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Growing a place of opportunity and ambition

Date of issue: Monday, 23 November 2020

MEETING	**HEALTH SCRUTINY PANEL** (Councillors A Sandhu (Chair), Smith, Ali, Begum, Matloob, Mohammad, Qaseem, Rasib and Sarfraz) **NON-VOTING CO-OPTED MEMBERS** Healthwatch representative – Mr Colin Pill Buckinghamshire Health and Adult Social Care Select Committee Representative
DATE AND TIME:	THURSDAY, 26TH NOVEMBER, 2020 AT 6.30 PM
VENUE:	VIRTUAL MEETING
DEMOCRATIC SERVICES OFFICER: **(for all enquiries)**	NICHOLAS PONTONE 07514 939642

SUPPLEMENTARY PAPERS

The following Papers have been added to the agenda for the above meeting:-

* Items 6 and 7 were not available for publication with the rest of the agenda.

PART 1

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SLOUGH BOROUGH COUNCIL

REPORT TO: Health Scrutiny Panel **DATE:** 26th November 2020

CONTACT OFFICER: Danny Bailey, Frimley Health NHS Foundation Trust

WARD(S): All

PART I
FOR COMMENT & CONSIDERATION

FRIMLEY HEALTH WINTER PLAN 2020-21

1. Purpose of Report

To share the Winter Plan for the Frimley Health showing how the plan links with system partners. The report also shows the various work streams and actions clearly outlining how each applies to the organisations across the system. This report illustrates how the acute hospital will be working with partners to deliver the key elements of the plan in the coming months. The plan outlines our approach to resilience, describes our plans for urgent and emergency care, hospital-based care, community care and flu planning. Finally, it demonstrates the resources we have to support and deliver our plans and any risks and associated mitigating actions to support delivery.

2. Recommendation(s)/Proposed Action

The Panel is requested to note the report.

3. The Slough Joint Wellbeing Strategy, the JSNA and the Five Year Plan

3a. Slough Wellbeing Strategy Priorities

The Frimley Health Winter Plan clearly supports the Slough Wellbeing priorities during this period with a particular focus on integration to ensure that people have timely access to the right services to meet their health and care needs. Integration across organisations supports the promotion of seamless health and care pathways so that transition across organisations is safe and effective.

Priorities:
1. *Starting Well*
2. *Integration*
3. *Strong, healthy and attractive neighbourhoods*
4. *Workplace health*

3b. Five Year Plan Outcomes

The Frimley Health Winter Plan supports the delivery of the Five-Year Plan Outcomes through the integration across the health and care sector ensuring the right services are in place at the right time supporting delivery.

- *Outcome 1: Slough children will grow up to be happy, healthy and successful*

- *Outcome 2: Our people will be healthier and manage their own care needs*
- *Outcome 3: Slough will be an attractive place where people choose to live, work and stay*
- *Outcome 4: Our residents will live in good quality homes*
- *Outcome 5: Slough will attract, retain and grow businesses and investment to provide opportunities for our residents*

4. **Other Implications**

(a) Financial

The financial implications of the plan form one of the key risks outlined in the risk log associated with the Winter Plan. Discussions about the appropriate level of financial support and the source of that finance are on-going as the plan is delivered.

(b) Risk Management

There are a number of risks identified with the delivery of the Winter Plan and these can be seen in, alongside the proposed mitigating actions, in appendix B attached to this report.

(c) Human Rights Act and Other Legal Implications – None identified.

5. **Supporting Information**

Appendix A: Detailed Winter Plan
Appendix B: Identified Risks and Mitigations

6. **Comments of Other Committees**
This plan has been signed off by the Frimley Health Foundation Trust Senior Leadership Committee (SLC)

7. **Conclusion**

The Frimley Health Winter Plan clearly outlines the overall approach to the plan for winter and provides a detailed action plan. The plan also shows how partners across the system will collaborate and co-ordinate to ensure delivery of the key elements.

8. **Appendices Attached**

'A' - Detailed Winter Plan 2020-21

'B' - Identified Risks and Mitigations

9. **Background Papers**

None

Workstream		Actions	Timescale	Lead
Resilience	Inpatient Bed Planning	Finalise and agree available core and escalation beds across FHFT	02.10.20	DCOO
		Sign-off escalation and de-escalation plan for winter/covid across FHFT	09.10.20	DCOO
		Agree comunications plan for ward moves/changes	02.10.20	DCOO
		Open any unused internal acute capacity across all sites	As req	DCOO/Gold
		Open agreed stage 1 escalation internally	As req	DCOO/Gold
		Ensure workforce plans in place to enable opening of community escalation beds	05.12.20	HoN/AD Community
		Open additional communitybed capacity: -10 beds Runfold (Farnham) - 18 beds Calthorpe (Fleet)	As req	HoN/AD
		Open agreed stage 2 escalation internally - consider cancelling elective procedures	As req	COO/DoN/Gold
		Open agreed super-escalation areas at risk	As req	COO/DoN/Gold
	EU Exit	Review existing FHFT Business Continuity Plans	As req	EPRR
		Link in with Surrey / Thames Valley LRF and LHRPs in relation to current risk assessment	As req	EPRR
		Awaiting confirmation of latest planning assumptions	As req	EPRR
		Reactivate established FHFT EU Exit working group made up of representatives from the seven key EU Exit risk areas	As req	COO
		Revise and activate FHFT EU Exit contingency plan as required	As req	COO
	Workforce	Provide regular sickness absense reporting to management teams	Complete	DDoW
		Ensure primary and secondary role coding on healthroster for all relevant clinical staff (for covid redeplopment)	Complete	DDoW
		Develop and implement temporary staffing plan to support Phase 3 recovery	16.10.20	DDoW/DDoN
		Ensure that vacancies are recruited to - include performance in regular Senior Management Team meeting	Ongoing	Chiefs/ADs/HoNs
		Bolster FHFT presence on social media and recruitment website	Ongoing	DDoW/Comms
		Create new microsite for new recruits	Complete	DDoW
Urgent and Emergency Care	Think 111	Existing DoS under review for implementation Nov 2020	23.10.20	AD ED
		Additional services in development - to be added to DoS	23.10.20	AD ED
		Think 111 First multi-media booths in site and functional	30.10.20	AD ED
		Implementation of Adastra It solution	27.11.20	AD ED
	ED Performance	Increase staffing to provide additional ambulance-line cover - business case to be submitted for more ED staffing to support ambulance line handover and safety	27.11.20	AD ED
		Additional medical SDEC capacity to be created for admission avoidance	20.11.20	Chief/AD Medicine
		Dedicated gynae SDEC capacity to be created for admission avoidance	27.11.20	Chief/AD Gynae
		Trial of virtual ward for step-up and step-down of patients	TBC	AD Community
		Upgrade of Symphony (FPH) to enable connectivity to Connected Care	13.11.20	DCOO
		Amend data on and roll out access to FHFT qlikview portal - with CRS data available	02.10.20	AD ED
		Embed daily and weekly performance management processes within the ED departments.	09.10.20	Chief/AD ED
		Implement RCAs for all patients waiting over 9hrs	02.10.20	Chief/AD ED
		Improve escalation process for specialty referral delays	06.10.20	Chief/AD ED
		Improve escalation process for long ED waits	Complete	Chief/AD ED
		Review Frequent Attenders to identify any gaps in services and take action to address through FHFT UEC Board	Ongoing	Chief/AD ED
		Continue engagement with Primary Care regarding patient flow via the Clinical Interface Committee	Ongoing	Chief/AD ED
	Frailty	Full frailty service available across FHFT	Complete	Frailty Cons
		Admission avoidance pathways in place for frailty	Complete	Frailty Cons
		Use of red bags and other initiatives to improve communication	01/10/2020	HoNs
		Connected Care available across FHFT - to improve commincaiton betweeen primary and secondary care. EMIS In FHFT community services, provide access for Frailty teams.	November	IT lead
Hospital Based Care	Discharge	Roll out of internal consultant-led delayed discharge reviews	23.10.20	Chiefs/ADs
		Regular review at Directorate level of long-stay patients	16.10.20	Chiefs/ADs
		Check & Challenge of patients over 21 days	Complete	Head of Site/DMD
		Promote pre 11am/pre-12pm discharges to help morning flow	Ongoing	Head of Site/HoNs
		Review discharge lounge capacity and appropriateness of space	Ongoing	DCOO
		Improve discharge to care homes – use POC testing to accelerate discharge.	Ongoing	Head of Site
		Embed trusted assessor to reduce burden on care home attending/calling FHFT.	21.12.20	Head of D/C Team
	LOS	Re-launch Alamac SAFER principles from 19/20 Winter.	06.11.20	Head of Site
		Ensure that accurate LOS data is avaiable at Directorate and ward level	06.11.20	DCOO
		Build LOS review into the bi-weekly performance review.	08.10.20	DCOO
		Implement escalation meetings to ensure health & social care follow discharge guidance and D2A process	Complete	Head of Site
		RCA to be complete for all 100+ day LOS	06.11.20	Chiefs/ADs
		Internal processes in place to accurate monitor MFFD and escalate issues.	In progress	Head of Site
		System escalation calls in place to highlight delays.	Complete	Head of Site
		Weekly exception report reviews in place to look at most complex cases.	In progress	Head of Site
	ICU	Escalation plans agreed and submitted to NHSEI	Complete	ToC/Gold
		Open Phase 1 additional ICU capacity in old ED (WPH) x 15	As req	Chief/AD TACC
		Open Phase 2 additional ICU capacity in old ED (WPH) x 10	As req	Chief/AD TACC
		Open Phase 3 additional ICU capacity in SADU (FPH) x 5	As req	Chief/AD TACC
		Open Phase 4 additional ICU capacity in MADU (FPH) x 5	As req	Chief/AD TACC
		Ensure robust workforce plan for staffing ICU escalation	09.10.20	Chief/AD TACC
		Ensure adequate ICU kit/beds for escalation	Complete	Chief/AD TACC
		Create clear trigger points for considering cancellation of elective activity	Complete	Chief/AD TACC
	Electives	Phase 3 activity plans agreed and implemented	23.10.20	DCOO
		Full use of independent sector - with robust exit strategies where appropriate	Ongoing	DCOO/ADs
		Further support with Diagnostics (radiology) required to meet plan - relocatable CT requested from NHSEI.	23.10.20	DCOO/Radiology
		Weekly activity performance reviews in place.	Ongoing	COO/DCOO
		Phase 3 'dashboards' created for monitoring against targets.	Complete	DCOO
		Create additional virtual 'pods' space	02.11.20	DCOO
		Expand day case capacity	30.09.20	DCOO/AD TACC
		Implement A&G in place where appropriate.	Complete	ADs
		Implement CAS/RAS across clinical areas to prevent inappropriate referrals being accepted.	Complete	ADs
		Ongoing work with ICS colleagues to highlight areas of poor referral practice	Ongoing	Chiefs/ADs
Community	Community	Pathways in place ERS@H and RR support to complex	01.10.20	Service Manager
		Integrated In Reach FHFT and VC for FPH	01.10.20	Service Manager
		Medical cover to continue	Ongoing	AD
		ERS@H therapy capacity in place 7/7	01.10.20	Service Manager
		Therapy input to be integrated across FHFT community wards	02.11.20	Service Manager
	Care Homes	Maintain Care Home Forum to ensure good comms between care homes, primary and secondary care	Ongoing	Care Home Matron
		Implement trusted assessment to relieve pressure on care homes attending	21.12.20	AD Community
		Ensure timely covid swabbing prior to D/C to care homes	Ongoing	Head of Site
Flu Planning	Flu Vaccines & Outbreak Management	Robust OH flu delivery plan in place - offered to all staff.	09.10.20	OH
		Implement online training course available for RGNs to become local vaccinators	Complete	OH & HR
		Existing FHFT Infection Outbreak policy available	Complete	IP&C
		Outbreak management to be in line with policy and advice from IPC	As req	IP&C/HoNs
		Depending on covid position - response might be altered.	As req	DCOO/DoN
		Isolation capacity identified	Complete	IP&C/Head of Site
		Rapid discharge rounds conducted by senior consultants to create inpatient space (where appropriate)	As req	Chiefs/ADs

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			Risk Rating	Organisational Response
ALL	Surge Capacity	✓		1. Open any unused internal acute capacity across all sites. 2. Open additional community bed capacity: -11 beds Runfold (Farnham) - 18 beds Calthorpe (Fleet) 3. Open agreed stage 1 escalation internally. 4. Open agreed stage 2 escalation internally - consider cancelling elective procedures. 5. Open super-esclation areas at risk.
	EU Exit - End of Transition year Readiness	✓		1.Existing Trust Business Continuity Plans. 2.Linked in with Surrey / Thames Valley LRF and LHRPs in relation to current risk assessment. 3.Awaiting confirmation of latest planning assumptions. 4.Trust has an established EU Exit working group made up of representatives from the 7 key EU Exit risk areas which can be reactivated upon receipt of items 2 & 3 above. 5.Trust has an existing EU Exit contingency plan which can be revised and activated as required.
	Workforce / Availaibilty / Resileince and Well being	✓		1. Robust sickness absence reporting/coding related to covid now in place. 2. Primary and secondary role coding on healthroster - for quick and easy redistribution of staff. 3. Additional temporary staffing to be put in place to support phase 3 plan. 4. Recruitment operating 'normally'and interest in vacancies is high 5. New social media presence is raising FHFT profile – most viewed employers on 'Indeed' in the region. 6. New recruitment microsite popular with potential recruits. 7. Trust turnover is under 13% which is lower than it has been for some time and been on a downward trend for over a year now. We continue with plans to improve retention (People at Work Plan) and a group meets monthly to discuss and review actions.
Urgent and Emergency Care	111 First additional capacity to deliver 111 First			1. Implementation underway - direct booking (via Ad Astra) to be available from Dec 2020).
	ED - Mean wait Times	✓		See line 22 UEC standards.
	Active DOS Profile in place & review completed	✓		1. Existing DoS under review for implementation Oct 2020. 2. Additional services in development - to be added to DoS.
	Core G&A Bed Capacity	✓		See hospital based care section
	Bed Escalation Capacity - Day to day	✓		
	Critical Care Capacity	✓		1. Escalation plans submitted to NHSEI and agreed. 2. Ability to increase ICU capacity from 24 to 60 if required - would impact on some existing G&A bed spaces). 3. Further super-escalation for ICU available if req - would involve cancellation of some elective workload.
	Ambulance Response Times (meeting targets) - increase in H&T, S&T, appropriate Conveyances			
	Ambulance Handovers	✓		1. Increase staffing to provide additional ambulance-line cover. Business case to be submitted for more ED staffing to support ambulance line handover and safety. 2. Decant areas being identified to be used in extremis.
	Alternative Pathways to conveyance			1. Access to specialty 'hot' clinics. 2. Access to SDEC - planned attendances.
	Ambulatory Care	✓		1. SDEC available 7 days a week. 2. Additional SDEC capacity to be available from Dec 2020. 3. Expand capacity for all areas: medicine, surgery & gynae.
	Safe and Effective Discharge Processes and timely coordination with Partners	✓		1. Roll out of internal consultant-led delayed discharge reviews. 2. Regular review at Directorate level of long-stay patients. 3. Check & Challenge of patients over 21 days. 4. Promote pre11am/pre-12pm dsicharges to help morning flow. 5. Review discharge lounge capacity and appropriateness of space.
	Admission Avoidance Pathways	✓		1. Implement 111 First across FHFT. 2. Improve and expand SDEC offering across both acute sites. 3. Virtual frailty ward for admission avoidance. 4. Availability of paeds hotline.
	Flu Delivery - Staff	✓		1. Robust OH flu delivery plan in place - offered to all staff. 2. Online training course available for RGNs to become local vaccinators.
	Effective Frailty Pathways	✓		1. Full frailty service available across FHFT. 2. Good admission avoidance pathways in place for frailty. 3. Use of red bags and other initiatives to improve communication. 4. COnnected Care available across FHFT - to improve commincaiton betweeen primary and secondary care.
	7 Day Services - where appropriate	✓		1. Produce and publish On Call Rotas by all Partners – "Home for Christmas" Plan. 2. Frailty cover 7 days of the week. 3. Review requirement for 7 day across all services and implement time-limted 7 day service where necessary (e.g. discharge teams). 4. Bolster senior OOH nursing presence.
	Meeting U&E Care Clinical Standard Targets	✓		1. Roll out access to FHFT qlikview portal - with CRS data available. 2. Embed daily and weekly performance management processes within the ED departments.
	Flu Vaccination at Risk Groups			1. Ongoing discussions about FHFT offering vaccines to vulnerable inpatient groups. 2. Communication of vaccines given through d/c letter.
viders)	Primary Care Capacity - Additional Winter arrangements			
	Flu Vaccination - At Risk Group			
	Flu Vaccination - Staff			
	Front Line Hot/Cold site pathways incl OOH			

Primary Care (including OOH Pro	Escalation Capacity			
	Direct booking slots available from 111	✓		1. Implementation underway - direct booking (via Adastra) to be available - but reliant on Symphony upgrade and implementation of adastra.
	"See" and treat Children (0-18 yrs) - Urgent Care			
	Deliver at Place 4 winter Pathways: 1) RSV Bronch, Fever, Hot Pathway, D&V			
	Place - Healthier together platform - supporting parents with Advice and Guidance			
	Front line service provision for Hot Children			
	Rapid Support to Paramedics			
	Provision for At Risk Groups			
	Care Home support			
	Long Term Conditions management			
Community Services incl Care Home beds and Dom Care	Assessment out of Hospital - D2A	✓		1. Pathways in place ERS@H and RR support to complex (3)
	Surge Demand - COVID 19	✓		1. Established business continuity plus additional escalation bed capacity 2. ICU escalation for Covid ready to be enacted.
	Surge Demand - Non COVID 19	✓		1. Established business continuity plus additional escalation bed capacity.
	Core Bed Capacity	✓		1. Community bed capacity increased to 74 with temp reloaction of Calthopre to Hale Ward.
	Escalation Bed Capacity	✓		1. Runfold beds increase to 21 (additional 10 beds) 2. Further super escalation beds on Calthorpe (18) 3. Core beds closed at WPH in advance of winter in order to create some escalation capacity. 4. Escalation capacity at FPH to include some of the 'spaced' bed areas - to reduce impact on elective surgery & phase 3 recovery.
	Admission Avoidance pathways	✓		1. Virtual frailty ward for admission avoidance - in planning stage.
	7 Day Services including Therapy and Medical input at weekend and Assessments	✓		1. Medical cover to continue 3. ERS@H therapy capacity in place 7/7 2. Therapy input to be integrated across FHFT community wards
	In reach Services	✓		
	Early supportive Discharge	✓		
	Domicilliary Care	✓		
	Specialist Community Nursing	✓		
	Rapid Response	✓		1. 2 hour response in place through ERS@H. Capacity increase proposed
	Minimising LoS when patient suitable for discharge	✓		1. Board rounds, 7/7 working and D2A pathways impleneted in community wards 2. ERS@H facilitated discharge
	Effective Frailty Pathways	✓		1. Already established. Consultant support to PCN MDTs, fraility out-reach.
	Long Term Conditions Rapid Access	✓		1. Specialist practitioner access through community hub.
Place Integrated Care	Discharge Capacity Planning (incl complex)			
	Integrated Care Delivery			
	2 Hour Community Response			
	Intermediate Care			
	Voluntary Sector Support			
	Vulnerable Patients management			
	Admission avoidance			
	Support to care homes			
Mental Health	24/7 Response			
	Adult Safe Havens			
	Children Safe Havens			
	Core Bed Capacity			
	Older people Capacity			
	Childrens and Young People Services			
	7 day services			
	Rapid Response - ED			
	Rapid Access			
	Specialist MH Perinatal			
	Wellbieng and Suppott			
	Psycholocial therapies			

	Primary Care Menatl Health			
	Adult MH community services			
Elective Care	Backlog Activity	✓		1. Phase 3 recovery plans in place. 2. Full use of independent sector - with robust exit strategies where appropriate. 3. Further support with Diagnostics (radiology) required to meet plan - relocatable CT requested from NHSEI. 4. Weekly activity performance reviews in place. 5. Phase 3 'dashboards' created for monitoring against targets.
	Capacity Planning	✓		
	Extreme Escalation Planning	✓		
	Effective Discharge Planning	✓		1. Improve discharge to care homes – use POC testing to accelerate discharge. 2, Embed trusted assessor to reduce burden on care homea ttending/calling FHFT.
	Appropriate Referrals	✓		1. A&G in place where appropriate. 2. CAS/RAS set up across most clinical areas to prevent inappropriate referrals being
Hospital Based Care	LoS reduction	✓		1. Re-launch Alamac SAFER principles from 19/20 Winter. 2. Ensure that accurate LOS data is avaiable at Directorate and ward level. 3. Build LOS review into the bi-weekly performance review. 4. Performance is reliant on community partners enabling the discharges dn following the new discharge guidance. 4. Ensure local ownership of LLOS reviews - with consultant-led RCA process undertaken for +21 days. 5.Performance is reliant on community partners enabling the discharges dn following the new discharge guidance.
	Same Day Emergency Care	✓		Included in the UEC section.
	Critical Care Capacity Planning	✓		See comments above on line 12. ICU and Crit Care are the same thing.
	ICU Capacity Planning	✓		
	ED Capacity Planning and effective Pathways	✓		Included in the UEC section.
	MFFD	✓		1. Internal processes in place to accurate monitor MFFD and escalate issues. 2. System escalation calls in place to highlight delays. 3. Weekly exception report reviews in place to look at most complex cases.
	SAFER Principles adopted and sustained	✓		1. Finish Train the Trainer on wards, embedding SAFER Bundle - plan in place.
	Effective Fraility Services	✓		See line 20 above.
	Management of High Intensity Users	✓		1. Review Frequent Attenders to identify any gaps in services and take action to address through FHFT UEC Board.
	Minimise Reattendances / Readmissions	✓		1. Review readmissions to identify any gaps in services and take action to address through FHFT UEC Board.
	Effective System Working			1. Continue engagement with Primary Care regarding patient flow via the Clinical Interface Committee. 2. Ongoing dialogue through the elective and urgent care boards.
ICS Flu Planning	Staff Vaccination	✓		As above in line 19.
	Flu identification of at risk / vulnerable groups?			
	At Risk Groups Vaccinations			
	Outbreak Response	✓		1. Existing FHFT Infection Outbreak policy available. 2. Outbreak management in line with policy and advice from IPC. 3. Depending on covid position - response might be altered. 4. Isolation capacity identified. 5. Rapid discharge rounds conducted by senior consultants to create inpatient space (where appropriate).
	Comms Plan			
	Staff vaccination monitoring			
	Vaccination Take up Monitoring			
Comms	NHSE Campaigns	✓		1. Plans in place to respond fully to current NHSE requirements - Flu vaccinations - Phase 3 - 111 First
	Targeted Local Campaingns			
	Reactive Messaging			
	ED Avoidance / alternative messages	✓		1. Traffic light leaflets available to signpost patients to the right service. 2. Working togheter with ICS to deliver comprehensive comms strategy.
	Place Comms including Local Authority Messaging			
	Partners Winter Comms Plan	✓		
	Voluntary sector engagement			

	Non Emergency Patient Transport	✓	

FHFT: General and Acute Core Overnight Beds	Type	Pre-Covid	Current	Future MAX	Future Closed
Total Core Beds G&A	**Core**	1312	1218	1300	56
Total Escalation Beds		137	97	72	N/A
Total Core + Escalation Beds		**1449**	**1315**	**1372**	**46**

The table below shows the pre-Covid, current and future G&A bed position for FHFT. The pre-Covid General & Acute position for FHFT was 1312 core beds and 137 escalation beds. Of those 137 escalation beds, 44 were within surgical areas and are now in use for elective care as part of the Phase 3 recovery. As of August 2020, Frimley Health had 1218 accessible G&A core beds. This figure will increase to 1300 during the autumn/early winter 2020 as the new infection control pathways embed around revised surgical pathways and capital works are commenced to put in new bed spaces. The table below shows the historical bed position, current available beds and the future state (pre-winter).

Demand and capacity		Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Average number of G&A Beds occupied per day		1189	1138	1227	1181	1233	1183	1260
Average number of G&A Beds available per day		1218	1218	1250	1280	1300	1300	1300
Average Occupancy		98%	93%	98%	92%	95%	91%	97%

Current local modelling assumes that the winter case load will be at a similar level to that seen in previous winters. This table shows the position including Phase 3 recovery. This includes a capacity of 21 community beds without including the associated demand projection as it is not include in historical levels.

Demand and capacity (adjusted for community)		Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Average Occupancy		99%	95%	100%	94%	96%	92%	99%

Adjusted to account for the additional capacity (by removing 21 beds), the occupancy increases slightly, as shown here

Demand and capacity		Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Average number of G&A Beds occupied per day		1189	1138	1227	1181	1090	1183	1260
Covid Occupied Forecast (75%)		13	44	83	95	96	80	45
Average number of **TOTAL** beds available per day		1290	1290	1322	1352	1372	1372	1372
Average Occupancy		93%	92%	99%	94%	86%	92%	95%

The forecasts above do not include any increased demand for Covid-19. Local modelling shows that we will see a rise in Covid-19 inpatient demand over the winter months (slightly different times for each acute site). In previous Covid-19 models FHFT has assumed 75% of the Covid-19 forecast, as a proportion of patients who would normally have presented will present with Covid-19 instead. If all available escalation beds are taken into account (72 across FHFT incl 28 community), then the impact of covid appears to be manageable within the available bed base. It is important to note that this assume that the majority of areas can remain open to full capacity during this time and that additional spacing between beds is not required.

	Core	Escalation 1	Escalation 2	Escalation 3	Escalation 4
Wexham Park	12	15	10		
Frimley Park	12			5	5
TOTAL (cumul)	**24**	**39**	**49**	**54**	**59**

Robust plans are now in place to deliver additional capacity across FHFT in the event of a second surge in Covid-19 demand for ICU. The table below shows the capacity available. There is a detailed plan which shows the requirements (kit, staff etc) for each bed space that is used and when the tipping points are for needing a further ward sister/consultant. The ICU escalation at Wexham Park will be used first (where possible) as it is a standalone bespoke unit that has no impact on any other area. In comparison, the Frimley escalation would replace 15 core G&A beds.

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Risks to Delivery of The Winter Plan 20-21

Organisation: FHFT

Risk	Mitigating Actions being taken	By whom	Details of any residue Risk

G&A: Inpatient acute capacity (including escalation)	• Additional capacity being identified and capital works taking place to create new bed spaces.
	• Review of escalation capacity to ensure robust escalation plans (into and out of).
	• Community escalation capacity (18 beds) currently being used by other services. Would require a further move/decant.
		DCOO & Heads of Site	• Unknown nature of demand.
			• Unknown impact of Covid on:
			  ○ Demand
			  ○ LOS
			  ○ Workforce availability
			  ○ Consumables
			• Reliability on maintaining back-end flow – through discharges

Financial support for additional escalation of services and/or capacity.	• Ongoing discussions	Dir of Fin & Dep Dir of HR	• All
Workforce – availability of staff due to covid, requirement to isolate, school closures and/or other sickness absence.	• Use of temporary staffing where appropriate. • Advertise and recruit to vacancies. • Reduce turnover – improve retention. • Robust reallocation strategy in place for covid surge.	Dep Dir HR & COO	• Unknown impact of covid sick leave/isolation. • Unknown impact of adverse weather conditions.
Delivery of 111 First	• Project team in place • Visit to Portsmouth organised • Internal UEC Board in place	ED Management Team & DCOO	• Ability to install multi-media booths prior to Dec 20.

			• Ability to install Adastra digital solution by Dec 20.
Delivery of CRS ED Standards	• Weekly ED performance reviews in place. • Robust realtime performance information available. • Trustwide UEC Board in place.	ED Management Team & DCOO	• Impact of covid spacing – on waiting areas and ambulance line. • Availability of sufficient space to adequately space patients. • Engagement of primary care to reduce attendances. • Availability of walk-in and MIU centres (St Mark's, Brants Bridge).
Delivery of Phase 3 elective recovery plan	• Robust recovery plans in place • Capacity and demand understood and elective inpatient capacity protected. • Weekly performance review in place.	COO & DCOOs	• Diagnostic delivery – relocatable CT req. • Adverse impact of patient behaviour (covid) - refusal to attend for appointments/surgery.
EU Exit	• EU Exit plans in place.	EPRR Team & COO	• Unknown impact of EU Exit. • Combined impact of winter, covid and EU exit.

SLOUGH BOROUGH COUNCIL

REPORT TO: Health Scrutiny Panel **DATE:** 26th November 2020

CONTACT OFFICER: Nadia Barakat, Associate Director – Mental Health, Learning Disabilities, Children and Families, East Berkshire CCG / Frimley Collaborative

Seb Byrne, Head of Mental Health Services, SBC and BHFT

Susanna Yeoman, Divisional Director BHFT.

(For all Enquiries)

WARD(S): All

PART I
FOR COMMENT & CONSIDERATION

ADULT MENTAL HEALTH UPDATE

1. Purpose of Report

This report provides the Health Scrutiny Panel with an update on mental health priorities highlighted in the NHS Long term Plan, on Frimley wide initiatives relating to transformation, and on local initiatives and commissioned services to promote mental wellbeing and prevent mental ill health. There is also a report on the impact of Covid-19 and the response of local mental health services.

2. Recommendation(s)/Proposed Action

The Panel is requested to note the report.

3. The Slough Joint Wellbeing Strategy, the JSNA and the Five Year Plan

Slough JSNA highlights health inequalities, and an aim to increase accessibility of lifestyle interventions to reduce premature mortality. In Frimley, people with a severe mental illness have reduced life expectancy of 17-22 years due to poor detection and intervention for physical health conditions such as diabetes, obesity and heart disease, that are largely preventable.

Smoking, substance misuse and alcohol intake are high amongst people with mental health issues.

Social connectedness and links with communities are known to be protective factors for good mental health. In Slough we have high numbers of older population described as chronically lonely.

COVID-19 pandemic and lockdown has significantly impacted on mental ill health.

3a. **Slough Wellbeing Strategy Priorities**

Mental health developments described in the presentation link closely with Priority 2 of the Slough Wellbeing Strategy: Integration relating to Health and Social Care.

Delivering effective mental health care support and treatment in the community can only be achieved if all parts of the health and social care system work together, so that medical, psychological and social needs can be met. Crucially, this includes the voluntary and community sector who are central to promoting positive mental health and engagement in communities. This means overcoming the traditional divide between agencies, to provide personalised and coordinated health care.

Co-production of mental health services is increasingly recognised nationally as the way to ensure services reflect the needs of local communities. Slough has a well-established tradition of co-production that will continue to shape mental health services in a positive way.

3b. **Five Year Plan Outcomes** (Compulsory Section)

Outcome 2 of The Five Year Plan describes how communities will be engaged in initiatives to support Slough residents to become healthier and to manage their own health, care and support needs. The new mental health developments are underpinned by a recognition of the impact of inequalities and social determinants upon health outcomes.

4. **Other Implications**

(a) Financial

There are no direct financial implications of the proposed plans to the Council. The initiatives are already commissioned, or proposed to be commissioned through investment being made through the NHS Long Term Plan.

(b) Risk Management

This report is for information only and there are no immediate risks to be considered.

(c) Human Rights Act and Other Legal Implications

There are no Human Rights Act Implications. All services are provided with respect to individuals' rights and preferences. Legal frameworks including Mental Capacity Act 2005 and Mental Health Act (1983, amended 2007) are applied where indicated.

(d) Equalities Impact Assessment

Equalities Impact Assessment is applied to all commissioned and established services where they are formally provided or commissioned by Slough Borough Council, East Berkshire CCG or Berkshire healthcare NHS Foundation Trust. The objective to improve accessibility and reduce inequality of provision for disadvantaged groups underpins the developments described in the presentation.

(e) Workforce

Recognising the acute national shortage of qualified and /or registered health and social care practitioners, community and voluntary sector initiatives are a crucial element of the overall mental health offer in Slough, and increasingly opportunities are being explored for joint approaches and innovative solutions. Peer mentors and 'Experts by Experience' are also key roles within the new workforce and will be developed as part of mental health plans.

5. Supporting Information

Supporting information is contained within the accompanying powerpoint presentation.

6. Comments of Other Committees

This report was presented to Slough Health and Social Care Partnership Board on 27th October 2020 for information and update.

7. Conclusion

The NHS Long Term Plan (2019) commits to an additional 3.2bn additional investment for mental health, and outlines priority areas for service development. It describes a 'new community based offer that will include access to psychological therapies, improved physical health care, employment support, personalised and trauma- informed care, medicines management and support for self harm and co-existing substance use….and proactive work to address racial disparities'.

The presentation outlines how these services will be implemented in Slough, including a pilot site for Transformation initiatives, and how this will build on the existing provision in the Town, including impact and responding to Covid-19.

8. Appendices Attached

Powerpoint Presentation attached

9. Background Papers

'1' The NHS Long Term Plan (January 2019)

'2' The Community Mental Health Framework for Adults and Older Adults - NHSE/I and National Collaborating Centre for Mental Health (September 2019)

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Healthcare from the heart of your community

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Partnership of Clinical Commissioning Groups

Adult Mental Health Update
Slough Locality

Nadia Barakat
Associate Director – MH, LD, Children's and Families

Seb Byrne – Head of MH Service, SBC and BHFT

Susanna Yeoman – Divisional Director BHFT

Partnership of the Clinical Commissioning Groups for East Berkshire, Surrey Heath and North East Hampshire and Farnham

Focus:

1. Community Mental Health Transformation & Mental Health Integrated Community Service (MHICs)
2. NHS Long Term Plan requirements
3. Deliverables - How are we doing?
4. Slough's Local Offer and East Berks developments
5. Covid-19: Demand, impact and response
6. Covid-19 & Health Inequalities
7. Winter plans
8. Surge Planning
9. What next…..

Frimley Health and Care

Community Mental Health Transformation:

The Mental Health Integrated Community Service (MHICS)

improving health and wellbeing of people with serious mental illness and significant mental health conditions

Frimley Health and Care

Community Mental Health Framework for Adults and Older Adults (2019):

- Recognises the need for more accessible MH services, particularly for people with long term severe mental illness, falling between IAPT and CMHTs.
- Outlines a Place-based community MH model with renewed focus on people living in their communities
- Promotes timely access to evidence based care and treatment
- Highlights the importance for a collaborative approach, supporting people to 'live well in their communities, maximise individual skills, , make use of resources and assets …help them stay well, connect with activities they consider meaningful, which might include work, education and recreation'.

Frimley Health and Care

Frimley Health and Care ICS

- NHS England has awarded £5.2m to Frimley Health and Care ICS to drive the transformation of Community Mental Health Services across Frimley, through development of the Mental Health Integrated Community Service (MHICS).
- The services will be available in 8 PCNs across Frimley by the end of 2020/21. MHICS is already live in some PCNs across Surrey Heath, NE Hampshire & Farnham CCG and Bracknell.
- LOCC PCN in Slough is one of the initial sites and has ‘soft launched’ in November 2020

Frimley Health and Care

Why are we doing this? Key messages across our patch

'Life happens': *clear feedback from service users that community mental health services form only a small part of a person's life and care – people need holistic support and access to services that help them long term with finances, physical health, housing, employment etc.*

GPs and people who use services have told us there is a gap: *Around half of people with significant mental illnesses see their GP to manage the majority of their care and treatment.*

People need support earlier: *People who use services don't want to get to the point of crisis before being able to access support.*

People with significant mental illness have **serious health inequalities**: *17 – 22 years shorter life expectancy across Frimley ICS*

Carers' rights to access support *need to be fully acknowledged and supported, recognising the enormous contribution and challenging role they play.*

Frimley Health and Care

Patient cohort of MHICS

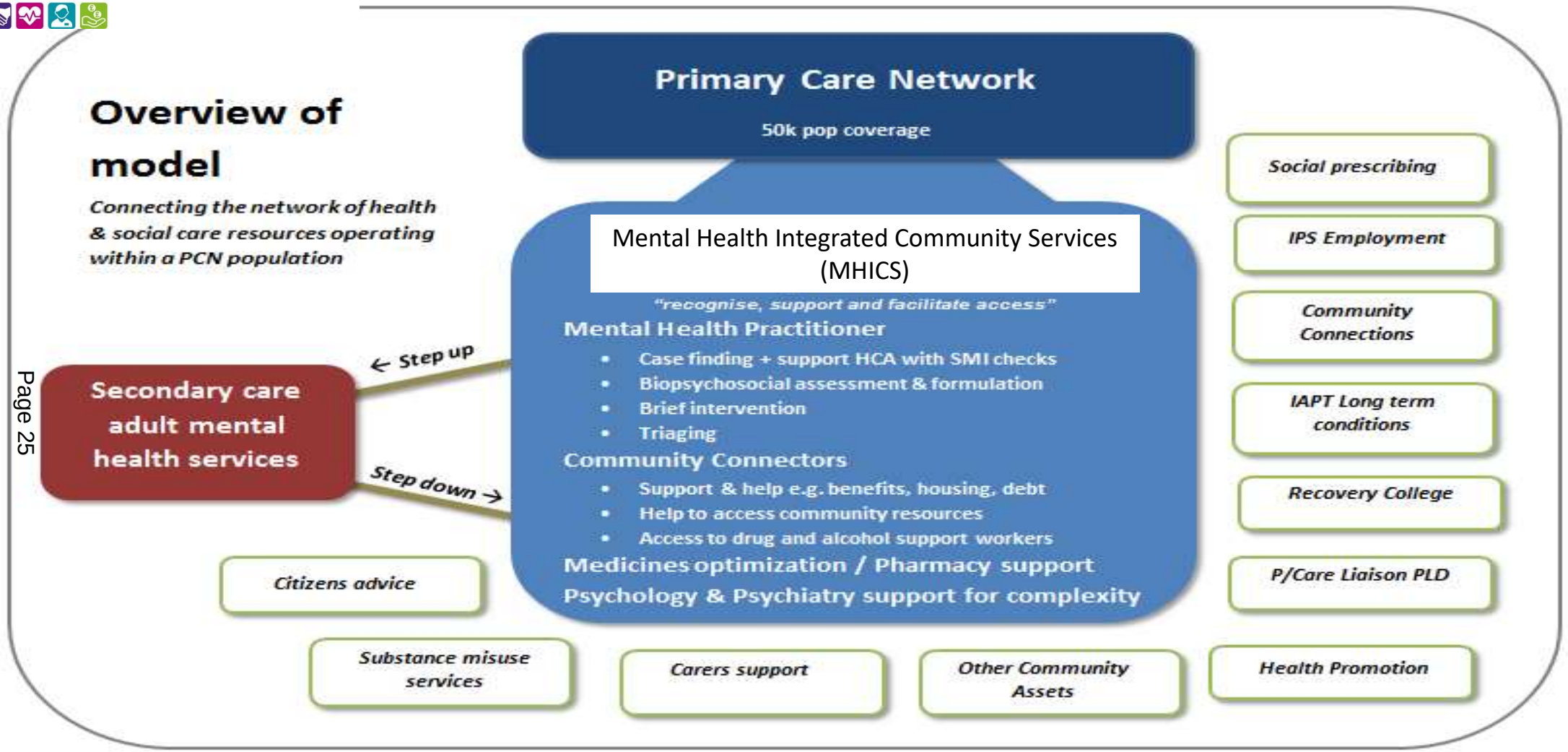
Adults of all ages with significant mental health needs in primary care:

- People falling between services
- People frequently attending GP appointments
- Supporting the outcomes of physical health checks for patients on primary care Serious Mental Illness register
- People with traits of/diagnosis of personality disorder
- 18 – 25 year old focus
- People stepping down from adult mental health services once stable

Frimley Health and Care

Core Principles of the new services

- Support delivered closer to people's communities by locating services in and around PCNs
- Builds on and develop what exists in the community
- An '*easy in, easy out'* approach for people with significant mental illness who may need specialist MH interventions, will improve access to NICE-recommended interventions, removing unhelpful thresholds and barriers
- Working towards care being stepped up and stepped down flexibly without cumbersome referrals & multiple assessments


Overview of model
Connecting the network of health & social care resources operating within a PCN population
Primary Care Network
50k pop coverage
Mental Health Integrated Community Services (MHICS)
"recognise, support and facilitate access"
Mental Health Practitioner
Case finding + support HCA with SMI checks
Biopsychosocial assessment & formulation
Brief intervention
Triaging
Community Connectors
Support & help e.g. benefits, housing, debt
Help to access community resources
Access to drug and alcohol support workers
Medicines optimization / Pharmacy support
Psychology & Psychiatry support for complexity
Secondary care adult mental health services
Step up
Step down
Social prescribing
IPS Employment
Community Connections
IAPT Long term conditions
Recovery College
P/Care Liaison PLD
Health Promotion
Other Community Assets
Carers support
Substance misuse services
Citizens advice

Frimley Health and Care

MHICS Resources: Model being piloted in LOCC

Small new team, co-located with LOCC, consisting of:

- Clinical psychologist practitioner
- Consultant clinical psychologist – supervisor
- Practitioner – Registered Mental Health Nurse / OT / Social Worker
- Consultant Psychiatrist session
- Pharmacist session
- Community connector /support worker – employed by voluntary sector
- Administrator – employed by Primary care

Resources being scoped:

- Support to 18-25s
- Peer support offer

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Additional focus for people with Personality Disorder or difficulty managing emotions

25% of the overall transformation funding is being used to develop pathways for people with personality disorders/ difficulty managing emotions, with three new community components:

- **Psychologically Informed Consultation & Training (PICT):** *specialist expertise available to primary care colleagues*
- **Service User Networks (SUN):** *The SUN provides community-based, open access peer support groups across Berkshire to those who may have found it difficult to engage with other services.*
- **Managing Emotions Programme**:– *3 distinct courses plus Carers workshops. being hosted via Hope College in Slough*

Frimley Health and Care

Next steps

- We will be part of National and local evaluation of impact
- Current submission to NHS England for additional transformation funds to enable the service to be rolled out to additional PCNs

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The NHS Long Term Plan

January 2019

The NHS Long Term Plan

Frimley Collaborative
Partnership of Clinical Commissioning Groups

LTP sets out what it describes as 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"

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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

Clear commitment to increase baseline funding for mental health services and to ensure that local NHS commissioners/system are held to account for achieving this

The LTP has a focus on key areas but local approaches and core MH services are part of a wider picture

*= continued FYFV ambition

All icons used via www.flaticon.com

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Thames Valley
Strategic Clinical Network

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Long Term Plan Deliverables

Area	Deliverable / Target	On Track	Comments
Crisis – Adults	24/7 adult crisis care CRHTTs (Crisis Resolution & Home Treatment Teams) by 20/21	✓	In place
IAPT – Talking Therapies	25% access in Quarter 4 50% recovery rate	✓	IAPT fully operational during Covid and have adapted and transformed by significantly increasing video consultation and computerised CBT, with limited face to face appointments. Anticipate increased referrals and eligibility for IAPT treatment in Q3 and Q4 and are therefore planning to meet the trajectory (25%) in Q4 2020/21.
Integrated Primary Community MH	Transformation programme to test out new model.	✓	This is on plan and have we commenced roll out via nominated PCN's in the programme with minimal delay. To date four PCN teams have launched with another 4 due to launch in Q3 & Q4.
Individual Placement Support (IPS)	Increasing numbers year on year 123 for 2020/21	☒	Q1 activity was lower than planned due to Covid original trajectory has been revised in discussion with IPS Grow. Despite this challenge work is being done to optimise IPS offer: • Stretching fidelity to the model to include job retention • Proactively monitoring caseloads to ensure capacity in the service is being maximised • Caseload management
Perinatal	Women accessing specialist Perinatal mental health services - 7% of birth rate	✓	Projecting to deliver this access rate
Eliminate Out of Area Placements - adult acute care (OAPs)	Inappropriate adult acute mental health Out of Area Placement (OAP) bed days	☒	The need to reduce the number of beds to adhere to Covid guidance, combined with increased demand has meant our trajectory for OAPs that does not see us achieve our original stated position by the end of 2020/21

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Long Term Plan Deliverables

Area	Deliverable / Target	On Track	Comments
Adults Crisis	Liaison MH Teams achieving Core 24 - Crisis Response (1 hr and 4 hr)	✓	In place and achieved
Physical Health Checks	60% of those on Serious Mental Illness (SMI)	☒	Health checks affected by Covid & the impact of social distancing , reduced face to face access in primary care and patient anxieties will have contributed to the reductions in health checks. This is likely to be further impacted by the expected increased pressure in primary care during winter period. Work being led by clinical leads to improve performance by year end.
Dementia	67% dementia diagnosis rate	☒	Our elderly population has been severely impacted by the pandemic which has resulted in a significant drop in QOF register numbers , demonstrating the number of people who have sadly died.
Early Intervention in Psychosis	60% of people with first episode of psychosis who have accessed or are waiting for treatment	✓	Achieved
Children & Young People Access	Improving CYP Access rate to MH services 0-18 yrs to 35%	✓	Significant work has gone into ensuring data is being submitted from all providers (NHS & voluntary) and on track to meet this target.
CYP Eating Disorders	95% Urgent referrals within 1 week 95% Routine referrals within 4 weeks	☒	Referral for CYP Eating Disorders steady but now an increasing number of urgent referrals. This upsurge in referrals aligns with research findings emerging from the UK and other countries exploring the implications of Covid-19 for CYP.
CYP Crisis	35% coverage across STP - 24/7 CYP mental health crisis provision for children and young people that combines crisis assessment, brief response and intensive home treatment functions	✓	Currently achieving but increasing provision of planned for implementation in 2021/22.

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Slough priorities

(from Slough Local Authority Voluntary and Community Sector Board)

Outputs	Outcomes	Overarching Outcomes
• Development of self sustaining low level support to improve mental health • Development of Community Champions/Peer mentors • Increased engagement and volunteering within communities. • More carers identified and supported within communities. • Increase in reported engagement in physical activity • Decrease in individuals reporting isolation and loneliness as an issue • Increase in those accessing support for benefits/ management of debt • Increase in those accessing digital support • Development of Community Champions/Peer mentors	• Improve the mental health of residents • Connect people and communities • Service • Individuals report they feel they are able to make informed choices to feel in control, safe and able to plan how to better manage their care and support needs. • Individuals feel they are more able to establish or maintain living independently • Improvement in the physical activity of residents • Improvement in the health and wellbeing needs of residents • Reduce poverty by providing support to maximise benefits and other schemes to improve quality of life. • Avoid or reduce the risk of eviction/homelessness • To access services through different channels.	• Our people will be healthier and manage their own care needs. • Slough children will grow up to be happy, healthy and successful. • Increase healthy life expectancy in Slough. • Increase the proportion of people living independently at home. • Reduce the amount of attendances and admissions to hospital, and the length of these stays. • Reduce the number of children classified as obese.

Healthcare from the heart of your community

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Some Local Developments in Slough and East Berkshire

Partnership of the Clinical Commissioning Groups for East Berkshire, Surrey Heath and North East Hampshire and Farnham

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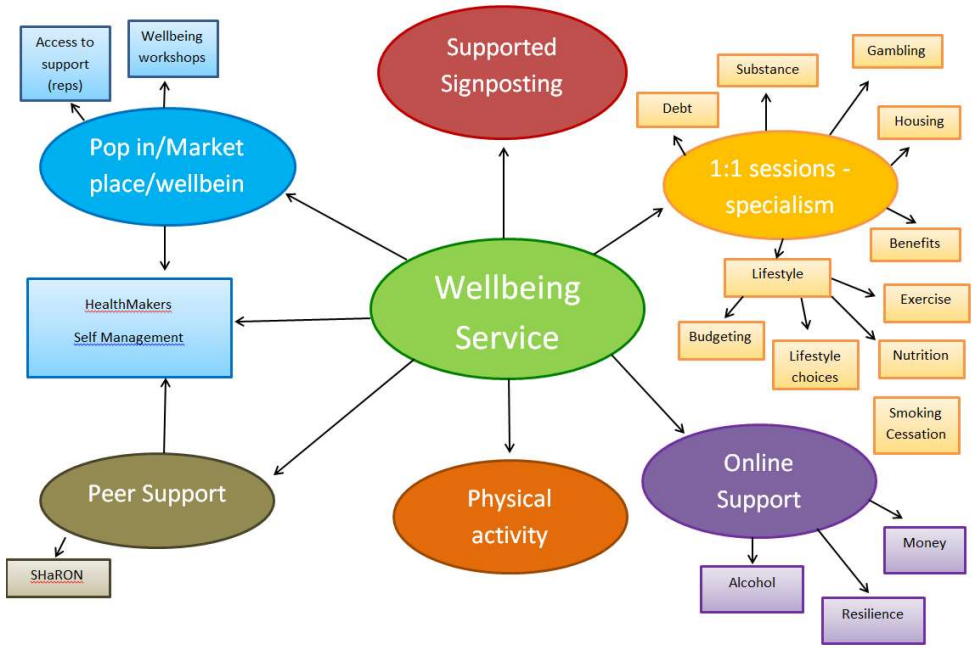
Wellbeing Service

Referrals	June	July	August
Slough	18	30	15



A person can self refer or be referred by a health care professional. If a patient wishes to self-refer they can via the Talking Therapies Self Referral page (this is due to be updated to include info on the Wellbeing Service) or a Health Care Professional can refer via the Gateway form.

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Employment Support Service - IAPT

What we do!! supporting Talking Therapies clients

Find…

helping unemployed clients to find work, including assisting with CVs, cover letters, job searching, application forms, mock interviews, and identifying key skills

Retain ….

supporting clients to stay in work, including advising on grievance procedures, informal workplace issues, the disciplinary process, and time management

Return…

helping clients who are signed off sick to return to the workplace, including help with return to work meetings, phased returns, reasonable adjustments, Wellness Action Plans, and the role of occupational health

Number of referrals…

Bracknell	WAM	Slough
		
212	232	295
29%	31%	40%

Outcomes …

Find	Remain	Return
		
172	158	45
46%	42%	12%

Healthcare from the heart of your community

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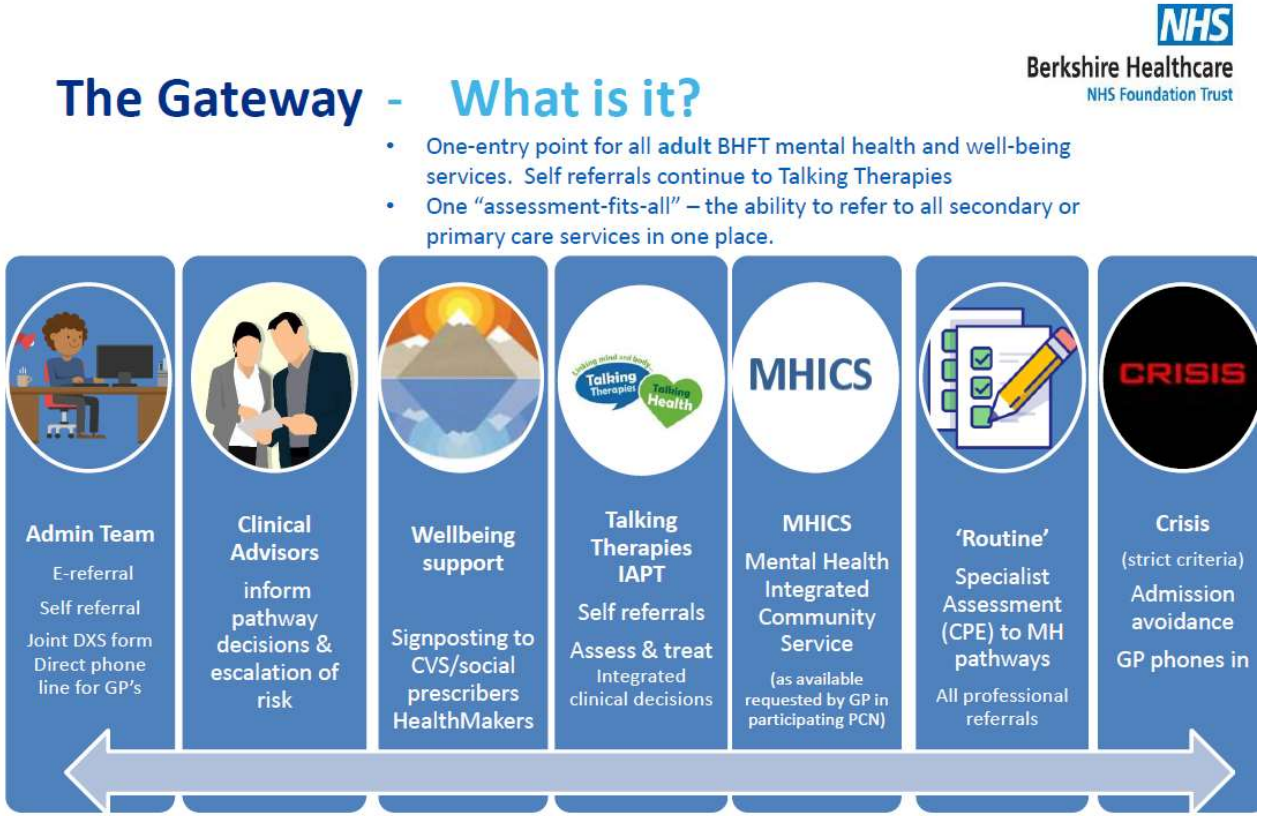
The Gateway



Regular community events celebrating and raising awareness of mental health: Reducing loneliness and increasing a sense of purpose and belonging

- Launch of our co-produced website: already over 6000 views

www.EnablingTownSlough.org

- Celebrated Mental Health Awareness Week in May: Challenged members to come up with and do an act of kindness over the week

- World Mental Health Day 10th October: over 50 service users, carers, peer mentors and community partners presented in 3.5hr-digital event, attended by dozens

ENABLING
TOWN SLOUGH

Why We Exist | Community Opportunities | Community Stories | Resources | News & Events | ENG

If you are a service user or carer, please login here.

BUILDING ON THE STRENGTHS AND ABILITIES THAT ARE INTEGRAL TO THE SLOUGH COMMUNITY.

Enabling Town Slough aims to create a common purpose, a sense of belonging and build connections throughout our community. Through these community connections we can be more innovative, and create an enabling environment in which we can all thrive by being Stronger Together, and address isolation and loneliness.

Our Mission, Vision and Values
What is Co-production?

EMBRACE therapeutic programme was formally Accredited in May 2020!

"The functionality of the fourth phase of membership encourages current members to go out and create their own groups and workshops in the community."

"The extent of co-facilitation and co-production in the community was abundantly clear. Members are clearly involved in all aspects of running the programme; the feeling of ownership that arises from this was apparent. The impact of such inclusion and co-facilitation was telling."

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NHS Foundation Trust

Hope College

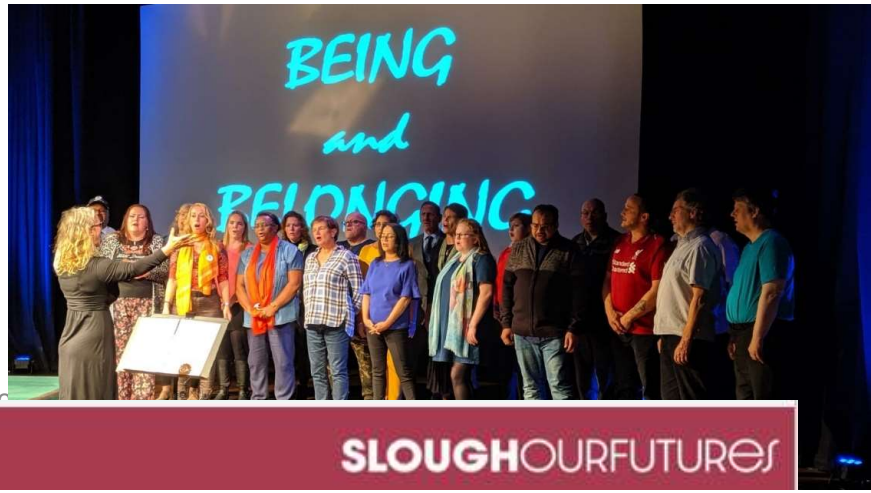
HOPE College
Slough Recovery Services

- Moved to digital offer during Covid: Over 20 digital courses

offered this term, including One Voice choir, Covid Emotions and Men Talk2

- Access through website
- Co-production with peer mentors, service users and carers strong through Covid
- Carers' support
- Independent Placement Support:

employment opportunities and successes



Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

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Partnership of Clinical Commissioning Groups

Covid-19 and Mental Health

Partnership of the Clinical Commissioning Groups for East Berkshire, Surrey Heath and North East Hampshire and Farnham

Covid-19: Local Demand & Impact

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- Initial drop in activity, now increasing activity to pre-Covid-19 levels
- CMHT increase of 28% in contacts, mainly phone and digital
- Greater % of more complex presentations and people with increased acuity
- New presentations of serious mental illness and admissions into acute psychiatric beds – occupancy sustained below 85% but included people not admitted for many years or some people previously unknown; Increasing number of patients with autism presenting to inpatient services
- More safeguarding referrals due to domestic abuse
- Increasing access to CYP online counselling, & steady increase in requests for voluntary sector advice & guidance from parents needing support with issues such as finance, family life & return to school; impact on CYP with autism
- PPE requirements/ cleaning regimes impacted face to face capacity & activity

Covid-19 – Local Responses

NHS
Frimley Collaborative
Partnership of Clinical Commissioning Groups

- Accelerated use of digital platforms - digital & telephone offers providing continued access to services including Recovery College; increasing accessibility overall and reduced Did Not Attend rates
- Digital safety plans and mood app available to all MH service users
- SH@RON online social network service is available for a number of services including Eating Disorders, IAPT, Perinatal, CAMHS, Learning Disabilities and Early Intervention in Psychosis
- One service piloted provision of IT kit to service users who would not otherwise have been able to access our online offer
- New innovation in IAPT - use of instant messaging, single session therapy and webinars. Wellbeing resources available online including brief mindfulness exercises and bite-size information videos and prioritising NHS, care & care home staff
- 24/7 all age crisis lines - streamlining the referral routes from NHS111 into local mental health services
- fast track workforce wellbeing offer and Bereavement support
- Proactive review of those with SMI - Safety planning & welfare checks across all CMHT/ CAMHS teams taking account of clinical risk, vulnerability, frailty and isolation
- Contacting shielded patients.
- Increasing voluntary sector community support

Covid-19 Response cont

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Children & Young People

- #coping guide for children and young people and families during lockdown
- Continued focus on the roll out of MH Support Teams ready for when schools re-open
- Online CYPF resource updated with local CAMHS offer, self-help, online resources, system support offer and is linked to the local authorities' local offer
- Proactive focus on the needs of CYP particularly with school closures & impact. Regular system partnership discussions taken place during 1st wave ensuring access to early help/intervention services, & oversight against the core LTP deliverables.
- Services continued through digital / virtual platforms as well as setting up webinars for system partners in supporting children and families.

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Addressing Health Inequalities

Caseloads and waiting lists reviewed to ensure those with highest risks & needs able to access help they need.

Continue blended offer of digital and face-to-face services, promoting choice & more opportunities for people to access support.

Restoration plans include face to face and home visits where clinically indicated, to improve access for those who are digitally impoverished & give better quality insights into clinical need and risk that is difficult to detect from digital media alone.

BAME targeted work:

- Targeted BAME staff support with development a risk assessment tool for vulnerable groups, personalised risk mitigation plans & regular engagement with all staff re: their protection
- The #OneSlough collaboration of key local organisations developed rapid pilot project to test approaches to strengthening ability of individuals & BAME communities to protect themselves from both the direct and indirect harms of Covid-19
- In parts of the system CAMHS have updated their dashboards to provide visibility of ethnicity in caseload and enable better monitoring and awareness.
- Standard work is in development in CPE to monitor vulnerable groups (including BAME) for prioritisation
- Working at place to map and coordinate 3rd sector support to the BAME community and develop care navigation
- Monitored uptake & use of digital and non-face to face use tracked against demography

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Surge Planning

- Beginning to see and feel impact of increasing demand and acuity in mental health
- Initial modelling demonstrates an upsurge of up to 30% p.a. in demand across all services
- IAPT modelling - working collaboratively with IAPT providers to model suppressed and Covid-19 demand and new ways of expanding workforce. Similarly expecting to see up to 30% increase in demand identifying types of referrals along with the timeline of referral types into the services over a 3 years period.
- Biggest challenge = when surge will commence

It is important to note the modelling carried out to date based on current position & doesn't take into account 2nd wave, winter pressures or impact of Brexit.

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Winter Plans

- National winter funding circa £20m for re-allocation to front line services facing significant challenges with a focus on:
  - ensure mental health patients of all ages continue to receive contact,
  - support and evidence based treatment during the upcoming winter and in context of ongoing restrictions associated with the Covid-19 pandemic;
- In addition to MH Investment Standard and additional Covid-19funding
- East Berks schemes include:

- additional capacity to A&E liaison
- Additional capacity to CYP rapid response
- Additional expertise to support referrals via 111 / CPE

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Partnership of Clinical Commissioning Groups

What next?

- Partnership working at Place with all Slough partners
- Continue to work to Long Term Plan ambitions - reporting regularly locally & nationally
- Community Crisis Transformation and Suicide Prevention initiative investments
- Planning for 2nd wave contingency
- Flexibility & agility to respond to what comes next….

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

NHS
Frimley Collaborative
Partnership of Clinical Commissioning Groups

Thank you

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Partnership of the Clinical Commissioning Groups for East Berkshire, Surrey Heath and North East Hampshire and Farnham

Slough Borough Council

SLOUGHOURFUTURES

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