Name of meeting: **Health and Adult Social Care Scrutiny Panel**

Date: **Thursday 5th November**

Title of report: **Planning for winter across Health and Social Care in Kirklees**

1. BACKGROUND/KEY POINTS

1.1 A&E Delivery Boards

The focus for the operational response to the winter pressures in Kirklees is through the two local A&E Delivery Boards which are based on the acute Trust footprints; Calderdale and Huddersfield and Mid Yorkshire (in Mid Yorkshire this is called the A&E Improvement Group).

The plans are developed by the A&E Delivery Boards, supported by a representative from NHS England who sits on the board. Any change or modifications to the plans are discussed and agreed at the A&E Delivery Boards and monitoring against the plans is part of the monthly A&E Delivery Board agenda.

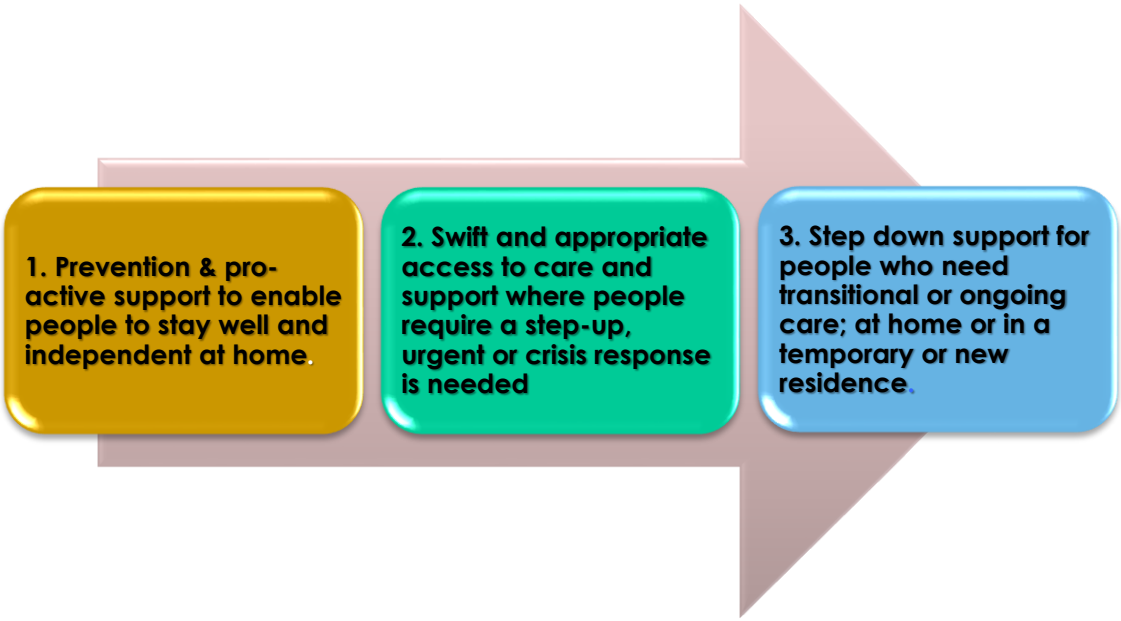
A perfect storm – this winter is likely to be our most challenging yet; Covid -19, peaks, seasonal flu, other winter-related conditions – set within context of huge reductions in capacity and social distancing (face to face care, support offers, beds etc), deepened health inequalities and financial pressure.
In the first Covid-19 - disproportionate impact on; people living in deprived areas, BAME population, those in certain occupational groups, people with long term conditions, and those who have not accessed essential physical and mental healthcare during the pandemic.

The huge economic/employment impact of Covid-19 on families and businesses, which will exacerbate the impact of winter.

It is not a challenge for one part of our system. We have learned that we work best together - taking learning from the work we did together during the first pandemic peak

1.2 Calderdale and Huddersfield

In relation to the Calderdale and Huddersfield Acute Urgent Care system, the focus of the winter plans was to combine the winter plan with the Covid reset plan in one plan focussing on 3 key areas as agreed by partners across the system;



Within each step above a number of priorities have been agreed;

Step 1; Prevention

- Maximise support for vulnerable households/individuals: food, warmth, isolation, transport, digital access
- Support unpaid carers
- Strong wrap-around multi-agency support to care homes
- Access to a menu of elective care offers
- Ensure resilience in home care market
- Timely access to community support, and reablement
- Clear and effective Directory of Services, deliver NHS111First, with links to Single Point of Contact/Gateway to Care
- GPs treating all their on-day demand
- Optimise A&E access by reducing avoidable attendances
- Greatest year for flu uptake; staff and population

Step 2; Access

- Clear and effective Directory of Services, deliver NHS111First, with links to Single Point of Contact/Gateway to Care
- Two hour community rapid response; admission avoidance, follow-up, reablement
- Community based frailty and Out-Parenteral Antimicrobial Therapy services (and identify any others)
- Protect critical care capacity for those who most need it (minimising avoidable hospital admissions)

- Access to appropriate End of Life Care (hospice care; beds, outreach, respite)
- Timely access to NHS111First , NHS111 and 999 capacity

Step 3; Step Down

- Timely access to reablement, intermediate care and discharge support to avoid readmission and provide on-going support as needed
- Integrated discharge teams (Reason to Reside tool), effective assessments in A&E, proactively on wards, Trusted Assessors
- Appropriate Discharge to Asses and community bed capacity
- Effective mental health pathways
- Maximise support for vulnerable households; food, warmth, transport, digital access (maintain volunteering support & restore 3rd sector support)
- Establish community stroke/rehab beds

Action plans are in place against each priority identified to show how this will be delivered.

As in previous winter planning the National Escalation Framework will be utilised and the ECS monitored alongside the use of OPEL triggers throughout the system and specific focus around, workforce, strengthened operational management, focus on SAFER and reducing delays, divisional winter plans and the usual EPRR around pandemic flu, EU Exit, Extreme Weather and critical incident plans to ensure Business as Usual is maintained throughout the period.

Additional command and control processes have been put in place which can be quickly stepped up as required through the winter period.

1.3 Mid Yorkshire

MYHT have approached winter in a similar way to CHFT having a combined winter 2020/21 plan and Covid-reset approach in conjunction with key stakeholders.

The aims are;

- To support a safe organisational increase in activity to the highest possible level within the new operational framework
- To work with system partners to establish alternative service delivery models and new methods / places of delivery where needed
- To maximise the value of any activity by eradicating waste and duplication
- To provide a resilient service delivery model in the event of a second Covid wave or other significant system impact

To achieve these aims a 5 working principals are adopted;

1. To optimise the Pontefract Site for “cold Surgery”. To offer 3 sessions days/7 days per week by offering staff a combination of additional activity and overtime. To support the clinical teams by investing in administrative staff and portering and domestic staff to reduce waste and optimise productivity.
2. To increase high volume daycase activity at Dewsbury District Hospital (DDH) with an opportunity to have 3 sessions days/7 days per week working as per

principal 1. To maintain a smaller and discreet surgical bed base in order to support their work but to allow Division of Medicine to increase capacity for the Winter surge.

3. To ensure that medical patients are contained in an extended medical bedbase (no outliers) with the following:
    - 2 site focus (DDH and Pinderfields)
    - Expanded bedbase at DDH with an associated medical staffing model
    - Maintain Medically Optimised For Discharge (MOFD) list to less than 30 patients
    - Achieve Referral to Admission of less than 60 mins
4. To maintain Out Patient Activity through the planned use of Non Face to Face appointments and video consultation plus use of weekend clinics where staffing allows. Note required increase in support staff.
5. To optimise the use of the independent sector and Any Qualified Providers (AQP) (in reach as well as off-site) to enable an increase in activity.

Delivery will be managed through local divisional activities with activity co-ordinated through existing reset structures. A dedicated Senior Responsible Officer (SRO) has been appointed for winter who is a member of the reset steering group.

Escalation will be to the twice weekly executive meetings that remain in place

External escalations will be delivered via the joint strategic oversight group and associated workstreams

1.4 Locala

Overview of preparations for winter;

Locala have been taking an integrated approach to planning and service delivery as part of the response to Covid and in preparation for the winter period. A review of current services have taken place, reformation planning is coming to an end as part of service re-starts, pathways relating to Discharge to Assess (D2A) and Admission avoidance have been prioritises to ensure the home first approach is embedded throughout services with the aim to avoid admissions and to ensure a speedy safe discharge.

Locala are working closely with partners at Trust and Community level to ensure an integrated, consistent approach to service delivery and problem solving. A winter plan has been submitted through internal governance systems and will be shared detailing the service offer and contingency planning during the winter period.

The Intermediate Care (IMC) beds review and model has ensured robust pathways as part of the step up and step down of patients, with excellent working relationship with the Local Authority as part of this along with the D2A bed modelling. Further work is ongoing with the D2A pathway to review the process and ensure that patients' needs are being met within this short term period.

All of the above links in with the Trusts area of focus relation to prevention of admission, step up and Urgent Community Response (UCR) as well as improved and enhanced discharge pathways and workforce.

Lessons learned from the winter period 2019/20;

- All partners continued to experience staffing challenges and are likely to do so for the foreseeable future. Mutual aid support was offered during this time
- System pressure calls with the local Trusts and partners have been effective across Kirklees
- Demand for health and social care services continued to rise in A&E attendances. Kirklees relied on additional capacity beds to manage demand.
- Partners have demonstrated good system working.
- Trusted Assessor roles within Kirklees Independent Living Team (KILT) were assessed which resulted in colleagues within Short Term Assessment Response Team (START) taking on the Trusted Assessor roles (through signed agreement) to support the speedy assessment and care being put in place.

Feedback and experiences of service users from last winter period;

Locala regularly monitor patient experience and feedback on a monthly basis including compliments and complaints. For example; we have some positive patient feedback relating to the speedy process of discharge into IMC beds with positive experience for their time within this setting.

Measures being put in place to mitigate any additional pressures created by a resurgence of COVID-19;

In addition to this learning, there has been learning in response to Covid-19 between March and September 2020.

- Increased demand to support patients to be rapidly discharged from hospital in line with the Discharge to Assess Guidance
- Additional D2A beds were procured across Kirklees with demand taking up approximately 60% of the beds (these will continue during winter)
- Increase in 0-2 hour response for the Integrated community care teams (ICCT) and START services
- Reduction in face to face consultations for GP practices and other health services
- New guidance and service offer for hospital discharge and admission avoidance pathways have been introduced and revised for winter
- Redeployed colleagues worked across the system internally within Locala and as part of mutual aid support
- New KILT referral form was introduced in September with the aim to adapt to be wider integrated discharge form for health and social care services.

New measures

- Discharge to assess process is under review with the move towards a more integrated referral form and pathway for patients with Health and/or social care needs (Pathway 1-3)
- D2A pathway to support patients therapy needs in the beds is in development

- Enhanced resources being put into to the hospital discharge team to support patient discharge in a timely manner
- Enhanced resources in START to support admission avoidance
- Enhanced resources in the Care Home Support Team to support discharge, admission avoidance and advance care planning
- Internal tactical system to escalate and manage risk
- Reviewing pool of trained staff who were redeployed in preparation of any national guidance for service priorities
- Locala representation at Trusts tactical meetings including Multi-Agency Discharge Event (MADE) to support integrated approach to discharge
- Additional funding for therapy input into non weight bearing pathways

1.5 Kirklees Council

The Council each year reviews its winter plan to ensure that the system works together to ensure that people with health and social care needs are supported in the most appropriate and joined up way. This year we approach winter whilst managing the impact of a pandemic. The government in response has provided guidance and resources to support hospital discharges and the wider health and social care system throughout what will be a challenging season. The measures below set out the actions to deliver the Kirklees Vision for Adult Social Care and to ensure resilience and business continuity over winter.

Support for people who are vulnerable

A team was created to contact all those Clinically Extremely Vulnerable requesting help and support on the NHS portal and contacting those who didn't use the portal. We have data and details on those supported be that provision of food, pharmacy and basic needs. We are therefore able to contact them again should shielding be reintroduced. All the resources allocated to this task have returned to their substantive roles as more services reopen.

Mutual aid groups and anchor Voluntary and Community Sector (VCS) organisations are helping with Covid testing, the flu programme and are on high alert for shielding patients needing support again. They are working to resume some services, develop new ones and deal with issues relating to furlough and reduced finances.

Assessment teams

The Assessment Hubs continue to complete virtual assessments and reviews using smart phones and laptops. This enables them to continue to identify both service user and carer needs and continue to support them in their own home. They have also continued to reach into the care homes to complete reviews to ensure that the residents needs are been fully met. We are continuing to engage virtually with other agencies and professionals to offer wrap around support to those in need.

The teams have continued to respond to Safeguarding alerts and enquiries and self-neglect and Depravation of Liberties (DOLS). Digital devices have been issued to care homes to enable the safeguarding Teams and hubs to reach into the care homes and for the care homes to maintain contact with adult social Care. This ensures timely and appropriate responses. Risks are identified and responded to early.

Urgent visits in the community are still completed when necessary and staff are deployed flexibly across the community and hospital service to meet peaks and demands where needed.

Discharge to Assess:

The hospital assessment team consists of Care Navigation, Social Workers and Community Assessment and Support Officers. The team liaises with Hospital Discharge Coordinators regarding patients with social care needs. This team works closely with the Brokerage and KILT (Kirklees Independent Living Team) teams.

The hospital teams operate 8am to 8pm 7 days per week.

We have been working with partners in both Trusts and in Locala to ensure we have a robust response to the National Hospital Discharge Service Requirement Action Cards and discharge guidance released on the 28th August 2020.

The essence of the guidance places an emphasis on joint working, trusted assessment and requires social care to focus on out of hospital assessment, to ensure patients are supported with either short or longer term options to manage their presenting needs following either an acute episode or an exacerbation of their long term condition.

A shared referral / assessment developed by Kirklees Council and Locala have been put in place to support information sharing. This is further supported by a Multi-Disciplinary Team (MDT) approach in the Hospital Trusts where members of the Social Work Team, KILT Team and Locala process referrals and support patients on pathway 1, 2 and 3 as determined in the guidance.

All hospital discharge and hospital avoidance care packages will be funded for up to 6 weeks by NHSE to protect hospital capacity and to facilitate the discharge to assess pathway and to support the continuing health care pathway. To ensure this is managed the Kirklees Council have installed two Discharge to Assess Coordinators (one in each Trust) to manage flow, monitor community bed usage and to act as a conduit and trusted assessor.

Kirklees Council in partnership the local CCGs have procured 90 independent sector care home beds (a mix of nursing and residential care) to facilitate the discharge to assess pathway. There is an option to spot purchase more beds if demand out strips capacity and we are assured there are currently enough beds in the system to support heavy winter demand. There are 63 intermediate care / therapy beds in the system provided in partnership by Kirklees Council and Locala which will be used flexibly alongside the 17 transitional beds owned by Kirklees Council to ensure hospital flow and community resilience is maintained.

Home from Home accommodation can be used to facilitate hospital discharge into temporary accommodation for individuals who are unable to remain, or return to their existing accommodation due to varying factors; or is part of a step programme of independent living. Home from Home (HfH) flats are located within Extra Care Housing facilities, retirement living and other independent properties across Kirklees. The homeless housing officer also works with the assessments teams to identify appropriate accommodation for hospital discharge. Housing Services have a plan in place for dealing with homeless people during severe weather – the plan will activate when the temperature falls below 0 degrees for 3 consecutive nights. Under the current system, homeless people will be provided with overnight accommodation until the weather improves.

Note:

- Where needed an up to date Covid-19 test result must accompany the patient out of hospital
- All temporary services including Non Weight Bearing Pathway, Intermediate Care and Continuing Health Care (CHC) will be funded by the NHS for 6 weeks – out of hospital assessments must be completed within this window

Kirklees Independent Living Team:

The Kirklees Independent Living Team (KILT) is an umbrella term for short term services which provide care and support interventions to promote safety, wellbeing and independence and are delivered via the Council and Locala.

Intermediate care services in Kirklees are made up of numerous bed based and home based services that provide short term interventions to maximise independence and include:

- Reablement
- Short Term Assessment Response Team (START)
- Intermediate Care Beds
- Rapid Response Service
- Long Term Conditions Service

Urgent Community Response (UCR):

The rapid response service is part of the KILT umbrella suite of services which supports people (over the age of 18) who need short term input to recover from an 'acute episode' within the community. Rapid response aims to support people at home through provision of a rapid (within 2 hours) response to support exacerbating needs, thereby avoiding an unnecessary hospital admission. Phase 1 of the urgent community response programme launched on the 1st November 2020.

The team provide short term domiciliary care, including some basic health care tasks and prescription of minor equipment, adaptations and assistive technology for those who do not need/ meet the criteria for reablement or intermediate care services. The service will accept referrals from the acute trusts via the KILT Triage to prevent hospital admissions, to facilitate discharge and to improve access to wider preventative services, linking to other council service such as assistive technology that could support people's ongoing recovery and independence

To support with Urgent Community Response, existing Rapid Response capacity is being enhanced by an additional 300 delivered hours of care

To improve the flow of people through the system and across the interface between health and social care joint 7 day working is ongoing providing more responsive services:

- Mobile Response Service (MRS) - provide a 7 day x 24 hour urgent response service in the community (i.e. respond to carephone activations with non-responsive service users, lifting people who have fallen at home, etc.) to avoid hospital admissions and ambulance call-outs to vulnerable people in the community

- Hospital Avoidance Teams (HAT) - provide a 7 day working week (9am – 9pm) service based in the Huddersfield and Dewsbury hospitals A&E and the Acute Care for the Elderly ward.
- Hospital Social Work Teams - provide a 7 day working week (9am – 5pm) service based in the hospitals.
- KILT Locality Managers - provide a 24 hour x 7 day service to ensure arrangements continue for existing packages of care and to arrange transfers of care

Both the KILT and UCR approach, based on the principles of 'home first', will support system flow and avoid unnecessary hospital admissions. The Council's Rapid Response service is currently recruiting to ensure required additional capacity is in place during the winter period to support UCR patients with rapid home care.

Kirklees Council as part of the demand and capacity work are looking to move their Social Care Occupational Therapists away from the social care hubs and create a team that supports Gateway to Care to channel initial referrals for care and support in to the Reablement Service to promote independence and wellbeing. This will also facilitate increasing provision of assistive technology and equipment for daily living to promote independence and wellbeing, promote meaningful occupation to reduce reliance on more intrusive services. The team will also focus on supporting the frailty and falls agenda.

Learning Disability:

Learning Disability services are currently working with service users and carers to increase uptake of Direct Payments to support individuals to access personalised care at home. This may result in an increase to Personal Protection Equipment (PPE) requests, but should also take pressure off group settings such as respite placements and Colleges should they need to respond to COVID guidance or are unable to run at full capacity. Teams are supporting Carers to be as resilient as possible in the community, providing increased Enablement services, greater focus on assistive technology solutions and providing a focus on reviews.

Mental Health:

SWYPT integrated community services continue to function as usual. Where possible service users are offered a choice of how they would like to keep in contact - by phone, by a video call, in their home or in a clinic. The way that teams communicate with individual service users is kept under constant review, taking into account risks, changes in mental health condition or social care needs.

AMHPS care currently supporting an increase in referrals for hospital admission, resources are being managed across the Hub and community to meet the increased demand. Mental health Intensive Home-based treatment teams and adult and older adult acute admission wards will remain in operation 24/7.

SWYPT are currently working with partners to develop a Personality Disorder Pathway to support service user in the community and reduce hospital admissions for this client group.

A daily 24 hour senior manager on call system operates in the local services.

Community Options:

Community Options provision is the name given to mental health services jointly commissioned by the Local Authority and the 2 CCG's. These services now work together as a partnership of providers in the voluntary sector and are generally known as the 'Working Together Better' partnership.

A range of services are offered including practical self-help solutions, activity sessions and courses, advocacy and physical activity. Services have continued through the current pandemic and have developed new larger scale online offers – these are set to continue.

Despite restrictions some activities have returned in a controlled and socially distancing way and providers will continue to look at how they may do this and increase the face to face support that people are missing. Regular meetings with the Commissioning Manager and the providers will continue and will consider emerging needs and the response to that.

Mental Health Community Crisis Provision:

Crisis café provision is closely linked to these services and have continued to offer a level of support throughout the current period. The Huddersfield Cafe has recently re-opened in a restricted manner and the intention is that the Dewsbury Café will also do so in the near future.

Additionally to the café the commissioned Peer Brokerage service has re-focussed their service in conjunction with the Local Authority. A change of focus was planned for this service to begin on 1 April 20 to offer more 1:1 support, however this was revised to respond to the changing Covid-19 needs and phone support was offered. This has proved successful and will continue and hopefully expand, providing more options during the winter for those who are seeking this type of mental health peer support.

Respite and Day Services:

The Council's in house day services (for adults with Learning Disabilities and for older people) and respite services will be incrementally increasing the offer (within current Infection Prevention and Control (IPC) risk assessments) to service users as we progress in to winter with additional overnight respite (at Mill Dale and Crescent Dale) and day opportunities sessions (physical, virtual and outreach sessions)

The Council runs two Dementia Care Homes with capacity for 60 beds across Kirklees (Castle Grange and Claremont House). Each care home includes 10 short stay beds which the Council will be reopening in a phased basis and in compliance with IPC guidelines in preparation for winter pressures (these beds have remained closed up to now due to Covid19)

The council's care homes at Ings Grove provides 7 transitional beds and at Moorlands Grange provides 10 transitional beds. Transitional beds are used for patients who are medically fit to return home but there is a delay in the availability of community based services. If there are no transitional beds available in the two council care homes the Hospital Social Work Team will, where possible, commission beds from the independent sector to meet the shortfall in needs.

Richmond Fellowship through their Trinity Street provision have worked with the Council and are now offering 3 beds to be used for respite and emergency needs for people experiencing mental health problems. Other options for this group are also

being considered in supported accommodation provision, both current and developing.

Kirklees' day opportunities services for adults with a learning disability are ordinarily based at Red Laithes Court (North Kirklees) and Highfields (South Kirklees). Kirklees' day opportunities services for adults living with dementia are based at Knowl Park House (North Kirklees) and The Homestead (South Kirklees). Adults using these services receive support between the hours of 8am and 5pm. Contingency plans in place to support with winter planning including strong links with the Community Learning Disability Team to ensure service users are supported with alternative support arrangements in the event of additional winter pressures.

Shared Lives respite is still available as usual and will remain so throughout winter, however access to the resource may be restricted if Kirklees enters Tier 3 Covid measures. Teams are sighted on this and are working on contingency plans for service users who may become affected.

Support for carers:

Carers Trust is providing 5,000 hours of breaks per month, including fast-track prioritisation where there is risk of carer break down.

The Carers Emergency Breaks service is supporting around 28 carers per quarter who need short term breaks due to an emergency or unforeseen crisis. The service is available to all carers, regardless of whether they are already known to health and social care and provides domiciliary registered cover within 2 hours. The service will support a family for up to 3 days.

Regular communications go to all carers registered at Carers Count, including updates and information each month to reassure carers that services continue to be available when needed. This is distributed electronically as well as being physically posted via Document Solutions to all carers known to the service who do not use electronic communications.

Peer support and socialisation activities are run electronically to help reach isolated carers. Regular phone calls are made to Carers who need this support but don't use electronic devices. Check-up calls are made where a client may be particularly vulnerable and isolated.

Support is in place to help carers who are reticent or not confident to use electronic devices for socialisation and accessing services to do this, learn, and gain confidence. A library of electronic devices is being procured for carers who would benefit from this but who do not have the means to purchase an electronic device.

Provider arrangements:

Living Well at Home

We have recognised that during the pandemic domiciliary care providers have quite naturally worked differently to meet the ever-changing priorities of people using the service. Instead of sticking rigidly to the 'time and task' model, providers have told us about the creative ways their teams have supported people; GP appointments and 'shopping trips' via WhatsApp, getting people acquainted with smart phones and tablets to keep in touch with families, having film nights and baking sessions with people who couldn't use the social element of their care plans go out and about. Providers have also created 'tighter' rounds for infection control purposes. This has

meant that people enjoy more consistent staff teams, build better relationships which in turn enables staff to really get to know how to support people to 'live well at home'. We have supported this change by paying on commissioned time which enables providers to work more flexibly with people to plan their care and support.

As a consequence of the above we have therefore continued to work with all providers across Kirklees to embed a more personalised and outcome focussed approach to arranging and delivering the service. There is work progressing within the Council to change documentation, systems and processes to enable the different approach. Officers are currently working to bring together the Brokerage, Sensory Services and Care Navigation services into one team called Support Options. The team will work closely with individuals and their carers, assessment and provider colleagues to arrange personalised services which help people to achieve what is important to them.

We have changed the name of the initiative to 'LIVING WELL AT HOME'. This is because we recognise that the language we sometimes use can create barriers and alienate people, including the people who use the service. We have therefore decided that moving forward we will be using more everyday language which we all understand and use. We believe that this fits with a more person-centred approach.

Residential Care:

The Council has provided 2 phases of financial support to providers which included placing a 5% premium on the current care home fee rates, payment for 3 days after death for a resident rather than 1 day and payment toward the cost of COVID related voids. In addition, it has purchased, with the CCG 90 beds on a block purchase basis to support hospital pressures which has also supported care homes.

The government has provided funding for care providers through a first phase of an Infection Prevention Fund (IPF) and this has been distributed to providers. This amounted to £4.553m in Kirklees.

Alongside this, the Council and CCGs have provided significant in-kind support to care providers to assist with operational delivery including IPC advice, continued recruitment and retention support through th2Care service and practical staffing support. To better support hospital discharge Kirklees Council, through the Kirklees Equipment contract, are loaning equipment to care homes where the equipment can be used to support single handed care.

Kirklees Council and the CCGs hold joint multi-disciplinary Care Home Early Support and Prevention (CHESP) meetings attended by the Council, CCG, Locala, Care Quality Commission (CQC) and other invited agencies. At these meetings early warning and alerts are raised and discussed to enable a more proactive approach with care home providers and offer support to care homes at an early stage. The purpose of this multi-disciplinary group is to improve provider quality and the quality of life and satisfaction of individuals living in residential and nursing care.

Over the past months the Council and key strategic health partners have been initiating and developing a Care Home Programme Plan. Kirklees Care Home Programme builds on the key element and sub-elements of The Framework for Enhanced Health in Care Homes (EHCH). The Framework lays out a clear vision for providing joined up primary, community and secondary, social care to residents of care and nursing homes via a range of in reach services

The Council and CCGs will continue to monitor the ever-changing crisis and take account of all guidance and possible Central Government funding for the Sector and act accordingly.

End of Life:

End of Life plans have developed at pace during COVID with system partners supporting the development of personalised care plans which include advanced care plans for residents in care homes. Kirkwood Hospice enhanced their care co-ordination service and their Social Workers are now completing Care Act Assessments for people they support and are able to access social care funding directly under a trusted assessor model. The Continuing Health care team provide end of life care through the Marie Curie support service.

1.6 South West Yorkshire Partnership Foundation Trust (SWYPFT)

Priorities for SWYPFT have been identified for winter 2020/21 and incorporated into winter planning;

- Ensuring system understanding of the delayed peak of mental health need hitting services
- Ensure the range of access points into SWYPFT services (Single Point of Access (SPA), wards, Mental Health Liaison Team (MHLT)) have the available capacity to manage demand in line with agreed tolerances
- A&E pathways exist to ensure minimum delays; availability of Section 12 Doctors, MHLT Capacity, Approved Mental Health Professional capacity
- Enhanced Team capacity to manage the increasing number of complex patients being referred to the service.
- Maintaining bed occupancy levels below 100%
- Reducing the use of out of areas beds to a minimum
- Effective pathways to meet potentially growing demand associated with; Children & Young People, Personality Disorder, Serious Mental Illness, Early Intervention in Psychosis, Improving Access to Psychological Therapies (IAPT), Psychology, identifying where there will be pathway challenges will affect the system
- Joint work with the 3rd sector to restore community support; Recovery College etc
- Continue to balance remote working opportunities with the requirements for Face to Face support in line with client need

SWYPFT will work with system partners to deliver the priorities as identified in 1.2 above