital. There will also be a clear link between community and inpatient services such as with intensive support teams and community support providers.	March 2027
We will continue to focus on staff training such as Oliver McGowan training to improve the quality of care that is delivered	March 2027

Our 3 year plan for autism is outlined as follows:

Year 1 Actions	**Target date**
Achieve BLMK inpatient performance trajectory target for (ICB adult inpatient beds) across LDA, no more than 12 admissions at any one time, reported monthly using AT data.	March 2025
Completing the Quality Oversight Visits for all adults (LDA) who are admitted in hospital (ICB beds) & include the sit & see element for the CTR/CETR, minimum every 8 weeks. Data to be added to the Assuring Transformation (AT) database and reports run weekly to monitor performance.	March 2025
Comply with the Dynamic support register and Care (Education) and Treatment Review policy and guide (January 2023) and trigger points for adults in non-secure inpatient provision. Report activity through the Assuring Transformation database and by exception, to the BLMK LDA board. Achieve 75% by September and 95% by March for all adults who meet the criteria.	March 2025

Market Development - Carry out a gap analysis for all OOA admissions covering adults LDA in non-secure inpatient provision, intelligence and information obtained will be used to inform the ongoing market development work and S117 programme for LDA.	March 2025
Carry out RCA (Root Cause Analysis) for readmissions for short term crisis in MK	March 2025
Carry out RCA (Root Cause Analysis) for patients with LoS exceeding five years	March 2025
Review the outcome, impact and benefits from the autism practitioner(s) and autism OT posts over a 12 month period.	March 2025
Self-assess BLMK inpatient service provision (LDA) against: - Five key elements for discharge, supporting people with LDA to leave hospital - Joint guiding principles for ICS - LDA	March 2025
We will focus on our acute mental health inpatient provision developments being co-produced with adults with a learning disability and autistic adults as well as with their families	March 2025
We will focus on ensuring that care, treatment and support plans are co-produced with people and their families, with appropriate advocacy support and any admission is appropriately supported by relevant specialists, for a specific indication for a mental health assessment and/or intervention that can only be delivered in an inpatient setting. We will ensure that any admission is for the minimum time possible, and with timely discharge enabled through effective multi-agency working	March 2025
We will focus on ensuring that reasonable adjustments are implemented including exploring how the environment can be improved.	March 2025
There will be a focus on ensuring that care is joined up across the health, education, care, and housing system with inpatient services working in a cohesive way with partner organisations, both during a person's inpatient stay and after discharge, so that people are supported to stay well and can further their recovery when they leave hospital. There will also be a clear link between community and inpatient services such as with intensive support teams and community support providers.	March 2025
We will continue to focus on staff training such as Oliver McGowan training to improve the quality of care that is delivered	March 2025
ELFT to pick up Autism diagnostic service	March 2025

Year 2 Actions	**Target date**
Achieve BLMK inpatient performance trajectory target for (ICB adult inpatient beds) across LDA, no more than 12 admissions at any one time, reported monthly using AT data.	March 2026
Completing the Quality Oversight Visits for all adults (LDA) who are admitted in hospital (ICB beds) & include the sit & see element for the CTR/CETR, minimum every 8 weeks. Data to be added to the Assuring Transformation (AT) database and reports run weekly to monitor performance.	March 2026

Comply with the Dynamic support register and Care (Education) and Treatment Review policy and guide (January 2023) and trigger points for adults in non-secure inpatient provision. Report activity through the Assuring Transformation database and by exception, to the BLMK LDA board. Achieve 75% by September and 95% by March for all adults who meet the criteria.	March 2026
Market Development - Carry out a gap analysis for all OOA admissions covering adults LDA in non-secure inpatient provision, intelligence and information obtained will be used to inform the ongoing market development work and S117 programme for LDA.	March 2026
Carry out RCA (Root Cause Analysis) for readmissions for short term crisis in MK	March 2026
Carry out RCA (Root Cause Analysis) for patients with LoS exceeding five years	March 2026
Review the outcome, impact and benefits from the autism practitioner(s) and autism OT posts over a 12 month period.	March 2026
Self-assess BLMK inpatient service provision (LDA) against: - Five key elements for discharge, supporting people with LDA to leave hospital - Joint guiding principles for ICS - LDA	March 2026
Continue the focus on our acute mental health inpatient provision developments being co-produced with adults with a learning disability and autistic adults as well as with their families	March 2026
Continue the focus on ensuring that care, treatment and support plans are co-produced with people and their families, with appropriate advocacy support and any admission is appropriately supported by relevant specialists, for a specific indication for a mental health assessment and/or intervention that can only be delivered in an inpatient setting. We will ensure that any admission is for the minimum time possible, and with timely discharge enabled through effective multi-agency working	March 2026
Continue the focus on ensuring that reasonable adjustments are implemented including exploring how the environment can be improved.	March 2026
Continue the focus on ensuring that care is joined up across the health, education, care, and housing system with inpatient services working in a cohesive way with partner organisations, both during a person's inpatient stay and after discharge, so that people are supported to stay well and can further their recovery when they leave hospital. There will also be a clear link between community and inpatient services such as with intensive support teams and community support providers.	March 2026
We will continue to focus on staff training such as Oliver McGowan training to improve the quality of care that is delivered	March 2026
MK Autism Diagnostic Service - development plans	March 2026

Year 3 Actions	Target date
Achieve BLMK inpatient performance trajectory target for (ICB adult inpatient beds) across LDA, no more than 12 admissions at any one time, reported monthly using AT data.	March 2027
Achieve 80% completion by September and 100% by March of completing the Quality Oversight Visits for all adults (LDA) who are admitted in hospital (ICB beds) & include the sit & see element for the CTR/CETR, minimum every 8 weeks. Data to be added to the Assuring Transformation (AT) database and reports run weekly to monitor performance.	March 2027
Comply with the Dynamic support register and Care (Education) and Treatment Review policy and guide (January 2023) and trigger points for adults in non-secure inpatient provision. Report activity through the Assuring Transformation database and by exception, to the BLMK LDA board. Achieve 75% by September and 95% by March for all adults who meet the criteria.	March 2027
Market Development - Service development plans all OOA admissions covering adults LDA in non-secure inpatient provision, intelligence and information obtained will be used to inform the ongoing market development work and S117 programme for LDA.	March 2027
Continue to analyse RCA (Root Cause Analysis) for readmissions for short term crisis in MK	March 2027
Continue to analyse RCA (Root Cause Analysis) for patients with LoS exceeding five years	March 2027
Review the outcome, impact and benefits from the autism practitioner(s) and autism OT posts over a 12 month period.	March 2027
Self-assess BLMK inpatient service provision (LDA) against: - Five key elements for discharge, supporting people with LDA to leave hospital - Joint guiding principles for ICS - LDA	March 2027
Continue to focus on our acute mental health inpatient provision developments being co-produced with adults with a learning disability and autistic adults as well as with their families	March 2027
Continue focus on ensuring that care, treatment and support plans are co-produced with people and their families, with appropriate advocacy support and any admission is appropriately supported by relevant specialists, for a specific indication for a mental health assessment and/or intervention that can only be delivered in an inpatient setting. We will ensure that any admission is for the minimum time possible, and with timely discharge enabled through effective multi-agency working	March 2027
Continue focus on ensuring that reasonable adjustments are implemented including exploring how the environment can be improved.	March 2027
Continue focus on ensuring that care is joined up across the health, education, care, and housing system with inpatient services working in a cohesive way with partner organisations, both during a person's inpatient stay and after discharge, so that people are supported to stay well and can further their recovery when they leave hospital. There will also be a clear link between community	March 2027

and inpatient services such as with intensive support teams and community support providers.	
We will continue to focus on staff training such as Oliver McGowan training to improve the quality of care that is delivered	March 2027
Continue to develop MK Autism Diagnostic Service	March 2027

Mental Health Inpatient Care for Children & Young People

The commissioning framework provides an overview as follows for mental health inpatient care for children and young people:

'The current specialised mental health inpatient provision for children and young people with a mental health need is commissioned by NHS-Led Provider Collaboratives. These are a group of providers of specialised mental health, learning disability and autism services who have agreed to work together to improve the care pathway for their local population. In late 2022 the NHSE Quality Transformation Team commissioned a review of the specialist part of the pathway; mental health inpatient service provision for children and young people with a specific remit to identify the changes required to transform care pathways. This review builds on the work of the National Quality Improvement Taskforce for children and young people's mental health inpatient services. This programme produced many resources and materials to support commissioners and providers that are located on the NHS Futures Platform and are directly relevant to this guidance.

The 2023 Mind report 'Our rights, our voices, young people's views on fixing the Mental Health Act and inpatient care' makes several recommendations for improving inpatient care for children and young people according to young people which include:

- Have fewer out-of-area placements
- Support young people in the community
- Stop young people going on adult wards
- Provide greater access to advocacy for young people
- Less restraint on young people
- Proper planning for leaving hospital
- Commit to wider reform of inpatient care

Despite significant improvements in local pathways and positive practice in many areas of the country, many children and young people are still being cared for far away from their home and families, in restrictive settings and experiencing longer lengths of stay.

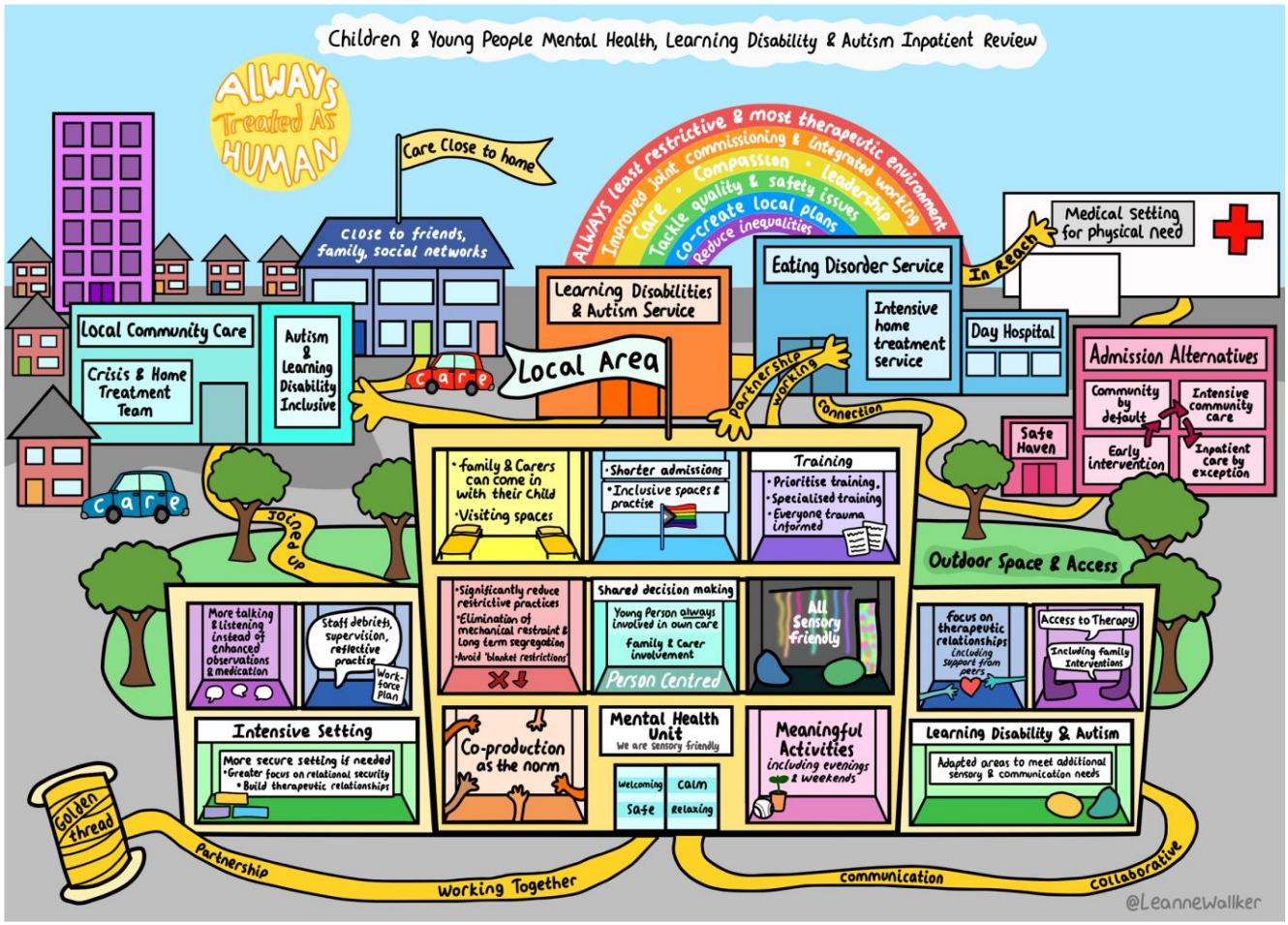
Therefore, a review has been carried out to provide a comprehensive analysis of the evidence base that supports England's current children and young people's mental health, learning disability and autism services. This work included reviewing alternative models of care, both nationally and internationally, and the views of multi-disciplinary workers and clinicians working in children's inpatient services, the young people, and their families. The review team visited 17 inpatient services and met over 117 young people across those sites who were currently receiving inpatient care. The review team also met with or spoke to 35 parents/family members with caring responsibilities and over 40 front line staff. The views of young people and their families, frontline staff has been combined with an analysis of existing evidence and comparisons to international models.

This intelligence has been used to develop a Future Vision for specialist services for children, young people, and their families. This vision is in the process of being co-produced into a future service model for specialist mental health care for children, young people and their families. Once the future service model has been agreed planning will begin with NHS-Led Provider Collaboratives and system colleagues to determine how to realise the changes to the service model. The implementation process will involve updated service specifications, impact assessments and commissioning plans and resources that may be useful to commissioners, as this work progresses the future iterations and further guidance will be made available.'

The Future Vision

The lack of available alternatives to admission was something that all groups recognised, often resulting in young people being admitted to hospital inappropriately, far away from home and for long periods of time resulting in a disconnection with their families, friends, and community. The overarching priority for young people was the need to ensure that they were involved in their care and that staff treat them as 'humans' and not see them as just a 'condition'. Parents of young people wanted to be involved in the care of their child and for the care delivered to them to be safe. All parties recognised that for care to be delivered close to home and for hospital admission to be shorter, more therapeutic, and least restrictive the current model of inpatient care needs to change and the specialist resource to be used in a more flexible way so it can follow the child to wherever they need such care to be delivered.

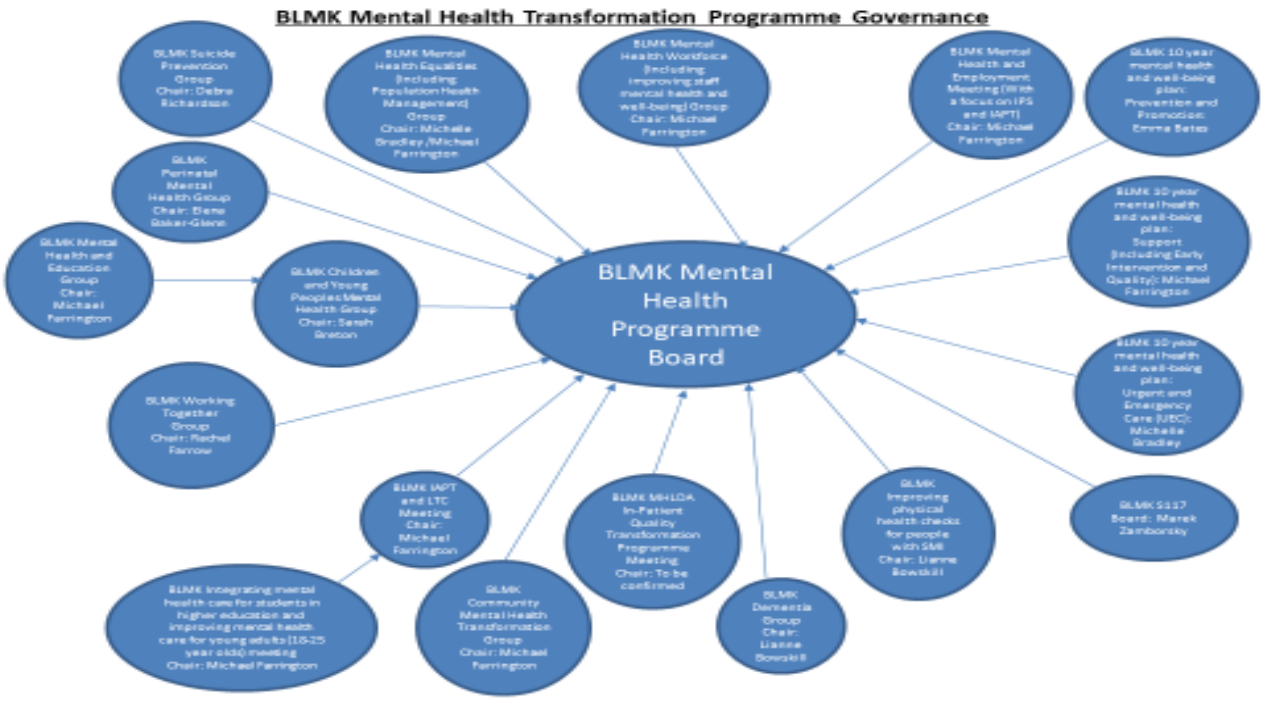
The following illustrations shows the vision and core components of vision:



The core components of the proposed vision for mental health inpatient services for children and young people

Governance structure to implement the BLMK Mental Health, Learning Disabilities and Autism In-Patient Quality Transformation Plan

There will be a BLMK Mental Health, Learning Disabilities and Autism In-Patient Quality Transformation Group which will oversee the implementation of the plan which will report into the Bedfordshire, Luton and Milton Keynes Mental Health Programme Board. It will also feed into the BLMK Learning Disability and Autism Transformation Board. The following diagram illustrates the governance structure:



Mental Health Workforce

As part of delivering of our BLMK Mental Health, Learning Disabilities and Autism In-Patient Quality Transformation Plan we will continue to implement our workforce plan that supports the delivery of our system's mental health delivery ambition, working closely with ICS partners including provider collaboratives and the voluntary, community and social enterprise (VCSE) sectors. We will continue to focus on improving retention and staff attendance through a focus on all elements of the NHS People Promise and will implement actions for 2024/25 from the Long Term Workforce Plan, particularly focusing on:

1. **Train**

- Increasing education and training and increasing apprenticeships and alternative routes into professional roles
- Increasing new roles designed to meet patient's changing needs and support the ongoing transformation of care.

2. **Retain**

- We will ensure that we keep more staff within the health service by better-supporting people throughout their careers and boosting flexibility.
- We will offer staff to work in ways that suit them and continue to improve the culture and leadership across our organisations.

3. **Reform**

- We will be focusing on improving productivity by working and training differently, building broader teams with flexible skills.
- Changing education and training to deliver more staff in roles and services where needed most.
- Ensuring staff have the right skills to take advantage of new technology that frees up clinician's time to care.

We will also be focusing on peer support workers which has been highlighted by service users and carers as an area of workforce development.