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BHFT Strategy

Update to Slough Health Scrutiny Committee

January 2021

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Jayne Reynolds, Regional Director
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Care Quality Commission Inspected and rated Outstanding

Diversity and Inclusion Bringing us together

GDE Digital solutions for outstanding healthcare

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- MH strategy
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- East Berks and Slough – priorities for 2021/22
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Three Year Strategy 2021/22-2024/25

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Our three strategic objectives

We aim to achieve our vision by focussing on three strategic objectives relating to our People, Patients and Population.

Over the next three years, we will:

- Make Berkshire Healthcare a great place to work for all of **Our People**
- Improve access, quality and experience of care for all of **Our Patients**
- Work with partners to improve the health outcomes of all of **Our Populations**

66.7%

Recovery plan on a page 2020/21

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Our **vision:** To be **recognised** as **the leading community and mental health service provider** by **our staff, patients and partners**.

True North goal 1: Harm-free care

✓ **To provide safe services by eliminating avoidable harm**

- We will protect our patients and staff from getting COVID-19 by using appropriate infection control measures
- We will make sure that we have safe levels of staffing to meet service demands
- We will engage with all services over the next six months and agree a plan to safely bring all services back to full operation
- We will continue to reduce falls, pressure ulcers, self-harm in in-patient services and suicide across all of our services
- We will recognise and respond promptly to physical health deterioration on our in-patient wards
- We will strengthen our safety culture to empower staff and patients to raise safety concerns without fear, and to facilitate learning from incidents

True North goal 2: Supporting our staff

✓ **To support our people and be a great place to work**

- We will sustain and improve staff engagement across all of our services
- We will make sure all staff have the appropriate skills, training and support for their roles
- We will support staff to embed working remotely and to operate safely and effectively
- We will protect and sustain the health and wellbeing of our staff, reducing sickness absence
- We will increase numbers of staff feeling they can influence how we work and make decisions
- We will increase numbers of staff recommending the care and treatment of our services
- We will improve staff recruitment, retention and satisfaction
- We will have a zero tolerance to bullying and harassment
- We will reduce violence and aggression towards our staff

True North goal 3: Good patient experience

✓ **To provide good outcomes from treatment and care**

- We will use patient and carer feedback to drive improvements in our services, with specific engagement on proposed new ways of working
- We will manage patient flow effectively, with minimum delays and make sure that patients stay within our services for no longer than is clinically appropriate
- We will engage and communicate with patients and the public to make sure that they understand how to access the right help at the right time
- Our services will support patients to manage any direct or indirect adverse impact of COVID-19

True North goal 4: Money matters

✓ **To deliver services that are efficient and financially sustainable**

- We will achieve our financial plan for the year
- We will transform our clinical and non-clinical services using a digital first approach, to improve patient experience, streamline our estate, reduce our carbon footprint and support work-life balance for our staff

With our health and care partners: **We will work in partnership** with **local systems** to **build Recovery and Restoration plans** to **build sustainable health and care** that **incorporate new ways of working.**

Mental Health strategy: The NHS Long Term Plan

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LTP sets out a 'new service model for the 21st century' with three over-arching principles, stating that "the NHS will increasingly be:

- More joined up and coordinated in its care…to support the increasing number of people with long-term health conditions…
- More proactive in the services it provides…with the move to 'population health management'…
- More differentiated in its support offer to individuals…to take more control of how they manage their physical and mental wellbeing"

- A key target is improving access to physical health checks for people with Serious Mental Illness, to address health inequalities: people with Severe Mental Illness may have reduced life expectancy of 17-22 years.

The NHS Long Term Plan

TOP-LINE—£3.2bn additional funding for mental health

Guarantee that investment in primary, community and mental health care will grow faster than the overall NHS budget, with Children & Young people budgets accelerating ahead of wider mental health funding

Community Mental Health

New Offer for Community Mental Health provision

Focus on those with complex needs

Integrated multi-disciplinary services aligned in Primary Care Networks

Alternative Provision for those in crisis

Increase alternative forms of provision for those in crisis, working with voluntary sector as well as alternatives to inpatient admissions

Access to Psychological Therapies*

By 2023/24 an additional 380,000 people per year will be able to access NICE-approved IAPT services including access to online therapies

Physical Health in SMI*

Continue trajectories on PSMI and by 2023/2024 a further 110,000 per annum

Children & Young People*

Extension of pathways from 0-25 (from 0—18 previously)

Increased investments in Eating Disorder services*

Schools & Colleges

Specifically trained mental health teams to work in schools and colleges

Learning Disabilities & Autism

Ensuring people with LD/Autism are offered better support including reducing wait times and faster diagnosis and support from specific keyworkers which enables them to live happier, healthier and longer lives

NHS 111 & Access to 24/7 community care*

Develop a single universal point of access for those experiencing mental health crisis via NHS 111

24/7 crisis response service in community to include mental health nurses, with a 2 hour response*

Perinatal Mental Health*

Increased access to services* to include a further 24.000 women by 2023/24

Offer of psychological therapies to include wider family and carer intervention

Father/partner support for those in services

Closer links from perinatal mental health services into maternity settings

Smoking Cessation

Universal smoking cessation offer in specialist mental health services

In-patient settings and e-cigarette usage to be considered (via PHE guidance)

Support into Employment*

Continued support for individual placement and support

Suicide Prevention & Support*

Suicide Prevention Quality Improvement Programme

Safety Improvement programme

Bereavement support

Out of Area Placements*

Elimination of all Out of Area Placements by 20/21*

Reduce OAPs down to national average of 32 days

Ambulance Services

Ambulance staff to be trained in crisis response

Mental health nurses in control rooms

Introduction of Mental health transport vehicles

Improved Dementia Care*

Enhanced community teams to include dementia support to align with Primary Care networks

Needs assessment for Dementia in Care Homes linked to Vanguards

Ensure the development of a Clinical Assessment Service incorporates "out of hospital settings" including care homes

Standards

National Clinical Standard Review

CYP IAPT

Primary Care & Access

Urgent & Emergency Mental Health Standards—commence 2020

Rough Sleepers

£30million to provide better access to specialist mental health support to work alongside outreach services

*= continued FYFV ambition

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The **Mental Health Investment Standard** (MHIS) (previously known as Parity of Esteem) is the requirement for CCGs to increase **investment** in MH services in line with their overall increase in allocation each year.

Local NHS Commissioners and ICS system are held to account for achieving this

Our **major MH initiative for Slough and east Berkshire** is implementation of the **Community Mental Health Framework** (Nov 2020) – to transform community MH services *(presentation delivered to Health scrutiny committee in November 2020)*

Covid-19 and Mental Health demand

Local demand and impact:

- Initial drop in activity, now increasing activity to pre-Covid-19 levels
- Greater % of more complex presentations and people with increased acuity across all services areas
- New presentations of serious mental illness and admissions into acute psychiatric beds – occupancy sustained below 85% in wave 1 but increased pressures since October 2020
- More safeguarding referrals due to domestic abuse

- National model predicts upto 20% population will need new or additional MH support (*Centre for Mental Health Oct 2020)*
- Increase in Anxiety, depression, trauma, complex grief
- Impact is likely to be unequal– higher risk groups will include BAME, care home residents, disabled people and front line staff, unemployed people

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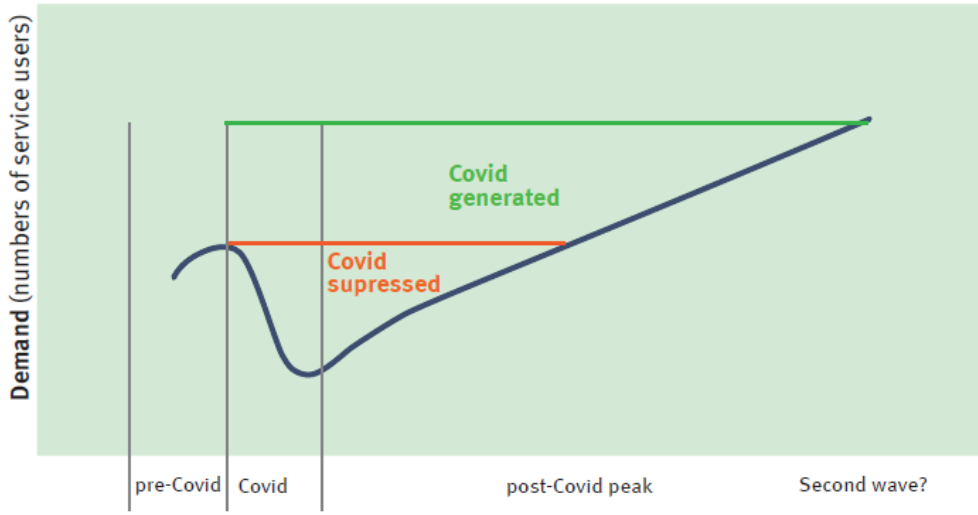
Visual explanation of the model: forecasting future demand

Adapted from graph created by Paul Bibby, Head of Strategy and Planning, Lancashire and South Cumbria NHS Foundation Trust



Model is broadly applicable to all areas but will vary in impact by service line

Covid-supressed

People known to services who have currently ceased/ postpone their engagement with these services. It is assumed these will return to services over time, however, their mental health could be changed from pre-Covid state.

Covid-generated

People not yet known to services, whose experiences of Covid, both direct and indirect, have caused them to develop a degree of mental illness.

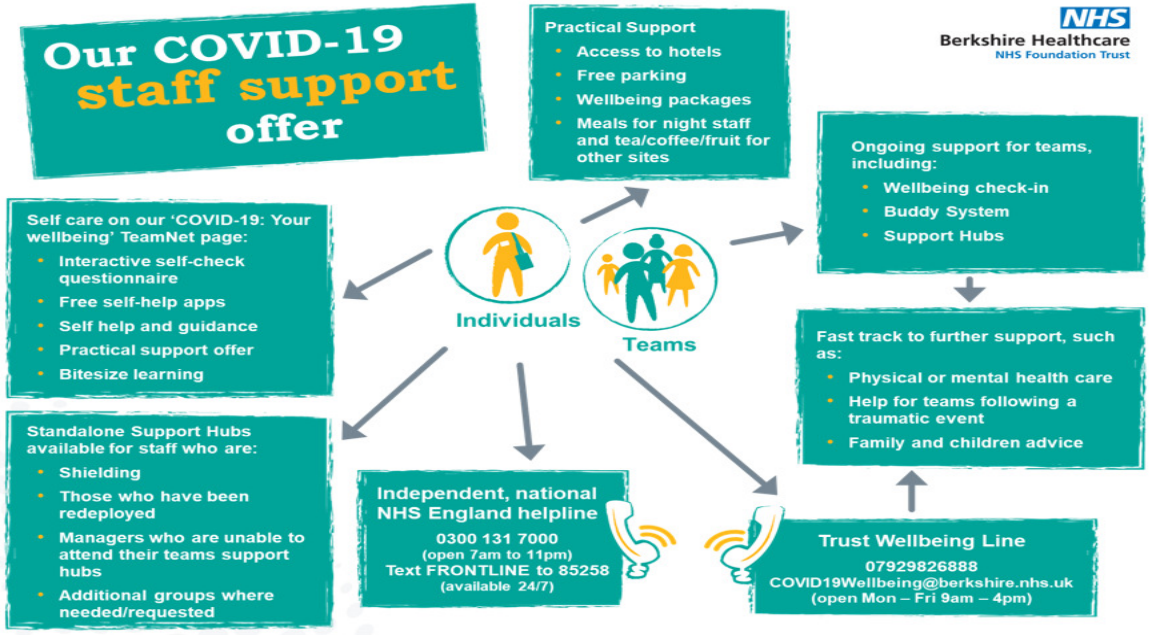
Covid-altered interventions

Service users in this group have remained in contact with services, but have received a changed intervention, i.e. telephone and/or video call. For some, this will result in a change in their mental health.

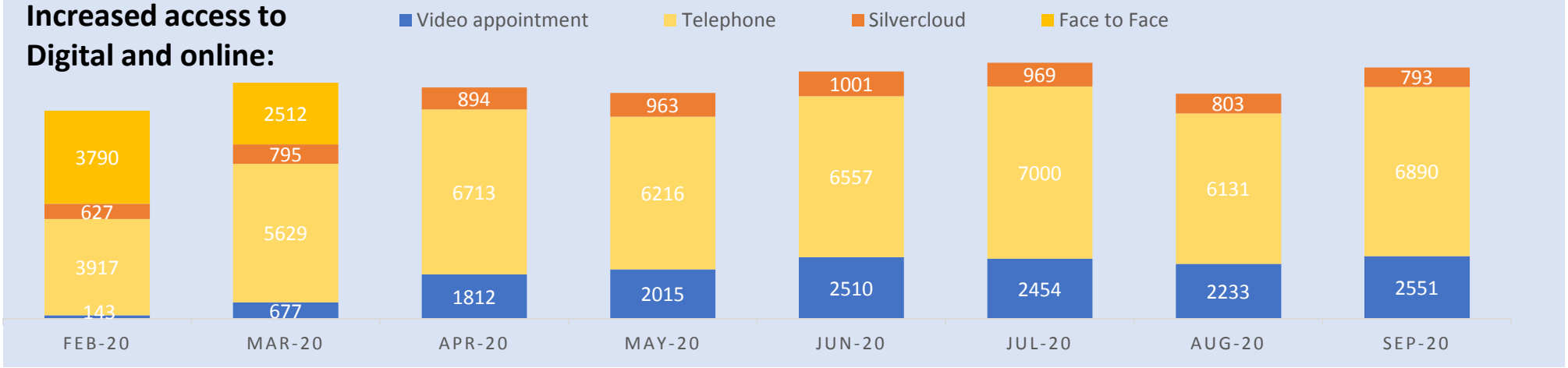
Current MH offer in BHFT

Locally:

- Publicised Talking Therapies offer
- Partnership approaches
- ‘No wrong door’ – MH Gateway
- Evidence based approaches
- Working with our local communities
- New Wellbeing service
- Developing Primary Care MH offer – MHICS
- Developed staff support offer
- Increased accessibility via digital and online



Increased access to Digital and online:



East Berks and Slough – Priorities for 2021/22 – Adult services

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Community Health Services

Complete Recovery Plans – in particular for Dental/Hearing and Balance and Diabetes that continue to have long waits

Continue to roll out our Integrated Frailty offer focussing on integration/admission avoidance, in particular working with Primary Care to support ACP (Anticipatory Care Planning)/management of Frailty/Ageing well programme of work/Extension and enhancement of the work/scope of the LAPs (Locality access points)

Service review to establish effective blended models of delivery i.e. virtual/F2F – embedding some of the innovations/learning from COVID-19

Estate plans to further drive integration between Community/Primary Care and LAs

Adult MH priorities

Continue to progress Transformation plans in line with Community MH Framework, with MH Integrated Community Services (MHICS) rolled out to all Slough PCNs and further developments in personality disorder and eating disorder pathways.

Prioritise Physical health checks for people with SMI to address health inequality, and maintain MH integration with social care and community health services for holistic approach.

Embedding MH pathways with NHS 111 First

Crisis and home treatment- Alternative to hospital admission schemes including development of virtual Safe Haven for Slough and east Berks, to reduce in patient demand

Talking therapies – maximise efficiencies and build on virtual offer in order to meet expected surge in demand

Continue to build partnership and integration in line with Slough Wellbeing Strategy Priority 2: Health and Social Care Integration

East Berks and Slough – Priorities for 2021/22 – Childrens services

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Community Services

Neurodiversity – Working with Berkshire East CCG to develop new models for autism assessment service and ADHD assessment and ongoing support

CYPIT (integrated therapies) – Working across the 3 LAs in East Berkshire and the CCG to develop new models and commissioning of paediatric therapy

Specialist Nursing – Working with the CCG, Frimley Health and Alexander Devine Hospice to implement palliative care pathway for children and their families

Eating disorders

Using NHSE/I Early Intervention Eating Disorder Funding to enable early access to evidence based interventions for 16-25yr old. Builds in national access & waiting time standards for CYP ED service, extending this to young adults and links with LTP ambitions re 0-25.

Continue to build partnership and integration in line with Slough Wellbeing Strategy Priority 1: Starting Well

CAMHS Priorities

Continue to embed MH Support Teams – NHSE funded programme following Green Paper on CAMHS Waiting Times, (launched in Slough Sept 2020).

Getting Help service –MH workers to support multi-agency early help triage and Single Point of Access(SPA) in each LA to improve access and integrated care.

Crisis - System review to determine local model of care to meet LTP targets for 24/7 crisis response & home treatment.

Closer links with primary care & join up with Connected Care

Extend webinars and training for education settings in emotional and psychological wellbeing

Website development and expanded digital offer including access to SHaRON

Reduce wait times for assessment and treatment through new posts (Specialist Community team and Children Looked After)

Streamlining transitions planning and improving experience for families and young people

East BHFT 'Winter Offer' INTEGRATED SERVICES

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Target for all referrals to be processed within 2 hours. Referrals can be sent via: the HUB
integratedhub@berkshire.nhs.uk
or 0300 365 1234, ICE, DXS, RiO

Falls & Frailty

ARC - triage & assess referrals from community teams, SCAS, GPs, Acute, alongside SBC

- **New - Physiotherapist home assessments** & virtual falls programme to include digital consultations/ assessments with physiotherapists, followed by treatment plan delivered by Teams or exercise sheets
- **New - Therapy** input in BHFT community & wards for patients 7 days a week
- **New - Virtual consultations** for Patients referred to ARC (Assessment and Rehab Centre) services with selective Face 2 face consultation
- **New – 'Nurse led domiciliary assessments'** with portable ECGs, Observations, Basic Investigations, with discussions with Comm Geriatricians for Medical Mx plans
- **Continued - ICS** supporting frailty patients on discharge 7 days a week

Admission Avoidance

2 Hr triage response for all referrals
Access into integrated pathway for LAP & Cluster MDT's

- **New** - **Direct referral pathway** from SCAS to Community Hospital Bed to avoid Acute Hosp admission
- **New** - **Point of Care** testing on the community wards/ARC to expedite results & initiate treatment, avoiding acute admission
- **In reach team covering 7 days** a week & extended hours to support admission to community beds from Frimley/Wexham & Community
- **GP advice hotline for Geriatrician support**

Welfare Checks / Safety Net

Welfare Check Pathway- Patients discharged from community wards are contacted by Admin staff, Nurse or Doctor (based on clinical need) to ensure they are safe & well at home.

- **New - Welfare check** pathway to support direct referrals from OOH GPs

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Thank You
Any questions?

Care Quality Commission Inspected and rated Outstanding

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