AGENDA FOR

HEALTH SCRUTINY COMMITTEE

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To: All Members of Health Scrutiny Committee

Councillors : J Grimshaw, S Haroon, M Hayes, T Holt (Chair), K Hussain, C Tegolo, S Walmsley, C Birchmore, R Brown, J Lewis and T Pilkington

Dear Member/Colleague

Health Scrutiny Committee

You are invited to attend a meeting of the Health Scrutiny Committee which will be held as follows:-

Date:	Monday, 21 March 2022
Place:	Council Chamber, Town Hall, Bury, BL9 0SW
Time:	7.00 pm
Briefing Facilities:	If Opposition Members and Co-opted Members require briefing on any particular item on the Agenda, the appropriate Director/Senior Officer originating the related report should be contacted.
Notes:	

AGENDA

1 APOLOGIES FOR ABSENCE

2 DECLARATIONS OF INTEREST

Members of Health Scrutiny Committee are asked to consider whether they have an interest in any of the matters on the agenda and if so, to formally declare that interest.

3 MINUTES OF THE LAST MEETING *(Pages 5 - 12)*

The minutes from the meeting held on 21 March 2022 are attached for approval.

4 PUBLIC QUESTION TIME

Questions are invited from members of the public present at the meeting on any matters for which this Committee is responsible.

5 MEMBERS QUESTION TIME

A period of up to 15 minutes will be allocated for questions and supplementary questions from members of the Council who are not members of the committee. This period may be varied at the discretion of the chair.

6 ADULT SOCIAL CARE COMPLAINTS REPORT *(Pages 13 - 34)*

Report from Adrian Crook, Director Adult Social Service and Community Commissioning attached.

7 PRIMARY CARE UPDATE *(Pages 35 - 50)*

Report attached. Cathy Fines Clinical Director, NHS Bury CCG to report at the meeting.

8 MENTAL HEALTH UPDATE *(Pages 51 - 74)*

Report attached from Adrian Crook Director (Adult Social Services and Community Commissioning) and Ian Mello (Director of Secondary Care).

9 ELECTIVE CARE WAITING LISTS UPDATE *(Pages 75 - 80)*

Report from Will Blandamer Executive Director of Strategic Commissioning is attached.

10 COVID-19 UPDATE

Will Blandamer Executive Director of Strategic Commissioning to provide a verbal update.

11 URGENT BUSINESS

Any other business which by reason of special circumstances the Chair agrees may be considered as a matter of urgency.

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Agenda Item 3

Minutes of:	**HEALTH SCRUTINY COMMITTEE**
Date of Meeting:	18 January 2022
Present:	Councillor T Holt (in the Chair) Councillors J Grimshaw, S Haroon, C Tegolo, S Walmsley, C Birchmore, R Brown, J Lewis and T Pilkington
Also in attendance:	Will Blandamer, Executive Director of Strategic Commissioning Catherine Tickle, Commissioning Programme Manager Philippa Braithwaite, Principal Democratic Services Officer
Public Attendance:	No members of the public were present at the meeting.
Apologies for Absence:	Councillor M Hayes and Councillor K Hussain

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HSC.12 APOLOGIES FOR ABSENCE

Apologies for absence are listed above.

HSC.13 DECLARATIONS OF INTEREST

Councillor Carol Birchmore declared an interest in the Bury Integrated Care Partnership and Locality Plan due to currently being in a dispute with Salford CCG.

Councillor Tom Pilkington declared an interest as he was employed by Manchester University NHS Foundation Trust.

HSC.14 MINUTES OF THE LAST MEETING

The minutes of the meeting held on 16th November 2021 were agreed as an accurate record.

Matters arising: With regards to mental health discussions at the previous meeting, it was noted that LANCuk had been rated as inadequate by a recent CQC inspection. Will Blandamer, Executive Director of Strategic Commissioning, advised that a written update regarding LANCuk could be provided outside of this meeting and a full update on mental health services would be given at the next meeting.

HSC.15 PUBLIC QUESTION TIME

There were no public questions.

HSC.16 COVID-19 UPDATE

Will Blandamer, Executive Director of Strategic Commissioning, provided a verbal update on COVID-19 and the vaccine programme on behalf of Lesley Jones.

Overview of community incidents and epidemiology:

- Case rates were decreasing with 1057 cases per 100,000 population in Bury, slightly about the national average but a decrease since the previous week.
- There had been a slight rise in the number of deaths in the previous two weeks, but rates were not near previous peak levels. This increase was expected as a result of the increased volume of incidents and admissions.
- Plan B review date was 26 January and, should measures be lessened, Bury was ready to respond to any effects of this.
- Challenges continued as well as disruptions in schools, with outbreaks expected over the next few weeks but levels then expected to come down.
- It was believed we had hit the peak and rates would continue to reduce; however, we will need to be vigilant in understanding the effects of any suspension of current guidelines e.g. in relation to face masks.

Update on vaccinations:

- Vaccination rollout had been very successful in Bury, exceeding the GM average for first and second doses, and third in GM for boosters.
- Demand was slowing and some primary care centres were being rested as a result, to allow staff time back in primary care.
- There was a continued focus on inequalities, although uptake was so high overall there was little scope for differences.
- There was a gap in 12-15 year olds being vaccinated; second dose rollout had begun this week in and out of schools, and community pharmacies were being used to encourage people to come forward in harder to reach areas.
- In response to questions from the previous meeting, it was noted that the United Reform Church in Radcliffe had been very successful as a vaccination centre, and thanks were extended to the church as well as support to help remove anti-vax graffiti.
- It was also confirmed that the Gillick competence test was a well-established principle and was being applied.

Overview of the health and care system:

- The health and care system remained under severe pressure but the effect of the omicron variant was beginning to reduce.
- The system had been holding up during the most challenging period, with exponential growth in demand over the Christmas period as well as staffing issues. This had been reflected across the country, with numerous critical incidents (to which Manchester had come close).
- Tributes were paid to frontline staff who had gone above and beyond to ensure doors remained open and patients received care.
- Significant pressures remained in primary care with regards to demand and staffing, as well as discharge pressures. Mental health and home care services were similarly suffering, with the latter coping remarkably.
- It was noted that across GM the suspension of all but the most urgent elective care was now being lifted.

Councillor Birchmore asked whether there were figures regarding those dying "of" Covid vs those dying "with" Covid and Will Blandamer undertook to come back with that information. In response to a question from Councillor Tegolo regarding their vaccination status, he advised that this information was not routinely

collected but, in response to a follow up question from Councillor Lewis, officers undertook to investigate if the information was held by secondary care.

Councillor Brown asked about further vaccination doses and Councillor Simpson, Cabinet Member for Health and Wellbeing, advised that immunocompromised people would be invited for a fourth dose but a decision had not been made about whether this would be needed more widely.

Councillor Holt queried if data was collected around why people were refusing vaccinations and Councillor Simpson advised that many people refused to share their reasons, but it was probably due to scaremongering on social media. She added that it was becoming harder to engage with unvaccinated people as there was a growing stigma around it and people were unwilling to come forward. Will Blandamer advised that work to address the gaps in young people being vaccinated was looking at these motivations to give a better understanding of the situation.

Catherine Tickle provided an update on the support given to patients waiting for elective care:

- Cancer and urgent cases were still being seen and measures were reviewed regularly to ensure impact of waiting was minimised and that any cases that became urgent while waiting were seen.
- The 'While You Wait' initiative provided information, advice and support to those waiting for elective care, directing them to social prescribing options.
- Work on the site allowed for constant improvement of the offer, including areas of focussed work (orthopaedics and urology) which would be rolled out to other areas. This ensured tailored support was provided while patients waited.

Councillor Walmsley asked that this service be made available to those not able to access online services, and asked if there was data on how long delays would be now elective care was being stood back up. Catherine Tickle responded that there was no data at the moment but it could be looked at. She advised standing services back up would take time, with a phased approach to return to business as usual, and that different groups would have different levels of delay.

Councillor Pilkington asked about the vaccine take-up by NHS staff who were now compelled to be vaccinated and Will Blandamer advised an impact assessment was being carried out and he would report back, but that in social care only a relatively small number of staff had refused the vaccine.

Councillor Birchmore asked about orthopaedic patients' need for painkillers and limited access to GPs and Catherine Tickle reported that access to GPs continued despite capacity issues. She advised that there wasn't just one approach to access care, there was a range of support available and patients just needed to be directed to where would be best for them. Will Blandamer advised that, in light of the Committee's concerns regarding GP access, Dr Cathy Fines, Chair of the CCG, was keen to listen to and speak with Councillors and as such a Member seminar was being arranged.

Councillor Grimshaw queried pharmacies not providing patients with their prescription and Councillor Simpson advised that pharmacies are private businesses so users could change pharmacy or reorder their slip from the GP.

It was agreed:

1. Figures and vaccination status regarding those dying "of" Covid vs those dying "with" Covid be provided;
2. Data regarding delays in elective care be provided;
3. The results of the impact assessment regarding NHS staff not taking up the vaccine be reported;
4. Thanks and praise to frontline staff be recorded; and
5. Will Blandamer be thanked for the update.

HSC.17 UROLOGY RECONFIGURATION

Will Blandamer, Executive Director of Strategic Commissioning, advised that urology was the treatment of problems of the female urinary system and the male genitourinary tract, including the kidneys, ureters, bladder, prostate and male reproductive organs.

He reported that the reconfiguration of urology services stemmed from the split of hospital services between Manchester University NHS Foundation Trust (MFT) and the Northern Care Allowance (NCA), which related to a small number of patients in Bury but demonstrated how the improved reconfiguration of a service could address the balance between a sustainable service with a critical mass of patients and issues regarding accessibility and access to services.

Catherine Tickle, Commissioning Programme Manager, advised that this reconfiguration represented the direction of travel for how the system could work more collectively and reflected ways of working discussed at a GM level. The advantage for Bury was that both urology sites would be run by the same organisation and so would be inherently more integrated.

Colleagues from the wider care system were coming together to look at the end to end pathway for patients and work collaboratively to develop a different way of working and of providing services. A Task and Finish Panel was reviewing pathways, delivery, inequalities, and inclusion. This multidisciplinary approach would ensure a better pathway with smoother or fewer 'hand offs', and Members noted there had been a real willingness for secondary care, GPs and community teams to come together and work differently, with some traditionally hospital-based services now proposed to be carried out in the community.

Councillor Walmsley queried where private practices fitted in, and Catherine Tickle advised that the desired pathway needed to be developed and validated, with providers (including private) then engaged to enable that patient journey.

Councillor Birchmore reported that urology problems were often experienced by older people and expressed concern that they would need to travel to Salford for care. Catherine Tickle responded that the number of services users affected was small, and they were currently travelling to North Manchester. The reconfiguration meant that more services would be delivered in the community to reduce the need

for patients to travel, but third sector organisations were involved to consider how travel could be supported. It was noted that this was part of the scope of the Task and Finish Panel so would be fully considered.

Councillor Pilkington asked about the alignment with other trusts to ensure same care was provided throughout the locality and to prevent "postcode lotteries". Catherine Tickle advised that CCGs and Trusts were working together to monitor the impact of the reconfiguration and how to ensure an equitable service. Will Blandamer reported that he would bring the service development strategy for the NCA to the Committee at a future meeting in order to discuss aggregation of services and the benefit of economies of scale.

Councillor Pilkington also asked what was being done to ensure GPs were aware of the different services available in order to refer patients to right area. Catherine Tickle responded that GPs were part of the system-approach to reconfiguring the service and would help shape what pathways and referrals would be available. She added that comms was a key part of any redesigned service and was part of the Task and Finish Panel's remit.

It was agreed:

1. That the service development strategy for the NCA come to a future meeting; and
2. That the contents of the report be noted.

HSC.18 HEALTH SCRUTINY TASK AND FINISH GROUP - PLANNING AND LICENSING

Councillor Holt updated the Committee on the work of the Health Scrutiny Task and Finish Group - Planning and Licensing of takeaways. He advised it had been a good meeting, and two recommendations had been agreed:

- Recommendation 1 – "Officers to create a blended Bury data system which uses data sets from both the Leeds and Tameside model to assist to inform licensing decisions"

- Recommendation 2 - "Officers of the Council will investigate potential options for ensuring health implications are taken in consideration when assessing planning applications for hot food takeaways, including the feasibility of interim guidance in the intervening period. Interim guidance will set out the Council's approach, in advance of the adoption of replacement development planning policies."

Councillor Holt reported that, unfortunately the latter recommendation would need to be a policy development and as such would have to be postponed. He advised that the Group had worked positively with planning officers and it was noted that this would be the general direction of travel, and interim measures were in place to support a healthy food environment including the role out of the healthy catering award, currently run by the climate change team, which encouraged businesses to provide healthy options.

Councillor Tegolo suggested that training on this be offered to Planning Members to encourage awareness of the issues, and Councillor Walmsley advised that there were a number of interrelated strategies which could be included to provide a wider context of how different factors were involved.

Councillor Lewis raised concerns about the potential this had to hinder businesses, particularly when growth had been affected by the impact of Covid. He advised that his preference was to encourage healthy eating through education. Councillor Simpson responded that reasons for obesity were complex and multiple strategies and policies were required to encourage people to think and act differently. She voiced her support for the reduction of takeaways near to schools, advising that, although she agreed that no one should be forced, enabling healthy choices to be easier was a positive change and should be pursued. Councillor Pilkington added that he agreed businesses should be supported, but also that healthy options should be facilitated.

Councillor Holt thanked Members for their input into this complex issue and proposed that one final meeting of the Task and Finish Panel meeting be held before the end of the municipal year.

It was agreed:

1. That a Member Development session be organised;
2. That one more Task and Finish Panel meeting be held before the end of the municipal year; and
3. That the update be noted

HSC.19 BURY INTEGRATED CARE PARTNERSHIP AND LOCALITY PLAN

Will Blandamer, Executive Director of Strategic Commissioning, presented a report regarding the operating model for the Bury Integrated Care Partnership and the refreshed Bury Locality Plan which set out the ambition for strategic reform.

Members noted that the legislation to abolish the CCG from 1 April 2022 had been delayed until 1 July 2022. CCGs currently carried the bulk of funding for NHS services in Bury, but CCG functions would be taken over by a Greater Manchester (GM) Integrated Commissioning Board (ICB). Recruitment of the leadership for that organisation had begun, with Sir Richard Leese appointed at the Chair and Chief Exec and Non-Executive Directors yet to be appointed.

Even though the CCG was being abolished, Bury was committed the Council and the NHS working together to establish a shared understanding of the needs of the borough and of budgets (including the pooled budget). Architecture for the wider integrated care system was forming, not just from the Council and CCG but including colleagues from all over the system collaborating to drive transformation. This would enable decision making structures currently working well in Bury to endure and be amplified.

Work was ongoing to build this architecture, with clarity over governance, relationships, and decision making required as well as need to ensure clinical expertise was not lost in the leadership of Bury. This was being addressed through a Clinical and Professional Senate which would support the Locality Board (which

led on strategy for the borough) and the Delivery Board (which would drive programmes of work). These groups were already operating in shadow form, and clarity over financial flows was being developed to ensure that oversight of funding for the borough as a whole was retained.

With regards to the Locality Plan, Will advised this was the strategy document setting out the aims and ambitions. A step-change was wanted, with residents in control of their own wellbeing and in control of how services were organised around them. Services would be provided close to home, joining up teams in neighbourhoods, and there would be a focus on early intervention and prevention. Retaining the best of having clinical and political leadership would enable every opportunity to collaborate with colleagues across the GM footprint to control costs through economies of scale, while ensuring Bury retained localised services to address residents' needs.

Councillor Andrea Simpson, Cabinet Member for Health and Wellbeing, advised that further investment into early intervention and prevention was needed if real change to health inequalities was to be achieved. Continuing as currently wouldn't secure a different outcome, and she hoped this change would provide the opportunity to do that. She stated that residents wouldn't see a huge change for the first few years, in order not to destabilise existing services, but that if services could be commissioned in a different way it may change the way our community worked for the better.

Councillor Lewis expressed his hesitancy about the proposals. He expressed concern that this was reliant on trust, with 10 boroughs working together but with their own interests, and believed each borough should control their own finances. Will Blandamer offered clarity that the issues regarding financial flows related to NHS spend, not Council budgets. He further advised that NHS monies already flowed to CCGs through a GM structure, so this would not be changing.

Councillor Birchmore raised a point regarding the complexity of the care system, particularly regarding independent living and institutionalised care, and stated she thought this would be worse in a bigger system.

Councillor Brown stated that there were suggestions the system was not working and queried GM involvement, stating that he suspected eventually GM would overrun localities. Will Blandamer advised that governance was important to ensuring Bury's needs were addressed. To this end, a Place Based Lead would be selected for each locality who would have accountability from GM and from the locality, as well as the authority to drive forward priorities from their borough. Local accountability and leadership were built into the model, with the Bury Locality Board and GM ICB holding each other to account. Will advised that GM was "of us" not "doing to us", and this model would help ensure a balance between some services being commissioned once throughout the GM footprint, and others commissioned locally and under local control.

Councillor Simpson advised that getting the structure right was important in ensuring Bury had a say in how things were managed. The biggest risk was around deprivation, with other GM boroughs having higher levels of deprivation and therefore possibly requiring more funding. She acknowledged that Bury was

part of GM and needed to be responsive to our partners and raise standards across the region.

Councillor Holt asked about the involvement of children's services and Will Blandamer advised that this was included in the locality plan, with opportunities being explored for health and care services to work with children's services and schools in neighbourhood.

It was agreed:

That the update be noted.

COUNCILLOR T HOLT
Chair

(Note: The meeting started at 7.00 pm and ended at 9.04 pm)

ANNUAL COMPLAINTS & COMPLIMENTS REPORT

APRIL 2020 – MARCH 2021

ADULT SOCIAL CARE SERVICES

1.0 PURPOSE AND INTRODUCTION

1.1 It is a statutory requirement to produce an Annual Complaints Report relating to Adult Social Care Complaints, received by the Corporate Core Department, Bury Council.

1.2 This report is to provide members of Health Scrutiny Committee with details of information relating to Adult Social Care Services.

1.3 The report relates to the period 1st April 2020 – 31st March 2021, and provides comparisons between previous years, as well as detailing the nature, scope and scale of some of the complaints received.

2.0 BACKGROUND

2.1 The council is required to operate a separate Statutory Complaints and Representations procedure, in accordance with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 which was laid before Parliament on 27th February 2009 and came into effect on 1st April 2009. From 1st April 2009 there has been a single approach to dealing with complaints to ensure consistency in complaints handling across health and social care organisations. This procedure is based on the Department of Health's guidance, 'Listening, Responding and Improving' which supports the statutory requirements for the handling and consideration of complaints. Its intention is to allow more flexibility when responding to complaints and to encourage a culture that uses people's experiences of care to improve the services provided by Bury Adult Care Services.

2.2 The complaints mentioned in this report typically relate to issues where customers, their families or carers feel that the service they have received have not met their expectations. In these cases, the Council will always have endeavoured to resolve any concerns or dissatisfaction before a formal complaint has been received. Complaints, therefore, usually arise when the customer does not agree with the Council's interpretation of events or, in some cases, where policy delivers an outcome which they do not agree with.

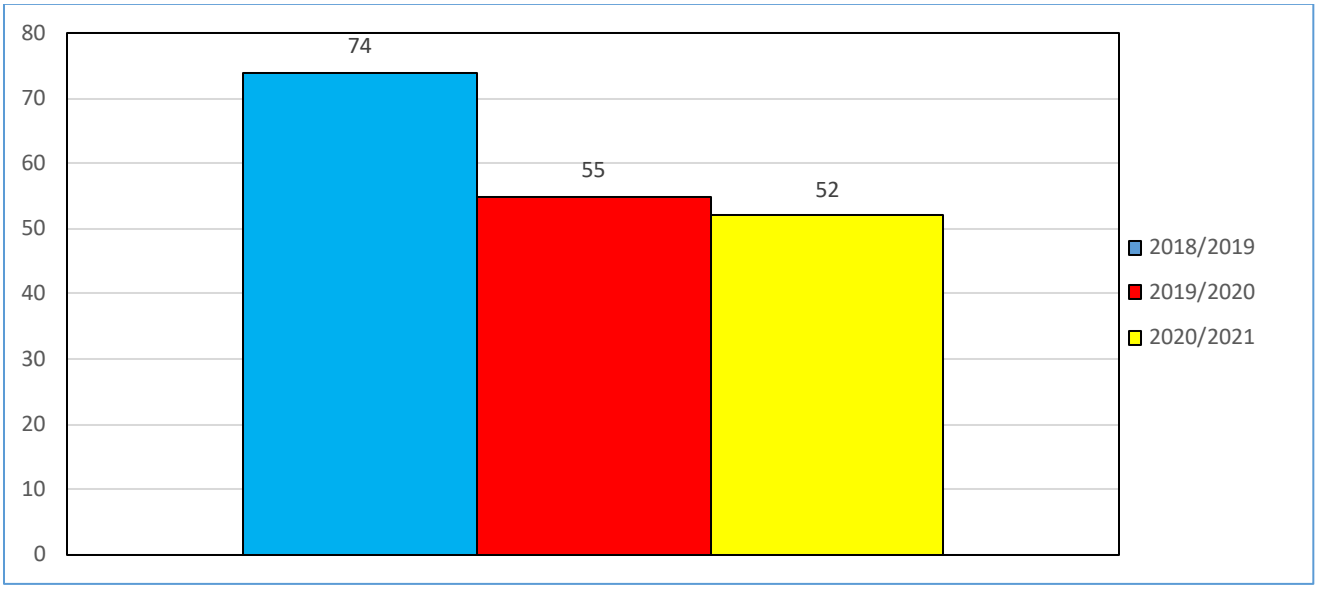
2.3 Within the regulations which govern the complaints process, the Council adopts a flexible approach which prioritises local resolution. However, where complainants remain dissatisfied, they have the option to take their case to the Local Government & Social Care Ombudsman.

2.4 Members of Parliament cannot make a complaint on behalf of a constituent using the statutory process. However, MP's can raise a 'Concern' on behalf of a constituent with the Council and these are then managed accordingly.

2.5 The Complaint Procedure is not intended for dealing with allegation of serious misconduct by staff. These are covered by and dealt with through the Council's separate disciplinary procedures.

DATA ANALYSIS OF COMPLAINTS RECEIVED

3.0 ADULT SOCIAL CARE COMPLAINTS



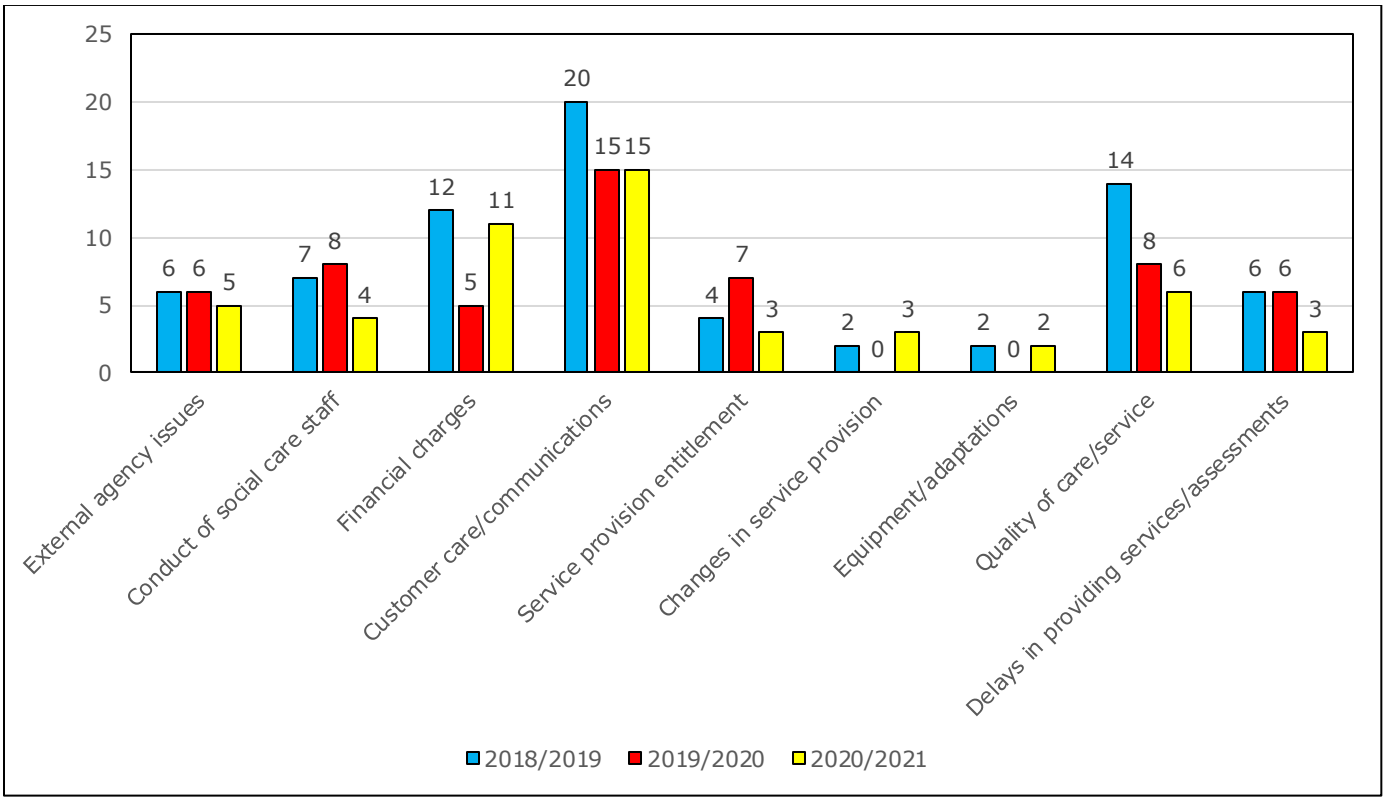
3.1 The total number of complaints received in 2020/2021 has slightly reduced from the previous year - 55 in 2019/20. Therefore, although the way services are being delivered has changed significantly and service pressures have increased for the department, the figure for 2020/2021 indicates that customers have complained less about the services they have received.

3.2 The number of complaints received should also be considered in context with the number of people actually having direct contact with Adult Social Care Services (excluding their relatives, friends or carers who might make complaints on their behalf). The number of people to have direct contact with Adult Social Care Services during 2020/2021 was 7,180. It is positive that the proportion of people wanting to make a complaint about the services they have received from the department is relatively low at 52.

3.3 As would be expected when dealing with complaints from predominantly vulnerable groups, the majority of complaints received are made by a family member, advocate or solicitor of a service user, rather than the service user themselves.

	Total Number of Complaints	Total Number of Complaints raised on behalf of a service user	%
2018/2019	74	53	72%
2019/2020	55	40	73%
2020/2021	52	33	63%

4.0 NATURE OF COMPLAINTS



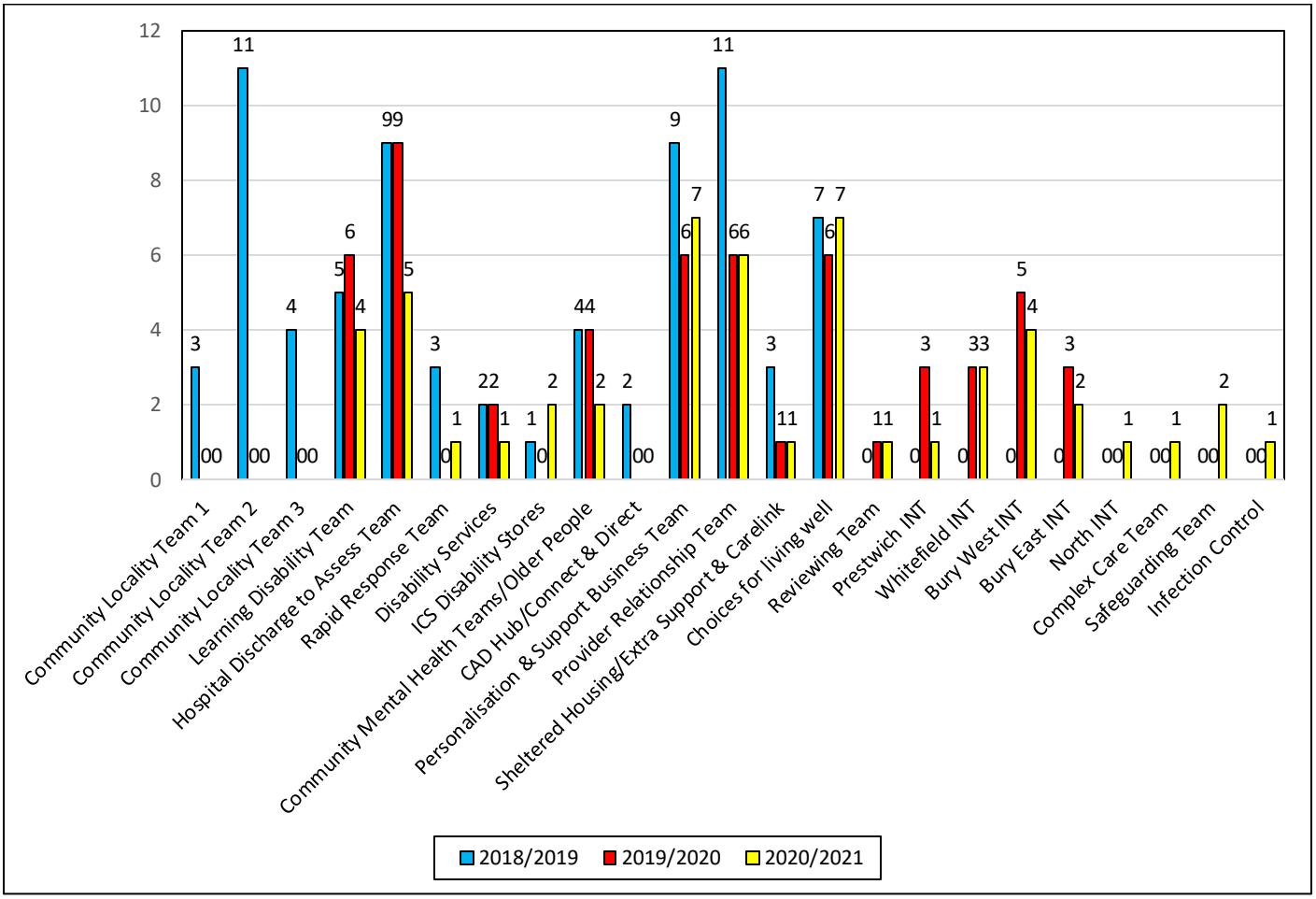
4.1 In general there has been an overall decrease on the number of nature of complaints, the most common type of complaint 'quality of care/service' has decreased (from 8 to 6) whilst 'customer care / communications', has remained the same as the previous year.

4.2 There has, however, been an increase in complaints relating to 'equipment/adaptations' (from 0 to 2), 'changes in service provision' (from 0 to 3) and 'financial charges' (from 5 to 11). The increase in complaints relating to financial charges can be explained by the hospital discharge policy introduced by the government where a number of weeks of free care was provided but following this became chargeable and customers being unclear.

4.3 During the period 2020/2021 although the number of complaints has been slightly reduced it has shown a decrease in complaints being upheld/partially upheld from the previous year 2019/2020. In all cases when complaints are received, learning is drawn from the comments received and the subsequent investigation.

	Total Number of Complaints Received	Complaints Upheld/Partially Upheld	Complaints Not Upheld	Complaints Withdrawn
2018/2019	74	39 (53%)	34 (46%)	2
2019/2020	55	42 (76%)	12 (22%)	1
2020/2021	52	24 (46%)	27 (52%)	1

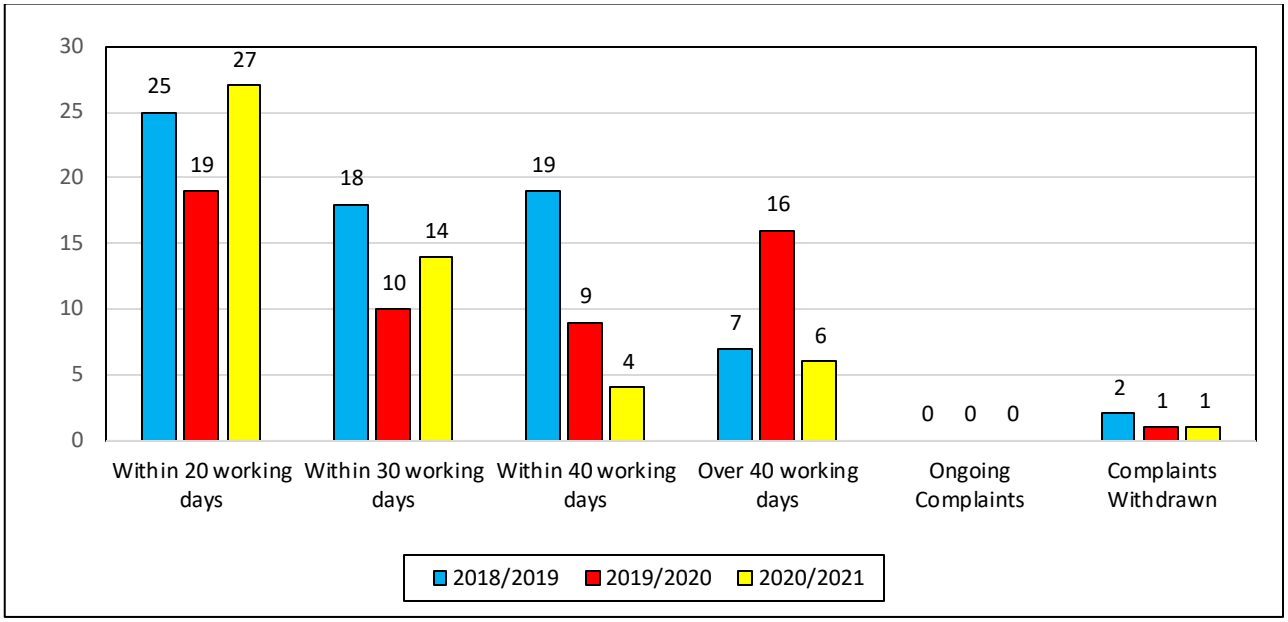
5.0 COMPLAINTS PER TEAM



5.1 In comparison the overall number of complaints has continued to decrease. The report highlights no significant increase in complaints from a particular service or team which is in despite of the pressure services were under due to the global pandemic.

5.4 All complaints are considered in terms of the learning that they can provide on how to improve the services and help us to make sure our staff are trained to give the correct advice and support.

6.0 TIMESCALES



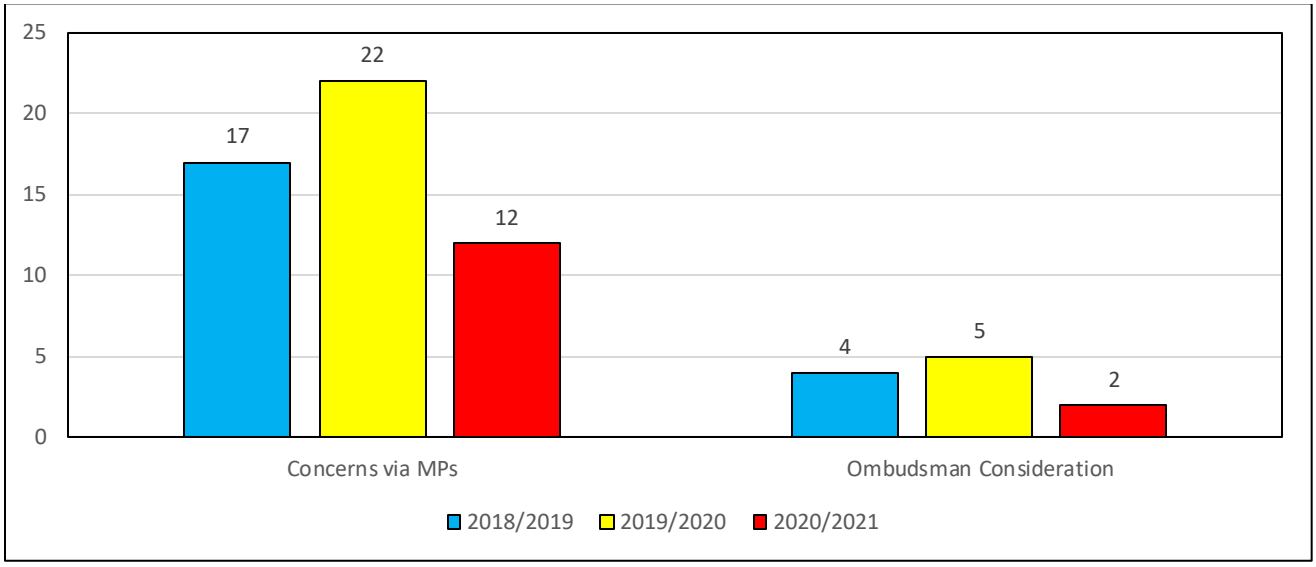
6.1 Whilst there are no statutory timescales with which the department must comply in responding to complaints, we do aim to resolve complaints within twenty working days on receipt of complaint. For more complex complaints which involve different service areas, 3rd party organisations, NHS for example, timescales will exceed the twenty working days.

6.2 It is for the council and complainant to agree how the complaint will be handled, the likely duration of the investigation and when the complainant can expect to receive a response.

6.3 In 2020/21, 27 (52%) of complaints were responded to within the 20 working day timescales, 24 (46%) of complaints were responded to outside of the 20 working day timescales. Complaints responded to over 40 working days has significantly decreased from the previous year which is excellent performance considering this was during the pandemic.

6.4 It is pleasing to see an increase in the number of complaints being responded to within 20 working days. The Local Government Social Care Ombudsman's office carried out a one-day training session with relevant staff on effective complaint handling. The session was well received and had a positive impact, staff felt more confident when investigating and responding to complaints. The Local Government and Social Care Ombudsman now run an online skills course which looks at how to investigate complaints, decision-making and remedy recommendations. Enquires are being made for the online course being rolled out to new members of staff and for those that wish a refresher session in 2022/2023.

7.0 MP CONCERNS AND LOCAL GOVERNMENT SOCIAL CARE OMBUDSMAN CONSIDERATIONS / ENQUIRIES



7.1 As has been previously mentioned, concerns raised on behalf of constituents by Members of Parliament are recorded separately. In 2020/2021, there has been a decrease from 22 in 2019/2020 to 12 in 2020/2021.

7.2 The number of complaints referred to the Local Government and Social Care Ombudsman (LGSCO) has reduced, at only 2 cases being considered. It is important to note that most complaints are resolved satisfactorily and are not referred to the LGSCO. Of the two cases received the LGSCO found no fault and considered one case to be a premature complaint.

7.4 Overall, and despite increased pressures on services, it is positive that the proportion of people who have made a complaint to the Council's Adult Social Care Department about the services they have received from the department has remained static over the last 12 months.

8.0 COMPLIMENTS

8.1 In addition to complaints received, the department also records the number of compliments.

Total number of Compliments received 2019/2020	Total number of Compliments received 2020/2021
212	333

Service Area	2019/2020	2020/2021
Hospital Social Work/Discharge to Assess Team	6	8
Choices for Living Well – Intermediate Care Reablement/Killelea/IMC @ Home	165	182
Sheltered Housing / Carelink / Support at Home	0	3
ICES Disability Stores	2	9
Learning Disability Team	2	4
Community Mental Health Teams	1	0
Older People's Community Mental Health Team	0	1
CAD Hub/Connect & Direct	7	1
Personalisation and Support Business Team	5	19
Rapid Response Team	7	56
Disability Services	8	5
Older Peoples Staying Well Team	14	37
Prestwich INT	0	1
Whitefield INT	5	1
Bury East INT	0	0
Bury North INT	2	3
Bury West INT	0	1
Adult Social Care Complaints Section	0	1
Urban Renewal Team	0	1

8.2 In 2019/20, 212 compliments were received with an increase of 333 in 2020/2021. On the whole the number of compliments received have generally increased from the previous year (2019/20). Team Managers are reminded and encouraged to record and share all compliments received.

8.3 It is pleasing to see the increase in compliments received, especially when those services are front line, for example there has been an increase in compliments for the Hospital social work team, Rapid Response Team, Integrated Neighbourhood Team and Choices for Living Well Service. Staff have been working tirelessly during the most challenging of times and it is pleasing to see that their hard work is being acknowledged and recognised.

8.4 When compliments are received that compliment an individual member of staff a personal thank you letter is sent by the Director - Adult Social Services and Community Commissioning. A copy is also placed on the individual's personnel record.

8.5 Here are some examples of positive feedbacks we received from people receiving a service: -

- "It was a very pleasant experience, made even more pleasurable by a gentleman who was a 'normal human being'. He was caring, efficient, and he enjoyed his company for the period of time that he was there. He spent time to listen to him and his wife and treated them with courtesy and politeness. He also commented on how professional he was in following safe social distancing and the wearing of PPE throughout the whole visit". **Integrated Community Equipment (ICS)**.

- "Thank you once again for all your help and support after my husband passed away. I have met so many new friends from attending weekly regular chair-based exercise classes in Whitefield and Unsworth area and attending the quiz night at the Bay Horse on Wednesday evenings, I have so much more independence now and have so many new friends". **Older People's Staying Well Team.**

- "I'm really happy with my social worker and the support I get from her, she's an amazing woman. Any issues that I have she always deals with them for me even if I do her head in at times. She is always at the end of a phone if I ever need her, I have no issues, she shouldn't be my social worker she should be a manager of the social workers". **Learning Disability Team.**

- Wished to pass on thanks to the Rapid Response Team that supported her grandfather over the weekend before his admission into hospital a big thank you, you were all great and very supportive. **Rapid Response Team.**

- **"**I am writing to say how helpful a member of your staff has been with regards to my 100-year-old mother going into care at Burrswood Home. He has been most helpful and supportive during which I can only describe as a stressful time for me. I would therefore be grateful if you would kindly pass on my sincere thanks to him nothing was a trouble, and it was appreciated". **Discharge to Assess Team.**

- **"**Good afternoon, my Mum has just had the services of reablement for the last couple of weeks, following a fall and the need to regain her confidence. I just wanted to pass on my thanks to the team for the wonderful service. It would not be fair for me to name anyone in particular as they were all brilliant. The good news is Mum has equipment to help her become independent and this could have not been achieved without the support of the team. They are amazing people and would like to pass my thanks on". **Choices for Living Well – Reablement.**

- "Support at home visited me to check my carelink equipment and noticed that I was unwell. They telephoned for an ambulance because of my breathing difficulties, my body was drowning in fluid and if it hadn't been for him, I wouldn't be here today". **Support at Home.**

- "Just to say thank you to the team for so quickly responding to home care needs for my mum who has come to live with me following her cancer diagnosis and with Advanced Alzheimer's. They were fantastic on the home assessment, sensitive with Mum, helpful in her advice to me, and efficient. The home adaptions were done quickly the next week and have really helped Mum in terms of safety going up and down the stairs, and when showering". **Disability Services.**

9.0 LEARNING FROM COMPLAINTS

9.1 While complaints highlight where customers are dissatisfied with the services they have received, they are also beneficial in helping to develop lessons learned to improve services and ensure any mistakes are not repeated.

9.2 Examples of action taken in response to investigation findings to improve services:

Complaint	Lessons Learnt
Various issues regarding the quality of care provided at an Intermediate Care Services facility: - • Medication errors • Monitoring of Food Temperatures • How the MUST score is calculated.	Following the initial investigation, a number of changes have been made. Nurses and pharmacists are now employed. The policy on food temperature checking has been changed and all staff have been retrained in the medication policy and recording MUST scores. A handover system between doctors, nurses and senior carers has been put in place which sees doctors accompanied on all visits and actions recorded to avoid another lapse in communication about an onward referral. They now employ a senior clinical lead nurse to improve care and support across all our Intermediate Care Services.
Difficulties / communication issues regarding arranging an emergency bed repair.	In order to rectify this and prevent it happening again the following actions have been taken: - • An email will now be sent to all staff who refer into Equipment Services to reiterate the process for out of hours' repairs. • All Social Workers and the Duty Social work team will be emailed with details of the process for out of hours' repairs. The Duty social workers will also be sent a copy of the weekly staffing rota with contact numbers. • Bury Council's – Out of Hours Service at Bradley Fold will be sent a copy of the weekly staffing rota with contact numbers. • All Staff in the Rapid Response & Intermediate Care team will be emailed with details of the process for out of hours' repairs including Killelea House. • The options on the telephone line into equipment service will be amended which will give an option for an out of hours repair. • An Equipment Services page will be added to the Councils website with detailed contact information.

10.0 SUMMARY AND CONCLUSIONS

10.1 Despite a global pandemic, staff remotely working, reduction in staff resources and an increase on services, the number / proportion of complaints received in each of the last two years has remained stable showing a slight reduction in 2020/2021.

10.2 Similarly, the number of concerns raised directly to Members of Parliament has remained stable showing a reduction in 2020/2021.

10.3 Positively, to date the number of complaints escalated to the LGSCO has reduced with both cases not finding fault with the Council.

10.4 The Council will continue to seek to learn from complaints, concerns and compliments raised with them.

10.5 Complaints and compliments provide valuable information to the department on how well it is performing, where resources need to be used, and where improvements need to be made. Details of all complaints, concerns and compliments are provided to senior officers on a monthly basis, enabling them to identify any trends or issues within the services they are responsible for.

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ADULT SOCIAL CARE SERVICES

ANNUAL COMPLAINTS & COMPLIMENTS REPORT APRIL 2020 – MARCH 2021

PRESENTED BY:
ADRIAN CROOK
DIRECTOR ADULT SOCIAL SERVICES AND COMMUNITY COMMISSIONING

REPORT PRODUCED BY:
LOUISE CARROLL
ADULT SOCIAL SERVICES CUSTOMER COMPLAINTS COORDINATOR

Bury COUNCIL

PURPOSE AND INTRODUCTION

- Statutory requirement to produce an Annual Complaints Report relating to Adult Social Care Complaints, received by the Corporate Core Department, Bury Council.
- This report is to provide members of Health Scrutiny Committee with details of information relating to Adult Social Care Services.
- The report relates to the period 1st April 2020 – 31st March 2021.

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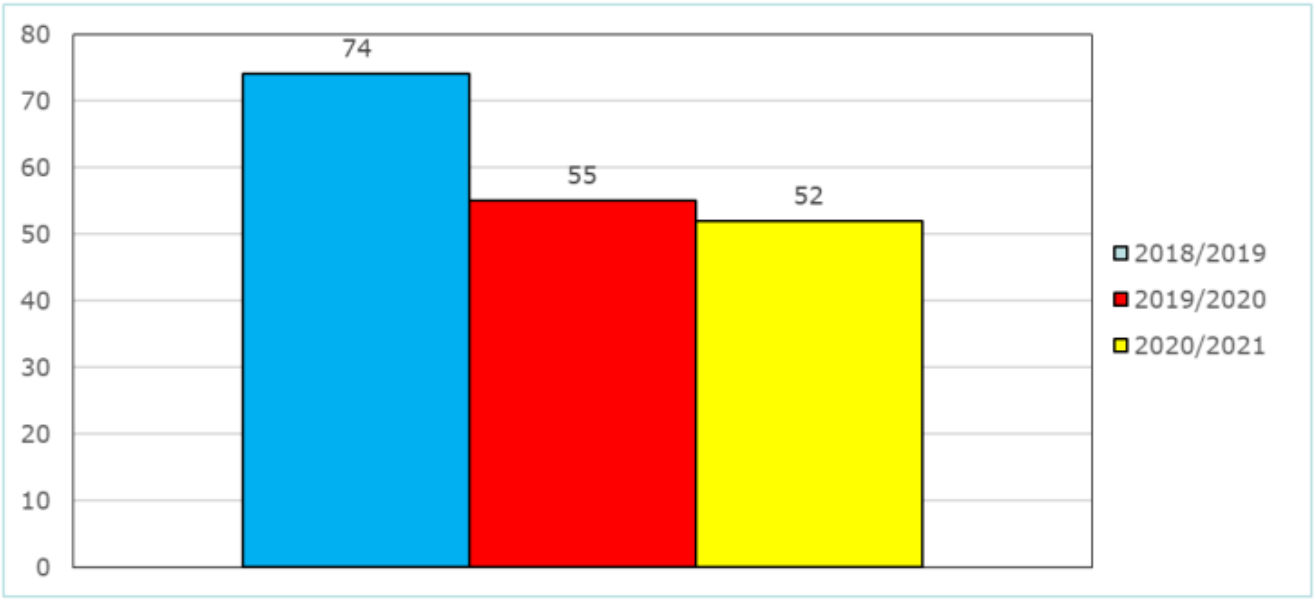
COMPLAINTS RECEIVED

Despite rising demand, pressures and expectations of the services from customers, the number / proportion of complaints received has shown a slight reduction in 2020/2021.



NATURE OF COMPLAINTS

While complaints have decreased in general, specific analysis shows:

- 'Quality of care/service' complaint have decreased (from 8 to 6)
- 'Customer care / communications' complaints have remained the same as the previous year.

- 'Equipment/adaptations' complaint have increased (from 0 to 2)
- 'Changes in service provision' complaints have increased (from 0 to 3)
- 'Financial charges' complaint have increased (from 5 to 11).

The increase in complaints relating to financial charges is likely due to the introduction of the Hospital Discharge Policy. Customers receive up to 4 weeks fully funded care on discharge from hospital but are then potentially liable for charges. Customer confusion around this policy has likely resulted in increased complaints.

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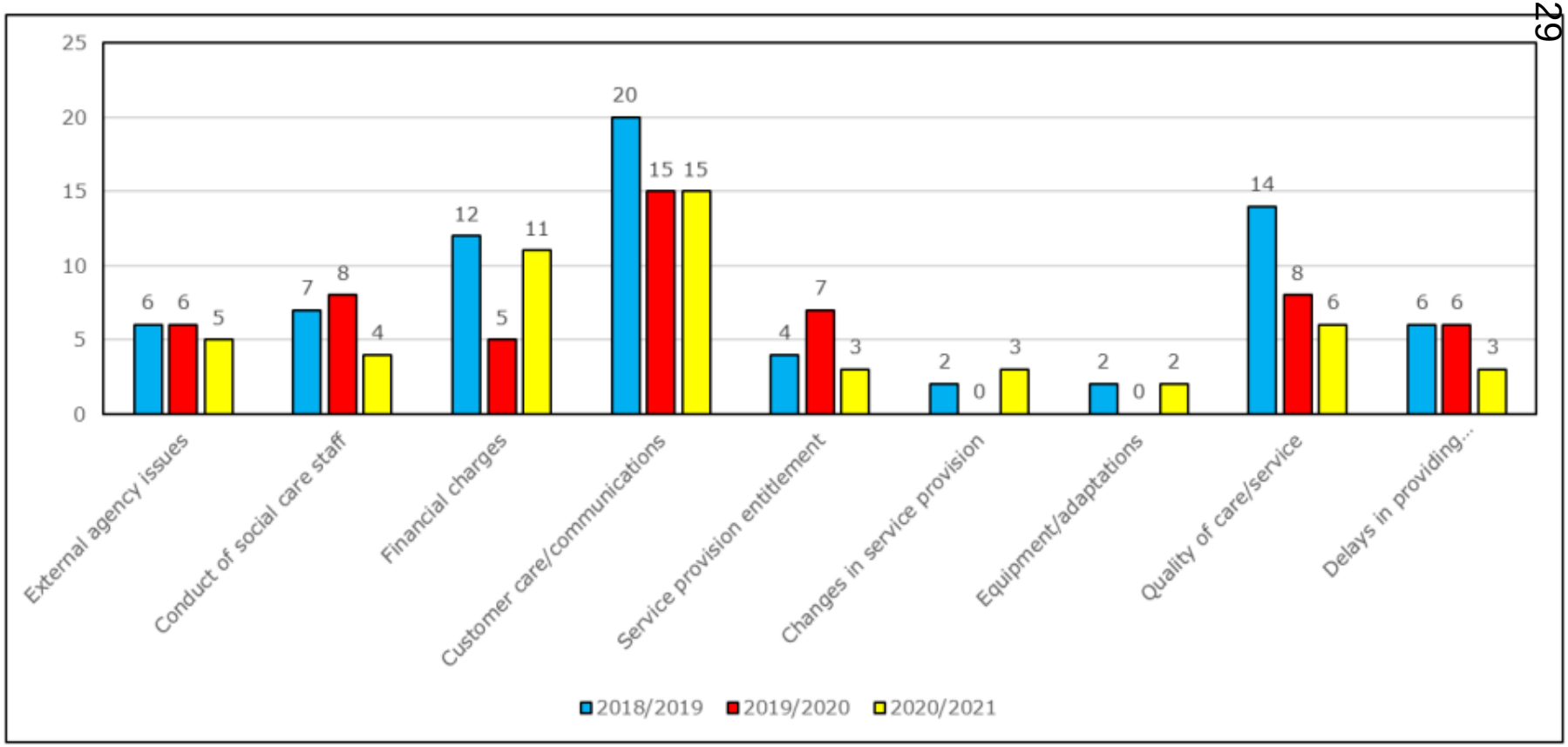
NATURE OF COMPLAINTS



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TIMESCALES

Whilst there are no statutory timescales with which the department must comply in responding to complaints, we do aim to resolve complaints within **twenty working days** on receipt.

In 2020/21:

- 27 (52%) of complaints were responded to within the 20 working day timescales,

- 24 (46%) of complaints were responded to outside of the 20 working day timescales.

- Complaints responded to over 40 working days has significantly decreased from the previous year which is excellent performance considering this was during the pandemic.

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Local Government & Social Care Ombudsman

Within the regulations which govern the complaints process, the Council adopts a flexible approach which prioritises local resolution. However, where complainants remain dissatisfied, they have the option to take their case to the Local Government & Social Care Ombudsman.

Positively, to date the number of complaints escalated to the LGSCO has reduced with only 2 of the 52 complaints received being referred.

Of the two cases, one case was considered a premature complaint and the LGSCO found no fault with the other case.

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COMPLIMENTS

Staff have been working tirelessly during the most challenging of times and it is pleasing to see that their hard work is being acknowledged and recognised.

It is also pleasing to see the increase in compliments received from those services that are front line including the Hospital social work Team, Rapid Response Team, Integrated Neighbourhood Teams and Choices for Living Well Service.

Total number of Compliments received 2019/2020	Total number of Compliments received 2020/2021
212	333

Bury COUNCIL

SUMMARY AND CONCLUSIONS

Despite a global pandemic, adapting to new ways of working, remote working, reduction in staff resources and an increase on services, the number / proportion of complaints received in each of the last two years has remained stable showing a slight reduction in 2020/2021.

Complaints and compliments provide valuable information to the department on how well it is performing, where resources need to be used, and where improvements need to be made.

Details of all complaints, concerns and compliments are provided to senior officers on a monthly basis, enabling them to identify any trends or issues within the services they are responsible for.

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Primary Care Update

February 2022

Update

General Practice Leadership Collaborative

Challenges and Opportunities

Tackling Health Inequalities

General Practice Leadership Collaborative

Who are we?

- Neighbourhood Clinical Leads
- PCN Clinical Directors
- GP Federation Leaders
- Practice Manager Representative
- Practice Nurse Representative
- LMC Secretary
- CCG Primary Care Representatives
- System Leaders

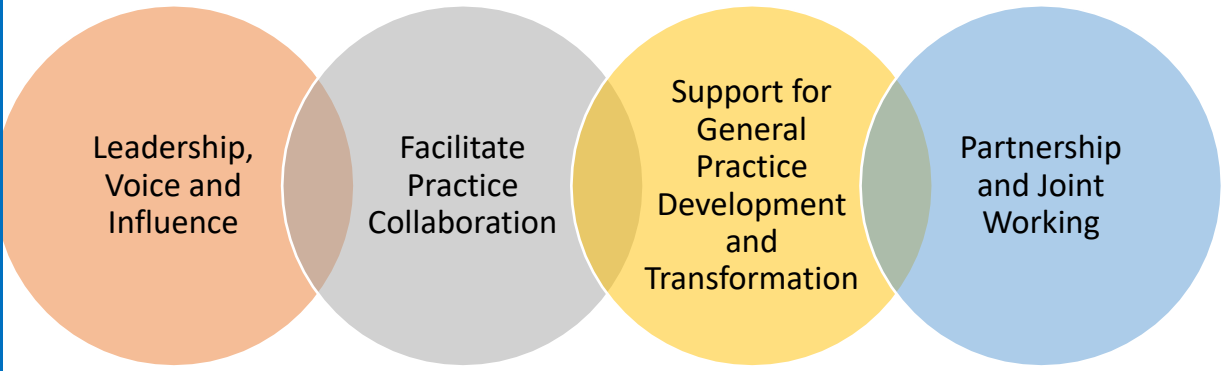
General Practice Leadership Collaborative

Purpose: To be the body through which practices in the borough are represented via their membership of Primary Care Networks, Bury GP Federation and the Local Medical Committee (LMC)

Objectives:

- Develop strong & unified leadership and voice for general practice.
- Develop a clear vision for sustainable, resilient and high quality general practice and its role within the integrated health and care system.
- Lead and advise on the strategic development of programmes that impact on the future resilience, quality and sustainability of general practice.
- Identify opportunities for collaboration, including the provision of support functions and the delivery of services.
- Provide a Forum for the sharing and adoption of good practice
- Draw on and utilise the expertise of all parts of general practice including expertise about provision of services, clinical matters including from medical, nursing and allied health professionals, managerial matters, commissioning and population health matters.
- Share information and keep members up to date with developments including policy and contractual changes; service redesign/ improvement programmes; leadership & development opportunities; new resources and investments.

Role:



Behaviours:

1. Solution focused. Bringing positivity; constructive challenge and problem-solving approaches into meetings.
2. Foster trust/stronger relationships by using transparent, open and honest communication.
3. Seek to understand motivation: behaviours that allow a greater understanding of motivation before a judgement is made.
4. Promote decisiveness/clear accountability for decisions and actions that are agreed by the membership.
5. Promote respect behaviours.
6. Encourage collaboration.

We will:

Optimise outcomes that matter to the people we serve with the resources available.

Provide high quality general practice equitably [to reverse the inverse care law]

Be sustainable (especially, but not limited to, positive and motivated people working in General Practice)

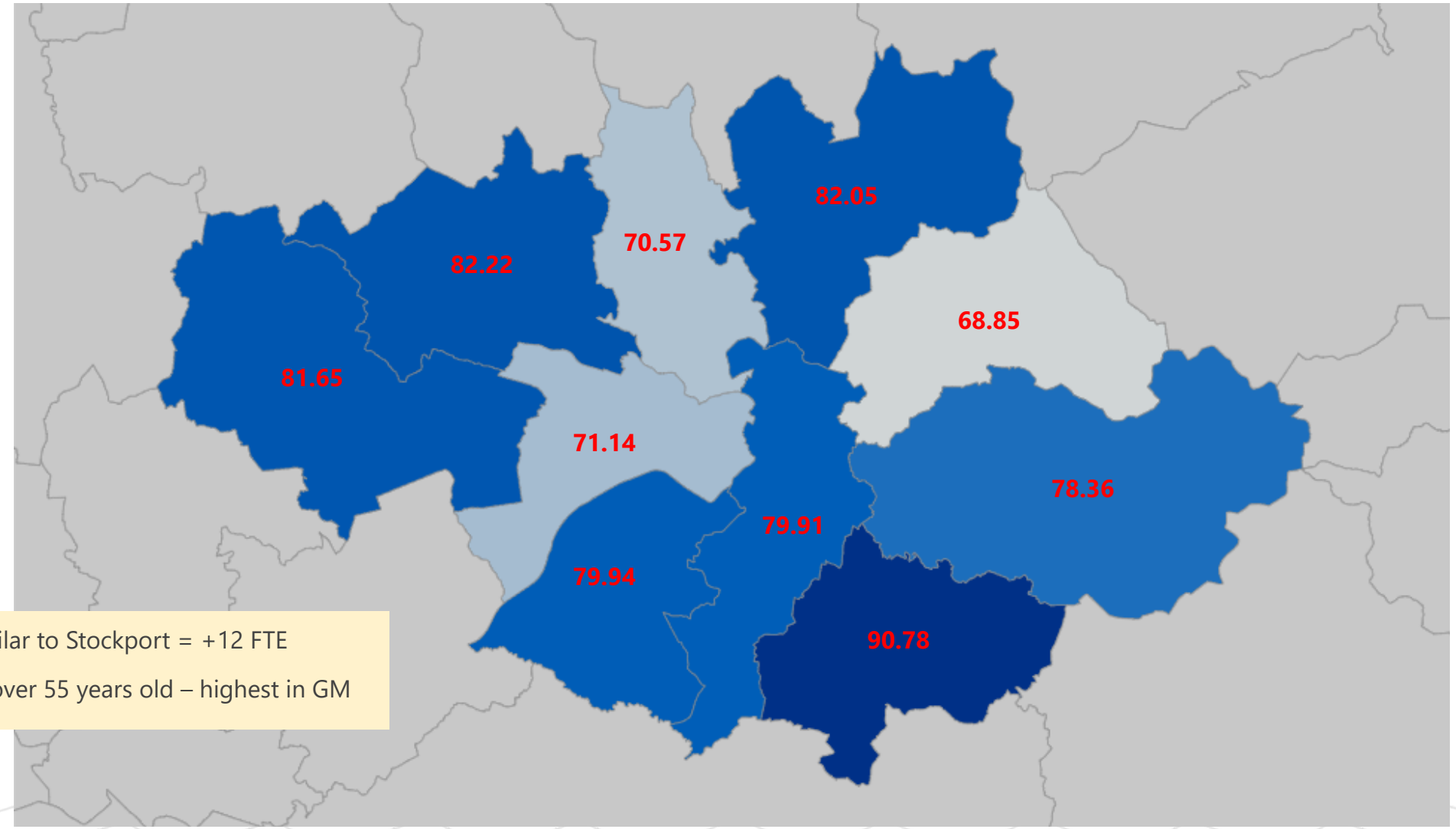
Be more effective by operating within general practice at multiple levels (practice, neighbourhood, locality and GM) – whichever provides greatest value and outcomes

Work collaboratively with others outside general practice at neighbourhood level; town-wide integrated services and GM level (e.g. through the GM ICS and associated sub-groups)

Be accountable to each other, and the people we serve by monitoring and publishing progress on the five principles above

Challenges and Opportunities

Number of GPs in GM per 100k - Headcount



If Similar to Stockport = +12 FTE

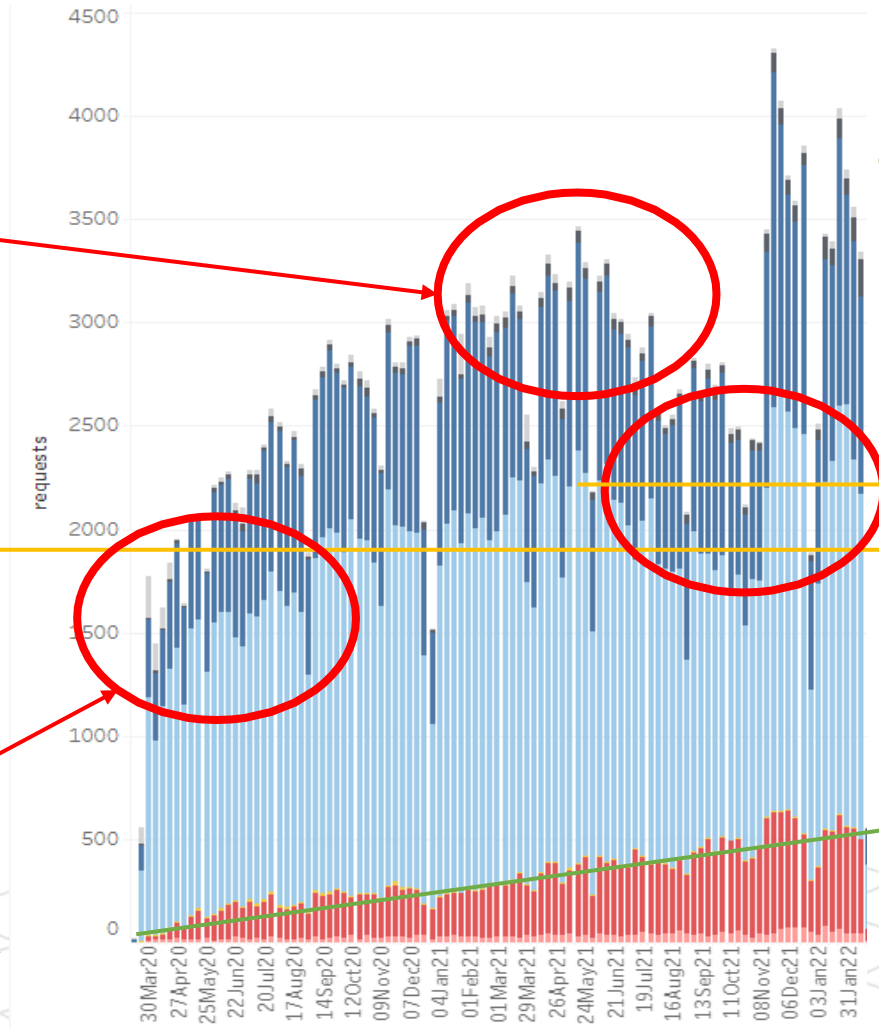
23% over 55 years old – highest in GM

Demand in General Practice – Tower Experience

Post COVID – saw a steady rise in demand

Pre-Covid demand > 2000 contacts per week

COVID Lockdown – reduction in activity



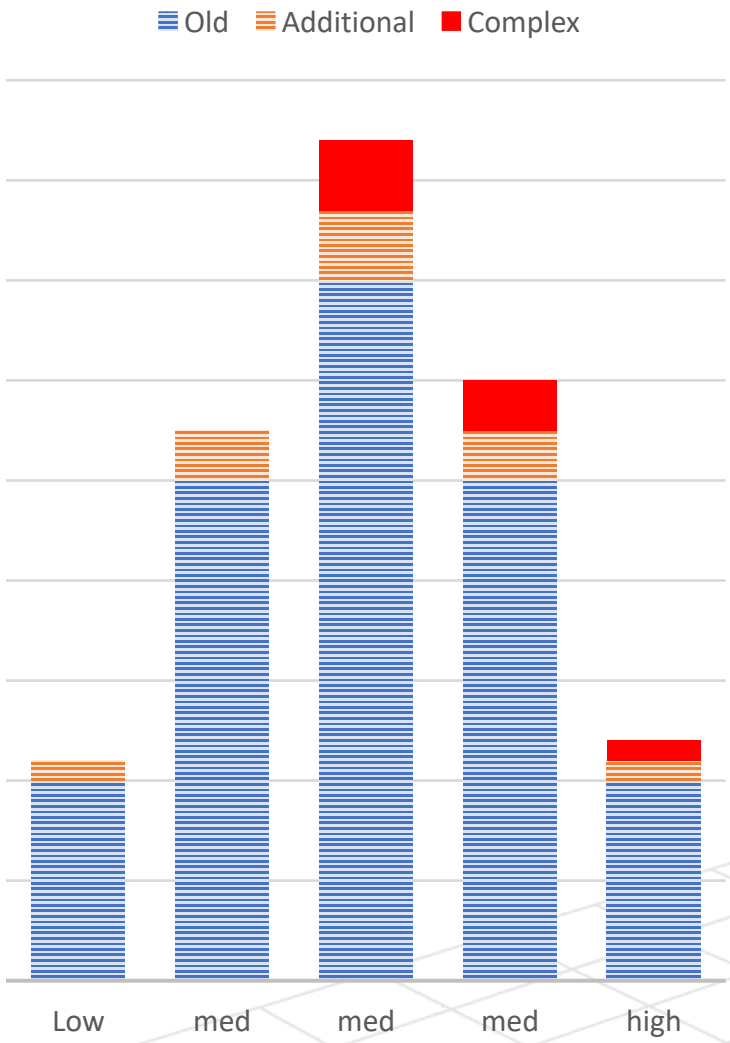
Additional demand – we cant meet

Capacity Available

Steady rise in F2F contacts

Day	No
Mon	1041
Tue	798
Wed	706
Thu	682
Fri	624
Total	**3851**

Issues for General Practice



Changes in demand	• Definite Additional Need • Increased Complexity
Problems	• Staffing Shortages • Premises & IT
Solutions	• Different workforce • Neighbourhood working
However	• Can't deliver everything • General Practice will be different
Risk	• Miss those with genuine clinical need

Tackling health inequalities

Neighbourhood Teams are tasked with developing Neighbourhood Health & Care plans for 2022-23

This requirement is mirrored within the Bury Locally Commissioned Service 2021-22 with the expectation that Practices working with their wider Neighbourhood colleagues identify both core and discretionary outcomes for delivery from 2022/23.

CORE (priority outcome applies to all Neighbourhoods but Neighbourhood level delivery plan may vary)	
1	Application of the Active Case Management (ACM) / Multidisciplinary Team (MDT) Quality Framework and SOP
2	Public health and prevention, relevant to that neighbourhood
3	A transformation programme (Elective, Palliative, Frailty, Mental Health, Strength based Conversations etc) again relevant to that neighbourhood
4	One specifically related to ACM outcomes and impact
DISCRETIONARY (Neighbourhood specific)	
5	Focus on the neighbourhoods top three attendances or admissions (to health or care) and designed by the neighbourhood team
6	Focused on ‘what matters to me’, and people in the neighbourhood, and designed by the neighbourhood team

Approach

The approach being taken is to as far as possible align Neighbourhood priorities and plans with relevant elements of the PCN DES. By taking this approach we are seeking to:

- Remove duplication of effort and resources
- Recognise that tackling health needs and reducing health inequalities at a population level requires a collaborative, systematic approach
- Focus resources at a Bury-wide and Neighbourhood level on reducing inequalities in access and outcome using evidenced based interventions

Public health and prevention priority

With respect to the public health outcome the proposal is to focus on the prevention of **cardio-vascular disease**. The rationale is that:

- CVD is a one of the most significant causes of preventable death in our population
- Bury is an outlier when compared with the national average
- There are known inequalities in access and outcome in our population and it is possible and realistic to target interventions in a way that will reduce these inequalities
- There are evidence-based interventions and treatments that can have a positive impact in reducing risk through primary, secondary and tertiary intervention
- Many of the preventative interventions for reducing the risk of CHD will have wider health improvement benefits
- There is the potential for achieving greater impact by public health, primary care, community and voluntary sector services working together at a Borough-wide and Neighbourhood level
- There is close alignment with the PCN DES [and in particular the requirements relating to tackling health inequalities and CVD prevention and diagnosis] and some QOF measures

Additional priority outcomes

In setting the other core and discretionary outcomes the attention where possible is to similarly align with relevant DES requirements:

- Anticipatory care
- Personalised care – personalised care planning, shared decision making and proactive social prescribing

For example, targeted Active Case Management through Neighbourhood MDTs could be a mechanism for delivering these requirements in a collaborative way.

Planning Process

The intention over the next period is to engage with practices and other stakeholders through Neighbourhood meetings and via PCNs to define the priority outcomes and then develop the plans to deliver these.

Engagement with PCN Clinical Directors and member practices	21st Feb – 30th Mar
Engagement with practices & Neighbourhood stakeholders	21st Feb – 30th Mar
Engagement with Bury Integrated Delivery Collaborative Board	16th Mar
Engagement with Voluntary Community & Faith Alliance Health & Care Network	30th Mar
Update to Bury Public Service Reform Steering Group	1st Apr
Final proposal to GP webinar	6th Apr
Development of Neighbourhood H&C delivery plans	11th Apr – 31st May
Neighbourhood H&C delivery plans sign-off at Neighbourhood Delivery Team	17th June

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SCRUTINY REPORT

Bury COUNCIL

MEETING: **Health Scrutiny Committee**

DATE: March 2022

SUBJECT: Mental Health

REPORT FROM: **Adrian Crook Director (Adult Social Services and Community Commissioning)**
Ian Mello (Director of Secondary Care)

CONTACT OFFICER: **Jane Case (Commissioning Programme Manager – Children & Young People), Kelly Winstanley (Commissioning Manager – (Adult Mental Health)**

1.0 Background

1.1 This report provides an update following the report in November which detailed the investment plan for the adult community mental health system and developments and investment into the children's mental health system.

1.2 This report provides a mid-year summary of provision and impact as well as a forward view for the additional investments across the system. It highlights provision to deliver the Long-Term Plan deliverables against the backdrop of the impact of the COVID pandemic for adults and children and young people (CYP)

2.0 Introduction

2.1 The impact of the pandemic has influenced Adult and CYP's emotional wellbeing and mental health nationally, regionally, and locally. This briefing is to update on the developments, impact, and progress of the agenda since the last report in November 2021.

2.2 This report provides a further update on Bury's progress in growing provision and meeting the deliverables within the Long-Term Plan.

2.3 It's essential the population of Bury have good positive mental health and recognising that promoting and supporting positive emotional health and wellbeing is everyone's business.

2.4 There is a need to build more capacity across other parts of the system to meet increased need and build a stronger system. The COVID 19 pandemic significantly impacted upon the delivery of acute and community services across the NHS.

2.5 National prevalence of childhood mental health disorders increased from 1:10 to 1 in 6.

2.6 Nationally evidence suggests COVID-19 has and will continue to impact mental health with higher prevalence and acuity. This has resulted in a 'backlog' estimate ~1.4m people have been accepted for / are eligible for care but are yet to receive it. An additional 8m people would benefit from care if access barriers were reduced based on national morbidity studies and prevalence data.

2.7 Increased complexity and acuity are evident in services such as IAPT and CYP, but even more so at the acute end, creating significant urgent pressures, and the growing backlog and acuity is translating into higher numbers of inappropriate Out of Area Placements.

2.8 Covid changed the nature of this demand with increased urgent and emergency presentations, due to crisis, increased eating disorders and anxiety. The most vulnerable cohorts of young people most severely negatively impacted by covid are children with SEND and those Looked After Children.

2.9 Locally, Omicron resulted in Pennine Care Foundation Trust (PCFT) operating under their business continuity model due to high numbers of staff illness.

2.10 A recent British Medical Journal article [1] into the impact of the pandemic on children's health found that Nationally :

- Between April and September 2021, there was an 81% increase in referrals for children and young people's mental health services compared with the same period in 2019.The increase for adults (19 years and over) in the same period was 11%
- During the same period, there were over 15 000 urgent or emergency crisis care referrals for children and young people, a 59% increase compared with the same period in 2019
- One in five children and young people waited more than 12 weeks for a follow-up appointment with mental health services between April 2020 and March 2021
- The number of children and young people waiting to start treatment for a suspected eating disorder quadrupled from pre-pandemic levels to 2083 by September 2021
- During the pandemic, the number of children and young people attending emergency departments primarily for an eating disorder doubled from 107 in October 2019 to 214 in October 2021.

2.11 Systems are experiencing increased mental health pressure brought about by increased complexity and demand because of the pandemic. Therefore, to support systems to address these pressures, as per the 2022-23 Priorities and Operational Planning Guidance, the following mental health system priorities have been agreed at a national level: **Mental Health Priorities**[i]

- Continue to expand and improve their mental health crisis care provision for all ages, including improving the operation of all age 24/7 crisis lines, crisis resolution home treatment teams and mental health liaison services in acute hospitals, as well as increasing alternatives to A&E and admission, and ambulance mental health response

[1] (Iacobucci G. Covid-19: Pandemic has disproportionately harmed children's mental health, report finds *BMJ* 2022; 376 :o430 doi:10.1136/bmj.o430)

- Ensure admissions are intervention-focused, therapeutic, and supported by a multidisciplinary team

- Continue to grow and expand specialist care and treatment for infants, children, and young people by increasing the support provided through specialist perinatal teams for infants and their parents up to 24 months and through continuing to expand access to children and young people's mental health services

- Continue the expansion and transformation of mental health services, as set out in the NHS Mental Health Implementation Plan 2019/20–2023/24, to improve the quality of mental healthcare across all ages

- Subject to confirmation, encourage participation in the first phase of the national Quality Improvement programme to support implementation of the Mental Health Act reforms

- Continue to support the health and wellbeing of our staff, including through effective health and wellbeing conversations and the mental health hubs

These national drivers are integral to the work articulated here alongside future continuing support for the Bury population.

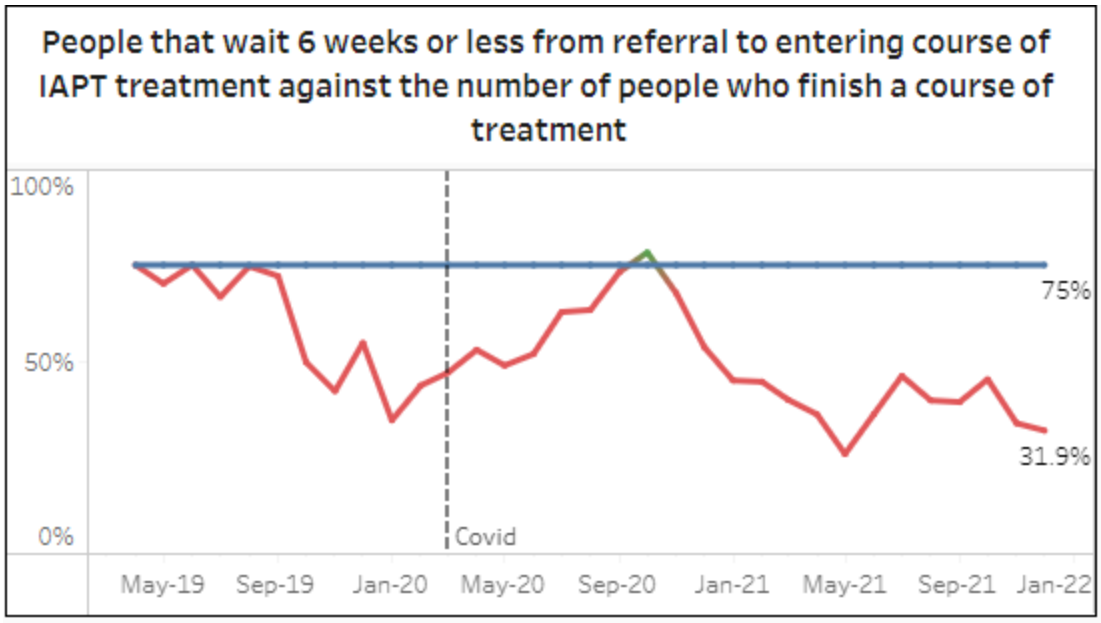
3.0 **Adult Mental Health – Ongoing Developments**

3.1 Recruitment for the additional 15 Mental Health Practitioners approved in September 2021 has commenced to bolster the Community Mental Health team (CMHT) and ensure demand can be met and deliver the CMHT restructure ensuring improved links with our neighbourhood system (See further update below).

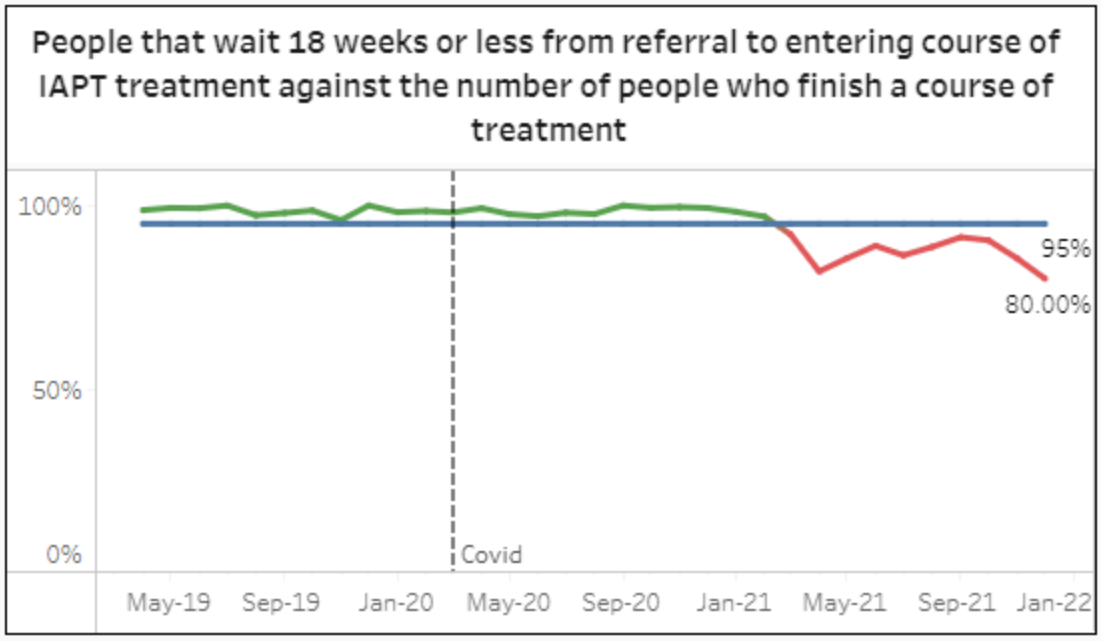
3.2 PCFT has recruited 5 Primary Care Networks (PCN) Mental Health Practitioners (1 per PCN) who start in February / March. They will support individuals in primary care and prevent people escalating to community with acute Mental Health needs. The number of practitioners will increase each year for the next 2 years.

3.3 Access to Healthy Minds / Improving Access to Psychological Therapy (IAPT) remains significantly below standard. PCFT has started to offer group therapy and people are offered digital support via Silver Cloud. An Action Plan is in place to address access and a review of staffing levels is being conducted based on demand due to staffing shortages.

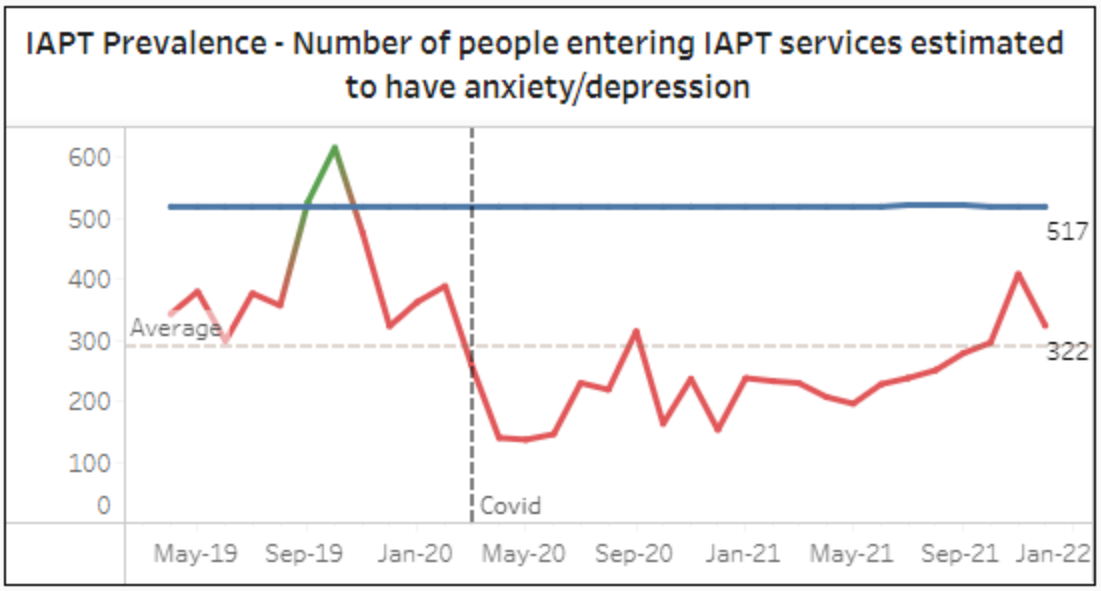
3.4 Indicative Data for the Provider - PCFT. There is a one-month lag in receiving this data. Latest data available is January 2022. The dotted vertical line relates to when the Covid Pandemic hit in March 2020.



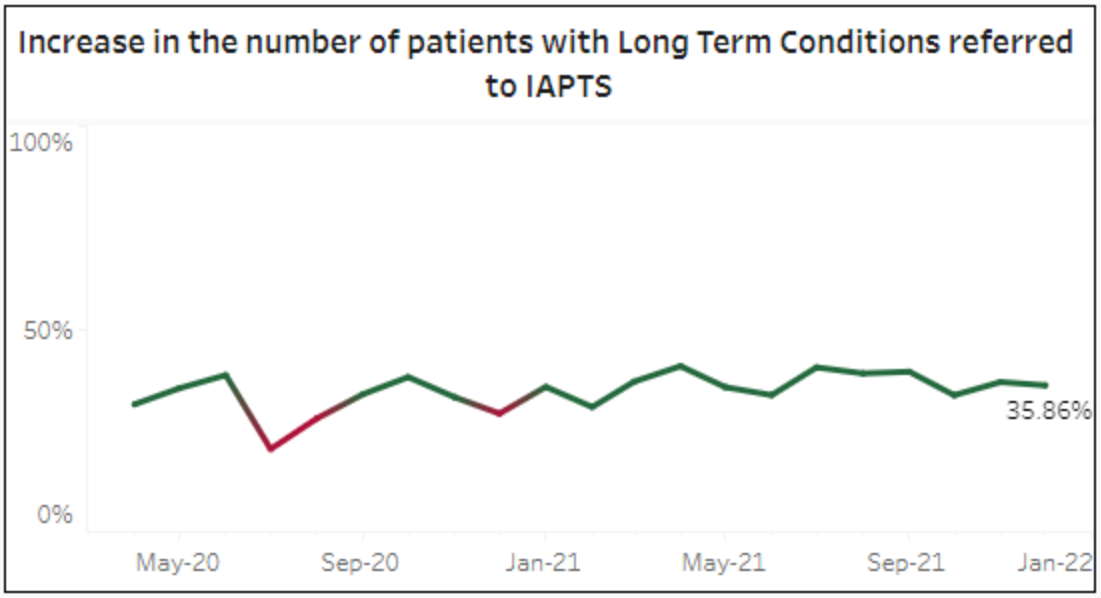
3.5 The above graph shows the proportion of people who wait 6 weeks or less from referral to entering a course of IAPT treatment. The performance of which has been consistently below the national target of 75%. Only once has the target been meet since April 2019 in October 2020 at 78% and was at its lowest in May 2021 at 26%.



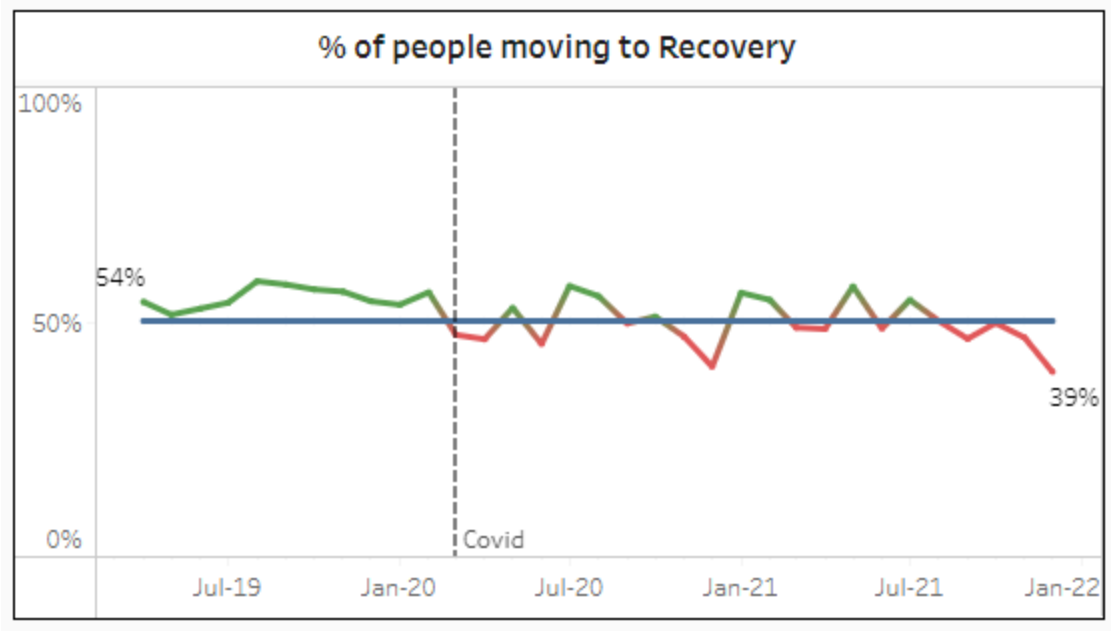
3.6 The above graph shows the proportion of people who wait 18 weeks or less from referral to entering a course of IAPT treatment. The performance of which has been above the national target of 95% up until March 2021 (92.11%) when the performance has been consistently below target.



3.7 The above graph shows the number of people entering IAPT services estimated to have anxiety/depression. There is a monthly target of 517 persons to be seen, for which we have not been achieving. Since April 2019 a monthly average of 322 persons were seen. At its highest 614 persons were seen in October 2019.



3.8 The above graph shows the number of patients with Long Term Conditions referred to IAPTs. There is no target for the measure. From April 2020 the monthly average referrals seen with a Long-Term Condition was 96 out of an average monthly referral total of 277. Consistently giving a % of around 34.81% referred into IAPTS.



3.9 The above graph shows the proportion of people moving towards recovery, for which there is a target of 50%. The performance of which was consistently just above target pre Covid and has since fluctuated around the target line, being both above and below target. The latest position as of January 2022 is 47.55%.

3.10 Community Mental Health Transformation and the development of the Bury Adult Mental Health "Living Well Model" has started, PCFT has recruited a Project Manager who is due to start in April 2022 to lead this work. This work aligns with the Bury place-based neighbourhood approach linking universal clinical services, VCFE, Physical health, Social Care, PCN's, INT's and wider public sector partners.

3.11 The Housing Learning & Improvement Network (HLIN) has been commissioned to prepare a housing accommodation assessment that will inform the supported Bury Housing Strategy. It will include accommodation for people with enduring mental health support needs.

3.12 Continued working to achieve the priorities in established Bury partnership groups such as Suicide Prevention, Homelessness, Drug & Alcohol, Police Partnership.

4 Adult Community Mental Health Team Update

4.1 Community Mental Health Team progress towards implementation

The additional investment allowed for the recruitment of 6 Mental Health Practitioners by March 2022; however, it has not been possible to fill these roles due to the poor quality of candidates and low number of applicants. The posts are currently occupied by agency staff to ensure that the resource is in place. This situation isn't unique to Bury, nationally there is a skills shortage. A high number of agency workers doesn't offer the service and their client's stability, the temporary staff are reluctant to move to permanent contracts.

4.2 The workforce lead is working with the PCFT recruitment team to explore joint recruitment opportunities to help fill the vacancies.

4.3 In addition, 3 CMHT Managers resigned in the last 4 months, securing new roles outside of Bury. The CMHT Service Lead has successfully recruited 2

replacements so far and is in the process of recruiting a 3rd. The Service Lead has been under pressure to support staff and lead on recruitment**.**

4.4 The service has successfully recruited several social workers, who will progress to become Approved Mental Health Practitioners**.**

4.5 Recruitment to vacant nursing posts has been challenging due to the national shortage of qualified nurses and is on-going.

4.6 The service is developing a Structured Clinical Management (SCB) team to support the personality disorder pathway, the new Consultant Psychologist will start in March 2022 and 2 practitioners to support the development of this pathway have also been recruited.

4.7 Two Trainee Associate Psychological Practitioners (TAPPs) have been recruited for Bury CMHT, which supports the CMHT re-design work and addresses some of the workforce challenges. However, it is recognised nationally that there is a shortage of mental health nurses and clinicians and so opportunities to train are integral to address this, on a national and regional level.

4.8 Caseloads are still high, with too many on waiting lists, the Service Lead has provided assurance regarding safeguarding, Care Act compliance and commissioning of care.

4.9 The CMHT team has good links with the INT's and will work closely with the PCN Mental Health Practitioners once in post. The team continues to use recognised techniques to better manage the improved flow of patients through the service; initiatives like caseload cleansing, providing regular supervision and regular staff supervision for its staff.

4.10 **The Getting Help line** The "Getting Help Line" was launched in April 2020 in response to the pandemic to support health and social care professionals with non-clinical emotional wellbeing clients, and in August 2020 it was expanded to accept calls from the public**.**

4.11 The service delivers a national, regional, and local priority: to support the crisis pathway by providing triage and managing all non-urgent, non-clinical mental health support for everyone.

4.12 Interventions include emotional support, advice and guidance, self-help tools, signposting to other organisations and formal referrals.

4.13 Between April '21 and December '21 (Q1, Q2 & Q3) there were 711 referrals.

4.14 The service is an integral part of the Bury Mental Health pathway and is a local single point of contact for the public and professionals seeking non-clinical mental health support and advice.

4.15 Following a formal service evaluation, the service has been re-commissioned for a 12-month period in 22-23' with some changes to the original model.

4.16 The peak time for calls is between 10am and 7pm, evenly spread over the 6 days. The newly commissioned service will operate during these hours to meet demand (54 hours), this would provide capacity for 108 referrals per month.

4.17 The money created from this change in operating hours will now fund a dedicated Getting Helpline Plus worker to support the vulnerable people with mental health needs, such as the repeat callers and people from ethnic minority groups, men, and young people.

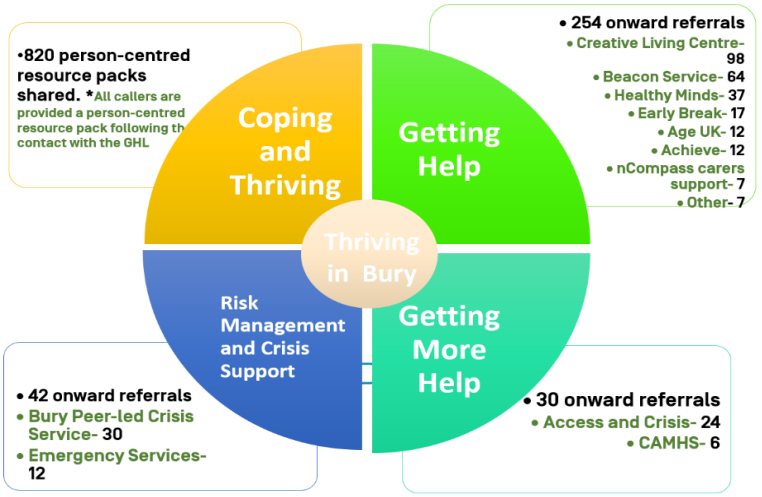
4.18 The service has 13 frequent callers, majority are known to PFCT services, dedicated support from the same caller has reduced the number of times these callers have accessed A&E and police services. The service sits within the Thriving in Bury framework Getting Help offer.

4.19

Support provided to callers by percentage:

- Coping and Thriving- 62%
- Getting Help- 30%
- Getting More Help- 3%
- Risk Management & Crisis - 5%
- The model to the right details the on-ward referral destinations for callers into the framework.
- To date, 38% of callers had follow-on referrals into 'Getting Help'/ 'Getting More Help' & 'Getting Risk Support' groupings.
- 62% of callers were supported with Coping & Thriving support, advice & guidance & no onward referral was required (508 callers)

Support provided to GHL callers aligned with the Thriving in Bury framework.



4.20 The organisation has used a variety of ways to promote the service across Bury to increase awareness and access opportunities for Bury residents. Development of a service brand and patient information resources Information packs and promotional materials distributed to general practices and schools Primary care information webinars (including GP webinars)

4.21 Banners promoting the service are displayed in key areas across Bury (town center, parks) Information packs and presentations to community partners Local press release and radio interviews.

4.22 Extensive social media campaign, links with Bury CCG / Council communications team Development of a webpage

4.23 There is targeted work ongoing to promote the service to have impact on the following groups (inequality issues).

- Young males
- Whitefield residents
- GP practices who have low referrals/uptake
- BAME organisations and communities

4.24 There is follow-up and-holding and support work for repeat callers and those who struggle to access community resources as well as pperson-centered support plans for those with additional needs.

4.25 Deflections from other services - Early data indicates that 56% of people who contacted the service would have accessed statutory services had support not been available. 6% wouldn't have sought any help for their problems.

5 Priorities

5.1 The Getting Help Line service links to the NHS Long Term Plan priorities.

5.2 Responds to GM's ask that each locality provides a local non-urgent, non-clinical mental health telephone support service as part of the GM Mental Health Acute and Crisis model.

5.3 The establishment of an all-age non-clinical mental health helpline also aligns with both the local Bury adults and children's mental health priorities that have been identified as part of the Thriving in Bury framework in 22/23.

5.4 It supports the aims and principles of providing good early access to mental health and wellbeing support in the community with less people requiring urgent and acute clinical provision.

5.5 Re-commission of the service was agreed in Governing body in Dec '21 for a further twelve months and will be reviewed as part of the Living Well Development.

5.6 **The "Peer Led Crisis service"** launched in April 2021 for a 12-month pilot.

5.7 The service provides peer led support to adults experiencing a mental health crisis including those who are at risk of suicide.

5.8 It is a requirement of the NHS Long Term Plan that each locality provides a range of complementary and alternative Mental Health crisis services to A&E.

5.9 The Peer Led Crisis Service is a non-clinical service provided by a local community group BIG in Mental Health.

5.10 Referrals are accepted from clinical and community services. Pathway links with the service are now well established across the mental health crisis care system.

5.11 The service provides one-to-one appointments and uses de-escalation techniques tailored to each visitor, such as grounding techniques and coping strategies.

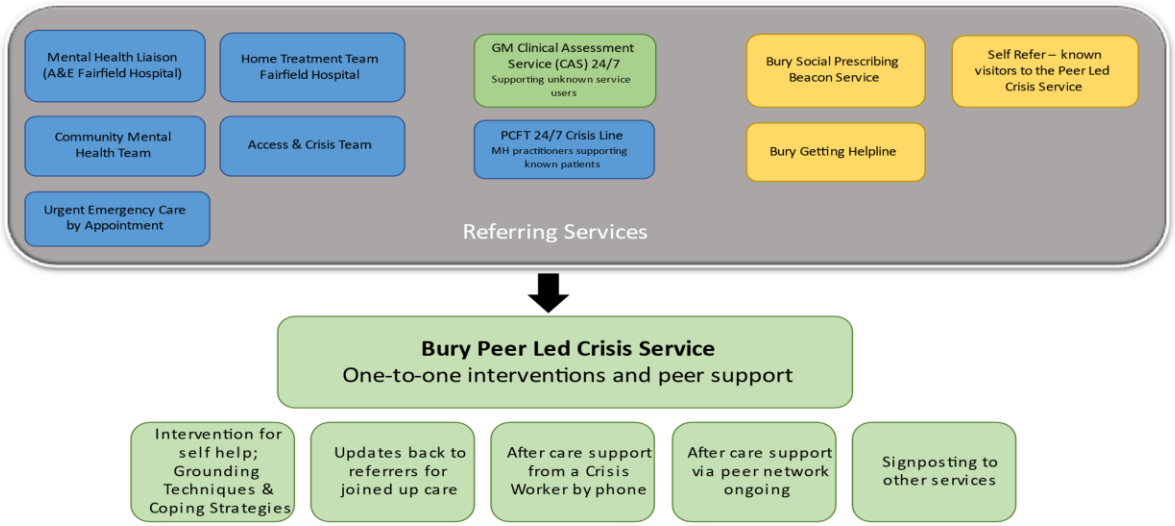
5.12 Service visitors are supported by the same Crisis Support worker for each appointment.

5.13 During the pilot 3 Crisis Support workers were operating 3 evenings per week with a maximum capacity of 7 individual appointments per evening.

5.14 In the first 6 months, 67 people had been supported and projections indicated the service would support 187 people over the full year of the pilot.

5.15 The Peer Led Crisis Service aligns to the local Thriving in Bury framework and sits within the Risk Management & Crisis Support quadrant.

5.16



5.17 The main presenting issues are depression / low mood / anxiety, with some individuals presenting with multiple issues. The service has supported individuals at risk of self-harming and / or suicidal feelings.

5.18 The main contributing factors captured from visitors to date are health worries, loneliness, and alcohol / substance misuse.

5.19 Outcomes / Impact - The outcomes achieved for visitors include reduced distress, suicide prevention, reduced self-harm, reduced isolation, increased ability to cope, increased social confidence and connected to other services. This clear evidence demonstrates the need for this service, and it has become a valuable part of the mental health crisis pathway providing people with the right care at the right time.

5.20 As a result of these outcomes and feedback from service users and health professionals in Bury the Service received additional non-recurrent Winter Pressures funding (until the end of March 2022) from Greater Manchester Health & Social Care Partnership (GM) to fund temporary expansion to provide support for an additional 60 people.

5.21 Following the service evaluation, the service has been re-commissioned for a further 3 years to support sustainability and certainty for this sector.

5.22 Operational hours will increase to 6 sessions per week, supporting 480 people per year. This will offer a mixture of both day and evening appointments with access to drop ins.

5.23 The service could potentially expand the pathway to include Neighbourhood Teams, Healthy Minds, Police Ambulance Service, and other Voluntary Community Social Enterprise partners such as foodbanks and homelessness groups with the expanded service capacity.

5.24 The number of children and young people presenting in crisis has increased and the Peer Led Crisis Service model could be developed to support this vulnerable cohort.

5.25 Deflections - The service has supported people who would have unquestionably accessed universal services had they not received timely crisis care. All people referred to the service are contacted within 24 hours and offered the first available appointment; this is sometimes the same day and always within a week.

5.26 In the pilot within a six-month period between April and September '21, the service recorded the following deflections, 24 from GP, 29 from A&E of which 13 would potentially have been admitted to a ward and 4 from the Home Treatment Team. Approximately 85% of visitors accessing the service were deflected from other services.

5.27 The service has deflected presentations at Accident & Emergency and inpatient admissions and the number of deflections will continue to increase.

5.28 The wider cost to society of each death by suicide is £1.7m, and those affected by the death are at a higher risk of suicide, the ripple effect on society is high.

5.29 Priorities **-** The commissioning of this service is acknowledged as a national, regional, and local priority. Local mental health priorities presented to Local Care Organisation (LCO) Executives in December 2021 included the provision of alternatives to A&E for mental health crisis care, to ensure people receive the right type of care at the right time.

6 Eating Disorder Service investment

6.1 Eating disorders are serious mental health conditions with the highest mortality rate of any mental health problem (BEAT 2015). Effective psychological treatments exist and therefore, early access to these is of paramount importance. Whilst CYP Eating Disorder Services (EDS)have been a focus of the 5 Year Forward View, seeing increases in funding to achieve improved waiting targets, adult EDS have not received the same focus, creating disparity within the offer. Revisions of the National Institute for Health and Care Excellence (NICE) guidance in relation to treatment length and changes to diagnostic criteria have added further pressure to local services.

6.2 In addition, it is recognised that the Bury service had been significantly under commissioned in relation to the level of presenting demand and was not commissioned to provide medical input to support monitoring of people with more complex presentations. This resulted in waiting lists to access the service and a challenge from primary care to ensure that the right treatment, support, and medical oversight was in place for this population.

6.3 Bury CCG received a business case from its Adult Community Eating Disorder provider Greater Manchester Mental Health (GMMH) to consider expanding the current commissioned service offer which reflects the updated clinical guidelines and service gaps. In addition, the following key asks have been specified:

- A clinical model that reflects the same service as approved and invested by the other GM Localities.
- A clinical model that was approved via the GM Eating Disorder Steering Group.
- Medical monitoring as an essential component of this model
- Parity of provision across all GM Boroughs, and as such, commitment to progressing investment to support this.

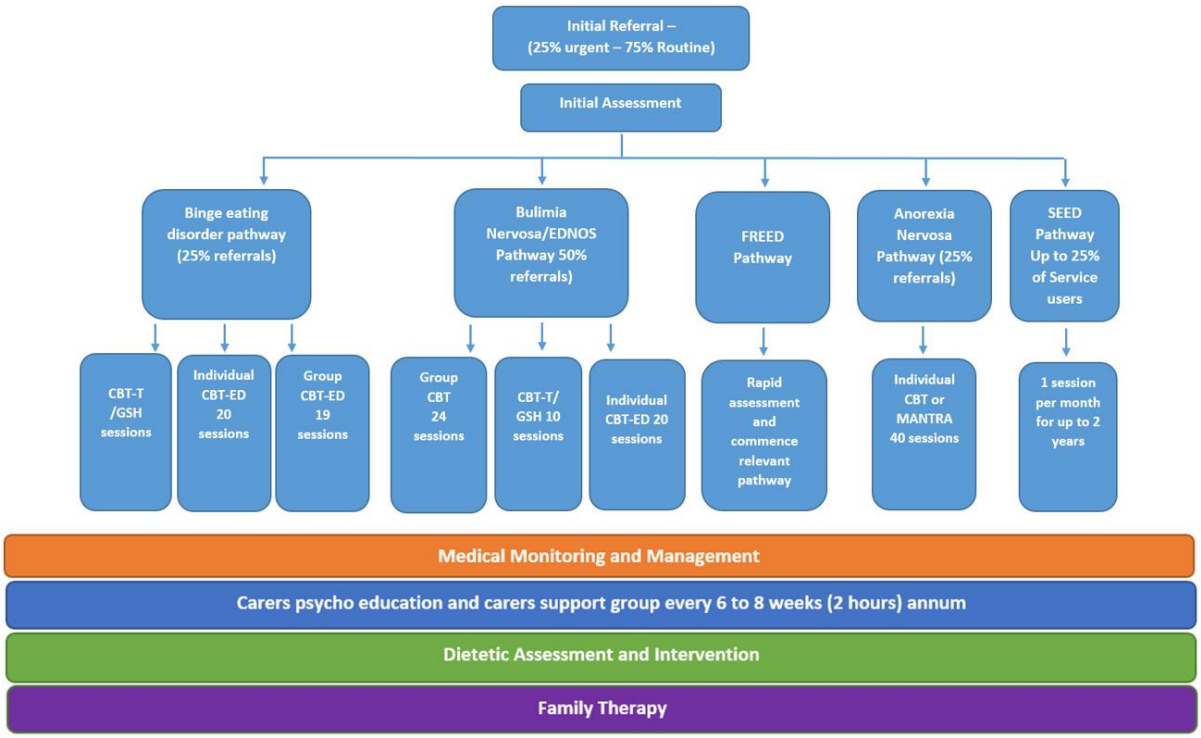
6.4 In December 2021 the additional investment was agreed through Governing Body. For Bury residents this will deliver increased quality through providing a service response time matching CYP services of 1 week from referral to treatment for urgent cases and 4 weeks for routine. There will then be access to a range of evidence-based treatment pathways including individual and group therapy.

6.5 The clinical model was developed from current clinical guidelines (NICE, 2017, Nice Quality Standards, 2018, NCCMH, 2019). An understanding of future changes in provision of adult EDS (waiting times in line with CYP EDS, increases in threshold of inpatient admission due to Provider Collaborative) and stakeholder feedback (service user, carer, GPs/primary care/referrers, providers of intensive parts of eating disorder pathway).

- Increased psychological therapist and dietitian capacity to meet the demand for the service from each CCG. This will enable the service to be responsive and achieve the same waiting times for treatment as CYP.
- It will also allow the service to continue to offer high quality NICE compliant/evidence-based interventions.
- The increased capacity of psychological therapist and dietitian time will allow for the service to have capacity to meet the treatment length of interventions for anorexia nervosa.
- A range of NICE compliant/evidence-based interventions delivered in both group and individual formats. This will enable service user choice.
- Psychiatry/medical input to enable robust medical monitoring and management and support for staff in other setting managing individuals with the physical risks of an eating disorder. As part of the new psychiatry/medical pathway, the service will also be able to offer phlebotomy and ECGs within the service to enable ease of access and more rapid results and therefore a safer pathway.
- Psychiatry time to enhance the service offered to referrals accepted by the service with increased physical/mental health complexity.
- A FREED pathway to enable a responsive service and treatments tailored to the needs to emerging adults with ED to be delivered.
- A SEED pathway to enable a pathway for those individuals who meet criteria for a severe and enduring eating disorder
- The service will continue to attend CPAs of individuals referred to the intensive parts of the ED pathway to contribute to care planning and discharge planning and a smooth transition back to GMMH EDS.
- The service will continue to offer regular coproduced and cofacilitated eating disorder training accessibility to staff, services users and carers in all boroughs via GMMH Recovery Academy and other bespoke training as required.

- The service will continue to offer carer psychoeducation, skills training, support, and a regular carers support group cofacilitated by staff and carers with expertise by experience.

6.6



6.7 Table 1 provides a summary of the service from 2018 to the end March 2020. The new service will be based on a demand of 53 referrals per annum.

6.8 **Table 1 - Activity**

CCG	2018	2019	2020	Average per annum (last 3 years)
Bury	57	82	75	71

4.65 In addition to the service demand there is currently a backlog of waiters due to demand having exceeded commissioned capacity. Therefore, additional non recurrent capacity was required to address these waiting times.

Table 2 summarises the current number of waiters.

Table 2 – Backlog Waiters

CCG	Assessment	Routine Treatment	Urgent Treatment
Bury	20	23	0

4.67 The Mental Health leads at the Greater Manchester Health and Social Care Partnership (GMHSCP) have agreed to fund the investment required to manage the current waiting list to address the current backlog in order that the ongoing service demand could be effectively delivered.

7 Mental Health Core 24 Light

7.1 An All-Age A&E Liaison Mental Health (LMH) service that is Core 24 compliant is a requirement in the NHS Long Term Plan and GMMH Strategy. Its main objectives are to provide an all age 24/7 service to the A&E, and all acute wards in Bury and HMR. Access to medical staff for diagnostic assessment and treatment and to provide a self-harm follow up clinic within 72 hours.

7.2 Funding was secured in December '21 and agreed in Governing Body to enable implementing a Mental Health Core 24 Light model as the initial phase to developing a fully compliant Core 24 Mental Health Liaison service.

7.3 The request to the CCG for a scaled down version of a Core 24 model encompassing the all-age element of a Mental Health Liaison service however recognises the ambition to achieve Core 24 standards as per NICE guidelines over time and taking a phased approach to investment. At some stage in the future the expectation would be that the service is further developed to deliver a full Core 24 service in line with overall mental health long-term plan expectations. This would require further additional funding within the new ICS structure.

7.4 Drivers

- It is in the Long-Term Plan to have a fully functioning A&E with Mental Health Service.
- Bury locality will be meeting the National and GM requirements
- Bury locality will be meeting the Mental Health anticipated demands coming through to A&E with a clinically sustainable model developed with engagement with stakeholders.
- Core 24 Light is replacing our existing Mental Health Liaison service which will be redesigned to be fit for purpose
- It will support the Thrive in Bury work and links with the Bury Urgent Care Redesign Model.

7.5 Workforce recruitment is underway within PCFT.

7.6 The two new schemes to reduce '**delayed transfers of care' (DTOC)** are in implementation phase, staff have been recruited for both schemes and links are being made with PCFT.

7.7 The **Welcome Home** scheme is for people who are in hospital due to mental illness and are medically optimised and ready for transfer back into the community. The scheme will provide person centred nonclinical mental health support for their transition home and the weeks that follow. This is a new scheme for Bury provided by BIG in Mental Health.

7.8 The new **Housing and Welfare scheme** is provided by the Beacon Service and will offer support to those approaching discharge and those with delayed transfers on housing and welfare related matters provide. A Housing & Welfare Support worker will work alongside the inpatient team to help people to navigate social issues, such as tenancies, rent agreements, welfare benefits and help to understand their financial options for a smooth transition home.

7.9 Both schemes work towards **National & Local Context**

- There is significant pressure on the capacity of hospital beds nationally, there are shortages of beds across all types of care including mental health.
- In 2020/21 NHS England awarded funding for schemes which would reduce 'delayed transfers of care (DTOC's) and prevent escalation into crisis.
- In 2021/22, additional funding is available to build on these schemes to continue the focus on reducing the number of days recorded for delayed discharges.
- In Bury, adult acute mental health inpatient wards at Fairfield Hospital have a DTOC average between 2 and 4 people at any one time. DTOC is managed by a multi-agency hospital discharge meeting combined with a weekly Mental Health case planning meeting.
- The VCSE schemes will seek to enhance the discharge process by investing in specialist mental health community support for people, they will contribute to a reduction in delayed transfers of care, improved resilience for patients and their families and provide improved joint working.

7.10 They aim

- To help facilitate a reduction in the number of delayed transfers of care days.
- To improve resilience for patients and their families during hospital discharge and the weeks following.
- To enhance the discharge process by investing in specialist mental health community support for people.
- To work in partnership within the Delayed Discharge pathway to ensure discharge is smoothly co-ordinated across different services.

7.11 Both schemes are for adults, aged 18 years+ and will operate for a 12-month pilot period. Evaluations will inform future commissions; however, it should be noted that the funding from NHS England is non-recurrent.

8 Children's Mental Health

Children's and Young Peoples Mental Health developments and impact Over the last 12 months impact data and analysis

8.1 Over the last year there has been investment in the development and delivery across all the iTHRIVE quadrants commissioned on a locality level, this precludes the risk support quadrant which is predominantly a wider Greater Manchester Combined Authority commission.

8.2 Thriving, Bury Locality aims for all CYP to have the best opportunity to THRIVE, as such when schools returned after lockdown a range of materials and support was collated to better help schools to support children's emotional health and wellbeing. Placed on the Bury directory these are freely available to all. This was also plotted against the Thrive quadrants -

- Getting Advice (theburydirectory.co.uk.
- https://theburydirectory.co.uk/storage/6254/Getting-Help.pdf
- https://theburydirectory.co.uk/storage/6255/Getting-More-Help.pdf
- Getting Risk Support (theburydirectory.co.uk).

8.3 This year there has been investment in two pilots in nurseries and schools, Wellbeing Through Sport and myHappymind, these are currently being mobilised , with impact data to follow. Investing in evidence-based interventions to support resilience building and training within universal provision.

8.4 Kooth is on online digital platform that delivers a range of online activities including, counselling, helpful articles, personal experiences and tips from young people and the Kooth team. It has a range of moderated discussion boards. Messaging or live chat. It also offers Daily Journaling, to support emotional health and wellbeing. To date over the last quarter there were 212 new registrations with a total of 706 young people using the platform over the year. 24.3% of young people are BAME 58.27% of service users are returning to the platform 91.6 % of service users would recommend Kooth to a friend.

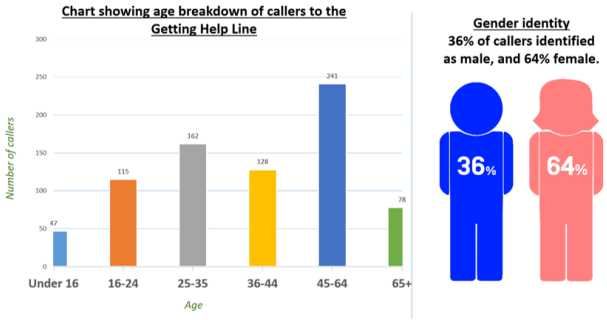
8.5 Top 5 presenting issues are:

- Suicidal Thoughts
- Self-Harm
- Anxiety/Stress
- Sleep Difficulties
- Family Relationships

8.6 Moving forward from April Kooths age range is growing from 18 to 25.

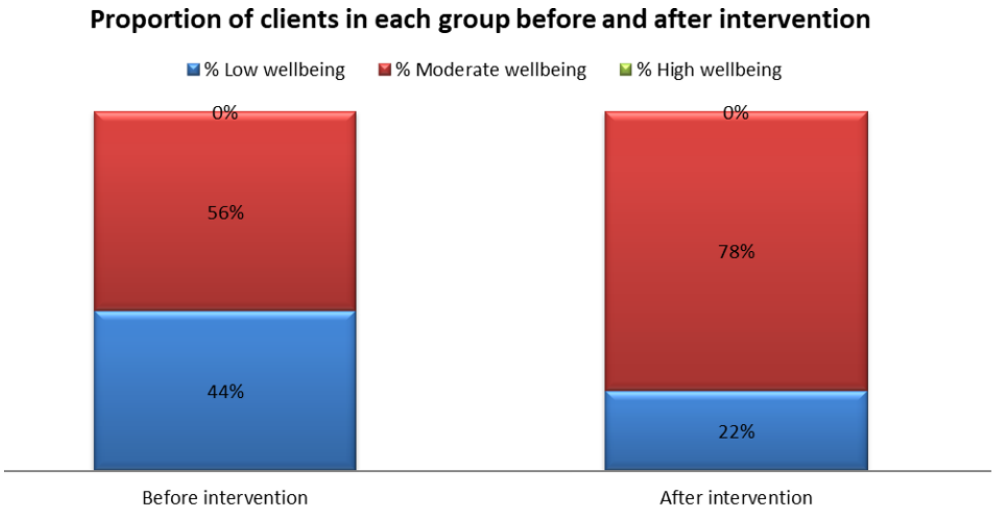
9 Getting Help

9.1 Getting Help. The launch of the All age getting help line has meant that support and advice has been provided to over 1045 people, this includes a growing number of CYP.



9.2 **Early Break** have 4 emotional health and wellbeing practitioners who support all the 13 High schools delivering in Bury. Offering 1-1 support and guidance. The service has supported young people , In a quarter the provision supports 49 active cases delivering 91 face to face support sessions, children and young people report a reduction in Young Persons Core (outcomes measurement tool) on average from 17.8 to 10.4, showing good progress and an increase in wellbeing.

9.3 **Early Break** also provide mindfulness sessions, on average to 23 children per quarter. They hosted 110sessions with an additional 27 virtual sessions delivered. Impact for this is gained via The Warwick-Edinburgh Mental Wellbeing Scales (wemwebs) these were developed to enable the measuring of mental wellbeing in the general population. Below are the pre and post scores.



9.4 **First Point Family (FPF)** deliver pre and post diagnostic support to children and families with ADHD and Autism. Over the last year they have had: 1879 contacts with families. Held 730 virtual meetings and undertaken 871 home visits.

9.5 They have supported families with medical visits (61) They have supported families with school / health meetings (377) .They have supported parents with a range of issues including (495) behaviour, (117) Relationships (30) suicide and self-harm. (69) low mood. ASD post diagnostic (76) ADHD (37) Other issues (229)

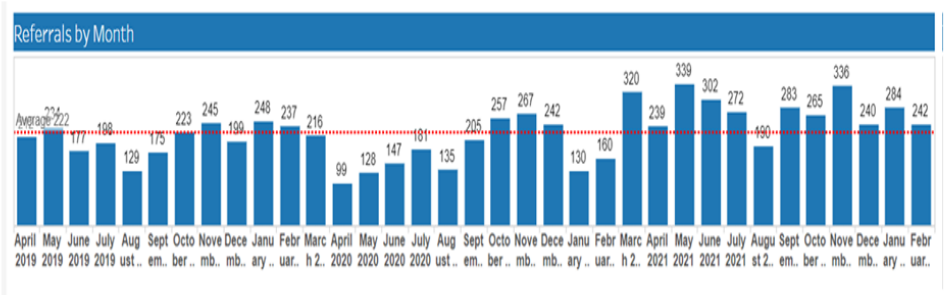
9.6 Impact 420 service users said that FPF had helped them with 27 reporting FPF sometimes helped them.

9.7 When asked where they would go if they didn't have FPF most families said in descending order they would have predominantly the majority 267 said that they would have gone to their GP. 74 reported they would have gone nowhere. 47 said they would have gone to their Family with 33 reporting they would have gone to Hospital and 24 reporting they would seek online support.

9.8 **CAMHS delivering Getting More help services**. Over the last year CAMHS accepted 2369 Children and Young People for service.

Impact: Referrals to CAMHS April 19- Feb 22

9.9



9.10 01/04/20 – 31/03/21 – Bury CAMHS accepted **2369** referrals. 01/04/20 – 31/03/21 Bury discharged **794** patients. Out of the **2369** referrals, Bury had the following breakdown:

55% were short term cases (up to 3 contacts)

28% were routine cases (19 sessions at 1 hour per session)
17% were complex cases (56 sessions at 1.5 hours per session)

1131 cases were short term
655 cases were routine.
403 cases were complex

9.11 CYP Mental Health
CYP access rate: There is a monthly national target of 120 with an access rate target of between 35% and 37%. For the first 4 months of 2021/22 both targets were met. However, since August 2021 PCFT did not meet the monthly 120 targets, but have achieved the access rate target. This clearly evidences the impact of the pandemic has had on the provider to deliver and the increased demand.

9.12 The Mental Health Services Data Set (MHSDS) is a PATIENT level, output based secondary uses data set which aims to deliver robust, comprehensive, nationally consistent, and comparable person-based information for PATIENTS who are in contact with Mental Health Services.

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
MHSDS FINAL	405	285	215	155	90	80	75	85
MHSDS Published Rolling monthly	48.62 %	49.39 %	49.52 %	49.52 %	48.88 %	48.10 %	47.33 %	46.56 %

9.13 CAMHS: 12 weeks (First contact) target is 95% and 18 weeks (commenced treatment) target is 98%. Both these targets haven't been met in the period April 2021 to December 2021.

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
CAMHS: 12 weeks (first contact)	59.85%	90.65%	83.13%	87.34%	89.29%	94.44%	82.43%	72.86%	77.27%
CAMHS : 18 weeks (commenced treatment)	75.61%	71.05%	71.95%	78.69%	79.41%	80.00%	83.33%	66.07%	66.67%

9.14 In this period there were on average 286 CAMH's referrals received monthly of which an average of 0.6 were rejected and 128 did not attend.

9.15 On a GM level a CYP mental health outcomes framework is in development with the business intelligence teams across Pennine and GM CCGs. This will enable outcomes data to be fed through to evidence the impact of provision. This is a work in progress, however there is clear commitment across the children's system to make this happen.

9.16 In Bury the local wait time to see CAMHS is 41 weeks

10 Getting Risk Support

10.1 **Bury Early Attachment Service (BEAS)** was launched during Covid, to date the provision has completed 59 consultations. The provision has 28 cases to work with.

- 11 families are currently open.
- 8 have are having a group intervention (2 groups).
- 5 are having an individual intervention
- 15 cases closed in total – of those .
  - 7 have completed an intervention (group or individual).
  - 3 of those closed have been assessment only.
  - 5 families have dropped out (mental health / child removed / alternative therapy).
  - On a wider system level, the provision has trained 90 people in wider attachment and understanding of perinatal mental health. This will deliver on the Long-Term Plan to increase the number of women receiving one+ contact with specialist perinatal mental health services.

10.2 Over the next year there will be an expansion of this provision to include three of the Local Transformation Plan (LTP) flexible ambitions that directly contribute to the expanding cohort (and so increased access numbers)

10.3 Expansion to 24 months: many women return to work at 12 months, and infant separation anxiety peaks at 12 months. These factors can trigger a relapse of mental health difficulties. Attachment difficulties can be detected from 12 months and referred for evidence-based treatment.

10.4 Increased access to psychological therapies: Evidence-based psychological interventions will be a core element of the work with the expanded cohort. Many women with perinatal mental health needs also experience difficulties in their parent-infant relationship. The couple relationship is one of the most significant modifiable risk factors for perinatal depression.

10.5 Establishing MMHS??: for women who have moderate to severe or complex mental health needs with a significant association with a trauma or loss in the maternity/perinatal/neonatal context (e.g., birth trauma, baby loss or removal, tokophobia)

10.6 Offering partner assessments: while this ambition does not directly increase the number of women supported, it is essential to offering a holistic "think family" service. And a national FAQ on delivering this ambition is in preparation.

10.7 Increasing access by reducing health inequalities. Reaching women from groups who are currently under-represented in services is an essential element of the LTP expansion. Consider in particular:

- Women from **ethnic minority backgrounds**, particularly Black African, Asian, and White Other (*who have lower rates of access to MH services in the perinatal period*)
- Young mothers (*45% PMH needs in 16–25-year-olds*)
- Women living in deprived areas
- Women in the criminal justice system or prison estate
- Migrant or trafficked women

- Women escaping domestic abuse
- Neurodivergent women
- Women with learning disabilities
- Parents from LGBT communities

11 **Community Eating Disorders** : The activity number are relatively low to this service for Bury CCG CYP. From April 2020 until December 2021 there were a Total of 42 new routine cases for PCFT, on average 2 new routine cases each month. New Routine cases must be seen within 4 weeks, with a target of 95%. We regularly achieved 100%, with only 2 months not achieving the 95% target. Over the same period there were a Total of 3 New Urgent cases. New Urgent cases must be seen within 1 week, with a target of 95%. We achieved 100% for these 3 persons.

11.1 However, over the last two years there has been a significant increase in eating disorder presentation at a national and GM level and much work is ongoing on the Pennine footprint.

11.2 Noting the pressures relating to young people with eating disorders, additional GM resources will be used to develop a Daily Home Intensive Treatment (DHIT) pathway. Staff will support young people in their homes before, during and after meals. This will be a bespoke team that will concentrate solely on support young people in their homes with young people identified by the CEDS team. The proposal has been approved the mobilization of the team/service is beginning with the team currently working up the model including pathway development, SOP, as well as job descriptions/adverts etc. for the recruitment to staff. It is planned that commencement of the DHITT will be July 2022 and a project plan being developed working back from this date. This will aid the CED Daytime service which is an LTP deliverable.

11.3 Support is also available for young people who present in crisis via the GM Crisis pathway. Hope & Horizon/ Home treatment Team.

12 **Additional Investment in the Children's workstream**

12.1 Looking ahead additional funding has been secured to deliver more services to children in the getting help quadrant. Providing opportunities to meet need earlier and explore invest to save models.

12.2 The Bury Domestic Abuse needs assessment, highlights that domestic abuse is increasing more quickly in Under 18s than in the rest of the population and has increased by 69% on the previous year.

12.3 In comparison with other Greater Manchester authorities, Bury has a high proportion of 'Repeat' cases recorded by the borough's Multi-Agency Risk Assessment Conferences (MARAC): Which means we are losing vital opportunities to provide the right support at the right time.

13 **Support for children who are victims of domestic abuse**. The CCG has invested in Talk Listen Change (TLC) to provide an enhanced offer to support children who are victims of domestic abuse, this will include support to children who use harm and those who are victim survivors.

13.1 By building additional capacity into the current 14 plus, pathway, Bury will be able to address the significant impact of domestic abuse and trauma earlier

within a child's life. Minimising harm by offering a comprehensive system wide support offer 5 -18. Linking the investment to the Bury LA contribution.

13.2 It's worth noting that between April 20 – March 21 there were 2,290 Operation Encompass notifications , the provision will provide support to those children known to be victims of domestic abuse as well as those using harm and system wide training and support.

13.3 Domestic abuse, future cost benefit and impact - What we know:

- It costs on average 14k to support a victim of domestic abuse
- 13 adult victims cost on average £182k (14K X 13 victims)
- Children are 50% more likely to be a perpetrator or victim of domestic abuse if they witness it within the family home.
- System wide cost of 200 victims-£2800,000
- This combined provision is calculated to support **200 young** people per year
- If this is funded for 2 years with the expectancy to support 400 young people
- Statically over 50% of these children may become victim or perpetrator of abuse- which equates to 200

13.4 Added Value The 200 figures of engagement does not include:

- The challenge on social norms
- Training delivered to professionals to enable them to support victim better through social care
- Group delivery within Schools to Young People

13.5 Estimated save to the future system**; £2,622,000** if all children supported did not go on to become a victim or perpetrator of abuse.

13.6 However, if even only 25% of the children supported didn't go on to become a victim or perpetrator of domestic abuse the long-term saving would be **£522,000.**

13.7 If provision was able to prevent only 13 children in Bury from becoming victims or perpetrators in the future, the service would pay for itself.

14 CYP early mental health hub. Another area of investment is the piloting of a CYP early mental health hub.

14.1 Building on all age Getting Help line, this early help hub would support face to face and guided digital support and therapy as well as advice and guidance for children and Young people, offering bookable appointments to receive low level support.

14.2 In Bury there is an opportunity to pilot this early support hub as we are developing a neighbourhood-based pilot for children and young people.

14.3 It is crucial that early intervention and prevention services can help children avoid reaching crisis point. Making an early support hub available for young people in Bury to have access mental health support without referrals will help reduce delays in receiving support. Linking the face-to-face offer with increasing access to digital therapies to address digital inequalities this provision will support access to provision up to 25 years

14.4 Areas that have already set up hubs – such as Southwark in south London– have seen the benefits, with some reporting a social return on investment of more than £3 for every £1 invested.

14.5 This pilot will enable Bury to explore proof of concept of this model with a view to wider role out subject to evaluation.

15 **Mental Health in Schools Teams**. One of the most exciting developments this year is the development of the Mental Health in Schools Teams.

15.1 This GM funded initiative will see the development of two new mental health teams in Bury operating in 30% of schools. These will deliver evidence-based interventions for mild to moderate mental health issues.

15.2 The new teams will carry out interventions alongside established provision such as counselling, educational psychologists, and school nurses building on the menu of support already available and not replacing it.

15.3 The MHST will provide:
Individual face to face work for example,

- effective brief, low-intensity interventions for children, young people and families experiencing anxiety, low mood, friendship, or behavioural difficulties, based on up-to-date evidence
- Group work for pupils or parents such as Cognitive Behavioural Therapy for young people for conditions such as anxiety.
- Group parenting classes to include issues around conduct disorder, communication difficulties
- Giving timely advice to school and college staff, and liaising with external specialist services, to help children and young people to get the right support and stay in education: Work as part of an integrated referral system with community services to ensure that children and young people who need it receive appropriate support as quickly as possible. External support could include more specialist NHS mental health support, support for Learning Difficulties and Autism, or physical needs, or for issues such as substance misuse. Ensure smooth transition from specialist services
- One of the key elements of this model is the Education Mental Health Practitioner (EMHPs). The EMHPs will start as a Band 4 whilst in training and move to a Band 5 once qualified. Throughout training and once in practice the EMHPs will be supported by a trained Supervisor. This is fully funded training by Health Education England which aims to address the workforce gap within mental health

15.4 This work has been mobilised and will launch this year.

16 CONCLUSIONS

16.1 Bury is committed to a programme of transformation and is determined to continue its work to deliver the long-term plan deliverables for Bury communities. An ongoing investment plan is being developed to ensure, as we

progress, we can continue to respond to the impact of Covid whilst building stronger pathways and provision for those who need support.

List of Background Papers:

Adult Mental Health Investment - GB Dec 2

Contact Details:

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i **Mental Health Operational Planning 2022/23**

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SCRUTINY REPORT

Bury COUNCIL

MEETING: **Health Scrutiny Committee**

DATE: **21st March 2022**

SUBJECT: **Elective Care Waiting List Update**

REPORT FROM: **Will Blandamer, Executive Director of Strategic Commissioning**

CONTACT OFFICER:

1.0 BACKGROUND

1.1 When a patient is referred to a Consultant-led team of a secondary care provider, they are added to an elective (planned) care waiting list with the waiting list entry referred to as an 'incomplete pathway'. The pathway will generally be ended either once the patient receives the awaited treatment or it is confirmed that treatment is not required.

1.2 Throughout the COVID-19 pandemic, the waiting list size has increased significantly, not only in Bury but regionally and nationally too. This reflects elective activity having been paused during the early months of the pandemic followed by capacity limitations linked to workforce and estate and the implementation of enhanced Infection Prevention and Control (IPC) measures.

1.3 In April 2020 there were 14297 incomplete pathways for Bury patients against a target of no more than 15800. The target has been revised twice since that time. Firstly, in April 2021 the target was for the waiting list size to stabilise at the March 2021 position (18853 pathways) and then at the September 2021 position (23993 pathways).

1.4 By December 2021 the waiting list for Bury patients had increased to 25542. This is 6.5% above the current target and reflects an increase of 79% when compared to April 2020.

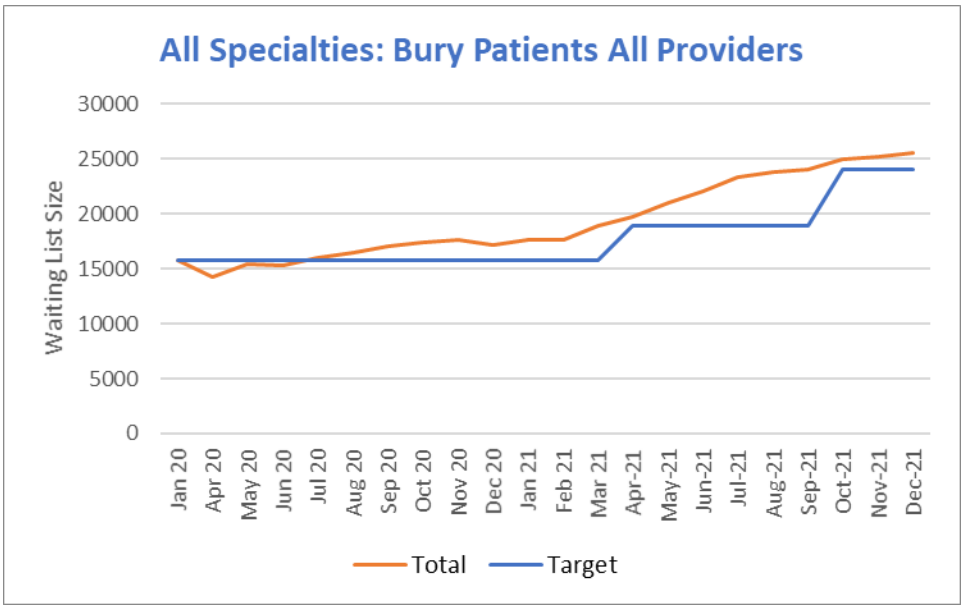
1.5 In addition to the waiting list increasing, the pandemic has also resulted in longer waits for many patients. Under the NHS Constitution, no patient should wait longer than 52 weeks to commence treatment though in December 2021 there were 1186 Bury patients with such waits. Of these, 81 pathways had exceeded 104 weeks.

1.6 In February 2022, NHS England published a delivery plan for tackling the COVID-19 elective care backlog, setting the following ambitions:

- 104+ week waits to be eliminated by July 2022;
- 78+ week waits to be eliminated by April 2023;
- 65+ week waits to be eliminated by March 2024; and
- 52+ week waits to be eliminated by March 2025.

1.7 To support this, there is an expectation for there to be a year on year increase in the amount of elective activity undertaken alongside improvement in the number of patients receiving diagnostic tests within six weeks of referral.

1.8 Bury's waiting list growth to December 2021 is shown in the following chart.



2.0 Waiting List Update for January 2022

2.1 As COVID-19 community cases and hospital admissions increased during the most recent wave, a decision was taken for elective activity to be paused across Greater Manchester (GM). This temporary cessation in activity took effect between the 4th and 24th January 2022. Waiting list data for January 2022 was published on 10th March 2022 and this section of the report will highlight the impact of this pause.

2.2 NHS published data for January 2022 shows a waiting list size of 26166 for Bury. This is an increase of 624 pathways compared to December and represents the largest in-month increase since October. At 26166, the waiting list is now 9.1% above the September 2021 baseline.

2.3 As at January 2022, 70% of Bury's waiting list is held at the Northern Care Alliance NHS FT (NCA) with 20% at Manchester University NHS FT (MFT) and 3.6% at Bolton FT. Prior to the North Manchester General Hospital (NMGH) transaction to MFT in April 2021, the NCA share of the waiting list had been 78%.

2.4 Between September and January, there has also been an increase in incomplete pathways assigned to some independent sector providers, particularly BMI Healthcare and Oaklands Hospital. Whilst this in part reflects some increased use of the independent sector, it is also linked to a new Patient

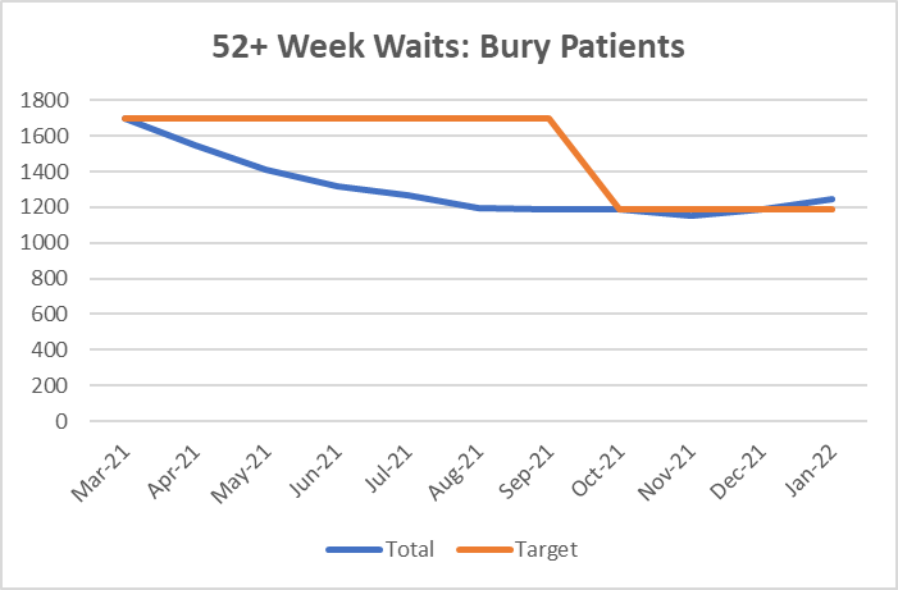
Administration System (PAS) being installed at Oaklands Hospital. Previously, some CCG pathways had been incorrectly allocated to NHS England though this has now been rectified. As lead commissioner, NHS Salford CCG is liaising directly with the provider about this on behalf of other GM CCGs.

2.5 Since the new target of returning to the September 2021 waiting list size was introduced, the most significant increases at a specialty level have been seen in dermatology (+25.8%), Ear Nose and Throat (ENT) (+16.9%), cardiology (+32.6%), orthopaedics (+9.1%), gynaecology (+17.5%) and urology (+11%).

2.6 In the same period there has been improvement in some specialties, for example, gastroenterology and respiratory medicine where the waiting lists have reduced by 6.5% and 20.1%, respectively.

2.7 For the first time since targets were revised, the number of pathways exceeding 52 weeks has increased beyond that target level with January data showing 1248 Bury patients with such waits. Overall, since September 2021 the biggest increases in 52+ week waits have been in gynaecology (+48 pathways) and ENT (+26 pathways). 52+ week breaches for 'other' surgery and general surgery have decreased since September by 47 and 33 pathways, respectively.

2.8 Prior to the recent increase in 52+ week waits, there had been a reducing trend, as shown in the following chart.



2.9 The biggest in-month increase for January was in 'Other Services' and relates to the new PAS at Oaklands Hospital referenced above. Oaklands has indicated that detailed reviews of patients on the waiting list are taking place with a particular focus on long waiters to ensure that those on active pathways are both willing to continue treatment and that they are correctly prioritised.

2.10 In terms of those waiting more than 104 weeks to commence treatment, January saw a further increase to 120 pathways. Apart from the increase in 'Other' which relates to the Oaklands PAS implementation, the biggest increase in these waits has been in urology. Feedback from the NCA is that many of the longest waiting urology patients have been awaiting a new procedure which is

now being undertaken at the 23-hour day unit at the Rochdale site. An improvement in urology is therefore expected in future months.

2.11 The table below summarises the waiting list numbers as at the end of January 2022 and also includes a specialty breakdown of 52+ and 104+ week waits.

Specialty	Incomplete Pathways		52+ Week Waits		104+ Week Waits	
	Sept 2021	Jan 2022	Sept 2021	Jan 2022	Sept 2021	Jan 2022
General Surgery	1,476	1,438	235	202	14	16
Urology	1,568	1,740	130	125	6	20
T&O	2,986	3,257	201	201	5	10
Ear Nose Throat (ENT)	1,981	2,315	99	125	12	16
Ophthalmology	2,076	2,165	28	30		*
Plastic Surgery	160	174	21	22	*	*
Gastroenterology	2,802	2,620	21	38	*	
Cardiology	886	1,175	6	*		
Dermatology	1,908	2,400	9	20		*
Rheumatology	391	373	*			
Gynaecology	2,094	2,460	179	227	10	15
Other: Medical	1,241	1,316	8			
Other: Paediatric	1,598	1,683	110	111	6	12
Other: Surgical	2,237	2,271	126	79	*	*
Other: Other	54	238	5	53		20
All other specialties	535	541	*	12	*	*
Grand Total	**23993**	**26166**	**1190**	**1248**	**63**	**120**

** denotes a value that is less than 5*

2.12 As stated within paragraph 1.6 of this report, the NHS England ambition within the delivery plan published in February 2022 is for 104+ week waits to be eliminated by July 2022. The NHS operational planning process for 2022-23 is currently underway and a GM level trajectory for reducing these numbers will be set as part of that process. Although there is a real focus on reducing long waits, it is as unclear whether this is achievable by July.

2.13 The While You Wait progamme continues to progress as a mechanism to offer patients increased support whilst waiting. The initial scope was to offer access to generic information with a drive now to develop specialty specific information, commencing with orthopaedics, gastroenterology and children's surgery. Work had already commenced in Bury prior to this on developing orthopaedic specific information.

2.14 Some GM analysis previously indicated that it could take up to eight years to clear the elective backlog that has grown significantly since the pandemic commenced. A major focus of operational planning is therefore to increase elective capacity beyond the level seen in 2019-20. The ambition for 2022-23 is for elective activity to reach 110% of the 2019-20 level with a year-on-year increase planned for thereafter.

2.15 There is a GM programme of work underway that all GM providers and CCGs are linked into. This includes looking at workforce expansion and increasing productivity, for example by increasing theatre utilisation. There is also a

structure of Clinical Reference Groups in place to ensure that specialty specific action plans are developed that ensure consistency across GM and equity in access across localities. Bury are full participants in the GM Elective Care Recovery and Reform Programme Board.

2.16 Locally, the challenge presented in elective care is the focal point of Bury's Elective Care and Cancer Recovery and Reform Board. This Board will report to the Integrated Delivery Collaborative Board (IDCB) and subsequently to the Locality Board, and is attended by all key system partners.

2.17 There is also a significant outpatient transformation programme underway. This includes increasing the amount of specialist advice provided by secondary care to General Practitioners and thus reducing the number of referrals made. The target is for 16 specialist advice requests to be facilitated for every 100 first outpatient attendances. Following treatment, there are also plans to increase the number of Patient Initiated Follow-up (PIFU) pathways in place to ensure that follow-up attendances only take place where required.

2.18 Locally at the NCA, the outpatient transformation work is being managed within a Being Well programme which is split into three main areas: Deciding and Referring Well, Waiting Well and Recovering Well. The CCG is engaged in each of the working groups associated with this work programme. The initial focus will be in gynaecology before progressing to other specialties.

3.0 CONCLUSION

3.1 Prior to the pandemic, capacity constraints meant that there were already backlogs in place in some areas of elective care. This position has been worsened by the impact of the pandemic and has been compounded still further by the pause in elective activity seen during January 2022.

3.2 As shown in the report, the overall waiting list and numbers of pathways exceeding 52 and 104 weeks have all increased during January and the prediction is that the knock-on effect of this will see continued increases over the next couple of months before any reduction becomes evident.

3.3 The scale of the problem means that to do nothing is not an option. Therefore, plans for the next financial year and beyond are focused on increasing the amount of elective activity undertaken, with a particular focus on treating those waiting the longest and addressing health inequalities, and transforming the way that outpatient care is delivered.

3.4 As outlined above, a focal point for partnership leadership in addressing this challenge is provided through the Bury Elective Care and Cancer Recovery and Reform Board which is attended by all key system partners.

List of Background Papers:-

Contact Details:-

Author: Susan Sawbridge, Head of Performance, NHS Bury CCG

Executive Director sign off Date: Will Blandamer, 11/03/2022

JET Meeting Date:_____