Bury Mental Health Strategy (3rd draft)

Contents

1 Introduction

1.1 Bury recently carried out a review of mental health services, and where the locality was in relation to the Five Year Forward View (FYFV) and NHS Long Term Plan (LTP) requirements. The review also took into account local requirements (including those resulting from the pandemic) and recognised the need for all mental health stakeholders in Bury, to work in partnership. The result of the review led to the creation of this mental health strategic plan, which as well as looking at national priorities, leans heavily on the ambitions and direction of the Bury Let's Do It! Strategy.

1.2 Both locally and nationally there has been an acknowledgement that a lot has been achieved in terms of implementing the FYFV and LTP, however there is still more to do. Bury aims to have high quality mental health services that can be accessed in a timely way by everybody who needs them and will focus on tackling inequality of access, experience and in outcomes.

1.3 The focus of this mental health strategic plan is that of mental ill health, also identified as mental disorder or mental illness rather than mental wellbeing. That is not to detract from the importance of mental wellbeing but it is not the focus of this strategy and is picked up in other Bury workstreams and planning guidance.

1.4 The strategy is all age and recognises that there is a separated governance structure for children and young people's services. There is also a recognition of the need for adult and older adult services (age 65+) to be equitable. Any ambitions included within this document that relate to adults should be read as relating to all adults and not just those of a working age.

1.5 A set of delivery plans have also been written to accompany this strategy and they will enable local planners to implement the recommendations that have been made within this document.

2 Summary

2.1 As of 1 July 2022, the provider/commissioner split within the English NHS was fundamentally changed with the abolition of clinical commissioning groups (CCGs). The requirement now is one of collaboration across the health system. The expertise for planning, managing and running mental health services sits across the system and is not just in one place. Therefore, new ways of collaborative system working are required.

2.2 The approach that Bury Locality has taken is to set up a joint Mental Health Programme Board with representation from the Local Authority, Mental Health Trust, VCSE and GM NHS (both those working with a locality focus and a regional focus). The Board will oversee the development of this mental health strategic plan and associated delivery plans. Doing this means Bury will be taking a collaborative working approach with partners to agree a set of principles and key outcomes for how Bury mental health services should develop.

2.3 Using evidence from national, regional and local sources this strategy aims to move the Bury mental health system to become a system that works in a unified way, rather than being fragmented and inefficient. Recommendations have been agreed with all partners who are clear that they need to work together to achieve them.

2.4 There are specific overarching problems that will impact the Bury system and to some extent are outside of the Locality's power to resolve. These include workforce shortages that are being seen at a national level, increased demand on health and social care services as a result of the global Coronavirus pandemic and the impact of the cost of living crisis that is impacting many people in Bury and the rest of the country.

2.5 The following **recommendations** have been grouped under four strategic rationales and have the economic impact of doing them identified. The associated delivery plans provided detail the actions and considerations for how each recommendation can be implemented. The strategic rationales are

a. Understanding the future needs and planning requirements of Bury locality
b. Developing and improving system working to support the prevention agenda and reduction in health inequalities
c. Redesigning services in line with national policies and proven evidence base

d. Creating the right processes to support planning decisions and enable more integrated and efficient ways of working

Recommendations	
Strategic rationale: Understanding the future needs and planning requirements of Bury locality **Links with other strategic plans:** The Bury Let's Do it Strategy aims to ' build *'…a fairer society that leaves no-one behind'* and plans to address inequality of opportunity within the borough. **Timeline:** 12- 36 months **Economic impact:** Cost Effectiveness – understanding what is needed and what is working well will support reductions in service duplication, identify poor outcomes and help to better target the right interventions to neighbourhoods and communities that need them	
1	A specific mental health needs assessment is not available for Bury currently and it is recommended that this is carried out to support the identification of assets and resources available that can be used and targeted appropriately. The JSNA should also be used to identify population changes so as to adapt recommendations in this and future strategies.
3	As part of a Bury mental health JSNA, include a current picture of health inequalities experienced by Bury residents and use as a baseline for ongoing monitoring of services (so to understand equality of access and outcomes for the 5 Bury neighbourhoods and their residents)
9	Create a system of service user and carer partnerships to co-produce service development and planning
16	Review data collection requirements and consider aligning performance and activity data to the Thrive quadrants within neighbourhoods. Ensure there is clarity regarding data requirements and move to a transparent and intelligent review and collection of data
Strategic rationale: Developing and improving system working to support the prevention agenda and a reduction in health inequalities. **Links with other strategic plans:** The Bury Locality Plan which aims to create *'…a population health system which embraces housing, education, environment, and policing, with citizens in communities taking control and identifying local prioritoes which are going to make the biggest difference for them* **Timeline:** 24-36 months **Economic impact:** Cost Efficiency – aligning plans across a system at a locality level can reduce the number of people accessing multiple services and services at a more intense/specialist level, as well as using system resources more efficiently. AND Cost saving – reproviding services locally and reducing gaps in provision can reduce overall spend	
2	Cross working between different Local Authority departments and VCSE organisations should be considered and plans developed to strengthen collaborative approaches aimed at reducing/minimising the risk factors known to impact negatively on mental health.
8	Consider how working arrangements could and should change post 1 July and identify the best locality arrangement for Bury. For the Mental Health

	Transformation programme and its commissioning and programme management resource to sit within Bury's Integrated Delivery collaborative (IDC)
14	Work with Primary Care colleagues to identify what is needed to improve the number of physical health care checks carried out for people with SMI and devise an appropriate plan
17	Consider implementing regular networking opportunities between providers and planners to improve the interconnectivity between services and sharing of information to facilitate working as a system so there is 'no wrong door' for accessing mental health support.
19	Identify opportunities for services (statutory and VCSE) to better align and review options for drop-ins and out of hours provision e.g. crisis cafes
Strategic rationale: Redesigning (and/or developing) services in line with national policies and proven evidence base **Links with other strategic plans**: The NHS Long Term Plan implementation plan provides a clear description of how services should be delivered. The Bury Let's Do it Strategy seeks to use an evidence-led approach to understanding risk and impact to ensure the right interventions are delivered at the right time. **Timeline:** 12-36 months **Economic impact:** Cost effectiveness – ensuring people access the right services early on and that those services provide evidence based interventions reduces the need for more expensive specialist interventions and escalation	
4	Develop and share plans for the Bury Living Well Model
5	Develop and share plans for Bury's CMHT transformation ▪ And include plans for specific Personality Disorder and Eating disorder pathways and Care Act compliance
6	Review the dementia care pathway to ensure it is NICE compliant
7	Review the CAMHs care pathway to ensure there is no gap in provision between CAMHs and AMHs and to ensure processes are put in place to support smooth transitions with consideration to the creation of 0-25 pathways where appropriate and linked in with GM plans
10	Agree an IAPT recovery plan that ensures the service is NICE compliant and has a clear trajectory identified to meet all access and recovery targets and ▪ Consider how the service better integrates with PCNs and acute providers in order to deliver the LTC IAPT LTP requirements and enables increased referrals to IAPT services for the people of Bury
11	Review the EIP service to ensure it is NICE compliant and 14-18 year olds are being referred as appropriate
12	Identify funding to make the CRHTT a 24/7 service and ensure that as a team (and not as part of a wider system) it meets core fidelity ▪ Review options to add appropriate (specialist) resource to ensure the service can deliver to 65+ age group
13	Devise and share the plan for implementing CORE 24 at Fairfield hospital. The plan should focus on linking in with other locality services (both statutory and VCSE e.g. peer-led crisis support) to ensure that there are clear pathways out of and into mental health crisis services provided within acute emergency department settings.
15	Review existing mental health OAPs to identify people who can be repatriated and review DToCs to identify what locally commissioned resource is required to keep people within Bury/GM and reduce DToCs

Strategic rationale: Creating the right processes to support planning decisions and enable more integrated and efficient ways of working **Links with other strategic plans:** The Bury ethos is be enterprising and to do things in a way that works best for local communities and neighbbourhoods **Timeline:** 12-36 months **Economic impact:** Cost efficiency – ensuring the mental health system and care pathways are joined up and streamlined to ensure that more people can be seen when needed and gaps in and between services are closed	
18	New workforce solutions to be proposed which mitigate some of the workforce issues and challenges in service delivery, including opting for peer support and other VCSE workers to be more integrated within statutory service
20	Develop a CAMHs investment plan to increase service capacity and close any identified gaps
21	Use CYP MH Charter Group to agree and design processes for achieving a joined up system wide approach of support for CYP
22	Get and maintain clarity about what is delivered at neighbourhood, locality and GM (noting this will change over time)
23	Agree specific finance reporting process to ensure clarity at a borough/locality level so that service developments can be planned and delivered within realistic timescales
24	Establish what is needed at a locality level re finance to implement all the above recommendations and wider strategy/delivery plans. I.e. How is money released and distributed in accordance with agreed plans and who monitors?
25	Establish and secure a shared strategic accountant within the Integrated Delivery Collaborative (IDC) (with has access to all stakeholder finance plans) for the implementation of recommendations 22-24 of this MH strategy

	Enablers
	Getting Help/Getting More Help
	Acute Risk and Crisis

3 Who we are

3.1 About Bury

3.1.1 Bury is a vibrant and dynamic place to live and aims to stand out as a place that is achieving faster economic growth than the national average, with lower than national average levels of deprivation. By 2030 the local ambition is for the borough of Bury is to have made the fastest improvement in reducing levels of deprivation than any post-industrial northern locality.

3.1.2 Bury has a population of approximately 200,000 people and is comprised of 6 Towns: Bury, Prestwich, Radcliffe, Ramsbottom, Tottington and Whitefield, each of which has a distinct identity and diverse community. There are also five Primary Care Networks – East, North, Radcliffe, Prestwich and Whitefield.

3.1.3 There are seventeen wards: Besses, Church, East, Elton, Holyrood, Moorside, North Moor, Pilkington Park, Radcliffe East, Radcliffe West, Radcliffe North, Ramsbottom, Redvales, Sedgley, St Mary's, Tottington and Unsworth.

3.1.4 Although Bury is less deprived than some of its statistical neighbours, deprivation is highly concentrated and was reported to be getting worse in both 2015 and 2019.

3.1.5 The highest levels of deprivation are around the centre part of Bury with the highest levels of poverty identified in the Central and Eastern parts of the borough.

3.1.6 The more affluent parts of the borough include the North, West and Southern parts of Bury where household income is higher than elsewhere.

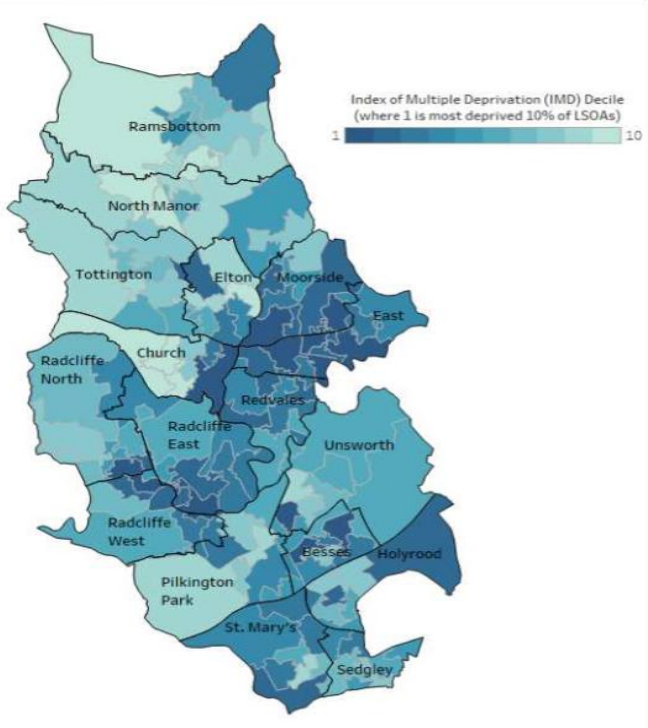


Figure 1: Bury, Index of Multiple deprivation

3.2 Mental Illness

3.2.1 Mental illness is the leading cause of disability in the UK and represents significant inequalities in terms of outcomes for those suffering from mental ill-health. When compared to the general population, people with a mental illness have a greater risk of poorer physical health, reduced life expectancy, poorer educational and employment outcomes and face discrimination.

3.2.2 It is essential that people who need treatment for mental illness receive the best care needed for their condition and can access that care when they need it. For many people, the more time that passes before they access the treatment they need, the more likely it is that their condition will become more severe, resulting in the need for more specialist interventions.

3.2.3 In Bury levels of depression and anxiety are higher (15.3%) than the national average (13.7%). Levels of long term mental illness are also higher in Bury (10.8%) when compared to the England average (9.9%)

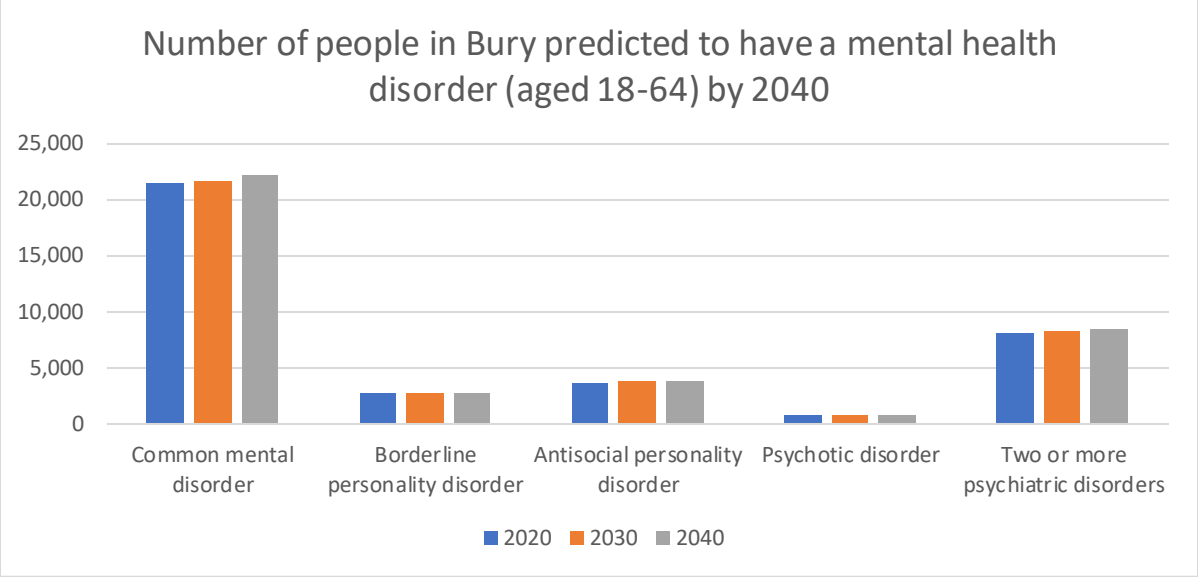
3.2.4 For children and young people (CYP) estimated prevalence rates of mental illness is 9%. With 1.98% of children in Bury primary schools estimated to have an emotional and mental health need rising to 2.88% in secondary school

3.2.5 Data for 2016/17 shows that Bury had a much higher than national or regional average of CYPs admitted to Tier 4 inpatient wards.

3.2.6 For older people with dementia Bury does well in terms of recorded prevalence and had the fifth highest recorded rate in the country in 2020/21. 4.63% of all over 65s registered with a GP practice against an England average of 3.9%. Diagnosis rates for dementia in 2021 were good as was the quality rating for residential care and nursing home beds. However, annual reviews of people's dementia care plans is poor - only 26% of plans are annual reviewed (England average is 39.7%). Bury also had the 12th worst direct standardised mortality rate in England in 2020/21.

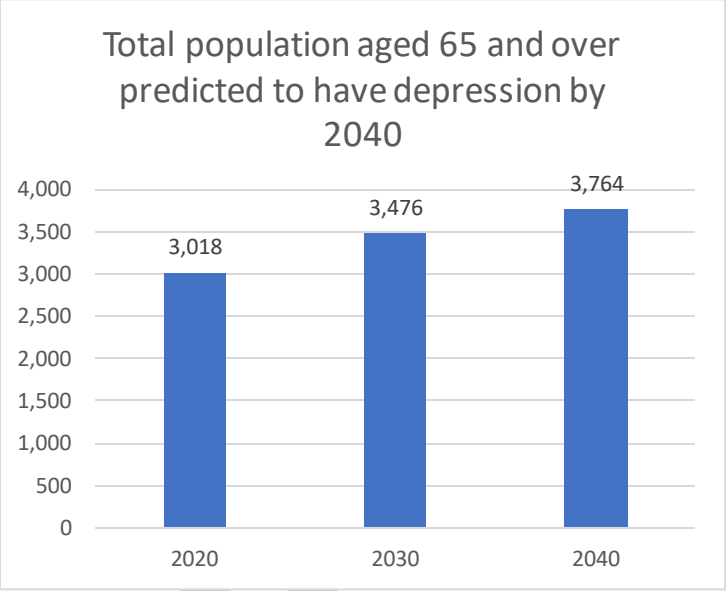
3.2.7 Bury has a higher than average number of people who claim Employment support allowance as a result of their main condition being mental and behaviour disorders

3.2.8 The predicted number of people aged 18-64 with a mental health disorder in Bury by 2040 will increase by 3.5% across all disorders. This equates to around 20% (37,660) of Bury's total population.



Source: Projecting Adult Needs and Service Information (PANSI) website

For older adults predictions are that 3,764 people will have depression, which is an increase of almost 25%.



Source: POPPI website

3.2.9 The latest prevalence study for Children and young people's mental health identifies that (nationally) one in six children and young people aged 5 to 16, had at least one type of mental health disorder which is an increase from one in nine in 2017. Among children of primary school age (5 to 10), 14.4% had a probable mental disorder in 2020, an increase from 9.4% in 2017. This increase was particularly evident in boys, with the rate rising from 11.5% in 2017 to 17.9% in 2020.1

[1] Mental Health of Children and Young People in England, 2017 [PAS] - NHS Digital

3.2.10 For secondary school aged children (11 to 16), 17.6% were identified as having a probable mental disorder in 2020, which is an increase from 12.6% in 2017. For young adults (17 to 22), one in five (20.0%) were identified with a probable mental disorder in 2020. Approximately one in four (27.2%) young women were identified with a probable mental disorder, compared with one in eight (13.3%) young men. (Mental Health of Children and Young People in England, 2020)

3.2.11 During the Covid-19 pandemic mental ill health deteriorated across all age groups. However, the deterioration had started prior to the pandemic. Evidence from national studies showed that the longer containment measures were in place the worse mental health became. Greater Manchester experienced longer periods of restrictions in 2020, which is likelier to have had a bigger toll on people's mental health than other regions in the UK.

3.3 Demographics

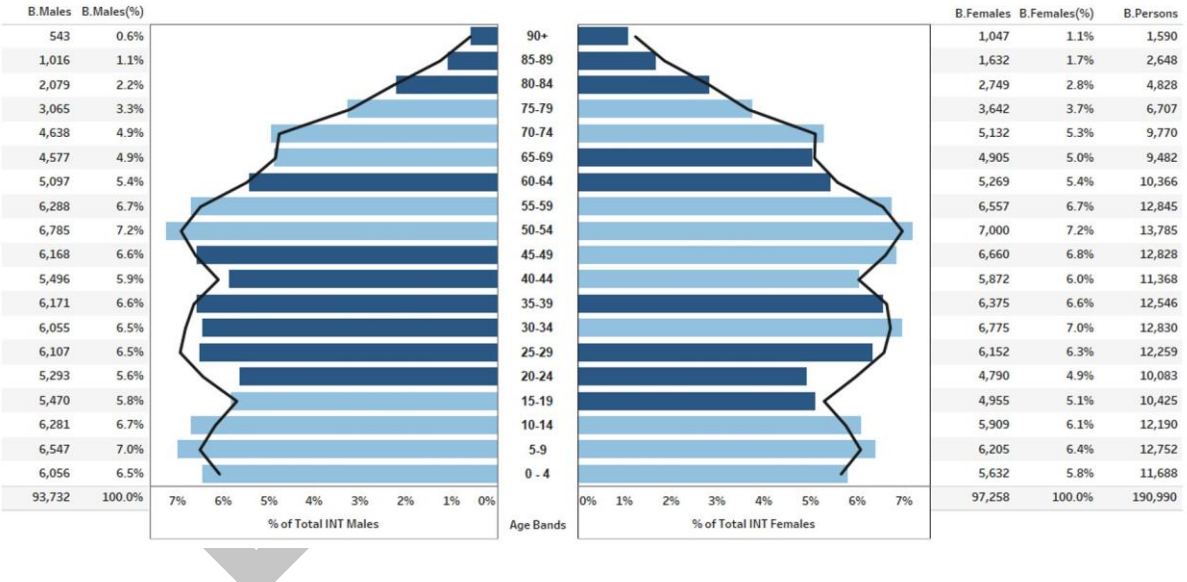
3.3.1 Who we are, in terms of sex, gender, ethnicity, age, sexuality, socio-economic status etc has a major impact on how we experience health and care services. This is both in terms of access and outcomes. Our wider life experiences are also impacted by these factors and in turn have a significant impact on our mental health and wellbeing.

3.3.2 Of the 190,990 people living in Bury 93,732 are male and 97,258 are female. For men Bury has a higher percentage of males aged 0-19, 50-59 and 65 -79 than the overall percentage in England. For females, Bury has a higher percentage of 0-14, 30-34, 40-59 and 70-79 than the rest of England.

3.3.3 89.2% of Bury residents are from a white ethnic group (compared to 85.42% for England). 7.2% are from an Asian/Asian British group (compared to 7.8% for England). 1% are from a Black/African/Caribbean/Black British group (compared to 3.48% for England). 1.8% are from a Mixed/multiple ethnic group (compared to 2.25% for England and 0.7% are from An Other ethnic group (compared to 1.03% for England)

Bury population by National Identity Categories

Ethnic Group	Background/Identity	Bury	England
White	English/Welsh/Scottish/Northern Irish/British	157,897	42,279,236
	Other White	4,706	2,430,010
	Irish	2,357	517,001
	Gypsy or Irish Traveller	72	54,895
Asian/Asian British	Pakistani	9,002	1,112,282
	Other Asian	1,607	819,402
	Indian	1,387	1,395,702
	Chinese	1,100	379,503
	Bangladeshi	311	436,514
Mixed/ multiple ethnic groups	White and Black Caribbean	1,307	415,616
	White and Asian	1,005	332,708
	Other Mixed	609	283,005
	White and Black African	444	161,550
Black/ African/ Caribbean/ Black British	African	1,116	977,741
	Caribbean	593	591,016
	Other Black	184	277,857
Other ethnic group	Any other ethnic group	898	327,433
	Arab	465	220,985



3.4 Mental health prevalence

3.4.1 There are a range of biological, genetic and social factors that are associated with mental illness and mental wellbeing. The prevalence of mental illness is determined by how such factors interact and impact us. Specific factors increase our risk of mental illness and poor mental wellbeing and disproportionately affect certain groups of people who are exposed to a higher numbers of risk factors (at the same time) than the general population.

3.4.2 Risk factors include; childhood adversity (accounting for approx. 30% of all adult mental disorders), socioeconomic inequalities (such as low income, poverty, financial difficulties, job insecurity, unemployment, insecure accommodation etc), stigma and exclusion, conflict and environmental factors among others.

3.4.3 Nationally rates of child poverty have increase since 2010 affecting workless families the most – estimates suggest 70% of this group experience child poverty. Food poverty among children and young people has increased significantly during the pandemic and is set to increase further. Rates of unemployment amongst young people has also risen.

3.4.4 At the time of writing this strategy the UK is experiencing the worst cost of living crisis for 30 years as a result of multiple factors including high levels of inflation. The effects of which will impact levels of mental illness as a result.

Recommendations	
1	A specific mental health needs assessment is not available for Bury currently and it is recommended that this is carried out to support the identification of assets and resources available can be used and targeted appropriately. The JSNA should also be used to identify population changes so as to adapt recommendations in this and future strategies.
2	Cross working between different Local Authority departments and VCSE organisations should be considered and plans developed to strengthen collaborative approaches aimed at reducing/minimising the risk factors known to impact negatively on mental health.

3.5 Health inequalities

3.5.1 In large part, health inequalities are a result of the conditions we are born, grow, live, work and age in. As health inequalities are a result of social inequalities, there is a need to ensure we work collectively in order to reduce inequalities and build a fairer society.

3.5.2 In 2019 Greater Manchester Health and Social Care Partnership worked with UCL Institute of Health Equity to establish a Marmot City Region, to focus on reducing health inequalities and inequalities in the social determinants of health. This work was reoriented as a result of Covid-19 to evidence the health inequality challenges across GM and make recommendations to reduce them2

[2] https://www.instituteofhealthequity.org/resources-reports/build-back-fairer-in-greater-manchester-health-equity-and-dignified-lives/build-back-fairer-in-greater-manchester-main-report.pdf

3.5.3 The 2020 NHS England, Advancing Mental Health Equalities Strategy stated that

- Different groups access services differently, with underrepresentation in some services and overrepresentation in others. This is an **inequality in access**.
- Different groups report having different levels of satisfaction with the healthcare they receive. This is an **inequality in experience**.
- Different groups receiving the same treatment also have different recovery outcomes. This is an **inequality in outcomes.**

3.5.4 Evidence available currently demonstrates a range of inequalities such as

- Evidence from the Royal College of Psychiatrists shows older people who have self-harmed or are depressed are much less likely to be referred to specialist mental health service than younger people.
- The *Modernising the Mental Health Act* final report identifies that black adults are more likely than adults in other ethnic groups to have been detained under a section of the Mental health Act and are also more likely to have come into contact with mental health services via the criminal justice system.
- The Women's Mental Health Taskforce report showed that on average, women have longer lengths of stay in mental health secure care and struggled to receive adequate aftercare.
- Rates of suicide are higher in the LGB population compared to their heterosexual counterparts.
- Lesbian, gay and bisexual people along with people from black, Asian and other minority ethnic groups report lower levels of satisfaction with community mental health services than their heterosexual and white-British counterparts.

Recommendation	
3	As part of a Bury mental health JSNA, include a current picture of health inequalities experienced by Bury residents and use as a baseline for ongoing monitoring of services (so to understand equality of access and outcomes for the 5 Bury neighbourhoods and their residents)

3.6 Current service provision

3.6.1 As described in the diagram below (page 14), broadly speaking adult mental health services in Bury are split into

- Coping and Thriving
- Getting Help
- Getting More Help
- Risk and Crisis
- Acute Care

3.6.2 **Coping and Thriving** includes help lines, community support groups and digital support services.

3.6.3 **Getting Help** services include, self help and lifestyle programmes, GPs and PCNs and the single point of contact for psychological therapies, single point of access for the community crisis teams.

3.6.4 **Getting More Help** includes secondary care mental health services such as community mental health teams (CMHTs), nursing and residential care and the urgent care by appointment service.

3.6.5 **Risk and Crisis** includes the mental health liaison service, AMPs and the emergency duty team (EDT), the peer-led crisis service and the section 136 suite.

3.6.6 **Acute Care** includes inpatient services and specialist placements.

3.6.7 Each level of provision is interdependent and does not operate in isolation. It is important to understand that changes in the community services within getting more help or risk and crisis, will have a direct impact on acute services and vice versa. Therefore the aim should be to create a more integrated approach to the management of mental ill health.

3.7 The context and evidence for mental health service delivery

3.7.1 Problems such as depression and anxiety are commonly experienced alongside physical health problems such as COPD, diabetes and/or neurological disorders. The Long Term Plan has set specific targets for IAPT and long term conditions in recognition of this. Plans for IAPT services should clearly align them with PCNs and GPs, and with the acute and general healthcare providers.

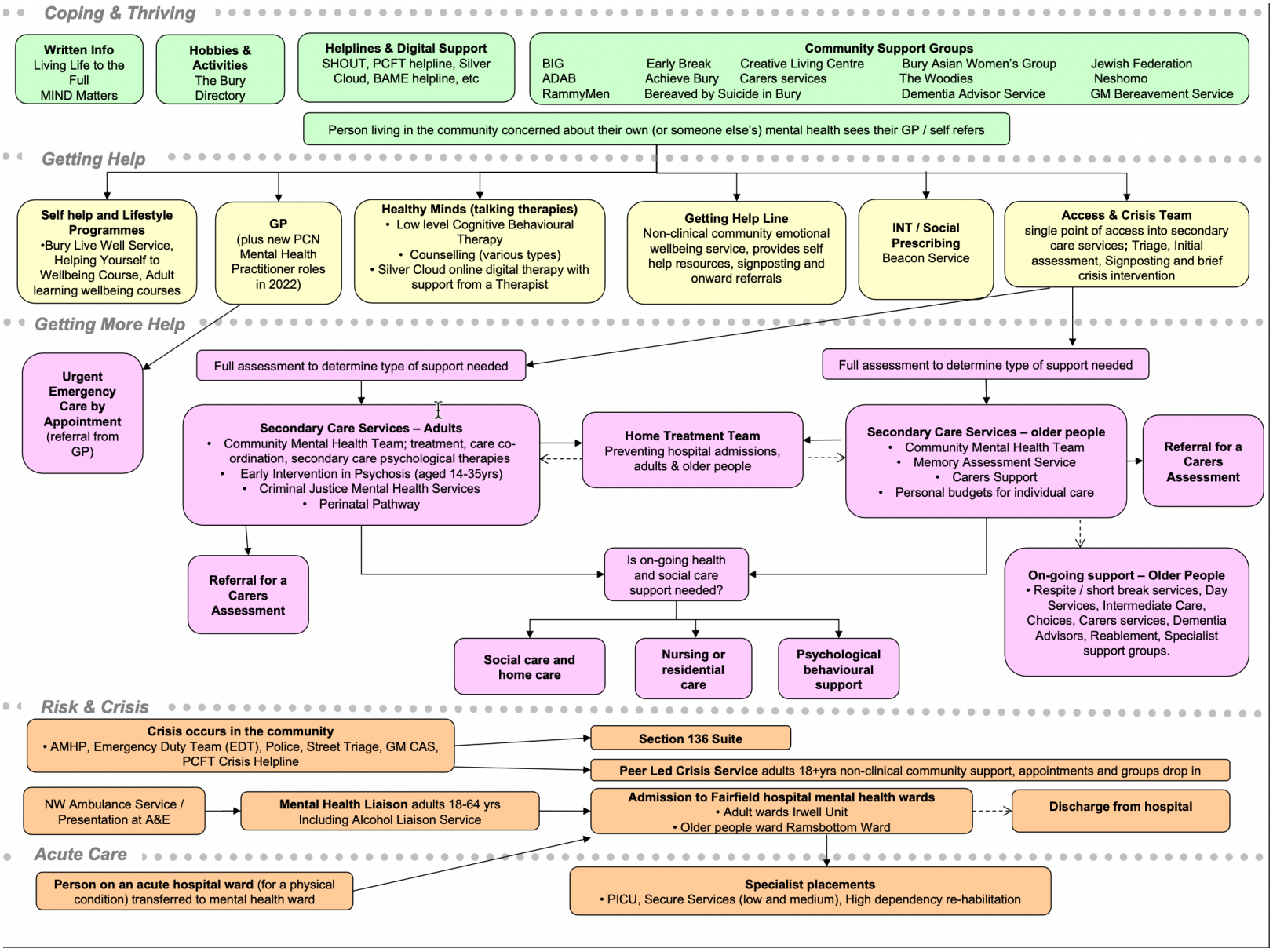
3.7.2 The evidence for early intervention in psychosis (EIP) has long been established and whilst the service sits within adults it works with people from 14 years upwards. The 14 – 25 year old population who experience their first psychotic episode can have their risk of future episodes significantly reduced by receiving NICE compliant interventions within 2 weeks of being referred into the EIP service. Ensuring that there is an integrated approach to working with CAMHs colleagues and GPs to ensure referrals are made at an early stage to the right service needs to be prioritised.

3.7.3 Risk, crisis and acute services deal with the most serious of mental illness. Such illnesses can cause a high levels of distress to service users, their families and sometimes the wider community. Therefore, it is a priority to ensure these services work effectively. In 2016 *the commission to review the provision of acute inpatient psychiatric care for adults* identified eight key national problems in acute care:

a) *"Inadequate availability of inpatient care or alternatives to inpatient admission when needed.*
b) *Many patients remain in inpatient beds for longer than is necessary in significant part because of inadequate residential provision out of hospital*
c) *Variable quality of care in inpatient units, reflecting the environment, the interventions available and the number and skills of health and care workers*
d) *Variation in terms of access to evidence-based therapies across the entire acute care pathway*
e) *A lack of clarity as to the quality of outcomes expected and how these should be reported in a transparent way*
f) *Variable involvement of patients and their carers in both the care received and in the organisation of services*
g) *Significant differences in the quality of leadership and the culture of organisations*
h) *A fragmented approach to the provision of services providing inpatient care."*

3.7.4 PCFT is already part of wider GM work looking at where it stands against the eight problems identified and how they can be remedied. However, it is already clear that in terms of Bury, there is a gap in terms of CRHTTs not operating on a 24/7 basis and not being equitable as there is an absence of provision for over 65s. There is also a gap in terms of alternatives to inpatient care in the form of a crisis house and/or safe haven.

3.7.5 There are also issues with the accommodation based services available locally to discharge people to – developing local (and/or GM) plans to address this would support inpatient services to discharge people in a timely way. The Bury Housing Strategy acknowledges the need to address this and states that *'[There is] a great need to focus on mental health housing solutions both as a step down from the hospital setting and in supported living'*


Coping & Thriving
Written Info
Living Life to the Full
MIND Matters
Hobbies & Activities
The Bury Directory
Helplines & Digital Support
SHOUT, PCFT helpline, Silver Cloud, BAME helpline, etc
Community Support Groups
BIG
ADAB
RammyMen
Early Break
Achieve Bury
Bereaved by Suicide in Bury
Creative Living Centre
Carers services
Bury Asian Women's Group
The Woodies
Dementia Advisor Service
Jewish Federation
Neshomo
GM Bereavement Service
Person living in the community concerned about their own (or someone else's) mental health sees their GP / self refers
Getting Help
Self help and Lifestyle Programmes
•Bury Live Well Service, Helping Yourself to Wellbeing Course, Adult learning wellbeing courses
GP
(plus new PCN Mental Health Practitioner roles in 2022)
Healthy Minds (talking therapies)
• Low level Cognitive Behavioural Therapy
• Counselling (various types)
• Silver Cloud online digital therapy with support from a Therapist
Getting Help Line
Non-clinical community emotional wellbeing service, provides self help resources, signposting and onward referrals
INT / Social Prescribing
Beacon Service
Access & Crisis Team
single point of access into secondary care services; Triage, Initial assessment, Signposting and brief crisis intervention
Getting More Help
Urgent Emergency Care by Appointment
(referral from GP)
Full assessment to determine type of support needed
Full assessment to determine type of support needed
Secondary Care Services – Adults
• Community Mental Health Team; treatment, care co-ordination, secondary care psychological therapies
• Early Intervention in Psychosis (aged 14-35yrs)
• Criminal Justice Mental Health Services
• Perinatal Pathway
Home Treatment Team
Preventing hospital admissions, adults & older people
Secondary Care Services – older people
• Community Mental Health Team
• Memory Assessment Service
• Carers Support
• Personal budgets for individual care
Referral for a Carers Assessment
Referral for a Carers Assessment
Is on-going health and social care support needed?
On-going support – Older People
• Respite / short break services, Day Services, Intermediate Care, Choices, Carers services, Dementia Advisors, Reablement, Specialist support groups.
Social care and home care
Nursing or residential care
Psychological behavioural support
Risk & Crisis
Crisis occurs in the community
• AMHP, Emergency Duty Team (EDT), Police, Street Triage, GM CAS, PCFT Crisis Helpline
Section 136 Suite
Peer Led Crisis Service adults 18+yrs non-clinical community support, appointments and groups drop in
NW Ambulance Service / Presentation at A&E
Mental Health Liaison adults 18-64 yrs Including Alcohol Liaison Service
Admission to Fairfield hospital mental health wards
• Adult wards Irwell Unit
• Older people ward Ramsbottom Ward
Discharge from hospital
Acute Care
Person on an acute hospital ward (for a physical condition) transferred to mental health ward
Specialist placements
• PICU, Secure Services (low and medium), High dependency re-habilitation

3.7.6 Feedback from people who have used Bury **inpatient services** has been good. Inpatient staff are known to build trusted relationships with their patients. However, Bury inpatient admissions are higher than other GM boroughs and people have longer stays, which indicates deficits elsewhere in the pathway.

3.7.7 Referral rates per capita relative to other GM boroughs for **community teams** are higher, however length of episode profiles show relatively short stays for many community teams. CMHT pathways have good outcomes but evidence suggests people could be stepped down to other services within the community if there was a better understanding of what was available. Feedback from service users shows they would like more therapeutic treatment options to be available to them.

3.7.8 Referrals into **CAMHS** are high when compared to other GM boroughs and throughput is high. There is evidence that the neuro development pathway provides good outcomes for patients.

3.7.9 In terms of **crisis** support, service users have fed back that there are limitations to the support available and a lack of knowledge about what they should do, who they should contact or where they should go. It is important therefore to ensure the crisis pathway link in with the rest of the health and care system so as to be able to signpost to specific Bury support options that are available once a person's crisis has been resolved.

3.8 Required mental health transformation work

3.8.1 There is currently a lot of work happening to change and develop the community services offer in Bury. CMHTs are being redesigned alongside the development of a *Living Well* model to improve the primary and secondary mental health care interface. This approach is based on the Lambeth model in South London and more recently the Salford model in Greater Manchester.

3.8.2 Further redesign/development of CMHTs to enable an improved interface between community and inpatient services and with specialist provision is also required. This, overtime will support a rebalancing of inpatient and community provision within Bury and improve treatment pathways for personality disorders and eating disorders in line with Long Term Plan requirements.

3.8.3 There is also a requirement to review the whole of the dementia pathway to ensure that people diagnosed with Dementia have access to the post diagnostic support they require (e.g. Cognitive stimulation therapy, cognitive rehabilitation, occupational therapy) and that ongoing enhanced annual reviews (including reviewing, behaviour, risk and social circumstance, Physical health check, care plan and medication) takes place in line with NICE guidance. People with a diagnosis of dementia must also be provided with a named coordinator of care who will support partnership working with other agencies as required to support the development of a holistic personalised care plan.

3.8.4 In addition, there is a need to resolve issues within the CAMHs pathway and ensure that services are provided until transition into adult services in line with NICE guidance. This will include reviewing transitions for 16–18-year-olds and reviewing whether some services should be provided on a 0-25 basis as per national guidance and in line with existing GM plans.

3.8.5 Feedback from service users and carers along with other stakeholders has indicated that information on where to get help outside of statutory services is limited and that people are not routinely signposted to relevant accessible information. Partners and stakeholders across the Bury system have also identified that services appear fragmented and difficult to navigate.

3.8.6 Bury mental health providers and planners have already begun identifying issues and transforming the mental health system and are seeking to ensure that this work is done in a coherent way.

3.9 Thriving in Bury Framework

3.9.1 As part of the mental health transformation work, the Thriving in Bury Framework brought Bury stakeholders together to work on redesigning mental health services in the borough. A quadrant approach to looking at services was adopted and stakeholders are working together to transform services within this context. The quadrant approach mirrors the iThrive model used in Children and Young People (CYP) services.

3.9.2 With programmes of work and anticipated outcomes being identified as

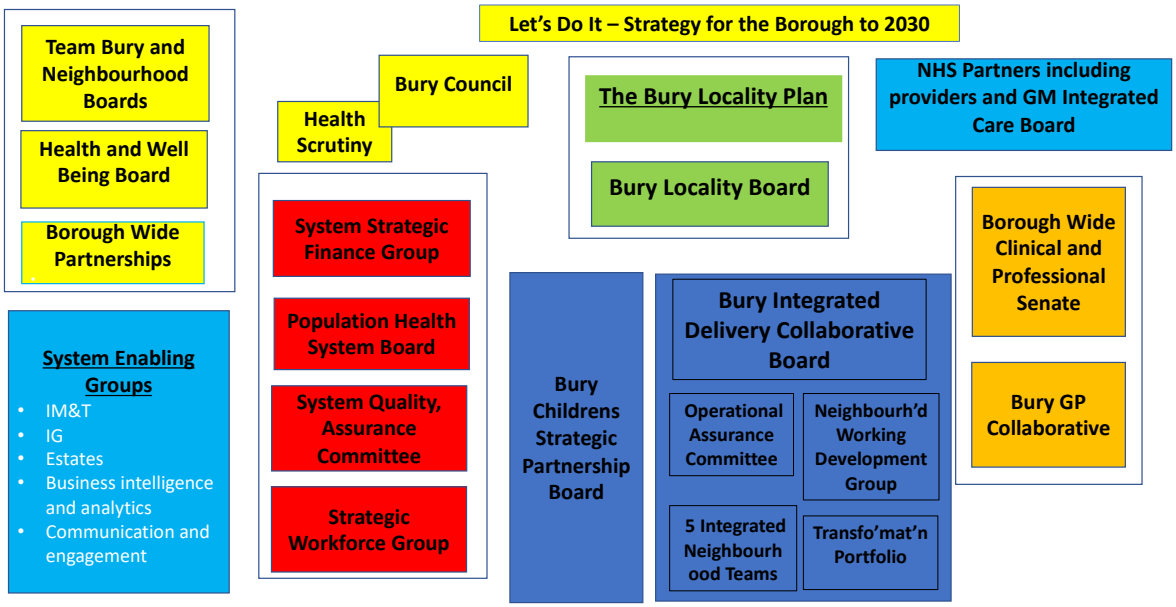
Bury Mental Health Transformation Programme Plan (adults)

	Outcomes	Key Programmes of work
Coping & Thriving (population)	People are motivated to stay well and in control of their own mental health. People are living happy lives.	Deliver targeted communications campaigns to connect people with support for early intervention and prevention. Provide mental wellbeing support, linking with Connect 5 and LLTTF.
Getting Help ↓ Living Well	People are offered short term, goal focused interventions which help them to manage. Those in at risk groups in our neighbourhoods are offered targeted support.	Increase access to IAPT, achieve waiting times and recovery targets. Develop an IAPT Long Term Conditions pathway. Establish PCN Mental Health Practitioners in each Neighbourhood. Develop the Getting Helpline offer.
Getting More Help	People are supported to recover from an episode of mental ill health, allowing them to live well in the community with their condition.	Develop the **Living Well Model**, integrating VCSE, primary and community care, including Personality Disorder Pathway, Eating Disorder Service and MH Rehab. Ensure people with SMI receive physical health checks. Ensure people with SMI have access to Individual Placement & Support (IPS).
Risk & Crisis	All people have access to timely crisis management support 24/7. People who have been ill are supported to live well with a risk management and crisis plan.	Implement MH Liaison Core 24 provision at Fairfield. Expand alternatives to crisis provision in the Peer Led Crisis Service. Develop Home Treatment Team to the core fidelity model. Eliminate all inappropriate adult out of area placements.

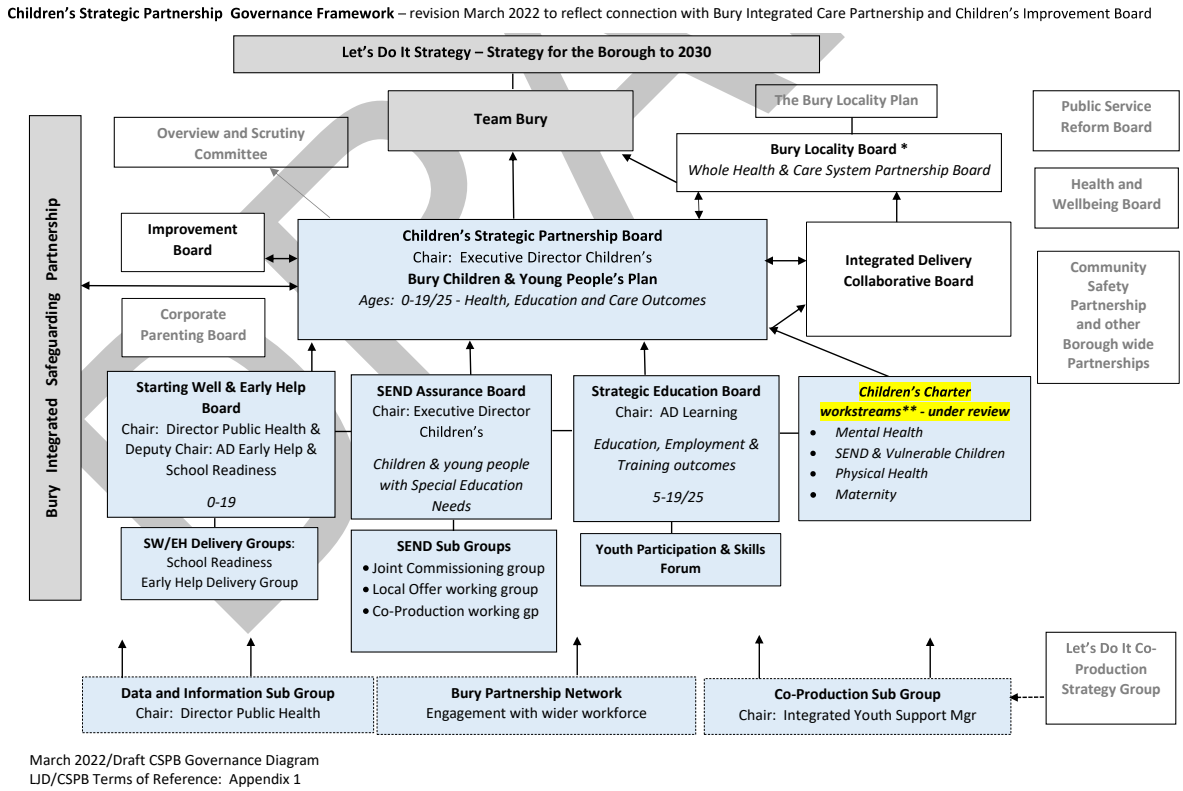
3.10 New Governance Arrangements

3.10.1 Governance structures in Bury are evolving in response to the wider national NHS reorganisation which will see CCGs abolished and replaced with Integrated Care Systems (ICS). As a locality Bury will operate as an Integrated Care partnership (ICP) under the following governance arrangements

The Bury Integrated Care Partnership - System Arrangements



3.10.2 For Children and Young People (CYP) governance arrangements are as follows



March 2022/Draft CSPB Governance Diagram
LJD/CSPB Terms of Reference: Appendix 1

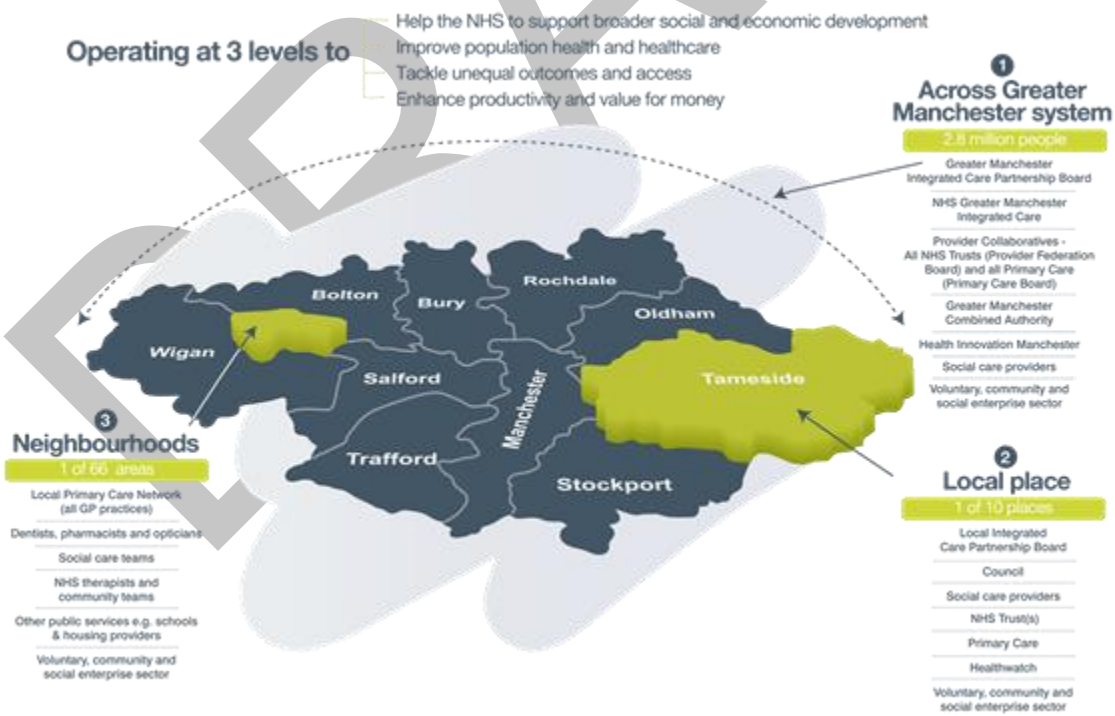
3.11 Greater Manchester (GM) arrangements

3.11.1 Within GM there has been a simplification of the national language used to describe Integrated Care Systems (ICS)

Description	National name/description	GM name
The whole system in an area, made up of all the organisation who support people with health and care	Integrated Care system (ICS)	GM Integrated Care Partnership
The meeting representing the whole system	Integrated Care Partnership (ICP)	GM Integrated Care Partnership Board
The new NHS organisation taking on the functions and staff of the CCGs	Integrated Care Board (ICB)	NHS GM Integrated Care, abbreviated to NHS GM

3.11.2 In addition, a Greater Manchester Provider Federation Board (PFB) has been created to provide a structured provider voice in the region and to take a strategic approach to transformation and provider quality and efficiency. There is also a Primary Care Board (PCB) that provides a primary care perspective on work programmes.

3.11.3 Working alongside the GM system are the 10 localities (ICPs)) that currently operate as locality boards.



3.12 Collaborative working

3.12.1 A Mental Health Programme Board (MHPB) was set up in Bury in April 2022, it is a partnership of mental health stakeholders from across the locality working together. There are representatives from statutory and VCSE providers and Bury locality commissioners and planners. Work is also happening concurrently (as part of the strategy work) to develop processes that enable co-production and engagement with service users and carers

3.12.2 With the removal of the provider/commissioner split there is a requirement for systems to take collaborative approaches to planning, recognising that the expertise to do this and to manage and run mental health services sits across the system. Agreeing a set of principles and key outcomes for how Bury mental health services should develop is the foundation for ensuring the system works in a unified way, rather than being fragmented and inefficient.

3.12.3 Notwithstanding regional GM workforce plans, in Bury there is an opportunity to further consider how best commissioners and providers work together to develop local mental health transformation plans. This has already begun in part under the Thriving in Bury Framework approach but there are further opportunities to integrate teams and to mitigate some of the wider workforce issues.

3.13 Working with service user and carers

3.13.1 There is a range of information currently available to people planning mental health services that comes from users of those services and the people that care for them. Often information such as complaints and serious incident reports highlight gaps and failures which is then backed up by investigations and other performance indicators. Service planners react to this information but would like to put in a place a system that allows for a more proactive approach to planning.

3.13.2 Bury mental health service providers and planners want to be able to meaningfully and effectively, co-design, and co-produce mental health services with people who currently or will in the future use those services. As well as ensure that there is a system of mutual aid in the borough. There is also a need to check back with people on a regular basis about their experience of using services – what could be improved and what is working well.

3.13.3 Ideally the approach to do this would be to create a system that supports the development of equal service user and carer partnerships. With people who use Bury mental health services being intrinsically involved in the planning and management of services. Creating a tiered approach to this would see

- Board level responsibility whereby a dedicated role/person would ensure that co-production including hearing the service user and carer voice was considered, designed and supported as part of all board level discussions

- Structures were in places to pull together existing service user and carer networks or develop new approaches to co-production and design as each situation required
- Processes for engaging and receiving feedback from wider groups on services and plans were facilitated as needed

Recommendations	
4	Develop and share plans for the Bury Living Well Model
5	Develop and share plans for Bury's CMHT transformation (non-Living Well) ▪ And to include plans for specific Personality Disorder and Eating disorder pathways and Care Act compliance
6	Review the dementia care pathway to ensure it is NICE compliant
7	Review the CAMHs care pathway to ensure there is no gap in provision between CAMHs and AMHs and to ensure processes are put in place to support smooth transitions (noting that people should only being transitioned once stable enough to do so) with consideration to the creation of 0-25 pathways where appropriate and linked in with GM plans
8	Consider how working arrangements could and should change post 1 July and identify the best locality arrangement for Bury. For the Mental Health Transformation programme and its commissioning and programme management resource to sit within Bury's Integrated Delivery collaborative (IDC)
9	Create a system of service user and carer partnerships to co-produce service development and planning

4 What are we working to

4.1 Long Term Plan (LTP)

4.1.1 The NHS Mental Health Implementation Plan was published in July 2019 and offered a framework for delivering the national Long Term Plan (LTP) commitments, using 'fixed, flexible and targeted' approaches. Implementation was to be from 2019/20 – 2023/2024 and clear performance, finance and workforce target were included to ensure the transformation of mental health care in England. LTP commitments focussed on

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Long Term Plan Ambition	Fixed/Targeted/ Flexible	Bury position
Children and young people		
345,000 additional CYP aged 0-25 accessing NHS-funded services [by 2023/24] (in addition to the FYFVMH commitment to have 70,000 additional CYP accessing NHS services by 2020/21)	Fixed	
Achievement of 95% CYP Eating Disorder standard in 2020/21 and maintaining its delivery thereafter	Fixed	
100% coverage of 24/7 crisis provision for CYP which combines crisis assessment, brief response and intensive home treatment functions by 2023/24	Fixed	
Joint agency Local Transformation Plans (LTPs) aligned to STP plans are in place and refreshed annually	Fixed	GM requirement with locality support
CYP mental health plans align with those for children and young people with learning disability, autism, special educational needs and disability (SEND), children and young people's services, and health and justice	Fixed	
Comprehensive 0-25 support offer that reaches across mental health services for CYP and adults in all STPs/ICSs by 2023/24 [drawing from a menu of evidence-based approaches to be made available in 2020]	Flexible	
Mental Health Support Teams (MHSTs) to cover between a quarter and a fifth of the country by 2023/24	Targeted	
Perinatal Mental Health		
At least 66,000 women in total accessing specialist perinatal mental health services by 2023/24	Fixed	GM requirement

Maternity Outreach Clinics in all STPs/ICSs by 2023/24 [following a piloting phase in select sites commencing in 2020/21]		Flexible	with locality support
Extended period of care from 12-24 months in community settings, and increased availability of evidence-based psychological therapies by 2023/24		Flexible	
Evidence-based assessments for partners offered and signposting where required by 2023/24		Flexible	
Mental Health Crisis Care and Liaison			
100% coverage of 24/7 crisis provision for CYP which combines crisis assessment, brief response and intensive home treatment functions by 2023/24		Fixed	
100% coverage of 24/7 adult Crisis Resolution and Home Treatment Teams operating in line with best practice by 2020/21 and maintaining coverage to 2023/24		Fixed	
All acute hospitals will have mental health liaison services that can meet the specific needs of people of all ages by 2020/21		Fixed	Funding agreed move to green once plans in place
100% coverage of 24/7 age-appropriate crisis care via NHS 111		Flexible	
Complementary crisis care alternatives in place in each STP/ICS by 2023/24 [drawing from a menu of approaches to be made available in 2019]		Flexible	
100% roll-out of mental health professionals working in ambulance control rooms, Integrated Urgent Care services, and providing on-the-scene response in line with clinical quality indicators		Flexible	
70% of Liaison Mental Health Teams achieving 'core 24' standard by 2023/24		Targeted	Funding agreed move to green once plans in place
Adult Common Mental Illness (IAPT)			

A total of 1.9m adults and older adults accessing treatment by 2023/24			**Fixed**	
IAPT-LTC service in place (maintaining current commitment) year-on-year			**Fixed**	
Achievement of existing IAPT referral to treatment time and recovery standards			**Fixed**	
Adult Severe Mental Illnesses (SMI) Community Care				
370,000 people receiving care in new models of integrated primary and community care for people with SMI, including dedicated provision for groups with specific needs (including care for people with eating disorders, mental health rehabilitation needs and a 'personality disorder' diagnosis)			**Fixed**	
390,000 people with SMI receiving physical health checks by 2023/24			**Fixed**	
55,000 people with SMI accessing Individual Placement and Support services by 2023/24			**Fixed**	
Delivery of the Early Intervention in Psychosis standard: **- Achieve 60% EIP access standard by 2020/21 and maintain its delivery thereafter** **- Achieve 95% Level 3 EIP NICE-concordance by 2023/24**			**Fixed**	
Therapeutic Acute Mental Health Inpatient Care				
Maintain ambition to eliminate all inappropriate adult acute out of area placements			**Fixed**	
Improved therapeutic offer to improve patient outcomes and experience of inpatient care, and reduce average length of stay in all in adult acute inpatient mental health settings to the current average of 32 days (or fewer) by 2023/24			**Flexible**	
Suicide Reduction and Bereavement Support				

Localised suicide reduction programme rolled-out across all STPs/ICSs by 2023/24			**Targeted**	
Suicide bereavement support services across all STPs/ICSs by 2023/24			**Targeted**	
Problem Gambling Mental Health Support				
Establishing a total of 15 new NHS clinics for specialist problem gambling treatment by 2023/24			**Targeted**	
Rough Sleeping				
Funding at least 20 areas to deliver new mental health provision for rough sleepers by 2023/24			**Targeted**	

4.2 Bury specific requirements

4.2.1 Locally Bury stakeholders wants to improve the quality and performance of all services. For mental health services it is important to streamline access and referral processes to support people getting the support they need in a timely way. Feedback from stakeholders has identified concerns about the mental health system being fragmented and difficult to navigate.

4.2.2 Work is already underway locally to bring people together to meet and work in a partnership approach under the Thrive framework. Adding to this some ongoing networking and learning events can further improve how the wider system works together and understands what support is available outside of their direct service provision. Reviewing access and waiting time targets should be used as proxy indicators to take a view of the success/impact of doing this.

4.2.3 In respect of where Bury is in delivering the Long Term Plan there are a number of gaps and areas that need further development, these have been RAG rated above.

Recommendations	
10	Agree an IAPT recovery plan that ensures the service is NICE compliant and has a clear trajectory identified to meet all access and recovery targets and ▪ Consider how the service better integrates with PCN and acute providers in order to deliver the LTC IAPT LTP requirements and which enables increased referrals to IAPT services for the people of Bury
11	Review the EIP service to ensure it is NICE compliant and 14-18 year olds are being referred as appropriate
12	Identify funding to make the CRHTT a 24/7 service and ensure that as a team (and not as part of a wider system) it meets core fidelity ▪ Review options to add appropriate (specialist) resource to ensure service can deliver to 65+ age group
13	Devise and share the plan for implementing CORE 24 at Fairfield hospital the focus of which being the pathways in and out that link with and can be supported by other Bury locality services/providers e.g. peer-led crisis support
14	Work with Primary Care colleagues to identify what is needed to improve the number of physical health care checks carried out for people with SMI and devise an appropriate plan
15	Review existing mental health OAP to identify people who can be repatriated and review DToCs to identify what locally commissioned resource is required to keep people within Bury/GM and reduce DToCs

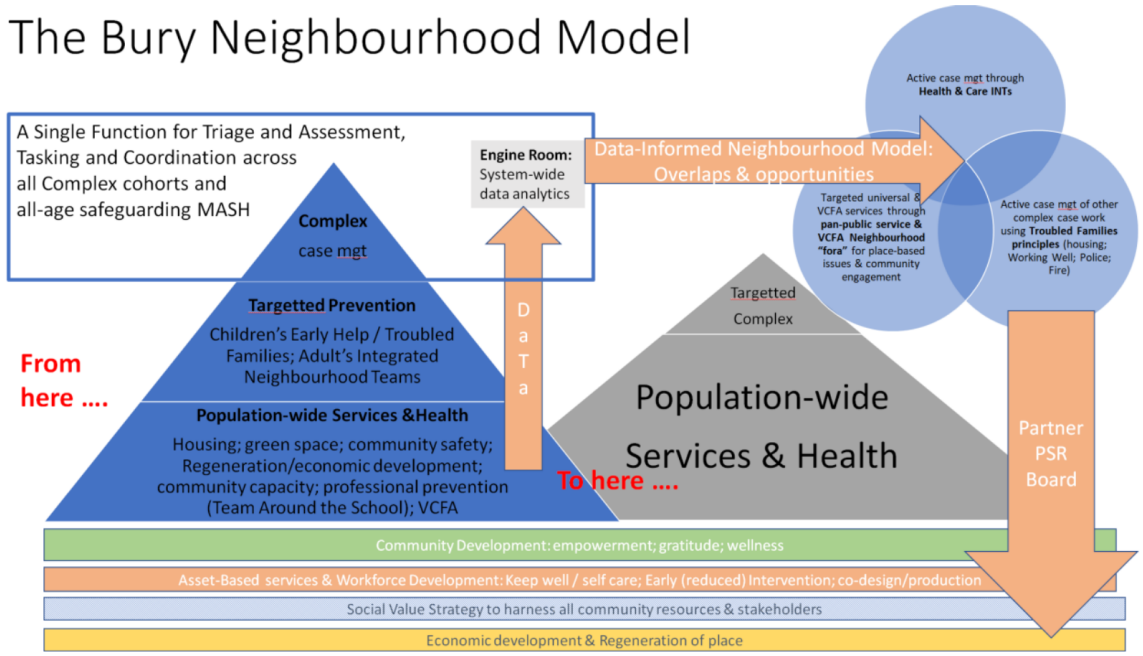
16	Review data collection requirements and consider aligning performance and activity data to the Thrive quadrants within neighbourhoods. Ensure there is clarity regarding data requirements and move to a transparent and intelligent review and collection of data
17	Consider implementing regular networking opportunities between providers and planners to improve the interconnectivity between services and sharing of information to facilitate working as a system so there is no wrong door

5 Our story so far

5.1 Bury was rated as the happiest place to live in Greater Manchester place in 2017 by Rightmove and Prestwich was described as *Manchester's funkiest family suburb* by the Sunday Times in their 2022 *Best Place to Live* list.

5.2 The vision in Bury's Locality Plan 'is to *ensure that people have a good standard of living, a decent place to live and meaningful relationships with others as active members of society.'*

5.3 To support this vision and the creation of a better integrated health and care economy Bury is taking a neighbourhood approach that brings together relevant health, care and services which contribute to the wider determinants of health.



5.4 This way of working focusses on a whole system approach and recognises the need to 'untangle' the complexity of accessing services and reduce the number of unnecessary contacts with services as a result of that complexity. As this model evolves and embeds plans and recommendations for mental health services must align with this approach.

5.5 Mental health investments

5.5.1 A series of investments into mental health services have also been made over the last two years. These investments were in response to identified gaps in service provision and made to ensure that people could get timely mental health support when they needed it. There is a new

- peer-led crisis support service, that provides an alternative to A&E and/or inpatient admission. The service delivers bio-social support to de-escalate crisis in a non-clinical environment.
- a getting help phone line that operates outside of working hours, offering the public non-clinical mental health support, advice, guidance and signposting
- a new community eating disorders service and
- increased investment into CMHTs to significantly increase their capacity.

6 Future goals and ambition

6.1 The LTP aims to establish integrated primary care and community services which enable patients to access the support they require at the earliest point of need as this will enable them to continue living in their communities and neighbourhoods. To do this well services will need to be cohesive and properly resourced.

6.2 There also needs to be an understanding of the interdependencies across the wider health and social care economy and clarity about how services interact with each other. If people are to receive help when they need it and before they have reached a crisis, there needs to be enough capacity in the system to step people up and step them down based on the level of care they need. If this is achieved and maintained it can reduce the numbers of people requiring inpatient treatment enabling more people to 'stay in their lives' within their communities and neighbourhoods.

6.3 Locally Bury stakeholders have already identified the need to ensure that individual services (both statutory and non-statutory) work well together and do not appear to create gaps, that people seeking help/support can fall through. Individual services will need to move away from focussing only on their own access criteria but consider their role in a wider pathway/system. Services must no longer turn people away without thought for what will happen next for the person.

6.4 Crisis and Acute care - National evidence

6.4.1 The Getting It Right First Time Mental Health – Adult Crisis and Acute Care team identified three core pathways that people access and receive mental health services

- ***Route 1.*** *At-risk people who enter the service via a preventative referral (typically via their GP or through self-referral) and remain within the service (mostly under the care of CMHTs, IAPT or EIP services) until the purpose of accessing the service has been achieved.* ***This is the best-case scenario****, and the pathway that most patients follow.*
- ***Route 2.*** *People try to access Route 1 services, but systemic barriers impede that access and/or there are lengthy waits for assessment or essential interventions required after assessment. Some people's conditions then deteriorate without them receiving the necessary intervention. This results in them falling out of Route 1, thus leaving them* ***more likely to present at a late stage in crisis****.*
- ***Route 3.*** *Some people either do not think they have a mental health condition that will benefit from mental health interventions or have significant worries about accessing mental health services. Such people are at high risk of presenting at a very late stage – often in crisis presentations, which sometimes take place in A&E or via emergency services including the police –* ***raising the potential of secondary and tertiary complications****.*

6.4.2 Whilst the majority of people will access and receive services via route 1, there are still too many people accessing services in crisis. Bury mental health services therefore must focus on reducing the systemic barriers (including long waiting times) that push people away from route 1. In addition, there is also a piece of work required to ensure that people seek help earlier about their mental health problem. This will require working with local communities to show the benefits of accessing support early, and to understand and address the issues that stop people seeking help from statutory health and care services.

6.4.3 Working towards this goal will not only achieve better outcomes for people but will create a more efficient system where resources are used effectively to support more people.

6.5 Adult mental health - Locality position

6.5.1 Within the newly designed Thriving in Bury Framework there is clarity regarding care pathways and what should happen for people trying to get support from services.

- Within the Getting Help and Getting More Help quadrants
    - people are offered short term, goal focussed interventions which help them manage and recover from episodes of ill health. They should be able to live well in their community and neighbourhoods with their condition

    - at risk groups should be offered targeted support to enable them to keep well and living in their communities
- Within the Risk Management and Crisis Support quadrant
    - people are able to access support 24/7 in a crisis to prevent escalation or further harm

6.5.2 This clarity is helpful and has also led to increased investments in mental health services as a result of realising gaps in provision. However, it is worth noting that some people may need on going support to remain well and that recovering from episodes of ill health does not always equate to being symptom free, so the focus should be on supporting people to stay in their communities and have the best quality of life possible.

6.5.3 Also, with so much change happening (both in terms of mental health transformation and health service reconfiguration) there is a need to ensure that developments and changes are implemented as a part of a wider system/pathway. Any changes that are agreed and implemented must be done knowing what their impact on the wider system/pathway will be. If this cannot be known in advance, ongoing monitoring should take place so that any unintended negative consequences can be identified and managed.

6.5.4 As part of the quadrant approach Bury partners should begin to understand and share the interdependences between services and identify any gaps. This has begun to happen within the Getting Help and Getting More Health quadrants as VCSE providers came together to agree and develop approaches to the reorganisation and delivery of community based services. Some key principles they agreed included

- Creating immediate access for people who needed it – drop-ins that deflect from universal services
- Ensuring there were a variety of offers to meet different individual needs
- Delivering 'out of office hours' support
- Developing a community 'front door' to reduce multiple referrals and people falling through gaps
- Having a strong peer/lived MH involvement ethos
- Inclusion rather than exclusion focus – saying 'yes'

6.5.5 There is a willingness and opportunity to build on this work and for VCSE and statutory services to work together in their approach to delivering mental health community services. Such an approach can also mitigate some of the effects of current workforce pressures as well.

6.5.6 **Service specific developments** identified include:

- **Include peer support workers (PSW) within statutory community services** – CMHTs CRHTT and EIP teams can benefit form including peer support workers as part of their skill mix. There is clear evidence that being supported by someone who has had a similar experience to you (and is further along in their own recovery) can aid recovery and has a positive impact on the wider team. In addition, PSW can add additional capacity and

bring complementary skill sets to community teams. PCFT have already recruited PSWs to work in their CMHT so reviewing the job description and evaluating the impact of the role should be included. There is also an option where by PSWs are not directly recruited into mental health trusts but work in VCSE organisations and join statutory team meetings holding a caseload and carrying out specifics tasks with the wider support and infrastructure of the organisation they work with.

- **VCSE led drop-in sessions with input from statutory services** – Provided by the VCSE these drop-in sessions could be supported by social care sessions including benefits/welfare or housing advice, CMHT input to support people with clinical issues and PCN workers to support people with physical health checks. Drop-in sessions provide a specific place and time where people can go when they need support and can be of benefit for people with longer term rehabilitation needs as well as those unsure of how to navigate a complicated mental health system. There are a range of approaches to how these are provided and they may not always be mental health focussed. Thinking about working with communities that statutory services have traditionally not linked in with before, there are opportunities for representatives from mental health statutory services to themselves 'drop-in' to community led groups to share information and create links.

- **Out of** office **hours support –** There is already a Getting Help Line that operates between 8am – 8pm Monday – Saturday (which has formal links with the PCFT statutory 24/7 crisis line) and a peer-led crisis service that operates 6pm – 11pm three evenings per week. However other areas operate crisis cafes and/or crisis houses/safe havens that support people struggling socially or emotionally with life challenges or who are in crisis. There are a range of models run either by statutory services or the VCSE or a combination of both. Whether Bury would benefit from something similar would need to be based on a review of activity data of the existing services (included NHS community services and social work duty).

- **Community front door –** There is clear evidence that reducing the number of referrals made in relation to an individual is beneficial and can reduce waiting times, improves access to services and ensure appropriate services are accessed early. There are a range of approaches to reducing referrals often termed single point of access, however they can range from being a coordinated approach for referrals triaged by an admin team to a team of practitioners reviewing referrals in order to identify the best support package. It is certainly recommended that a review of referral pathways takes place with the aim of reducing the complexity of getting into services and improving equity of access. Adding the VCSE offer to this community front door should be included in Bury.

6.6 Children and Young People – National Evidence

6.6.1 It is vital that people experiencing mental illness receive the right treatment in a timely way close to home. For children and young people (CYP) there is the added requirement of ensuring that their educational networks do not break down either. Therefore there should be a clear focus on services for CYP that are aimed at avoiding crisis and that there are good evidenced based alternatives to admissions. Pathways of care for CYPs should be seamless and enable people to be stepped up and stepped down in terms of treatment intensity as required.

6.6.2 Even more so than adult services, there is a significant amount of complexity in providing services for CYPs. There is a need for a wide range of partners from education, children's social care, acute hospitals, mental health services, paediatrics, families, VCSE, the police and other emergency services, to work collaboratively. In Bury, there are already strong partnerships supporting and developing collaborative and holistic ways of working. However, there are still a range of gaps that need to be understood and addressed.

6.6.3 As with adult services there is clear evidence that accessing good quality effective community services can lead to better outcomes for young people, such services include, early intervention in psychosis, personality disorder community-based services and eating disorder services amongst others. Where there is no alternative but to admit a young person to an inpatient ward, there should be a clear plan in place to ensure length of stays are kept to a minimum and that the inpatient therapeutic offer is of good quality and is safe. It is worth noting that the cost of a single inpatient care episode equates to approximately 100 CYPs treated in the community.

6.6.4 Evidence obtained from the Getting Right First Time, children and young people's mental health team found that, with regard to general adolescent units, forensic and learning disability units *….young people are exposed to restrictive interventions which risk re-traumatisation, decreased therapeutic engagement, and subsequent increased time in service.*

6.6.5 It is therefore important that CYP mental health is developed within a system wide approach which aims to support resilience, emotional health and wellbeing. And, with the acknowledgement that demand for services has significantly increased as a result of the covid pandemic. Therefore there is clear need to identify additional investment in order to achieve this.

6.7 What needs to be prioritised – short, medium and longer term

There are a number of considerations to take into account when agreeing what needs to be done in the short, medium and longer terms. The delivery plans associated with this strategy go into more detail but the overarching principles behind prioritisation are as follows

- Ensuring that services are safe
- Closing any gaps in provision that impacts on patient safety
- Making necessary changes to provision that free up resources that can be invested elsewhere

6.8 Objectives/What needs to be achieve

Services are needed in a way which:

- Reduces the current fragmentation between services and encourages a more integrated and partnership approach to service delivery, 'no wrong front door'.
- Focusses on improving the outcomes which services achieve, rather than on the detail of how they are structured
- Provides for clear pathways through services, so that, irrespective of how people come into services, there is a shared understanding as to how people will be supported to move through those services and into recovery – without being blocked or delayed by organisational boundaries
- Improves access and reduce any inequity of access

The outcomes which we would want mental health services to achieve, are:

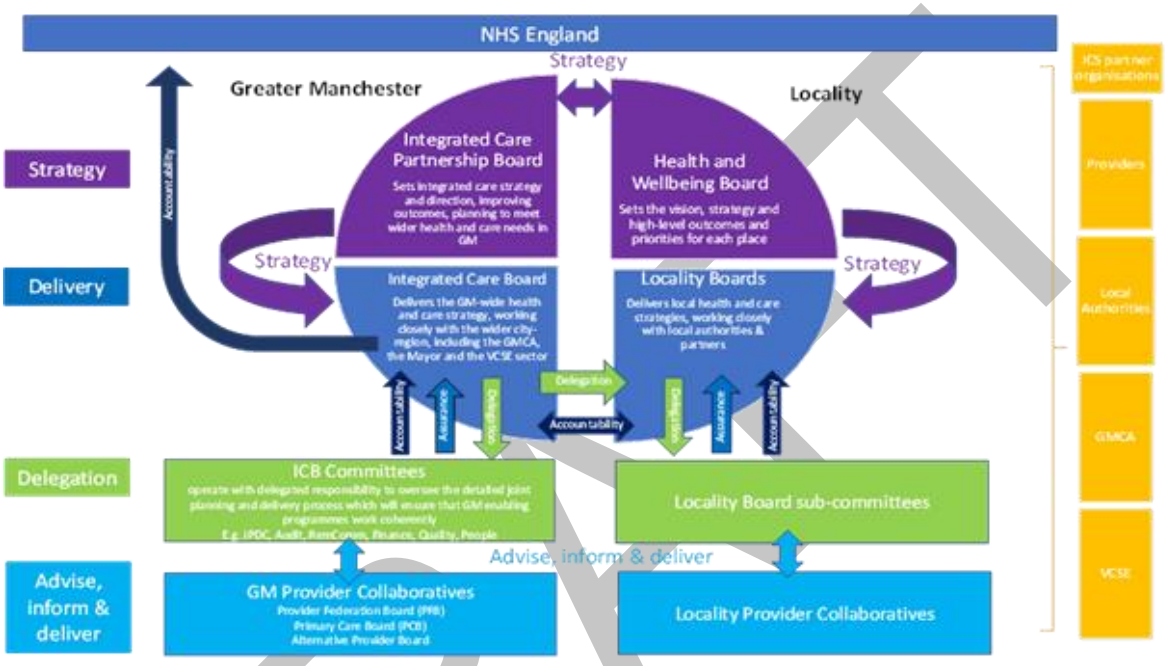
- **Health outcomes** – reductions in symptoms, and/or maintenance of the best possible quality of life despite continuing illness
- **Social outcomes** – good relationships, stable housing, contributions to the community through work, education, or family
- **Risk and harm outcomes** – the lowest possible risk of suicide, deliberate self-harm, or self-neglect; and minimisation of the risk which a very small minority of patients present to others. Minimisation of the risk of stigma arising from contact with mental health services
- **Choice and relationship outcomes** – respecting patients' choices and preferences, and working well with other agencies
- **Physical health outcomes** – supporting patients to access services they need, and to maintain or achieve healthy lifestyles despite mental illness
- **Fair and straightforward access** – clear communications, and equity across Bury's communities
- **Value for money** – costs comparable with the typical cost of good quality mental health services

Recommendations	
18	New workforce solutions to be proposed which mitigate some of the workforce issues and challenges in service delivery, including opting for peer support and other VCSE workers to be more integrated within statutory service
19	Identify opportunities for services (statutory and VCSE) to better align and review options for drop-ins and out of hours e.g. crisis cafes
20	Develop a CAMHs investment plan to increase service capacity and close any identified gaps
21	Use CYP MH Charter Group to agree and design processes for achieving a joined up system wide approach of support for CYP

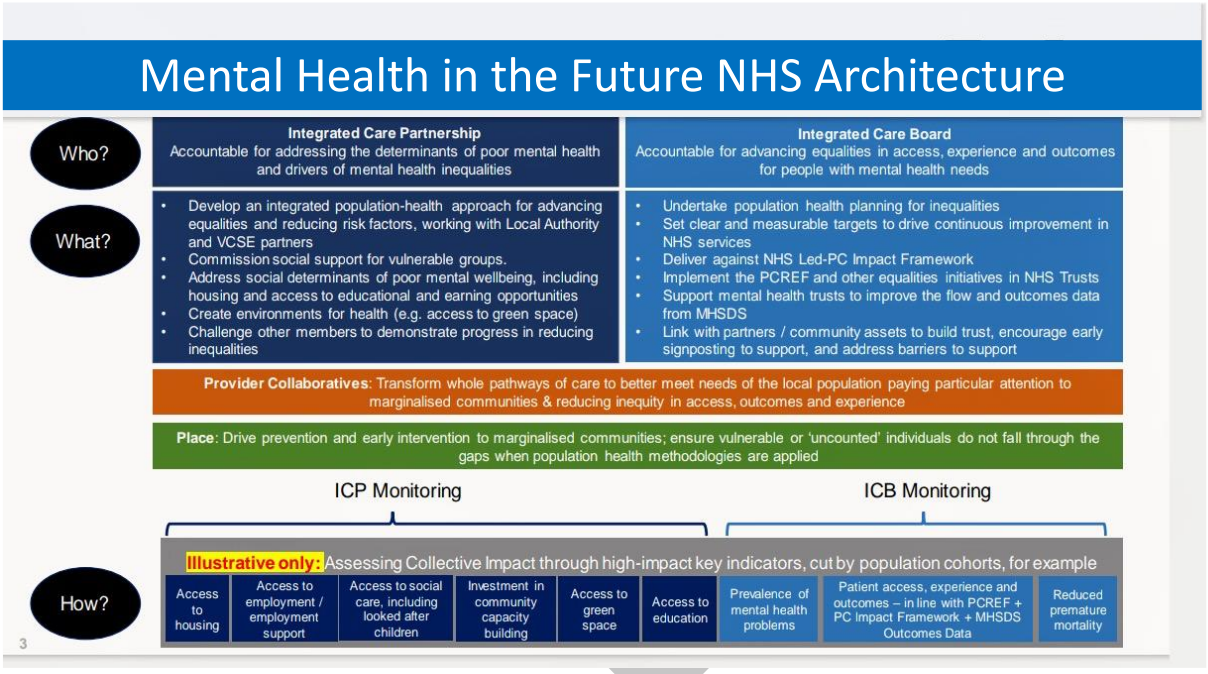
7 Governance

7.1 From 1 July, delivery of the NHS Long Term Plan for MH/LDA priorities will be transferred to the GM Provider Federation Board and MH LPCs, overseen by the system GM Mental Health, Learning Disability and Autism Partnership Board.

7.2 The national decision making map below shows the flow of decisions and accountability within an integrated care system:

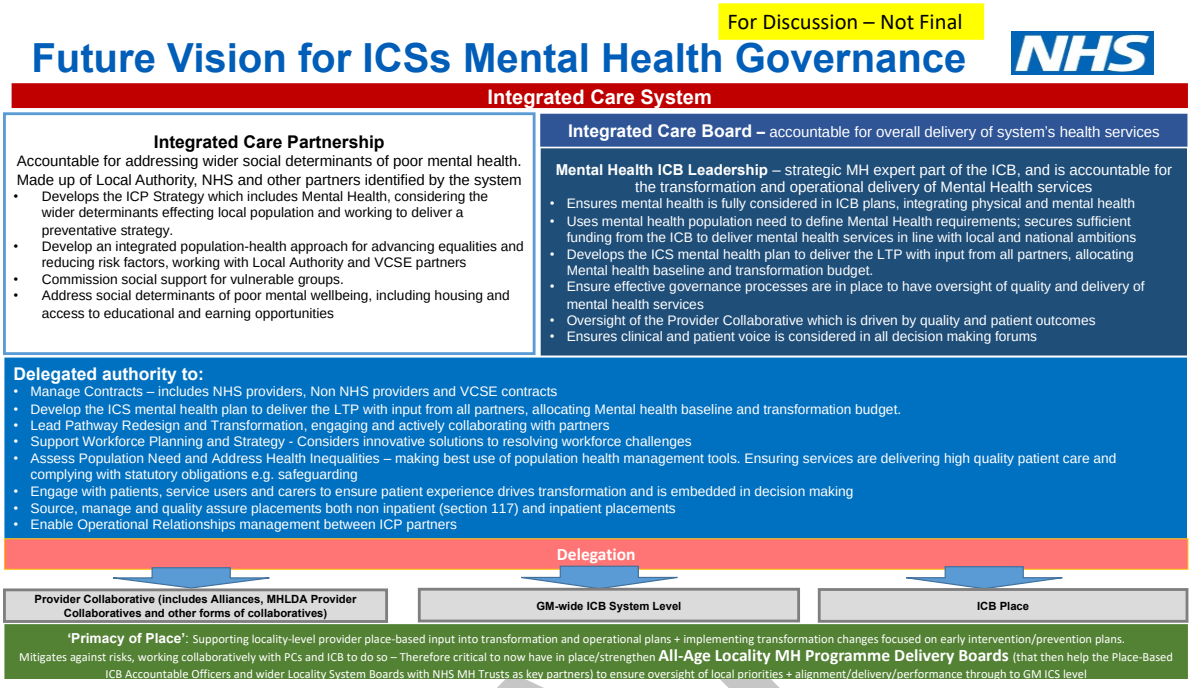


7.3 The proposed future NHS architecture for mental health is likely to be similar to the following diagram

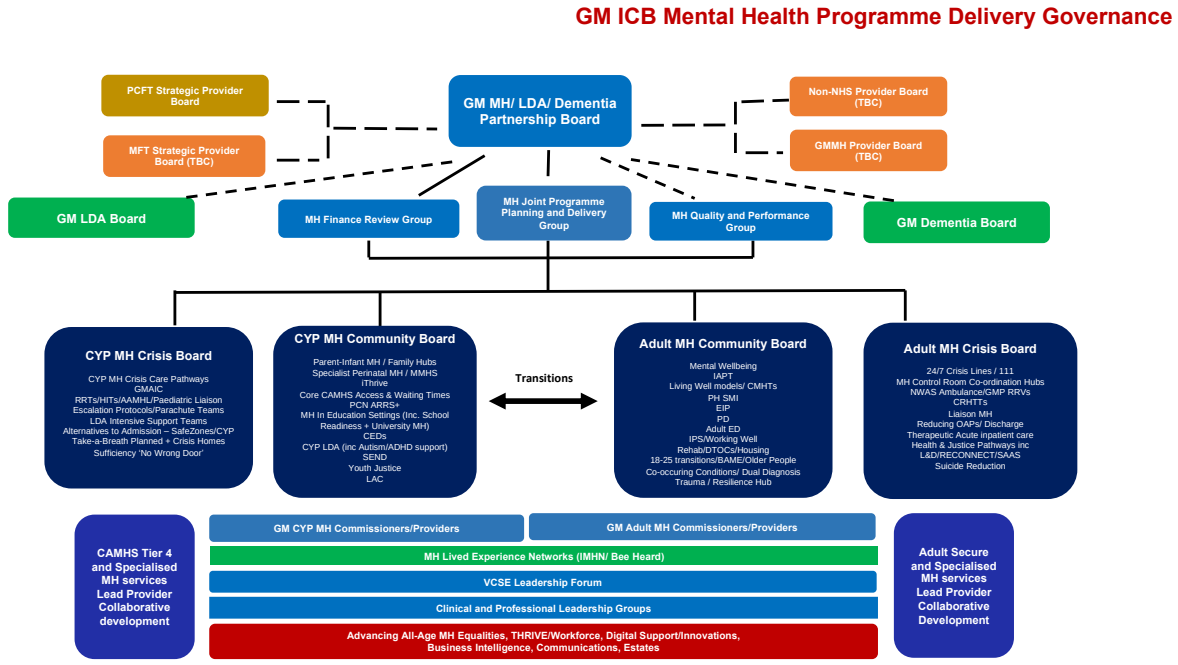


7.4 The details for where mental health decisions will be made are still being worked through, however it seems clear that decisions will be made at the most appropriate level. Decisions that require a Bury specific response as there will be an impact on the borough as a whole or specific neighbourhoods in particular will be made at the Bury Locality Board. Decisions on the configuration of statutory mental health services are likely to be made by providers at a GM level. However, given the integration of Bury social workers within some of these services Bury's locality board will need to be a partner in decision making at the GM level. 2022 - 2023 will be a transition year and governance arrangements will evolve and change during this time.\

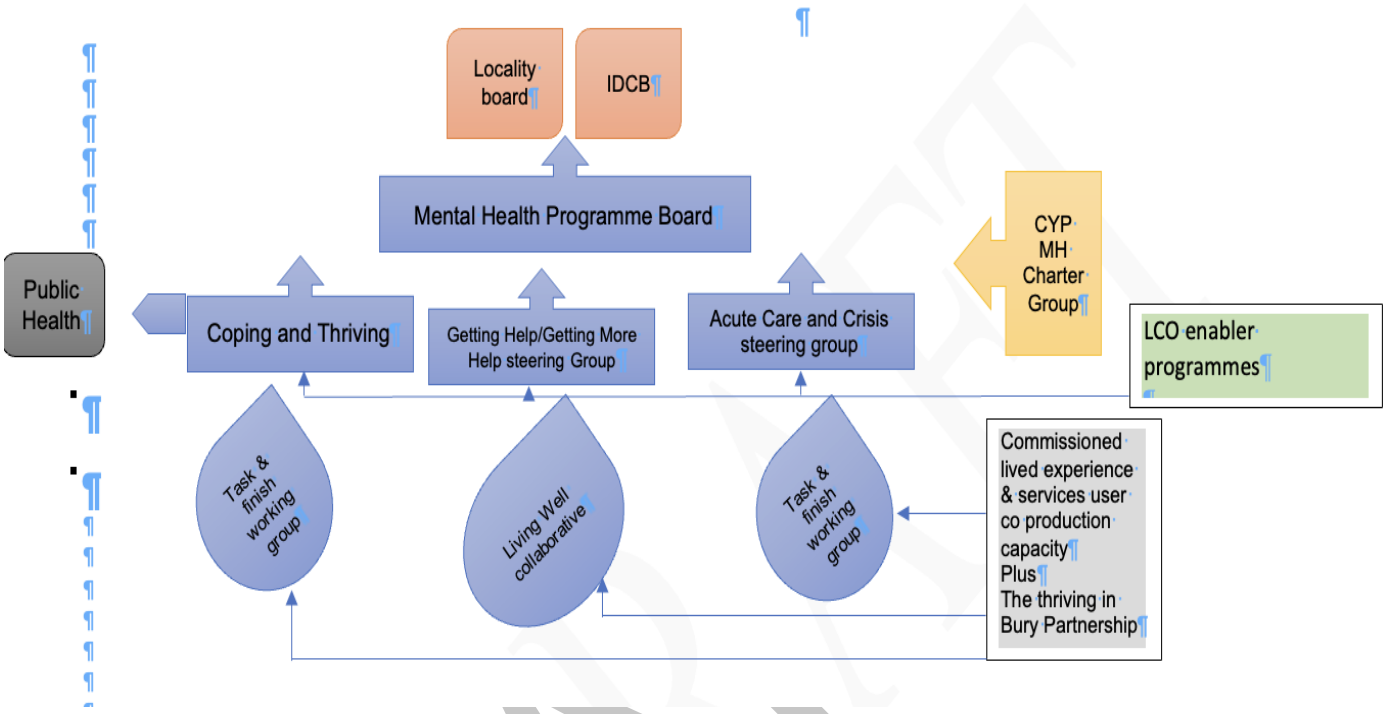
7.5 Currently the future vision for GMICS mental health governance is being describes as below, however this is still be discussed and may change over the next 12 months:



7.6 There have also been a range of boards and meetings set up to oversee the delivery of the GM mental health programme, which is shown below



7.7 A Mental Health Programme Board (MHPB) has been set up in Bury with the aim of overseeing the delivery plans that will be developed as a result of this strategy. The MHPB is a collaboration of partners from across Bury, including local NHS, Bury Local Authority, VCSE representatives and representatives from Pennine Care Foundation NHS Trust (PCFT).



Recommendations	
22	Get and maintain clarity about what is delivered at neighbourhood, locality and GM (noting this will change over time)

8 Financial Plan

8.1 With the establishment of the GM ICS, NHS funding will go directly to NHS providers based on their existing budget allocations. Additional monies, (some of which are already available) will also be made available to providers with details included as to what the money can be used for. Examples include system development funding (SDF) and additional roles reimbursement scheme (ARRS). Within Localities there will still be funding from the Local Authority and possibly other charitable funding from both national and local sources.

8.2 There is a need to develop a financial plan that will allocate resources to the proposed service developments that have been recommended within this strategy. Some proposals will be made within the individual service development plans where feasible, but these will need to be agreed and included within a wider plan. It is understood that there are no new funding streams available, and conversations will need to be had as to whether doing things differently will release funding that can be invested elsewhere and/or what might need to be decommissioned/stopped.

8.3 Available/existing budget

The agreed total NHS budget for mental health in Bury for 2022/23 is £39,336,424 and broken down accordingly

Ref:	Mental Health Investment Standard Categories	22/22 Plan
1	Children & Young People's Mental Health (excluding LD)	4,545,875
2	Children & Young People's Eating Disorders	202,138
3	Perinatal Mental Health (Community)	489,208
4	Improved access to psychological therapies (adult and older adult)	3,872,395
5	A and E and Ward Liaison mental health services (adult and older adult)	1,233,836
6	Early intervention in psychosis 'EIP' team (14 - 65yrs)	770,997
7	Adult community crisis (adult and older adult)	1,544,487
8	Ambulance response services	0
9a	1. Community A – community services that are not bed-based / not placements	7,385,504
9b	2. Community B – supported housing services that fit in the community model, that are not be delivered in hospitals	761,135
20	Mental Health Inpatient Re-hab (Complex Placements)	3,823,707
10	Mental Health Act	1,498,997
11	SMI Physical health checks	0
12	Suicide Prevention	7,383
13	Local NHS commissioned acute mental health and rehabilitation inpatient services (adult and older adult)	7,402,701
14	Adult and older adult acute mental health out of area placements	653,090
	Sub-total - MHIS (exc CHC, Prescribing, LD & Dementia)	**34,191,454**
16	Mental health prescribing	0
17	Mental health continuing health care (CHC)	0
	Sub-total - MHIS (inc CHC, Prescribing)	**34,191,454**
	Learning Disability	15,091
	Autism	300,582
18	Learning Disability & Autism - not separately identified	3,112,529
	Learning Disability & Autism (LD&A) (not included in MHIS) - total	**3,428,202**
19	Dementia	290,849
	Sub-total - Learning Disability and Autism & Dementia	**3,719,050**
	Total - Mental Health Services	**37,910,504**
	Non-MHIS MH Allocations excluded on non-ISFE	0
	Non-MHIS Non recurrent funding/balancing fig	1,425,920
	Sub-total - non -MHIS	**1,425,920**
	Total - Mental Health Services	**39,336,424**
	Budget setting	**39,336,424**

In 2020/21 Bury Local Authority spent approximately £5,430,607 on mental health provision [awaiting updated figures]

Type of Spend	Council Expenditure
Residential Care	£2,226,092
Nursing Care	£269,656
Supported Living	£1,838,858
Direct Payments / Personal Health Budgets	£388,031
Residential Respite Care	£278,229
Residential Respite Nursing Care	£3,006
Care at Home – complex / community support	£188,610
Domiciliary care	£59,334
Employment Support and Training	£13,220
Day Care	£2,829
Advocacy Services	£155,000
Other community services	£7,742
Total for FY2020/21	**£5,430,607**

SDF monies

Funding for the three years to 2023/24

Programme	21/22 SDF +SR Actual	22/23 SDF Actual	23/24 SDF TBC
CYP incl ED & 18-25 Adults	£8,881	£5,880	£9,688
MH Support Teams	£5,590	£8,670	£10,528
Adults Community SMI	£10,126	£16,678	£20,656
Other Adults -including Hubs + Crisis	£5,601	£4,720	£5,191
LD & Autism SDF	£4,786	£5,128	TBC
Discharge Planning, IAPT, Dementia	£10,167	TBC	TBC
Sub Total	**£45,151**	**£41,076**	**£46,063**
Additional confirmed MH SDF- Feb 22	£0	£1,585	TBC
Total	**£45,151**	**£42,661**	**£46,063**

Notes

1. Programmes are grouped to allow a more meaningful comparison across years.
2. SR funding in 21/22 was to bring forward 22/23 SDF. Programmes funded by SR will be funded recurrently through SDF and MHIS in 22/23 and subsequent years.
3. In 21/22 GM received £1.8m SR for IAPT. Funding after 21/22 is through MHIS. The NHS Analytical Tool requires additional funding to deliver LTP

IAPT Ambitions through CCG/ICS baselines of £5m in 22/23 and a further £7m in 23/24.

4. Further national Discharge Planning funding may be available in 22/23, but the quantum will not be known until later in the year.
5. SDF income will flow from NHSE to Trafford CCG.
6. MHSTs is still to be confirmed - discussions are in process with NHSE to agree GM "fair-share" percentage allocation. However, the amount in dispute is not material enough to impact on 22/2 mobilisation plans.
7. GM recently received an additional £1,585k: CYPED-£283k, CYP acute support-£331k, SMI Outreach-£678k, CYP ARRS/Primary Care-£283k, and Perinatal-£10k.
8. A reconciliation at Q1 will support the CCG transfer to the GM ICS. Reporting will be to FRG, Partnership Board and other relevant governance groups.

Summary of 2022/23 funding allocation to providers

Programme Areas SDF	GMMH	PCFT	MFT	Non-NHS / TBC	Total
CYP MHLDA Community & Crisis/18-25	£1,032	£2,929	£2,509	£1,300	**£7,770**
MH SDF Adult MH Community Transf'n	£6,661	£4,258	£0	£6,934	**£17,853**
Other MH SDF	£792	£1,831	£0	£12,141	**£14,764**
Support & Infrastructure Costs @ 2.5%	£0	£0	£0	£906	**£906**
TOTAL ALL	**£8,485**	**£9,018**	**£2,509**	**£21,281**	**£41,293**

1. This first plan does not take account of recently confirmed additional SDF of £1,585k.
2. The £21.3m identified as "Non-NHS/TBC" includes funding not yet allocated. For example, the £8.67m for MHSTs, which are currently progressing cost plans for 22/23 and subsequent years.

Recommendations	
23	Agree specific finance reporting process to ensure clarity at a borough/locality level so that service developments can be planned and delivered within realistic timescales
24	Establish what is needed at a locality level re finance to implement all the above recommendations and wider strategy/delivery plans. I.e. How is money released and distributed in accordance with agreed plans and who monitors?
25	Establish and secure a shared strategic accountant within the Integrated Delivery Collaborative (IDC) (with has access to all stakeholder finance plans) for the implementation of recommendations 22-24 of this strategy