Meeting: Strategic Commissioning Board			
Meeting Date	02 November 2020	**Action**	**Approve**
Item No	10	**Confidential / Freedom of Information Status**	No
Title	Proposal for Mental Health provision as part of the Urgent and Emergency Care by appointment model at Fairfield General Hospital.		
Presented By	Will Blandamer, Executive Director of Strategic Commissioning		
Author	Kez Hayat , Commissioning Programme Manager Nasima Begum, Commissioning Manager		
Clinical Lead	Dr Daniel Cooke, Clinical Director		
Council Lead	Councillor Andrea Simpson, First Deputy, Cabinet Member Health and Wellbeing		

Executive Summary

This paper is seeking approval to commission mental health provision as part of the Urgent and Emergency Care (UEC) by appointment model at Fairfield General Hospital (FGH). The attached business case which has been received from Pennine Care Foundation Trust (PCFT) outlines a proposal for providing a sustainable, effective and financially viable UEC by appointment service at FGH.

In light of the current COVID-19 pandemic and wider impact on the urgent and emergency system, this PCFT proposal is replacing the Core 24 Business Case that was developed in March 2020 (Pre Covid-19) to mobilise a Mental Health Liaison service across Bury and Heywood Middleton and Rochdale (HMR).

The implementation of the Greater Manchester (GM) UEC by Appointment model from December 2020, will introduce significant changes to how patients access urgent and emergency care services. It is therefore, important to ensure potential anticipated demand for Mental Health services can be resourced and managed in a coordinated way. This proposal has been developed with Urgent Care redesign colleagues and outlines the liaison service covering FGH and UCC managing all MH attendances at ED/ UCC with opportunity to stream out to alternative provision.

The proposed business case from PCFT is requesting funding to develop a mental health UEC by appointment model for Bury which will be situated at FGH and be part of the wider front-end UEC streaming service.

Staffing & Hours of Operation

The service will require the following staffing:

- Provision of 4 WTE Band 6 Nurses
- Provision of 1 WTE Administrator
- Provision of 0.4 Band 7 Management

The Hours of Operation will match the streaming hours at the ED department – for 12 hours per day.

Wider system impact

This is a new proposal to support the GM UEC by Appointment model at front end of Fairfield General Hospital. As part of the Urgent Care Redesign, it has requested that there is a mental health provision within the front end of UC. This would mean a wider Multidisciplinary team to support initial assessment and sign posting. This would bring added benefits for mental health patients during a crisis to ensure that an MDT response is provided alongside Acute physical health.

It is important to acknowledge that the current RAID team will remain the same within the Hospital to support patient needing mental Health intervention in the pathway. This new model is for 12 months and it is anticipated that learning of the streaming function would allow better understand of mental health support needed to develop/remodel in RAID/CORE24 service in the future.

As part of the GM Strategy for the implementation of Core 24 standards, Fairfield General Hospital is part of Phase 3 (2019/20 onwards). A business Case was developed following review of the of the old RAID service in order for the services to meet demands towards a Core 24 Compliant services. This has been put on hold due to COVID 19 and wider cost pressures but may be prioritized in the future to ensure GM CCG's are CORE 24 compliant by 2023/24).

In response to covid-19, GM has bolstered crisis services with a number of 24/7 phone lines such as the GM expanded Clinical Assessment Service (CAS) and Trust helplines for patients and carers. These services are part of a GM wide plan to facilitate a centralised 24/7 crisis response for urgent mental health needs with the aim of trying to diverts activity away from hospital A&E and into the most appropriate mental health provision for service users.

Bury CCG have commissioned a Bury Community mental health Safe Haven. It is an alternative to the clinical approach that is currently being operated in the other PCFT footprint safe havens. The Bury model will focus more on delivering a peer led bio-social support to de-escalate crisis in a non-clinical environment with a solution focused approach.

The Bury Community Safe Haven model and pathway is supported by and has been developed in conjunction with the PCFT lead consultant for Bury and service leads from the A&E Liaison, Home Treatment, Access & Crisis and Community Mental Health teams. It will strengthen existing local crisis pathways, link in with the wider GM crisis pathways and the local social prescribing team to offer person centered support to prevent further episodes of crisis.

Heywood Middleton and Rochdale CCG

This is a joint proposal for UEC and mental health streaming in both Rochdale Urgent Care Centre and Fairfield General Hospital. This proposal will have cost implication for both CCGs. As of 26th October, this is still awaiting Governance sign off from HMR CCG.

Finance

The full year recurrent cost of the service model is £260,717 with an additional £12,958 non-recurrent set up costs. This cost would be the same for HMR CCG.

Rather than return the CQUIN underperformance for 19/20 PCFT have requested if this funding of **£122k** which was part of the overall 19/20 PCFT contract value can be used to support the proposed service model for the remainder of 20/21. This is a non-recurrent financial envelope for the remainder of 2020/21. However, future recurrent funding decisions will need to be considered as part of 2021/22 MHIS priorities before April 2021.

Any financial approval to fund the recurrent costs of the service model beyond the end of the current financial year (March 2021) will need to be made as part of the overall Bury OCO Mental Health Investment Standard (MHIS) budget and priorities. As such, it is important that an evaluation as to the effectiveness of the service is ascertained in January/February 2021/22 to determine recurrent funding decisions as part of future MHIS funding priorities.

In order to support Mental Health Winter Pressures, PCFT have also submitted this proposed bid to Greater Manchester Health and Social Care Partnership (GM HSCP) to access non-recurrent funds to the value of £110,996 to support the proposed Mental Health UEC by appointment service at FGH for the remainder of 20/21.

As part of the Mental Health Winter Pressures, another bid has been submitted by PCFT to support 136 pressure across the Pennine footprint. Divisional service offer £359,298 (2 teams, 1 north and 1 south). This is for staffing for S136 suites. The investment would provide 24/7 dedicated staffing for each division (1 North Bury, Oldham and HMR and 1 Stockport and Tameside and Glossop) ensuring timely access, assessment, observation and onward referral. (1 qualified member of staff 1 unqualified). The staffing would deliver a peripatetic service to support the delivery of a consistently high quality, timely S136 service

supporting urgent care and broader system efficiencies. S136 staffing would ensure resources commissioned to provide liaison services in ED can remain in ED meeting the presenting demand

A decision to approve the PCFT winter pressures bid has had initial support from the GM HSCP however; a final decision for approval of the PCFT bid and associated costs will not be made by GM HSCP until 2nd November 2020.

Recommendations

Strategic Commissioning Board is asked to note the content of the paper and approve Option 2 as the recommended option which is to:

Develop a Mental Health UEC by appointment model in Bury as part of the Urgent and Emergency Care (UEC) by appointment model at Fairfield General Hospital (FGH). A Mental Health Urgent care team will provide urgent support outside of A&E to prevent unnecessary attendance and admission into acute services and also pilot urgent care streaming for those patients who do not need immediate Mental Health intervention.

The rationale for the recommendation is that:

- It is in the Long-Term Plan ambition - a fully functioning A&E with Mental Health Service
- Bury One Commissioning Organisation (OCO) will be meeting the National and GM requirements in relation to Mental Health Urgent Care and wider Urgent Care.
- Bury OCO will be meeting the Mental Health anticipated demands coming through to A&E post COVID -19 and it is a clinically sustainable model developed with engagement with stakeholders.
- The service will provide urgent support outside of A&E to prevent attendance and also pilot urgent care streaming for those patients who do not need immediate Mental Health intervention.
- Urgent and Emergency Care by appointment is an alternative to the CORE 24 model and the existing commissioned RAID service model.
- It supports the Mental Health Thrive in Bury model and is an integral part of the current Urgent Care Redesign Model at FGH.

In the event that PCFT do not secure the Mental Health Winter pressures monies from GMHSCP, Strategic Commissioning Board is also asked to approve for PCFT to utalise non-recurrent funding from CQUIN 19/20 underperformance to fund the provision needed for a Mental Health Urgent care team as outlined in the proposal until the end of the 2020/21 financial year.

Any decisions to fund recurrent service costs beyond March 2020/21 are made following an evaluation of the effectiveness of the service and as part of the overall 2021/22 Bury OCO

MHIS priorities to be outlined to SCB for approval in due course.

Links to Strategic Objectives/Corporate Plan	Choose an item.
Does this report seek to address any of the risks included on the Governing Body / Council Assurance Framework? If yes, state which risk below:	Choose an item.
Add details here.	

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☒	N/A	☐
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☒	No	☐	N/A	☐
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☒	N/A	☐
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☒	N/A	☐
Are there any financial implications?	Yes	☒	No	☐	N/A	☐
Are there any legal implications?	Yes	☐	No	☒	N/A	☐
Are there any health and safety issues?	Yes	☐	No	☒	N/A	☐
How do proposals align with Health & Wellbeing Strategy?						
How do proposals align with Locality Plan?						
How do proposals align with the Commissioning Strategy?						
Are there any Public, Patient and Service User Implications?	Yes	☒	No	☐	N/A	☒
How do the proposals help to reduce health inequalities?						
Is there any scrutiny interest?	Yes	☐	No	☒	N/A	☐
What are the Information Governance/ Access to Information implications?						

Implications						
Has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☒	No	☐	N/A	☐
If yes, please give details below:						
EA attached to report						
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☒
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☒	N/A	☐
Are the risks on the CCG /Council/ Strategic Commissioning Board's Risk Register?	Yes	☐	No	☒	N/A	☐
Additional details						

Governance and Reporting		
Meeting	**Date**	**Outcome**

Funding Request

For the GM Urgent and Emergency Care by appointment

Sign-Off Information

Business Case Details	
Title	Funding Request in support of GM- Urgent and Emergency Care by Appointment
Date	October 2020
Version Number	0.10
Status	**DRAFT/FINAL** (delete as applicable)
Document Prepared By	

The following parties can confirm that appropriate engagement with all stakeholders (clinical and corporate, internal and external) has taken place to provide assurance that, to the best of their knowledge, the proposal provides a true and accurate reflection of risks and benefits (financial and non-financial.)

Function	Name	Job Title	Date (DD MMM YYYY)
Core			
Borough Lead			
Finance*			
Estates			
Health Informatics			
Business Development			
Additional			
[add as required]			

* The Finance Lead will sign on behalf of all other corporate teams not specifically identified)

Abstract

The purpose of this paper is to request funding to meet the GM - Urgent and Emergency Care (UEC) by Appointment across Bury and HMR requirement by GM

The implementation of the GM UEC by Appointment model from September/October 2020, will introduce significant changes to how patients access urgent and emergency care services. It is therefore, a priority for each locality and GM to establish processes that will help provide assurance that patients:

- can access services easily,
- are kept safe and that we reduce existing inequalities.

The NHS 111 First Programme will deliver a new approach to the radical streaming and direction of non-urgent patients away from Emergency Departments into other urgent care settings and promote this to the public as the best route to care.

In support of this, NHS 111 will maintain its place as the 'first line of defence' for the Urgent and Emergency Care (UEC) system by:

- Becoming the single universal point of access for people experiencing mental health crisis by 2023/24, ensuring that anyone experiencing mental health crisis can call NHS 111 and have 24/7 access to the mental health support they need in the community.

GM Urgent and Emergency Care (UEC) by appointment has set out principles for Mental Health as indicated below and the following proposal identifies how this model will meet these principles

- Mental Health patients, vulnerable adults and their families should be streamed prior to ED registration in an accessible compassionate and safe way.
- All streaming practitioners across the UEC system should utilise the UK Mental Health triage Tool, already operational in GM CAS to provide standardisation of practice and a shared language of mental health clinical prioritisation across the UEC system.
- To achieve parity of esteem with physical health. Emergency Departments should have mental health streaming pathways in place to refer more clinically stable patients to either community-based alternatives or appropriate on-site alternatives or specialities. Ideally this will be 24/7 but at least 12 hours a day, 7 days a week from any point in their journey of care, such as the advocated mental health urgent care areas within acute trusts.
- Ensure where mental health and vulnerable adults and children present at an ED they are treated and/or referred to the on-site mental health speciality for treatment in agreed and safe time scales. The mental health speciality should be involved with all mental health patients streamed away from ED and the front door 24 hours a day, 7 days a week.
- The quality of care of mental health patients, vulnerable adults and children should be measured and acted upon to ensure continuing improvement.

Contents

Strategic fit: the strategic case

The purpose of this document is to enable a decision to be made on the preferred option for commissioning a sustainable, effective and financially viable Urgent and Emergency Care by appointment service across Bury and HMR.

Background

An options paper to fund core 24 was taken to the Commissioners in January 2020 and a decision was made by Bury CCG to revisit the requirements in line with the new GM– Urgent and Emergency Care (GM-UEC)

The proposals within this document will aim to work towards meeting the requirements of the GM-UEC by appointment, by enabling the Bury and Rochdale mental health teams to provide bookable appointments for the clients who have been appropriately streamed away from the urgent care system.

In January 2020, prior to the current Covid 19 Crisis, the GM UEC Improvement and Transformation Board approved a high-level urgent care by appointment model as a refreshed priority for UEC integration with two primary ambitions:

- To reduce attendances to Emergency Departments by improving access to, and utilisation of, primary and community-based services by rapidly developing and testing a GM 'UEC by Appointment' model.
- By April 2022, we will reduce:
    - Ambulance attendances by 100 per day across GM
    - ED walk in attendances by 300 per day across GM

Current Service Provision

The Liaison Mental Health (LMH) service was developed using the historical investment in A & E liaison services. Further investment through a CQUIN, supported the development of A and E RAID services using the principles of the RAID service in Birmingham. The service was developed based on an available financial envelope rather than developed based on an assessment of demand/need, it is acknowledged by all partners that the level of service available for crisis care does not meet the population need nor reflect the staffing profiles in the national guidance.

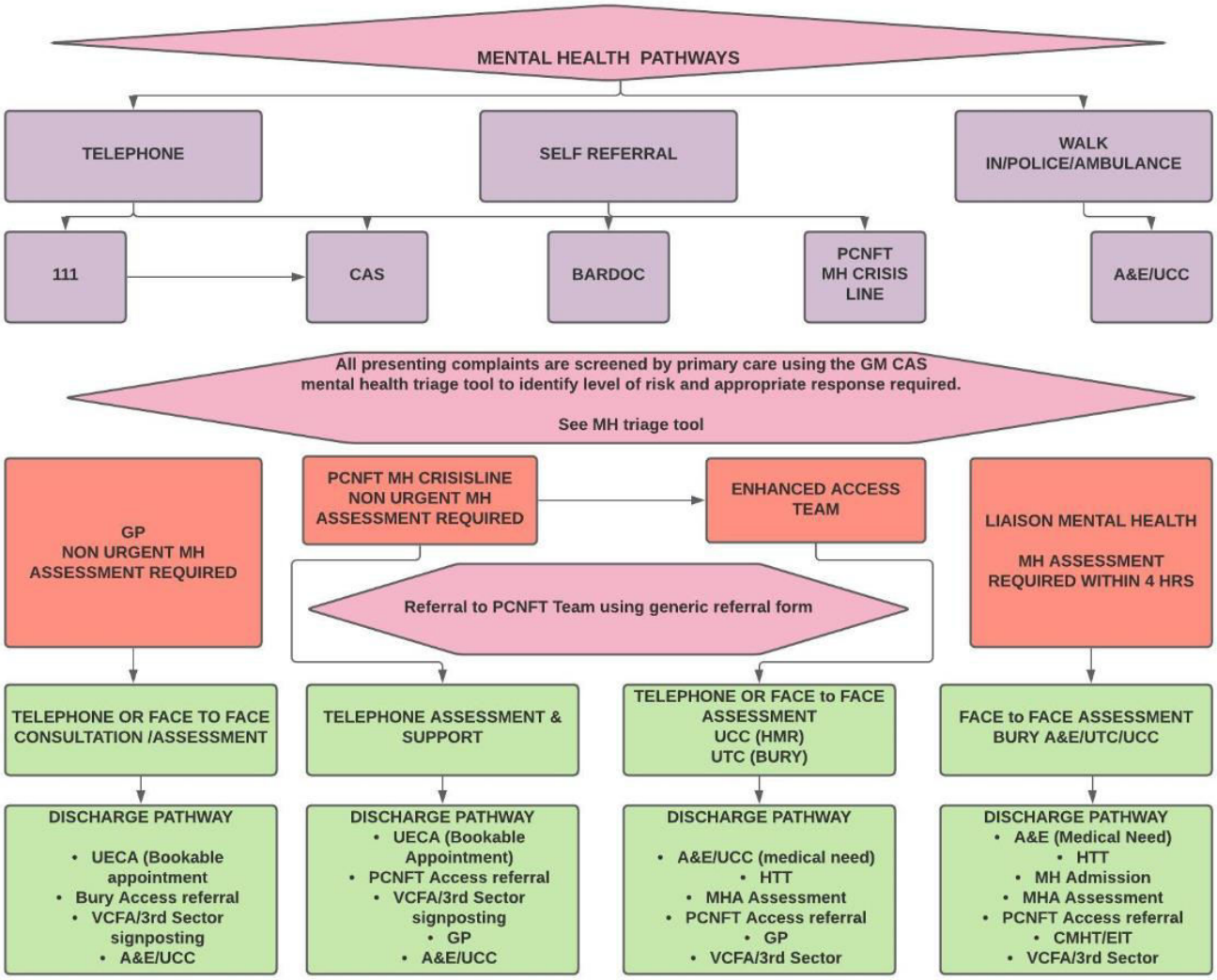
The current level of investment in liaison services does not afford opportunity for service transformation supporting service delivery outside of the Emergency Department whilst maintaining a core but minimal service in ED for those patients presenting.

To respond to the GM-UEC by appointment requirements, a pathway has been developed which enables the deflection from the Emergency Department in Fairfield Hospital to suitable appointments. To support the deflection and service the appointments, there is a need for 4 x Band 6 Nurses with additional management input of 0.4 band 7 and 1 WTE admin. This will be required in each of the two boroughs, Bury and HMR.

Proposed Pathway to support GM-UEC by Appointment

The following diagram shows the points of entry to Mental Health Services and indicates the proposed pathway to the UEC by appointment team

The intention is to provide this new pathway to the UEC by appointment teams a test bed/pilot until March 2021. This will enable the service to capture actual demand to enable a review of this model in both Boroughs.

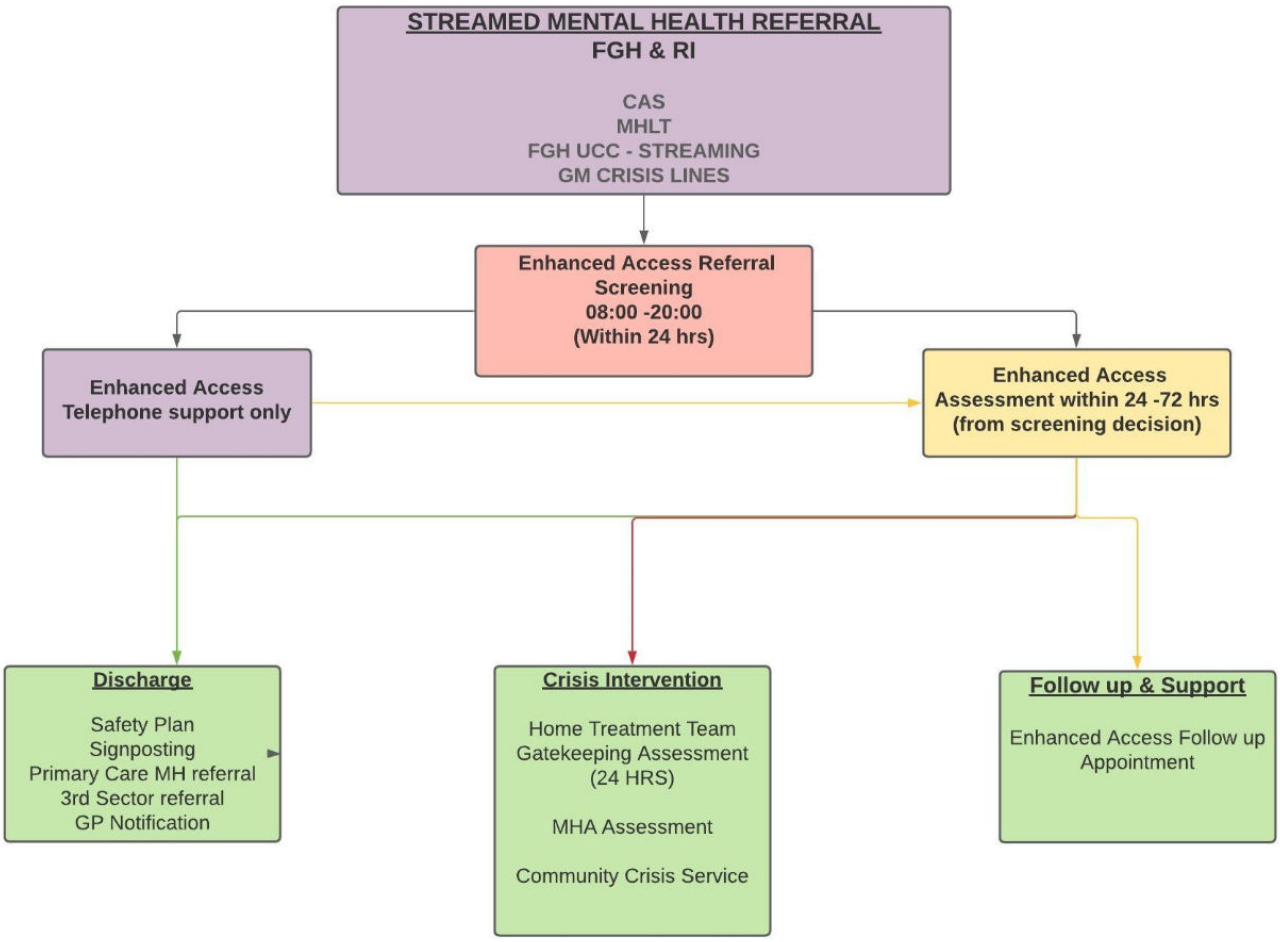


Access teams (Single Point of Access)

- The Access teams in Bury and HMR provide the Single Point of Access to services for GP's and provide one urgent appointment per day. The teams will screen all referrals from primary care services and offer a non-urgent appointment dependant on the risk of the individual.
- Both teams have to respond to the NCA acute wards for non-self-harm assessments increasing the demand and reducing the capacity.

- The Bury team have representation into the 5 integrated neighbourhood teams enabling a multidisciplinary approach to managing complex clients in the community.
- The proposed UEC by appointment team, which will be managed across both sites, and will sit alongside the existing Single Point of Access team to provide the additional appointments for Urgent and emergency care by appointment.
- The Access service in HMR is currently managing significantly more demand than capacity with daily urgent appointments oversubscribed with primary care referrals

Proposed Referral Process streamed by a non-MH professional



Proposed staffing model for Urgent Care by Appointment Team

This staffing model is per Borough

Staffing Model		
Staff Group	Band	WTE
Team Manager	7	0.4
Access Practitioner	6	4
Team Administrator	3	1

4 WTE will provide:

Each practitioner will provide 3 assessment slots and 1 follow up appointment per day

Options Appraisal

Option 1 (Do nothing)	**Brief Description:** Without investment the risks identified below will remain
Advantages: None	
Disadvantages: Unable to provide urgent and emergency care by any appointment to reduce activity in the Urgent Care Centre (UCC) and the Emergency Department	
Opportunities, Risks and Issues: **Risk:** • Inability to offer any Urgent and emergency care by appointments to divert from the ED or UCC • 1 liaison service covering FGH and UCC managing all MH attendances at ED/ UCC as no opportunity to stream out to alternatives • Inequality in service provision for people attending ED with MH problems • Inability to offer Urgent and emergency care by appointment to reduce the activity in the ED and UCC departments. • Lack of capacity to provide practitioner cover to ED, UCC and all ward patients especially overnight. • The team have one room in each borough to complete assessments. The FGH room 10 is specifically adapted to the mental health team with alarms on each wall, ligature free and two access points for staff, patients, family to exit in the event of an incident. There is currently only one dedicated assessment room in both A & E and UCC, this has an impact on capacity to undertake assessments in the appropriate environment and will often result in the use of	

medical cubicles if the service is busy reducing the capacity for physically unwell patients to be seen and increasing pressure on the ED and UCC department

- Inability to meet the Key Performance indicators of 1 hour, 2 hour and 4 hour.
- The pressures of responding to the high demand of section 136 presentations further reduces the ability to respond to the Wards, ED and UCC
- Undertaking a 136 assessment on average is 8 hours per patient which accounts for 92 days per year, during this time the Liaison service is unable to perform their primary duties.
- There are no paediatric beds within Fairfield or Rochdale infirmary hospitals. In the event that a CAMHS patient requiring a TIER 4 assessment they would require transfer to NMGH or ROH to be admitted until this assessment could take place
- Inability to provide an appropriate and timely service to clients
- The service only provides assessments on the wards for persons with self-harm behaviours for patients aged 16 – 65, all other non-self-harm assessments are to be carried out by either HMR or Bury access teams reducing their capacity to respond to urgent referrals.
- The older people's team provide in reach for over 65 within the Bury borough. There is no service line agreement to provide older peoples assessment in the ACU in Rochdale infirmary, these assessments are then referred to the older people's psychiatrist can only attend once they have concluded their existing pre-booked clinics.
- Negative impact on patient outcomes and experience. Patients often have a long wait to be seen in the ED and UCC departments due to the demand and the split site. This can lead to patients leaving before being seen.
- Increased clinical risk while patients wait for assessments, patients waiting with mental health crisis can often present with risky behaviours and due to the small team and high demand there is often nowhere to wait apart from the public waiting area and this can lead to increased distress and deterioration in their mental health
- Poorer patient experience and outcomes
- Impact on staff morale and stress levels

Capital Costs:	Revenue Costs:	Other Comments:

Option Request 2	**Brief Description:** Develop an UEC by apt model in each of Bury and HMR Boroughs <u>Each Borough</u> will require the following staffing: • Provision of 4 WTE Band 6 Nurses • Provision of 1 WTE Administrator • Provision of 0.4 Band 7 Management Hours of Operation will match the streaming hours at the ED department – for 12 hours per day.

Advantages:

- Improved patient experience and outcomes
- Effective use of resources
- Avoid unnecessary admissions
- This additional provision will deliver the GM UEC by appointment requirement
- The 4 nurses would be able to provide 16 appointment sessions equalling 48 assessments and 16 follow up appointments per week in each Borough
- Develop a close working relationship with the community safe haven as another divert opportunity
- The service in each borough could offer assessments to the patients on the wards who have not self-harmed and could in HMR offer support to the ACU for mental health and age-related assessments this would allow the Liaison Mental Health to respond to the ED, UCC and future UTC in a timelier manner
- Following robust triage/screening the service will accept referrals from GM and Locality CAS teams, the Pennine Care 24/7 Helpline, the LMH team, the front door at A & E, the UCC and the new UTC being developed in Bury. This will enable a reduction in the presentation at the urgent and emergency care services
- The Bury and HMR LCOs are keen to include Mental Health Services as part of the new UTC development.
- Ability to provide follow-up appointments for all patients presenting with serious self-harm in timely manner.
- Improved staff and team morale for a team that can respond in a timely manner for MH Patients in crisis and refer to appropriate onward services as required.

Disadvantages:

- The LMH service covering the ED, UCC would still have the responsibility to manage any section 136 presentations and presentations streamed for immediate specialist assessment in ED within current resources reducing their availability at the front door services.

Opportunities, Risks and Issues:

Risks

- This model does not provide an All age service and the remaining requirements to meet a Core 24 standard
- The pressures of responding to the high demand of section 136 presentations, further reduces the ability to respond to the Wards, ED and UCC.
- Undertaking a 136 assessment on average is 8 hours per patient during which time the LMH service is unable to perform their primary duties.
- MH UTC staffing is not considered in this option. The Urgent Care Group are reviewing the staffing model required for the MH Service to input into a future UTC.
- Recruitment to any vacancies will take 2 – 3 months. There are existing vacancies within the mental health services which have historically proved recruit to

Capital Costs:	Revenue Costs:	Other Comments:

Costings

Please note the following costs is provided per Borough

Urgent and emergency care by appointment (per locality)	WTE	12 months
Team Manager	0.40	20,703
MH Practitioner	4.00	166,878
Admin	1.00	25,007
Non Pay		15,629
Estate Contribution		nil
Corporate clinical delivery support costs and Surplus		32,498
CQUIN		
Total		**260,717**

IT setup costs (Non recurrent)	**12,958**

Recommendation

The recommendation is that PCFT request funding for Option Request 2.

Equality Analysis Form		
The following questions will document the effect of your activity on equality, and demonstrate that you have paid due regard to the Public Sector Equality Duty. The Equality Analysis (EA) guidance should be used read before completing this form.		
To be completed at the earliest stages of the activity and before submitted to any decision making meeting and returned via email to GMCSU Equality and Diversity Consultant for NHS Bury CCG akhtar.zaman4@nhs.net for Quality Assurance:		
Section 1: Responsibility (Refer to Equality Analysis Guidance Page 8)		
1	Name & role of person completing the EA:	Nasima Begum (Commissioning Manager)
2	Directorate/ Corporate Area	Commissioning
3	Head of or Director (as appropriate):	Julie Gonda (Director of Community Commissioning
4	Who is the EA for?	NHS Bury CCG
4.1	Name of Other organisation if appropriate	Pennine Care Foundation Trust
Section 2: Aims & Outcomes (Refer to Equality Analysis Guidance Page 8-9)		
5	What is being proposed? Please give a brief description of the activity.	Development of Urgent and Emergency Care (UEC) by Appointment across Bury and Heywood, Middleton and Rochdale. This is a new proposal to support the Greater Manchester UEC by Appointment model at front end of Fairfield General Hospital. As part of the Urgent Care Redesign, it has requested that there is a mental health provision within the front end of Urgent Care. This would mean a wider Multidisciplinary team to support initial assessment and sign posting. This would bring added benefits for mental health patients during a crisis to ensure that a Multi-Disciplinary Team response is provided alongside Acute physical health.
6	Why is it needed? Please give a brief description of the activity.	This is a requirement of Greater Manchester UEC by Appointment model. A Mental Health Urgent care team will provide urgent support outside of A&E to prevent unnecessary attendance and admission into acute services and also pilot urgent care streaming

		for those patients who do not need immediate Mental Health intervention. This Business case focuses the Mental Health input at front door. For mental health, the streaming function would have: • additional nurses who would be able to provide more appointment sessions and assessment and follow up appointments per week in each Borough • Develop a close working relationship with the community safe haven as another divert opportunity • The service in each borough would offer assessments to the patients on the wards who have not self-harmed and could in HMR offer support to the ACU for mental health and age related assessments this would allow the Liaison Mental Health to respond to the Emergency Department, Urgent Care Centre (UTC) and future Urgent Treatment Centre in a more timely manner • Following robust triage/screening the service will accept referrals from GM and Locality Clinical Assessment Service (CAS) teams, the Pennine Care 24/7 Helpline, the Liaison Mental Health team, the front door at A&E, the UCC and the new UTC being developed in Bury. This will enable a reduction in the presentation at the urgent and emergency care services.
7	What are the intended outcomes of the activity?	This is a GM ambitions to reduce attendances to Emergency Departments by improving access to community provision. As part of the wider GM target, the intention is By April 2022, it will reduce: ○ Ambulance attendances by 100 per day across GM ○ Emergency Department walk in attendances by 300 per day across GM
8	Date of completion of analysis (and date of implementation if different). Please explain any difference	Date of completion of EIA: 27th October 2020 Implementation date: December 2020

9	Who does it affect?	All patients coming through to A&E front door.

	Section 3: Establishing Relevance to Equality & Human Rights (Refer to Equality Analysis Guidance Page 9-10)		
10	**What is the relevance of the activity to the Public Sector Equality Duty? Select from the drop-down box and provide a reason.**		
	General Public Sector Equality Duties	**Relevance (Yes/No)**	**Reason for Relevance**
	To eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by Equality Act 2010	Yes	**All** Mental Health patients, vulnerable adults and their families should be streamed prior to Emergency Department registration in an accessible compassionate and safe way. This will eliminate any unlawful discrimination, harassment and victimisation and other conduct prohibited by Equality Act 2010
	To advance equality of opportunity between people who share a protected characteristic and those who do not.	Yes	All streaming practitioners across the Urgent Emergency Care (UEC) system should utilise the UK Mental Health triage Tool, already operational in GM CAS to provide standardisation of practice and a shared language of mental health clinical prioritisation across the UEC system. This in essence should allow equality of opportunity between people who share a protected characteristic and those who do not.
	To foster good relations between people who share a protected characteristic and those who do not	Yes	Ensure where mental health and vulnerable adults and children present at an ED they are treated and/or referred to the on-site mental health speciality for treatment in agreed and safe time scales. The mental health speciality should be involved with all mental health patients streamed away from ED and the front door 24 hours a day, 7 days a week.
10.1	**Select and advise whether the activity has a positive or negative effect on any of the groups of people with protected equality characteristics and on Human Right**		

	Protected Equality Characteristic	Positive (Yes/No)	Negative (Yes/No)	Explanation
	Age	Yes		All age group will be assessed using UK mental Health Triage Tool
	Disability	Yes		Ensure where mental health and vulnerable adults and children present at an ED they are treated and/or referred to the on-site mental health specialty for treatment in agreed and safe time scales
	Gender	Yes		Ensure where mental health and vulnerable adults and children present at an ED they are treated and/or referred to the on-site mental health specialty for treatment in agreed and safe time scales Mental Health patients, vulnerable adults and their families should be streamed prior to ED registration in an accessible compassionate and safe way.
	Pregnancy or maternity	Yes		
	Race	Yes		
	Religion and belief	Yes		
	Sexual Orientation	Yes		
	Other vulnerable group	Yes		
	Marriage or Civil Partnership	Yes		
	Gender Reassignment	Yes		
	Human Rights **(refer to Appendix 1 and 2)**	Yes		
	If you have answered No to all the questions above and in question 10 explain below why you feel your activity has no relevance to Equality and Human Rights.			

Section 4: Equality Information and Engagement (Refer to Equality Analysis Guidance Page 10-11)		
11	**What equality information or engagement with protected groups has been used or undertaken to inform the activity. Please provide details. (Refer to Equality Analysis Guidance Page 11-12)**	
	Details of Equality Information or Engagement with protected groups	**Internet link if published & date last published**
	In January 2020, prior to the current Covid 19 Crisis, the GM UEC	

	Improvement and Transformation Board approved a high-level urgent care by appointment model as a refreshed priority for UEC integration with two primary ambitions: • To reduce attendances to Emergency Departments by improving access to, and utilisation of, primary and community-based services by rapidly developing and testing a GM 'UEC by Appointment' model. • By April 2022, we will reduce: o Ambulance attendances by 100 per day across GM o ED walk in attendances by 300 per day across GM	
11.1	**Are there any information gaps, and if so how do you plan to address them**	No
Section 5: Outcomes of Equality Analysis (Refer to Equality Analysis Guidance Page 12)		
12	**Complete the questions below to conclude the EA.**	
	What will the likely overall effect of your activity be on equality?	Improve access to A&E and more urgent cases can be seen in a timely manner. this will apply to equality groups
	What recommendations are in place to mitigate any negative effects identified in 10.1?	None
	What opportunities have been identified for the activity to add value by advancing equality and/or foster good relations?	This from door streaming would allow Ability to provide follow-up appointments for all patients presenting with serious self-harm in timely manner. Establish relationship with wider community team to divert patient who are clinically non-urgent. Improved staff and team morale for a team that can respond in a timely manner for MH Patients in crisis and refer to appropriate onward services as required.
	What steps are to be taken now in relation to the implementation of the activity?	The intention is to provide this new pathway to the UEC by appointment teams a test bed/pilot until March 2021. This will enable the service to capture actual demand to enable a review of this

	model in both Boroughs

	Section 6: Monitoring and Review
13	If it is intended to proceed with the activity, please detail what monitoring arrangements (if appropriate) will be in place to monitor ongoing effects? Also state when the activity will be reviewed.
This new model is for 12 months and it is anticipated that learning of the streaming function would allow better understand of mental health support needed to develop/remodel in RAID/CORE24 service in the future. Robust monitoring criteria will be agreed between Commissioners and Providers to ensure a sustainable and cost-effective model of urgent and emergency care can be commissioned for the populations of Bury.	

Protected Group	**Explanation**
Race	There is currently no data in relation to Race collected nationally for this service. JSNA data for Bury CCG: According to the 2001 Census, 93.9% of Bury's population is white with 'White British' representing 90.7% (compared to 87% nationally). The remaining 6.1% is made up of ethnic communities with the largest group being Pakistani at 3% of the population. Indians are the second largest group representing 1.4% of the population. The largest concentration of non-white residents is in East Ward where ethnic groups make up over 20% of residents. The Census however was produced in 2001 recent estimates (2006) suggest that the white population has fallen to 87.9% (compared to 84% nationally), with the largest proportional increase being in the Bangladeshi community. This data shows a decreasing white population and a substantial increase in the Asian heritage community although it has to be considered that the Pakistani community is predominantly young (with 65% of the population aged under 30) and that many of the migrant workers settling in Bury may not be represented. Local Area Profile (Rochdale) 2011 for HMR CCG: Population Profile Rochdale (HMR CCG) 2011 vast majority of people in Rochdale Borough are from a White British ethnic background, equivalent to 83.5% of the total population. People of a Pakistani background make up the largest minority ethnic group, with 17,200 people (8.3%). A significant proportion of the Bangladeshi, Pakistani and Mixed ethnic groups are aged between 0-15 years old. In comparison to the White British ethnic group, the minority ethnic groups have a much younger age structure, with fewer older people (Irish and White Other are the exceptions). The 2011 Census revealed that in Rochdale Borough 166,481 people identify as White British which makes up 78.6% of the local population. The largest ethnic minority group is Pakistani which makes up 10.5% of the local population (22,265), and the second largest is Bangladeshi with 2.1% of the population (4,342). *Source: 2011 Census.*
Disability	Data from Bury BC gives a comparator between residents who are disabled compared to their non-disabled neighbours:

	<table><tr><th>Area</th><th>All people in thousands</th><th>disabled based on the DDA definition</th><th>work-limiting disabled</th></tr><tr><td></td><td></td><td></td><td></td></tr><tr><td>Bury</td><td>12.7%</td><td>4.8%</td><td>2.9%</td></tr><tr><td>ONS da</td><td></td><td></td><td></td></tr></table> Data from Rochdale Borough (HMR CCG) indicates: The number of Rochdale Borough residents reporting a long-term health condition or disability is 44,359 (21%). *Source: 2011 Census*
Gender	Bury CCG: In the 2011 census the population of Bury was 185,060 and is made up of approximately 51% females and 49% males. HMR CCG: According to the 2015 Mid-Year Estimates there are slightly more women than men in the Rochdale borough; with approximately 108,841 people identifying as female compared with 105,354 of the local population identifying as male.
Gender Reassignment	*At present, there is no official estimate of the trans population. The England/Wales Census and Scottish Census have not asked if people identify as trans…"* Equality and Human Rights Commission. The GIRES (2009) report on Gender Variance in the UK estimated that around 20 in every 100, 000 people had sought medical care for gender variance. Using 15+ ONBS data of current list size of 163,013 (ONS 2015-16) the Gender Reassignment figure for Bury would be approximately 33 Bury Residents and 34 Residents in HMR CCG.
Age	**BURY CCG:** The Bury population can be split by the following c ategories(JSNA 2015): <table><tr><th>Year</th><th>0-4</th><th>5-15</th><th>16-24</th><th>25-44</th><th>45-64</th><th>65+</th><th>85+</th></tr><tr><td>2015</td><td>12,430</td><td>25,630</td><td>18,910</td><td>48,100</td><td>49,420</td><td>33,410</td><td>3,950</td></tr></table>JNSA for Bury CCG: Bury has an estimated resident population of 182,600 (ONS 2009 mid year population estimates) but a registered (with a Bury general practice) population of 194,350 as at 31st March 2010. The resident population of Bury is expected to increase to 193,000 by 2022 (5.5% increase) mainly due to more births than deaths. By 2022, the number of people aged under 25 years old is expected to increase by only 2,600 so that their proportion of the population will decrease by 4%, whereas there will be 9,000 more people aged over 65 (29% higher proportion of the population) with 2,000 more people aged over 85 (54% higher proportion of the population).
Sexual Orientation	In 2015, 1.7% of the UK population identified themselves as lesbian, gay or bisexual (LGB). More males (2.0%) than females (1.5%) identified themselves as LGB in 2015. Of the population aged 16 to 24, there were 3.3% identifying themselves as LGB, the largest percentage within any age group in 2015. The population who identified as LGB in 2015 were most likely to be single, never

	married or civil partnered, at 68.2%. In 2015, the majority (93.7%) of the UK population identified themselves as heterosexual or straight, with 1.7% identifying as LGB, the remainder either identifying as “other”, “don’t know” or refusing to respond. Young adults (16 to 24 year olds) 3.3% are more likely to identify as LGB compared with older age groups, and a higher proportion of males identify as LGB than females. Of those they were most likely to be single, never married or civil partnered, at 68.2%. There are no accurate statistics available regarding the profile of the lesbian, gay and bisexual (LGB) population either in the UK as a whole. Sexuality is not incorporated into the census or other official statistics. It's acknowledged that approximately 6-10% of any given population will be LGB. *Source: MYE 2015 and Stonewall*
Religion or Belief	Bury CCG: 88.9% of people living in Bury were born in England. Other top answers for country of birth were 1.9% Pakistan, 1.2% Scotland, 1.0% Ireland, 0.6% Wales, 0.5% Northern Ireland, 0.4% India, 0.3% Iran, 0.2% Hong Kong , 0.2% South Africa. 95.1% of people living in Bury speak English. The other top languages spoken are 0.9% Urdu, 0.8% Polish, 0.7% Panjabi, 0.2% Persian/Farsi, 0.2% Pashto, 0.2% Arabic, 0.1% All other Chinese, 0.1% Italian, 0.1% French. Religion is given as The religious make up of Bury is 62.7% Christian, 18.2% No religion, 6.1% Muslim, 5.6% Jewish, 0.4% Hindu, 0.2% Buddhist, 0.2% Sikh. 11,069 people did not state a religion. 476 people identified as a Jedi Knight and 42 people said they believe in Heavy Metal.
Pregnancy and Maternity	Public Health England March 16 Child Health Profile gives a live birth figure for Bury (2014) as 2,329. Children and young people under the age of 20 years make up 24.9% of the population of Bury. 23.6% of school children are from a minority ethnic group. The health and wellbeing of children in Bury is mixed compared with the England average. Infant and child mortality rates are similar to the England average. The level of child poverty is better than the England average with 17.1% of children aged under 16 years living in poverty. The rate of family homelessness is similar to the England average. Children in Bury have better than average levels of obesity: 7.8% of children aged 4-5 years and 17.2% of children aged 10-11 years are classified as obese. There were 295 children in care at 31 March 2015, which equates to a higher rate than the England average. A higher percentage of children in care are up-to-date with their immunisations compared with the England average for this group of children.
Married/ Civil Partnership	Bury CCG: 46.6% of people are married, 11.5% cohabit with a member of the opposite sex, 0.8% live with a partner of the same sex, 24.3% are single and have never married or been in a registered same sex partnership, 9.4% are separated or divorced. There are 10,162 widowed people living in Bury.
Other Groups:	Asylum Seekers/ Refugees - **Asylum seeker:** a person who enters a country to claim

Asylum Seekers Travellers Military Veteran Carers	asylum (under the *1951 UN Convention and its 1967 Protocol*).2 Individuals undergo the asylum process to have their claim assessed. **Refugee:** "… *a person who "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country*...". (5) Refugee status, or temporary 'leave to remain' (sometimes granted on humanitarian grounds) is awarded by the Home Secretary and affords the same welfare rights as other UK citizens. Entitlement to health and social care for asylum seekers and refugees is complex and dependent on their stage in the asylum process. Rules on entitlement are also subject to review and up to date advice should therefore be sought (see also footnote). However, there are some principles that generally apply: • necessary or urgent medical treatment should never be denied to any person, regardless of whether or not they are resident in the UK, or are able to pay in advance; • for life-threatening conditions and for the purpose of preventing any conditions from becoming life-threatening the appropriate treatment is normally given regardless of ability to pay; • maternity services should always be classed as 'immediately necessary treatment Whilst many asylum seekers do arrive in the UK in relatively good physical health, health problems can rapidly develop whilst they are in the UK.7 Reasons for this include: • difficulty in accessing healthcare services; • lack of awareness of entitlement; • problems in registering and accessing primary and community healthcare services, particularly if their claim has been refused; • language barriers. However, some asylum seekers can have increased health needs relative to other migrants. There are several reasons for this: • a number have faced imprisonment, torture or rape prior to migration, and will bear the physical and psychological consequences of this; • many may have come from areas where healthcare provision is already poor or has collapsed; • some may have come from refugee camps where nutrition and sanitation has been poor so, placing them at risk of malnourishment and communicable diseases; • the journey to the UK can have effects on individuals through the extremes of temperatures, length of the journey, overcrowded transport and stress of leaving their country of origin; • health needs of asylum seekers can be significantly worsened (and even start to develop in the UK) because of the loss of family and friends' support, social isolation, loss of status, culture shock, uncertainty, racism, hostility (eg. from the local population), housing difficulties, poverty and loss of choice and control. <u>Travelers</u> - The literature specific to the Gypsy and Traveller population indicates that, as a group, their health overall is poorer than that of the general population and poorer than that of non-Travellers living in socially deprived areas (Parry *et al*., 2004; Parry *et al*., 2007). They have poor health expectations and make limited use of health care provision (Van Cleemput *et al*., 2007; Parry *et al*., 2007). Van Cleemput *et al*. (2007) refer to many Gypsies and Travellers sense of fatalism with regard to treatable health conditions and low expectations of enjoying good health (particularly as they age). They also mention the commonly held belief that professionals are unable to significantly improve patients health status and may in fact diminish resilience by imparting bad news, such as a diagnosis of cancer. The impact of such beliefs is a heightened

	suspicion of health professionals and a reluctance to attend for screening or preventative treatment. The report by Parry *et al*. (2004), entitled *The Health Status of Gypsies and Travellers in England*, shows that both men and women often experience chronic ill health, frequently suffering from more than one condition; that carers experience a high level of stress; and that secrecy about depression keeps it hidden and increases the burden on both the individual and the family as they try to manage. Many Gypsies and Travellers face high levels of bereavement, which is also a precipitating factor of depression. Poor psychological health is often found in the context of multiple difficulties, such as discrimination, racism and harassment, as well as frequent evictions and the instability caused by this. <u>Military Veterans</u> A veteran is someone who has served in the armed forces for at least one day. There are around 2.6 million veterans in the UK as a Regular or Reservist or Merchant Navy serving in an active theatre of war. Estimates for the Bury population by the British Legion are 12,000-14,000 Veterans currently resident within the Borough. This figure does not include the Spouses or close family members of those who have served who may have specific needs due to service life. Taken as a whole, the ex-Service population, which has been estimated at around 3.8 million for England, has comparable health to the general population. The current generation of UK military personnel (serving and ex-serving) have higher rates of heavy drinking than the general population. However, this difference may attenuate with age. The most common mental health problems for ex-Service personnel are alcohol problems, depression and anxiety disorders. In terms of the prevalence of mental disorders, ex-Service personnel are like their still-serving counterparts and broadly like the general population. Military personnel with mental health problems are more likely to leave over a given period than those without such problems and are at increased risk for adverse outcomes in post service life. The minority who leave the military with psychiatric problems are at increased risk of social exclusion and on-going ill health. The British Legion 2012 gave estimates of the Military Veteran population of circa 12,000 (Bury) and 14,000 (HMR). <u>Carers</u> The role of the carer is especially important when the person who receives care (the care recipient) is unable to live independently without the carer's help. A young carer is a child or young person under the age of 18, carrying out significant caring tasks and assuming a level of responsibility for another person that normally would be undertaken by an adult. Underpinning the caring role may be life-long love and friendship, together with an acceptance of the duty to provide care. Carers can derive satisfaction and a sense of well-being from their caring role, receive love and affection from the care recipient, gain a sense of achievement from developing personal attributes of patience and tolerance, and gain satisfaction from meeting cultural or religious expectations (Cassell *et al*, 2003). Caring responsibilities may arise at any time in life. Carers may have to adapt and change their daily routine for work and social life, perhaps incurring personal and financial costs. They may become isolated from other members of their family, friends and work colleagues. In an ageing population, family members are expected to undertake complex care tasks, often at great cost to their own well-being and health (Schulz & Matire, 2004). The role of carer can be demanding and difficult, irrespective of whether the care recipient has a mental disorder, learning disability or a physical

	disability, either separately or combined. A survey of over 1000 carers in contact with carers' organisations found that just less than 50% believed that their health was adversely affected by their caring role (Cheffings, 2003). Mental health problems included stress and tension (38%), anxiety (27%) and depression (28%). Physical health problems included back injury (20%) and hypertension (10%). Back injury was associated with caring for individuals with physical disabilities. Similar figures were found in a survey by Carers UK (2002), in which the most frequently experienced negative emotions in carers were: feelings of being mentally and emotionally drained (70%), physically drained (61%), frustration (61%), sadness for the care recipient (56%), anger (41%), loneliness (46%), guilt (38%) and disturbed sleep (57%). Carers who are more vulnerable to health problems are women, elderly or very young people, those with pre-existing poor physical health, carers with arduous duties and those with few social contacts or support. Carers may attribute symptoms of an illness to their work as a carer and fail to recognise the onset of an illness. In Bury alone, we currently know of 3,320 adult carers but we acknowledge that there may be many more who do not receive any support to undertake their caring role (6). References (1) Gender, age, society, culture, and the patient's perspective inthe functional gastrointestinal disorders." *Gastroenterology* (April 2006): 130-35. Web. 17 July 2007 (2) Epidemiology, demographic characteristics and prognostic predictors of ulcerative colitis." *World J Gastroenterol* (2014): 20-28. Web. 17 July 2017. (3) Matthews, Z. (2008). *The health of gypsies and travellers in the UK*. London: Race Equality Foundation. (4) Parry, G., Van Cleemput, P., Peters, J., Walters, S., Thomas, K. and Cooper, C. (2004) *The Health Status of Gypsies and Travellers in England*, Sheffield, University of Sheffield. (5) The Health Needs of Asylum Seekers , Briefing Paper, The Faculty of Public Health (May 2008) (6) Bury Adult Carers Strategy Caring for Carers 2013-18