Berkshire Healthcare NHS
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Update to Slough Health Scrutiny Committee:
November 2017
Jill Barker - Regional Director
Susanna Yeoman - Locality Director

Healthcare from the heart of your community

www.berkshirehealthcare.nhs.uk

About us

- **Main provider** of **community** and **mental health services** to the **population of Berkshire.**
- We also provide the **Out of Hours GP service** in the West of Berkshire.
- Annual income of around **£240m**, employing approximately **4,400 staff** and providing services from just over **100 sites** – **"Healthcare** from the **heart** of **your community".**
- In terms of scale the Mental Health and Community Health services, portfolio are of equal size – we are a combined trust.

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Our **CQC rating**

In **December 2015** Berkshire Healthcare had its CQC inspection. More than 100 inspectors visited and assessed our services, teams and overall patient care.

In March 2016 we were awarded a rating of 'good'. This was the first time that any similarly combined Trust (mental and community health) in the south of England achieved this status. Feedback from our patients, staff and the inspectors was very positive and we are immensely proud of this rating.

We will continue to **work together** to improve the areas where recommendations were made - our goal in the future is to increase our overall rating to outstanding.

Care Quality Commission

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Berkshire map

- Population of just under one million, covering 500 square miles
- **Since 1998** made up of six unitary authorities – **West Berkshire**, **Reading, Windsor & Maidenhead**, **Wokingham, Bracknell Forest** and **Slough**
- 7 CCGs

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Our **services**

- **We provide nearly 100 different services –** many jointly with Local Authority partners.
- **Split approximately 50:50** between **mental** and **community health.**

Examples of the type and range of services we provide:

Mental Health Services

- **Community Mental Health Teams**
- **Older People's Mental Health Services**
- **Memory Clinic**
- **Talking Therapies (IAPT)**
- **South Central Veterans Service** – provided across the South Central Region
- **Child and Adolescent Mental Health Services**
- **Inpatient Mental Health Services** – Prospect Park Hospital, Reading

Community Health Services

- **District Nursing**
- **Sexual Health Services**
- **Podiatry Services**
- **Audiology Services**
- **Integrated Children's Services**
- **Learning Disabilities Services**
- **Physiotherapy**

Primary Health Services

- **WestCall – Out of Hours GP service in west of Berkshire**

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Annual Report and Accounts 2016-17

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Some Recent Highlights

STP and partnerships

Mental Health Liaison
Core 24 and CAMHs Rapid Response

Talking Therapies
IAPT and PINC for Long term conditions

Connected Care Record
Share My Care
Live from February 2017

Memory Clinic accreditation

Early Intervention in Psychosis

Compassionate Leadership

Agency Staffing Reduction

CYPF
On Line Resource
Eating disorders
T4 provision

Technology Developments
Global Digital Exemplar
Mobile working and SHARoN

LD
In patient quality
Transforming care
Community model

Perinatal mental health development

Patient experience

We ask patients and carers to tell us how they rate the care they received. An overall improvement on the previous years of those who would rate us as good or very good.

- **Community Hospitals – 96%**
- **Community Physical Health – 94%**
- **Community Mental health – 86%**
- **Mental Health Inpatients – 75%**

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Our **goals** for 2017-2018

Goal 1: **Improving patient safety and experience**

To provide safe services, good outcomes and good experience of treatment and care

Goal 2: **Supporting our staff**

To strengthen our highly skilled and engaged workforce

Goal 3: **Money matters**

To deliver services that are efficient and financially sustainable

Goal 4: **Working together**

Understanding and responding to local needs as part of an integrated system

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Annual Plan Summary 2017-2018

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Goal 1: Improving patient safety and experience

To provide safe services, good outcomes and good experience of treatment and care

- All our services will contribute to an outstanding Care Quality Commission rating
- Every team will use peer review, accreditation or bench marking to guide improvement, so we can achieve consistently good performance across services and localities
- Our Friends and Family Test response rates will be at least 15% in each service
- We will introduce a consistent approach to quality improvement, building the foundation of a long term commitment to improving services, informed by staff, service users and carers
- As part of our Zero Suicide initiative, we will work to achieve a 10% reduction in numbers of people known to us, taking their own lives by 2021
- We will reduce our use of restraint so we are in the lowest 10% nationally
- We will continue to achieve low numbers of falls (less than eight per 1000 bed days) and no pressure ulcers as a result of a lapse in our care
- We will expand our on-line access to services to include three new service areas using Skype and our Support Hope and Recovery Online Network (SHaRON).

Goal 2: Supporting our staff

To strengthen our highly skilled and engaged workforce

- We will achieve at least 77% of staff saying they recommend our Trust as a place to receive treatment as reported in our staff survey
- Staff recruitment and retention plans will be completed and implemented in all services with high levels of vacancy
- Staff development opportunities will be provided in a fair and equal way, so that people are supported to develop their careers with us
- Managers will receive training in Compassionate Leadership, with an agreed charter in each service area
- We will develop a new intranet to support staff to make the best use of technology, and identify three services to develop technology solutions that can be applied across the organisation.

Goal 3: Money matters

To deliver services that are efficient and financially sustainable

- We will deliver our financial plan for the year
- Our internal savings programme will save £4.7m
- We will improve efficiency through procurement, completing e-rosters six weeks in advance and reducing agency staff to less than 8% of the total, and lower as agreed with services
- We will reduce our out of area placements to ensure that these are eliminated for people needing non-specialist acute mental health care by 2021
- We will use benchmarking information and peer review to make sure that corporate services are performing effectively across our organisation and in comparison with others.

Goal 4: Working together

Understanding and responding to local needs as part of an integrated system

- All our health and social care joint teams will have access to joined up patient records – we will use Connected Care to improve both patient experience and job satisfaction of staff
- We will achieve reductions in urgent admissions, delayed transfers of care and out of area placements across our inpatient services
- As a result of the outcomes we are achieving, we will maintain or improve levels of commissioner satisfaction and investment
- We will achieve the objectives set out in the Equality Plans for each locality
- Our targets for use of fuel and water and our green travel objectives will be met.

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

caring for and about you is our top priority

committed to providing good quality, safe services

working together with you to develop innovative solutions

Some of Our Priorities for 17-18

- **Quality Improvement Programme:** *Launched our QI programme, with partners Thedacare and KPMG; Developing new ways of working for continuous improvement and positive patient experience across the whole Trust. Wave 1 –Community and mental health wards and Wave 2 - community nursing teams*

- **Workforce:** *continued focus on staff engagement and recruitment initiatives*

- **Equalities:** *7 goals to address service delivery and workforce inequalities*

- **Zero Suicide Initiative:** *Challenging the culture relating to suicide and giving people skills to address situations when people are at their most vulnerable*

- **Managing demand:** *Inappropriate out of area placements will have been eliminated for adult acute mental health care*

- **Continued partnerships** *with STP and system partners*

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Community Nursing

case study

Jane‘s story

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About Jane

- Palliative 48 year old lady, breast cancer, brain metastasis, query cord compression
- Lives with husband and supportive children (young adults)

The Context

- Deteriorating, towards end of life
- Headaches since reduction in steroids
- Back pain and totally immobile
- Husband providing all physical care but now not managing and emotional enormity of situation hitting home

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Emotional and
Psychological support

For patient and family

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- Difficult conversations around accepting hospital bed in living room, preferred place of care (to remain at home), when and why syringe pump being used and DNACPR. What to expect and what they need to do and who to contact following death.

- Signposting and referring to Marie Curie, Hospice services, continuing health care, benefits advice line as husband not working in order to support wife's care.

- Bereavement support - the District Nurses follow up to support, arrange collection of equipment, sign post as required to ongoing support.

(Communication and coordinating care can take up significant time, liaising with GP, Palliative care team, social service, reablement team, TVNs)

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Symptom control

Including ‘just in case’ medication’

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- Headaches since reduction in steroids, review of steroids in conjunction with GP and Palliative care team both for what immediate dose should be, to manage symptoms and plan for steroids in the future if unable to take orally.

- Review of back pain, assessed for cord compression by GP and MDT agree not appropriate for active treatment or management.

- Risk of aspiration, struggling to swallow oral medication, syringe pump commenced incorporating analgesia Morphine Sulphate and antiemetic.

- Monitoring, advice on oral medication with rectal intervention if required.

- Catheter inserted for patient comfort once unable to transfer out onto the commode. Family shown how to empty and manage catheter bags.

Personal care

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- Plan for care needs ahead

- Husband wanting to support and manage himself. Crisis on a Saturday morning when he is emotionally and physically struggling. Reablement do not have capacity to support over weekend but agreed to picking up on Monday and assessing first thing

- District Nurses provided immediate care and then liaised with rapid palliative support team at the Hospice who supported through Sunday to prevent a hospital admission

Skin care

- Limb oedema, mottling of legs as circulation compromised and shutting down. Support and advice for family around moving and handling, positioning limbs for comfort and use of hospital bed to support this.

- Assessment for risk of pressure damage
- Discussion with Tissue Viability Nurse to ensure all appropriate care given

Equipment

- Ordering hospital bed, commode sliding sheets, pressure relieving equipment all in place, can be ordered on same day delivery or on a forward planned basis.

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Thank you…

Any questions?

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