

BHFT DRAFT Mental Health Strategy Update for Reading Health & Wellbeing Board

V4

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GDE
Digital solutions for
outstanding healthcare

Vision – key elements to include

- Personalised care, an all age pathway
- Clinical leadership development (inc. non medical, nurse consultants working differently, working with communities)
- Provision for medical workforce development
- Approach to partnership working
- Cultural shift personalised, co-produced, social asset based approach
- Collaborative working with VCSE
- Urgent care close to home
- One team approach
- Patient centred – shared care, co-produced
- Responsive and flexible, adaptable and accessible
- Community

Vision – a 1st draft

- We recognise that people's wellbeing is a combination of emotional and physical health and aim to support the whole person as individuals and as a community.
- We will deliver personalised care, that is co-produced with the individual, based on a social assets based approach. We will work with communities and partners, providing responsive, flexible, adaptable and accessible services. We will maintain a focus on unwarranted variation and inequalities in outcomes.
- We will do this by supporting and developing our staff. We will create a clear pathway of Clinical leadership development (workforce development, non medical, nurse consultants working differently, and working with communities). We will work with our partners to develop new roles reflecting our holistic, community based approach to emotional well being.

Aiming to solve

- A focus on the whole person not just the diagnosis of mental ill health
- Complexity of our systems – for patients and our professionals
- Lack of consistency across localities/teams
- Disjointed working between teams
- Duplication of processes – we need to be more efficient
- Transition from CYP to adults
- Investing in and developing clinical leadership and operational and management leadership
- Integrated working with LA, PCNs and other providers (collaboratives)
- Focus on outcomes and experience, patient reported outcomes and tracking improvement
- The time it takes to deliver change!

Translates into 10 areas

Data
PHM
Demand and
capacity

Outcomes
Patient experience
Carers
Health inequalities

Shared care

Our people
One team
Role &
responsibilities
Staff wellbeing
Staff/team
development
Lived
carer/experience
roles

Efficient working
Processes
Assessments
Communication

“risk”
Internal
processes

Clinical
leadership
Driving &
leading care
Thresholds

Pathway
development
Partnership &
integration
In/out of CMHT
with PCNs
Digital treatment

Prevention
?IAPT
?Digital
Pre-assessment

ASD & co-
morbidity

Mental Health strategy: Outcomes



Community Mental Health

- One Team MDT approach to community based mental health services
- Focus on those with complex needs
- Integrated with Primary Care Networks, VCSE and Local Authority services
- Working across our two local systems in mental health provider collaboratives



Alternative Provision for those in Crisis

- Working with our voluntary and community partners to provide alternative forms of provision for those in crisis
- Extend the Urgent Community Response offer to include mental health nurses, with a 2 hour response



Physical Health in SMI

- Working with our community physical health services and voluntary and community partners maximising physical and mental health



Children & Young People

- Extension of pathways from 0 – 25 (from 0-18 previously)
- Working across Frimley with SABP to transform Eating Disorder services



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

Mental Health strategy: Outcomes



Out of Area Placements

- Elimination of all Out of Area Placements by end 23/24
- Reduce OAPs down to national average of 32 days

Access and waiting times



- Reduced waiting times in xxx
- Increase in referrals to Talking Therapies
- Improved early intervention and prevention in partnership with VCSE and communities



Improved Dementia Care

- Enhanced community teams to include dementia support to align with Primary Care networks
- Needs assessment to Dementia in Care Homes linked to Vanguards
- Ensure the development of a Clinical Assessment Service incorporates 'out of hospital settings' including care homes



Reducing health inequalities

- Deliver the MH Act Detentions programme of work
- Use data to understand variations in outcomes, service accessibility, wait times etc and have appropriate remedial actions in pace

Mental Health strategy: Enablers



Co-production

- Working with VCSE and communities
- Embedding lived experience in the heart of our planning and service design



Data and PHM

- Using data and evidence based interventions
- Using PHM to proactively identify patients and address areas of inequalities



Working SMART

- Reviewing internal processes, eliminating waste and duplication
- Using digital and technology



Our People

- Continue the focus on staff wellbeing
- Working across Frimley we will work with SABP supporting new roles and ways of working
- Continue to develop our lived experience workforce
- Supporting our staff embrace diversity across staff and patients