AGENDA FOR

HEALTH SCRUTINY COMMITTEE

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To: All Members of Health Scrutiny Committee

Councillors : E FitzGerald (Chair), S Haroon, N Frith, C Boles, L Ryder, M Rubinstein, I Rizvi, L McBriar, R Brown, D Duncalfe and K Simpson

Dear Member/Colleague

Health Scrutiny Committee

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

Date:	Thursday, 19 June 2025
Place:	Council Chamber, Town Hall, Bury, BL9 0SW
Time:	7.00 pm
Briefing Facilities:	If Opposition Members and Co-opted Members require briefing on any particular item on the agenda, the appropriate Director/Senior Officer originating the related report should be contacted.
Notes:	

AGENDA

1 APOLOGIES FOR ABSENCE

2 DECLARATIONS OF INTEREST

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

3 MINUTES OF THE LAST MEETING *(Pages 5 - 14)*

The minutes from the meeting held on 20th March 2025 are attached for approval.

4 PUBLIC QUESTION TIME

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

5 MEMBER QUESTION TIME

A period of up to 15 minutes will be allocated for questions and supplementary questions from members of the Council who are not members of the committee.

6 HEALTH AND CARE UPDATE *(Pages 15 - 28)*

Presentation from Will Blandamer, Deputy Place Based Lead - NHS GM (Bury) and Executive Director, Health and Adult Care - Bury Council attached.

7 NHS STRUCTURAL CHANGES UPDATE *(Pages 29 - 64)*

Will Blandamer Executive Director (Health and Adult Care) to support.

NHS Restructure paper

Appendix 1 Model ICB blueprint

Appendix 2 NHS Reform slides

8 ADULT SOCIAL CARE PERFORMANCE QUARTER FOUR REPORT 2024/25 *(Pages 65 - 122)*

Councillor Tamoor Tariq, Cabinet member for health and adult care to present the papers, Within the papers are,

Performance report
LGA Peer Review

Along with a verbal update about where we are in the process for the CQC inspection

9 FORWARD PLANNER *(Pages 123 - 128)*

Forward planner report attached to be used for discussion around items for the forthcoming municipal year.

10 STANDING ITEM CHAIRS UPDATE

Standing item verbal update following GMCA health scrutiny meeting, to be provided by the Chair Councillor E Fitzgerald

11 URGENT BUSINESS

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

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Agenda Item 3

Minutes of: **HEALTH SCRUTINY COMMITTEE**

Date of Meeting: 20 March 2025

Present: Councillor E FitzGerald (in the Chair)
Councillors C Boles, J Grimshaw, R Brown, D Duncalfe, J Lancaster, L Ryder, N Frith, R Gold, M Rubinstein and D Berry

Also in attendance: Councillor R Bernstein
Will Blandamer Executive Director for Health and Adult Care
Adrian Crook Director of Community Commissioning Department for Health and Adult Care
Salina Callighan Head of Medicines Optimisation in Bury
Jo Aldham from NHS
Fin McCaul Pharmacy First
Kath WynneJones Chief Operating officer, IDCB
Clare Postlethwaite (NHS Greater Manchester)

Public Attendance: No members of the public were present at the meeting.

Apologies for Absence: Councillor M Walsh

HSC.40 APOLOGIES FOR ABSENCE

Apologies for absence are listed above.

HSC.41 DECLARATIONS OF INTEREST

There were no declarations of interest.

HSC.42 MINUTES OF THE LAST MEETING

The minutes of the meeting held on 29th January 2025 were agreed as an accurate record.

HSC.43 PUBLIC QUESTION TIME

There were no public questions.

HSC.44 MEMBER QUESTION TIME

There were no member questions.

HSC.45 LOCALITY PLAN

To reflect the inclusion of children's health within the Bury Locality Plan, members of the Children and Young People's Committee were invited to join this item. The Locality Plan is scheduled to be presented to the Locality Board in April. This Committee has been asked by the GMCA Health Scrutiny Committee to review the local document in the context of the Greater Manchester Sustainability Plan for the next five years.

Members were expected to have reviewed the presentation in advance of the meeting.

Will Blandamer, Executive Director for Health and Adult Care, supported by Kath Wynne-Jones, Chief Operating Officer of the Integrated Delivery Collaborative Board (IDCB), presented the item.

Will Blandamer provided an overview of the presentation, noting that the Locality Plan is due to be submitted to the Locality Board, which is chaired by Dr Cathy Fines and the Leader of the Council. He emphasised that what happens in GP practices has a direct impact on outcomes and opportunities for children, and that the plan offers a comprehensive overview of the health and care system, including urgent care and other key areas across the year. He stressed the need for a strategy that supports both transformation and business-as-usual operations.

The Bury Locality Plan is embedded within the broader "Let's Do It" strategy and reflects the integrated care partnership model shared across all ten Greater Manchester localities. The plan identifies four key priorities, which are detailed in the presentation slides, and includes references to health checks in primary care and the growing demand within the community. Will acknowledged the ongoing challenges, describing the current situation as unsustainable for residents. However, he highlighted progress in neighbourhood working, with five integrated neighbourhood teams and community children's services now working together effectively.

This integrated model is seen as a cornerstone of the plan and is well advanced. He drew attention to page 18 of the presentation pack, which outlines key challenges in Bury. These include the need to build greater confidence in the first 1,000 days of a child's life and to strengthen operations around SEND services. While there are still gaps in mental health provision, investment is beginning to close those gaps. The plan also focuses on ensuring that primary care services are equipped to deliver early intervention and that services are co-designed with people who have lived experience.

The plan aligns with the "Let's Do It" strategy and recognises the vital role of the voluntary sector in supporting health and wellbeing. Will also noted challenges around clinical sustainability and the need to consider changes to the configuration of local hospital services, particularly in relation to critical mass and clinical specialisms. Urgent mental health needs, especially in children's services, were also highlighted.

Kath Wynne-Jones added that the team has developed a series of user case studies to illustrate the plan's ambitions and bring the strategy to life for both the population and the workforce. She shared examples including:

- **Brenda**, whose case focuses on menopause awareness and how community support can improve outcomes.
- **Muhammed**, whose case highlights the role of social prescribing and voluntary sector collaboration in supporting patients through GP practices.
- **Jack**, an older adult experiencing frequent falls, who now benefits from a care plan, pendant alarm, and support from rapid response neighbourhood teams.
- **Claire**, who is managing anxiety and depression while preparing for surgery and is receiving specialist community-based assessment and support.

These case studies were used to humanise the strategy and demonstrate its real-world application.

Will concluded the presentation by reiterating the importance of the locality plan and its alignment with broader GM priorities.

Councillor Tariq, Cabinet Member for Health and Adult Care provided further context, noting that the locality plan reflects discussions at the city-region level and is closely linked to work across the Integrated Care Board (ICB). They highlighted the importance of supporting young people through services such as SEND and children's social care, and acknowledged the ongoing challenges faced by local authorities. The recent changes to NHS England and the requirement for ICBs to reduce capacity by 50% were noted as significant, with questions raised about the potential impact on local services.

The Committee also discussed the need to refresh the health inequalities plan in line with the updated "Let's Do It" strategy. The locality plan includes key highlights from the recent LGA peer review, which described Bury's work as "outstanding." However, members acknowledged the ongoing pressures on the system and the need to continue delivering high-quality services despite these challenges.

Two key initiatives were highlighted:

1. **Work Well** – a programme linking health and local businesses to support employment and wellbeing.
2. **ADHD Services** – Bury's leadership in this area at the GM level, with strong national links and a focus on integrated care.

A question was raised about how the locality plan addresses non-clinical factors that influence health, such as the environment and community infrastructure. The example of the Trees Estate was cited, and the member asked how the strategy incorporates these wider determinants of health. In response, it was acknowledged that while the plan is primarily focused on service delivery, there is a growing recognition of the importance of environmental and social factors. The strategy aims to build stronger links with non-service providers and community assets to promote health and wellbeing more holistically.

Will Blandamer addressed the Committee on the broader context of NHS performance and sustainability. He noted that the health and care system particularly in areas such as mental health, primary care, and elective care is facing significant strain and is, in many respects, unsustainable. This challenge is directly linked to Priority 1 of the Bury Locality Plan. He explained that the Health and Wellbeing Board (HWBB) considers all determinants of health, including wider social and environmental factors.

The plan aims to connect NHS performance with community-level outcomes, including opportunities for physical activity and the role of the built environment.

A question was raised about the realism of the plan considering the 50% cuts to Integrated Care Boards (ICBs). Will responded that the recent announcement to abolish NHS England and reduce ICB capacity by half has created uncertainty. The ICB, as the commissioning body for NHS Greater Manchester, holds the budget and is responsible for orchestrating services locally. While the rationale for these changes may be to centralise control, the implications are not yet fully understood. Will acknowledged that a new operational model will be needed and that integration efforts to date have positioned Bury well. However, he cautioned that further guidance is awaited, and that the system is currently in a period of turbulence. Monthly meetings with the mayor and cabinet members across the ten localities are ongoing to address emerging budgetary challenges.

The Committee asked about the impact of these changes on the sustainability plan. It was confirmed that an update will be provided in April, which will clarify whether the changes involve service cuts or structural adjustments.
Concerns were raised about the implications for service users and the workforce.

A member referenced the positive experience with the falls team and questioned whether care plans are being regularly reviewed and monitored. Adrian Crook responded that Adult Social Care is monitored by a dedicated quality assurance team, with regular visits and oversight. He referenced the "State of the Care Sector" report, which shows that most agencies in Bury are rated good or better, placing the borough in the top quartile nationally. While the team cannot be everywhere at once, improvement actions are taken where needed.

The issue of GP shortages in Bury was raised. Will acknowledged that GP access remains a concern, particularly regarding face-to-face consultations. He explained that historical funding patterns have contributed to the current shortfall. Efforts are underway to make Bury a more attractive place to work, including offering additional payments and incentives to GP practices.

A question was asked about why childhood obesity was not explicitly mentioned in the locality plan, given the high levels of deprivation and the fact that 10% of reception-aged children are obese. Will clarified that childhood obesity is included in the full plan and is central to Priority 1, which addresses health inequalities. He emphasised the importance of physical activity and diet in tackling poverty-related health issues. Another member added that there had been extensive discussion around childhood obesity, including plans to pilot new support initiatives involving parents, schools, and community stakeholders.

The Committee also discussed the impact of delays in elective care, particularly in dentistry, on children's readiness for school. Will noted that only 60–70% of children had seen a dentist during the pandemic, and that this remains a challenge. He highlighted the role of neighbourhood teams and family hubs in supporting early intervention and linking services to children and young people.

A member raised the issue of screen time and its impact on children's health, asking how best to communicate this to parents. Will agreed to raise this with children's services and relevant stakeholders.

The discussion returned to the case study of Brenda, which focused on menopause awareness. A question was asked about how symptoms are being recognised and monitored, given the risk of misdiagnosis. Will committed to seeking a clinical response to this question.

Another concern was raised about communication with residents who are not already engaged with services. It was noted that those within the system tend to receive better support. Will acknowledged this and said that efforts are being made to proactively reach out to residents through GP practices and the Bury Directory. He noted that while there is no formal communication plan for the locality plan, work is ongoing with communications leads to improve outreach.

The usefulness of the case studies was praised, but it was noted that none of them featured children. A member asked how co-production with children and parents could be improved. Will agreed that this was a valid point and acknowledged the need for more systematic co-production. He referenced the work of the SEND Partnership Board and various co-production groups but accepted that more could be done to include children's voices in the planning process.

Finally, a member summarised two key challenges: the need to build greater confidence in the first 1,000 days of a child's life, and the need for a strengthened NHS response to the operation of the Bury SEND Partnership. These were identified as areas requiring focused attention and practical action.

It Was Agreed:

- The presentation be noted

HSC.46 YOUR MEDICINE MATTERS

Salina Calighan Head of Medical Optimisation in Bury provided an overview of the campaign, emphasizing its importance in reducing delays and ensuring effective use of medications to avoid waste and improve patient care. She highlighted the need to stop stockpiling medicines and the impact of small details on patient outcomes.

Jo Aldham Programme Manager for Greater Manchester Pharmacy Programme discussed the existing infrastructure and policies, such as drug lockers and patient stores, and the benefits of utilizing these resources to minimize waste and reduce costs. The project is subsidized by the NHS and addresses medicine shortages. Jo mentioned that an audit was conducted to ensure the right medicines are available for discharge, reducing the need for new supplies.

Emphasis was placed on using existing medicines to avoid waste and the risk of medicines going unused. Updating records around repeat prescriptions is crucial to minimize waste and improve patient care. Nurses and pharmacies are encouraged to ensure medicines are used up and records are updated when patients go home.

Councillor Boles inquired about the challenges in the next three months. Jo Aldham responded that the main challenge is engaging with residents and ensuring they are aware of the campaign. Patients and family members need to be informed and encouraged to participate. Jo emphasized the importance of secondary care providers and wider communications to continue promoting the campaign.

Councillor Lancaster asked about engagement with GPs and the role of local councillors. Jo Aldham mentioned the implementation group and another board that will be involved when the campaign is ready. Primary care boards will also be engaged, and campaign materials will be circulated to the committee. Councillor Ryder shared positive feedback about the system based on personal experience, highlighting its effectiveness.

Jo Aldham discussed the difficulties with timely availability of medicines in care homes and the steps being taken in pilot projects to address these issues. The MARS chart and baby steps with the pilot are aimed at ensuring the majority of patients receive timely medication.

Councillor Fitzgerald expressed support for the campaign and the committee's role in promoting it. He inquired about additional support and resources. Adrian Crook mentioned the availability of a toolkit to support the campaign, which will be promoted to ensure effective implementation.

The campaign aims to improve the efficiency of medicine use, reduce waste, and enhance patient care through better engagement and communication with healthcare providers and the community. The committee expressed strong support for the campaign and its objectives.

It Was Agreed:

- The report be noted
- Circulate campaign materials to the committee.
- Continue engagement with residents, patients, and family members.
- Promote the campaign using the available toolkit.

HSC.47 PHARMACY FIRST

Fin McCaul presented an update on the Pharmacy First initiative and its implementation across the Bury locality. He began by thanking the Committee for reviewing the presentation in advance. He noted that although the programme had a slow start in January 2024, it has since gained momentum, with increasing consultations across seven clinical conditions, including hypertension. Collaboration with GPs has been key to this growth.

He referred to slides 63 to 65, which demonstrated that Bury had achieved one of the highest completion rates across primary care boards. Slide 68 highlighted the initiative's role in protecting public health during challenging times, with no increase in costs and stable core finances. Page 69 outlined the advice provided across Greater Manchester, showing consistency in delivery and uptake.

A question was raised about the variation in referral rates between practices, specifically whether lower-performing practices were simply not engaging or whether the higher-performing ones were significantly larger. Fin responded that both factors could be contributing. Some practices may not yet be fully utilising the service, while others, despite their size, may face internal barriers. He acknowledged that further analysis is needed to understand these discrepancies.

Another member asked how residents could better access the service and why awareness remains limited. Fin explained that while the service is accessible, it is transitioning from a walk-in model to an appointment-based system to manage capacity more effectively. He agreed that awareness needs to improve and committed to sharing a communications pack with the Committee to support local promotion efforts.

Concerns were raised about public confidence in pharmacists' ability to prescribe. In response, Fin assured the Committee that pharmacists undergo extensive training, including a four-year university degree followed by a foundation year. Only after this are they qualified to prescribe. He added that patient feedback has been positive, and that cultural change is underway, though it takes time.

A member shared a positive personal experience with Pharmacy First and asked how awareness could be expanded beyond word of mouth. Fin noted that NHS England has been involved in advertising the service and that a bedding-in process is ongoing at the Greater Manchester level to ensure consistent messaging and uptake.

There was a question about whether the initiative was designed to relieve pressure on GPs and whether pharmacists have the capacity to take on this additional workload. Fin confirmed that reducing GP pressure was a key goal. He stated that while capacity exists, the service is currently only 50% funded, which limits its full potential. He emphasized the need to move towards appointment-based models to ensure efficiency and avoid overburdening staff. Concerns were expressed that if the service is not run efficiently, it could become counterproductive. Fin acknowledged this risk and stressed the importance of sustainable funding and operational planning.
Another concern was raised about the increasing workload placed on pharmacists and the risk of burnout, especially given that they are not being fully compensated. There was also worry that the sector could be pushed towards privatization or bankruptcy. Fin responded that pharmacists are currently being paid only 50% of what is owed under the national contract.

He emphasized that while pharmacists are not unhappy with the work itself, the financial model is unsustainable. He reiterated that pharmacists are highly trained professionals whose role is to ensure patients receive the most effective treatments. However, without changes to national policy and funding, the viability of community pharmacies is at risk. He also noted a

worrying trend of pharmacy closures and the rise of online-only providers, which do not offer the same community presence.

Finally, a question was asked about what local representatives can do to support the initiative and help raise awareness. Fin confirmed that a communications pack would be shared with the Committee to assist in promoting the service within local communities.

It Was Agreed:

- The presentation be noted
- Fin be thanked for the update and the committee provided support of the initiatiive

HSC.48 LGA UPDATE

Adrian Crook was invited to present an update on the new CQC inspection framework and the outcomes of the recent LGA peer challenge. The Committee had previously received updates on the new framework earlier in the year and had been kept informed of developments since. The Chair opened by thanking Adrian and his team for their continued efforts and dedication, particularly noting the positive comments about staff in the presentation. Appreciation was expressed for the hard work being done across the service.

An overview of the LGA peer review process was provided. The review team, made up of professionals from across the country, recognised that staff are the service's greatest asset. It was noted that, for the first time in a long while, the service has a full complement of leadership, practitioners, and social workers. This was acknowledged during World Social Workday, and the support provided by Adrian Crook and Sue Massel was highlighted.

The review also praised the contributions of individual staff members, including a senior social worker from Bolton and a newly appointed social worker from Tameside, both of whom were commended for their ability to manage multiple roles effectively. The integration of health and care services in Bury was described as outstanding and among the best seen nationally. The peer review was seen as timely, particularly in light of the upcoming CQC inspection.

It was noted that Bury could have been subject to intervention but instead is now well-positioned, with strong foundations and a clear direction. Only 27 councils remain to be inspected in the next six months and Bury is considered well-prepared. The feedback received during the review was described as emotional and affirming, with leadership across health services present and engaged in the process.

Verbal feedback from the review team was described as the best received in recent years. The final report is expected within the next few weeks, and work is already underway to implement the recommendations, which are considered achievable before the CQC inspection.

Adrian Crook added that staff are proud to work in Bury, with only four vacancies currently open. He emphasised that the level of integration achieved is exemplary, and that the team has travelled extensively to learn from best practices across the country. The peer review confirmed that Bury's collaborative approach is among the best observed.

Page 89 of the report highlighted the strength of political leadership, noting the skilled cabinet member, cross-party support, and the high regard in which the scrutiny committee and its chair are held by the independent peer reviewers.

A member expressed appreciation for the staff's efforts and reiterated the importance of transparency in reporting. They emphasised that the Committee should continue to receive updates on both successes and areas for improvement, to avoid any surprises and maintain public confidence.
Another member thanked Adrian for the report and acknowledged the hard work of the team.

A question was raised about safeguarding practices and whether there is sufficient awareness of safeguarding pathways. Adrian responded that the integrated neighbourhood teams had previously included a specialist safeguarding team, which has since been restructured. This change has been identified during the discovery phase, and the service is now moving into the design phase to address it. He acknowledged that some staff have moved into different teams but assured the Committee that the service is self-aware and actively addressing the issue.

Further discussion focused on the clarity of access to adult social care services. A member asked how the pathways could be made clearer. Adrian explained that one of the benefits of integration is the potential to simplify access but acknowledged that the current system has too many entry points. The digital access experience is not yet satisfactory, and improvements are needed to streamline the process and enhance the website.

A final question asked whether anything in the peer review findings had surprised the leadership team. Adrian responded that there were no major surprises, as the team is closely involved in all aspects of service delivery. However, one comment regarding care providers was particularly reassuring, as it confirmed that the service is not overlooking any critical areas.

The Committee noted the report and expressed pride in the achievements of the staff. Members agreed that the service is in a strong position ahead of the CQC inspection and commended the leadership for their proactive approach. The Committee wished the team continued success and reaffirmed their support moving forward.

It Was Agreed:

- The update be noted
- Adrian and the team be thanked for their hard work

HSC.49 WHITEFIELD HEALTH CENTRE RE-DEVELOPMENT PROPOSALS

Clare Postlethwaite was invited to present an update on the progress of the programme, particularly in relation to national funding and local implementation. The Chair opened by thanking Clare for the presentation and invited any additional comments from other members.

Clare provided an overview of the report, highlighting that national funding has now been agreed, which marks a significant and positive milestone for the programme. She described the current position as encouraging and full of opportunity, with key steps having been taken to secure NHS England funding. This funding agreement has now been signed, and the team is working through the necessary transactional processes with GP practice accounts. While there are some minor differences in how these are being handled, they are expected to be resolved by year-end.

She also confirmed that the lease agreement has been finalised, and the capital funding has been secured. Although there are still some risks to manage, Clare emphasised the importance of articulating these clearly. The construction team is expected to be on site by

September, and while there is still work to be done, the overall update was described as very positive.

A question was raised about the status of agreements with GP practices. Specifically, it was asked how the process of getting these agreements signed is progressing. Clare responded that the agreements have largely been signed and that the team is now working through the financial and administrative aspects with individual practices. She acknowledged that there are slight variations in how practices are managing this but confirmed that the process is on track and being actively supported.

Will Blandamer added a note of appreciation, stating that Clare has been outstanding in her role and is fully aware of the issues involved. He thanked her for her dedication and effective leadership throughout the process.

The Committee noted the report and expressed appreciation for the progress made. Members acknowledged the significance of the funding agreement and the positive trajectory of the programme. The Committee extended thanks to Clare and the wider team for their continued efforts and looked forward to further updates as the project moves into the construction phase.

It Was Agreed:

- The update be noted

HSC.50 CHAIRS UPDATE ON COMMITTEES

The Chair started the update by informing members of a change in role, having moved from Vice Chair to Chair of the GMCA Health Scrutiny Committee following the resignation of the previous Chair.
The Chair provided a summary of the March GMCA Health Scrutiny Committee meeting, which covered several key areas:

Elective Recovery
The Committee received an update on elective recovery across Greater Manchester. Members were asked to recognise the progress made in reducing the number of long-waiting patients and to support cross-cutting system programmes aimed at improving access. It was noted that waiting times over 18 weeks had been rising prior to the pandemic, increasing from 194,000 in 2015 to 284,000 in 2020, and reaching approximately 500,000 during the pandemic. This figure has since stabilised.

Greater Manchester has made significant progress in reducing the number of patients waiting over 18 months, down from 15,000 in 2022. The current focus is on ensuring patients begin treatment within 18 weeks. As of November 2024, Greater Manchester was achieving this for 54% of patients, placing it fourth lowest nationally. The government target is to reach 92% by 2029. The Committee noted that variation exists across localities and treatment types. Initiatives to support recovery include the development of a single point of access for referrals, the establishment of a GM-wide specialist service to support Primary Care, expansion of community services, and the optimisation of surgical hubs and Community Diagnostic Centres.

Major Trauma Centres Review
The Committee received a briefing on the review of Greater Manchester's Major Trauma Centres. Approximately 1,600 people in the region experience major trauma annually. The two designated centres are Salford Royal and Manchester Royal Infirmary. The review follows a national peer review in September 2024 and aims to ensure the best patient outcomes while making optimal use of resources. The site selection process is ongoing.

Service Reconfiguration Updates
Updates were provided on the reconfiguration of ADHD services for both adults and children. NHS England has approved the options appraisal for Adult ADHD services, with public consultation expected in July 2025. Children's ADHD services are currently progressing through governance for implementation.

The review was prompted by a significant increase in ADHD diagnoses, attributed to improved understanding and broader diagnostic criteria. The Committee noted the need to move away from the current "first come, first served" model and towards a system that prioritises those with the most severe needs. The proposed model includes single points of access in each locality, local hubs for support, and a focus on practical interventions. Officers highlighted the importance of face-to-face assessments and the need for early intervention. Engagement with families and young people has been extensive, and the approach aligns with national recommendations.

Action: The Committee agreed that this update should be shared with the Children's Committee.

Other Reports
The Committee also received updates on Dentistry, Pharmacy, and Urgent Treatment Centres and Emergency Access.

NHS GM Sustainability Plan
The Chair raised a question regarding the future of the NHS Greater Manchester Sustainability Plan in light of recent announcements about the closure of NHS England, significant cost reductions required by NHS GM, and back-office cuts across NHS Trusts. The Committee was informed that it is too early to determine the full impact of these changes. A briefing is expected at the April GMCA meeting. Members were invited to submit any specific concerns to GMCA governance officers by Tuesday, 25th March.

Future Planning
The Chair noted interest in developing a Greater Manchester-wide consultancy service focused on innovation. Further details will be developed in due course.

HSC.51 URGENT BUSINESS

There was no urgent business.

COUNCILLOR E FITZGERALD
Chair

(Note: The meeting started at 7.00 pm and ended at 9.15 pm)

Bury Integrated Care Partnership
The Role of Health Scrutiny,
and The Health and Care System in Bury

Bury Health Scrutiny Committee 19th June 2025

6

Will Blandamer
Deputy Place Based Lead - NHS GM (Bury)
and Exec Director, Health and Adult Care - Bury Council

Part of Greater Manchester Integrated Care Partnership

1. Health Scrutiny

Role of Health Scrutiny

The role of Health Scrutiny is to:

- review and scrutinise matters relating to the planning, provision and operation of the health service in the area.
- require information to be provided by certain NHS bodies about the planning, provision and operation of health services
- require employees, including non-executive directors of certain NHS bodies, to attend
- make reports and recommendations to certain NHS bodies and expect a response within 28 days
- set up joint health scrutiny and overview committees with other local authorities
- have a mechanism in place to respond to consultations by relevant NHS bodies and relevant health service providers on substantial reconfiguration proposals
- have a mechanism in place to deal with referrals made by local Healthwatch

Since the establishment of Integrated Care Boards and wider Integrated Care Partnerships in 2022, the Department of Health and Social Care suggests scrutiny committee can be proactive and constructive scrutiny of health, care and public health services, done effectively, can build constructive relationships that deliver better outcomes for local people and communities

In Bury we do not have a separate committee for scrutiny of adult care and/or public health

2. How the Health and Care System Works in Bury

Players – its complex!

BURY INTEGRATED CARE PARTNERSHIP

- Bury Council – Adults, Childrens, Public Health and other departments
- Northern Care Alliance (inc. Fairfield General, and Community Health Services)
- Pennine Care Mental Health Trust
- Manchester Foundation Trust
- Bolton Foundation Trust (mostly maternity) and other NHS Trusts (e.g Christie)
- NHS Greater Manchester – Centrally, and the local NHS GM (Bury) team
- Primary Care Providers – GPs/pharmacists/dentists/optometrists
- Private providers of health services , and care services for adults and children
- VCFA and wider Voluntary Sector
- Bury Healthwatch
- Persona – Wholly owned by the Council provider of Adult Care services
- Bury Hospice
- and other statutory and voluntary and private services

The Bury Integrated Care Partnership

- We have a duty to understand all parts of the operation of the health and care system in Bury on behalf of our residents. This is because:
  - Bury people access lots of different services sometimes at the same time
  - It is a system with a complex set of interdependencies
  - The success of one part of the system is often determined by other parts of the system.
- The **Bury Integrated Care Partnership** describes the joint work of key partners in Bury to manage and transform the health and care system in Bury and to provide better outcomes for residents.
- It is a partnership of sovereign organisations bound together by a commitment to improve health and well being and the health and care system for Bury people, and to work well together
- We have a meeting of senior leaders from all partners to the Bury Integrated Care Partnership - **The Locality Board**. It is Chaired by the Leader, and by Dr Cathy Fines a senior Bury GP and Associate Medical Director of NHS GM (Bury).
- The meeting sets strategy and seeks assurance on the operation of the system and ets the tone of the way in which we work together as partners.
- The Locality Board also has some specific duties delegated to it from the Greater Manchester Integrated Care Board

4 Clear Priorities (as per Locality Plan)

BURY INTEGRATED CARE PARTNERSHIP

We work together across the Bury Integrated Care Partnership to :-	
1	Scale our work on Population Health Management - Improve population health and reduce health inequality of those in the most disadvantaged areas
2	Drive prevention, reducing prevalence and proactive care – supporting Demand Reduction through primary intervention, secondary preventions and tertiary prevention
3	Transforming Community Care in Neighbourhoods - fully realising the benefit of neighbourhood team working with a focus on the assets of residents and communities and providing proactive care
4	Optimise Care in institutional settings and prioritising the key characteristics of reform.

Programmes of Work

BURY INTEGRATED CARE PARTNERSHIP

- So we have established **10 programmes of work** where partners come together to understand 'Business as Usual' and to identify opportunities to improve outcomes and support more efficient and effective services.

- We manage all this together through an Integrated Delivery Board – reporting to the Localiyt Board

1. Urgent Care
2. Major Conditions including Cancer
3. Learning Disabilities and Autism
4. Complex Care
5. Mental Health
6. Primary Care
7. Adult Social Care Transformation
8. Ageing Well inc. frailty and dementia
9. Planned care and community services
10. End of Life and Palliative Care

Children and Young People

BURY INTEGRATED CARE PARTNERSHIP

- The borough will re-establish the Childrens Strategic Partnership Board – where those partners particularly focused on the circumstances of the youngest residents of the borough come together – childrens services in the council, NHS childrens services, schools and others.
- We use this as the delivery board for the health and care system for childrens services – so it is a ‘sister’ to the integrated delivery board.
- We are conscious that children appear in many other of our programmes (e.g urgent care, in primary care) and we work hard to connect it all together.
- There is a Childrens Improvement Board in the Councul responding particularly to the Ofsted judgmenet, and NHS partners contribute.
- We have also established the SEND Improvement and Assurance Board to respond to the CQC/Ofsted Judgement of May 2024 on the Council and on NHS GM about ‘widespread and systemic failure’ of the SEND system in Bury
- Deputy Place Lead attends the Health Childrens Scrutiny Committee as required, and the Chair of the Health Scrutiny Committee, and the Childrens Scrutiny Committee, attend each others meetings.

What it means for our service users and workforce

1. Population Health Improvement including reducing health inequalities.

Brenda, a 48-year-old lady is struggling to cope with life as she approaches the menopause. She is encouraged through social media to take more control of her own health and well being through menopause. She sees a local walking group advertised in her GP Surgery, and starts to attend which means she is getting outside, moving and meeting new people. She visits her GP Surgery less about her menopause challenges, however she receives a text alert to inform her of drop in sessions happening at the women's health hub which she finds very educational and supportive.

2. Prevention, reducing prevalence and proactive care

Mohammed is diagnosed with diabetes by his GP aged 68. His GP provides medication and lifestyle advice and refers him to the diabetes education programme which is culturally sensitive to his needs. They give him information on what diabetes is , how to manage is diet and other aspects of healthy living. His practice enroll him in the chronic disease monitoring programme and ensure that he receives that 8 processes of care the practice (including being enrolled onto the diabetes eye screening programme. They advise him that if any complexities arise he will be referred to the community diabetes service

3. Transforming the Model of Care in the Community through neighbourhood working and strong integration

Jack is 85 and is experiencing regular falls due his increasing frailty. Sometimes this necessitates him calling for an ambulance, and results in him staying in hospital for unnecessarily long periods of time due to the waits in A&E. Jack is referred to the Integrated Neighbourhood Teams who devise him a care plan in conjunction with his GP and the falls prevention team, and ensure he has a pendant alarm in place. If Jack falls, the falls lifting service respond to him instead of ambulance. If he has any medical needs, they seek the support of the rapid response and hospital at home service to keep him in his own home.

4. Optimising Care

Claire is 32 and has been waiting for a diagnostic procedure at the hospital for her joint pain, which leaves her unable to play with her child or exercise, and is causing her to gain weight and feel depressed. In the future, she will receive a specialist assessment the community who determine the diagnostics she needs, and will undertake them promptly in the community. If she needs further assessment, she will attend an outpatient clinic in the community and will undergo treatment in a timely manner if she needs it. She will receive advice on how to keep herself well whilst she is waiting.

Neighbourhood Working

BURY INTEGRATED CARE PARTNERSHIP

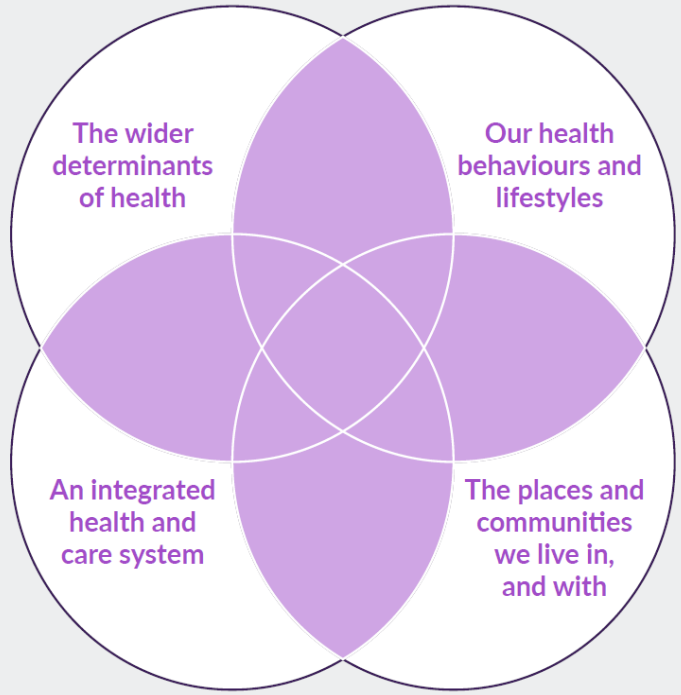
- We believe in creating opportunities for front line staff to know each other across different organisations, to work together more effectively, and to have a shared understanding of the assets of our communities.
- We have therefore built an integrated neighbourhood team in each of the towns in the borough – Prestwich, Whitefield, Bury, Radcliffe, and Ramsbottom (with Tottington)
- This currently includes adult care, community health services, and GPs, but we want to extend that to include other parts of the health and care system.
- A model of family hubs is being rolled out on this footprint to support children, young people and families
- We are also seeing the alignment of other public services on the same footprint and have established 'public service leadership teams' in each neighbourhood
- We have a detailed understanding of health needs of each neighbourhood in the neighbourhood profiles - https://theburydirectory.co.uk/neighbourhood-profiles

This map shows the wards included within each of Bury's five Neighbourhoods.

Population Health and Health Inequalities

BURY INTEGRATED CARE PARTNERSHIP

- Tackling health inequalities is a core priority of the Lets Do It Strategy for the Borough, and the Borough Locality Plan.
- We ask all of our programmes to ensure they understand and address inequality in access, treatment and outcome.
- But we also know that the health and care system is actually only one contributor to population health and health inequalities.
- So we have **charged the Health and Well Being Board** (a statutory committee of the council) to be a “standing commission” on health inequalities – to influence all the factors affecting population health that are within our control locally.
- The Health and Well Being uses the Kings Fund framework to define its work and to challenge partners in Bury to play their part.
- The public health team of the Council manage the business of the Health and Well Being Board under the leadership of the Director of Public Health
- We have a comprehensive Joint Strategic Needs Assessment available to all. https://theburydirectory.co.uk/jsna



Last year we reported to scrutiny on e.g:

BURY INTEGRATED CARE PARTNERSHIP

<u>In terms of Council Functions</u>

- Performance of Adult Care Services
- Progress on aspects of population health/public health improvement

<u>In terms of the NHS</u>

- Waiting Times for Elective Care
- Performance and access to GP services
- Urgent Care System
- Community Pharmacy
- Mental Health Services
- Reports from Healthwatch

8. Any questions

Health Scrutiny

Date: 19th June 2025

Subject: Our ambition for health and care in Bury in the Context of NHS Structural Change

Report of: Will Blandamer - Executive Director of Health and Adult Care – Bury Council, and Deputy Place Lead, NHS GM (Bury)

1.0 INTRODUCTION

1.1 The Bury Locality Board endorsed a refreshed strategy for the Health and Care systemin Bury at its meeting on 7th April. The Locality Plan describes a strategic ambition for the operation and improvement of the health and care system in Bury, and for improved population health and reducing health inequalities.

1.2 The Locality Plan is presented in the context of the revised Let's Do It Strategy for the Borough (2025), and in the context of the NHS Greater Manchester 3-year Sustainability plan (2025-2027)

1.3 This Locality Plan builds on a period of transformation and improvement in the operation of the health and care system in Bury since 2021. Progress has been built on high quality partnership working and a shared ambition for better outcomes for our residents. However, there is still more to do.

1.4 This plan outlines the next stage of our Health and Care reform journey, connected to the reform of wider public services and the economic ambition in the borough. The detail of the plan focuses on the first 12 months of delivery which includes the asks of the NHS operating plan for 25/26.

1.5 This Locality Plan outlines the current and forecast state of the health of our population, the policy context of this Locality Plan, and describes an ambition for the further reform of our health and care system and for the improved health of all people of Bury.

1.6 The Locality Plan highlights that improved outcomes for Bury residents and a clinically and financially sustainable health and care system is dependent on improved population health, improved prevention, transformed community care and the optimal delivery of health and care services.

1.7 Consequently, the Locality Plan identified 4 key priorities:

We work together across the Bury Integrated Care Partnership to :-	
1	**Scale our work on Population Health Management - Improve population health and reduce health inequality of those in the most disadvantaged areas**
2	**Drive Prevention, reducing prevalence and proactive care – supporting Demand Reduction through primary intervention, secondary preventions and tertiary prevention**
3	**Transform the Model of Care in the Community - fully realising the benefit of neighbourhood team working with a focus on the assets of residents and communities and providing proactive care**
4	**Optimise Care in institutional settings and prioritising the key characteristics of reform.**

2.0 NHS STRUCTURAL REFORMS – ANNOUNCED MARCH 2025

2.1 On 13th March, the Secretary of State for Health and Social Care announced that Integrated Care Boards (ICBs) across England would need to reduce their running costs by 50% by December 2025. Each ICB receives an allocation for 'running costs or administrative expenditure'. This sets the amount the organisation can spend on administrative, support and managerial staffing plus.

2.2 The Prime Minister also announced on 13th March that NHS England will be abolished with the majority of its functions expected to be adsorbed by the Department of Health and Social Care (DHSC). Administrative costs will we reduced at DHSC with a cumulative reduction of around 9,000 roles across NHS England and DHSC. There is an additional requirement for NHS provider trusts to reduce their corporate support costs.

2.3 A recent analysis of running costs for the 42 ICBs in England published by the Health Service Journal placed Greater Manchester ICB in the middle group of ICBs for our running costs in comparison to other ICBs.

2.4 A small amount of information has been released to date to follow on from the announcements. A letter from the Chief Executive of NHS England, Sir James Mackey of 1st April 2025 gave an early indication of the areas that ICBs will be expected to prioritise:

- The need to maintain some core staff, such as recently delegated commissioning staff and, in the short term until further options are considered, continuing healthcare staff
- The need to maintain or invest in core finance and contracting functions in the immediate term

- The need to invest in strategic commissioning functions, building skills and capabilities in analytics, strategy, market management and contracting
- The need to commission and develop neighbourhood health.

2.6 Equally, NHS England has indicated the areas where ICBs may wish to look at potential duplication:

- A number of assurance and regulatory functions (for example, safeguarding and infection control) where this is already done in providers and, in some cases, regions, without compromising statutory responsibilities
- Wider performance management (as opposed to contract management) of providers which again already takes place in providers and at regional level
- Comms and engagement which similarly exists in local authorities, providers and regions

2.7 Subsequently a high level ICB blueprint has been made available and this is attached at Appendix 1. In addition NHS England has indicated a predicted running cost reduction for the ICB of £65m – roughly £18 per head) which is just less than half of the running costs NHS GM currently

2.8 In Bury we are determined that we retain the quality of partnership working, transformational ambition, and improvement that characterises the operational of the health and care system.

3.0 NHS GM Bury

3.1 NHS GM has a corporate core and then 10 locality teams. In terms of leadership each locality has:

- A place lead (in 9/10 localities also the Council CEO) – Lynne Ridsdale
- A deputy place lead (in 8/10 localities this is a full time role but in Bury a joint appointment) – Will Blandamer
- An P/T Associate Medical Director – Dr Cathy Fines
- An P/T Associate Director Nursing and Quality – Catherine Jackson
- A finance Manager (shared between Bury and Rochdale) – Simon O' Hare
- In Bury Adrian Crook is formally a joint role as DASS in the Council and also Director of Community Commissioning in NHS GM.

3.2 There are a relatively small number of staff managed directly by NHS GM Bury

- The continuing health care /complex care team – mainly nursing staff
- The primary care improvement team

- Transformation capacity (e.g in urgent care, elective care, childrens services, adult mental health, cancer commissioning)
- Corporate support
- Safeguarding for adults and children
- Quality Assurance

3 A number of other functions are locality based and work closely with local stakeholders but actually formally managed on a GM wide basis – e.g finance, medicines optimisation (prescribing support to GPs mostly)

3.0 NEXT STEPS

3.1 NHS GM Bury leadership are meeting weekly with all staff (including a number of roles managed centrally) to share information, to ensure all necessary pastoral support, and to distil key messages for escalation to NHS GM.

3.2 NHS GM Bury leadership are working to influence the emergent new operating model for the NHS GM and ensure it retains the conditions as afar as possible to support the delivery of our locality plan.

3.3 At a GM level the ICB alongside the GM Mayor, GMCA and other partners we will seek to influence the direction of the reforms and how they are implemented in GM. This will include retaining the current geographical structure for the NHS in GM – which is coterminous with GMCA and the 10 local authorities.

3.4 Over the period June and July 2024 the ICB will develop its revised operating model – the current thinking on this as attached as Appendix 2.

Model Integrated Care Board – Blueprint v1.0

Introduction

On 1 April, we wrote to Integrated Care Board (ICB) and provider leaders outlining how we will work together in 2025/26 to deliver our core priorities and lay the foundations for reform. The letter set out the critical role ICBs will play in the future as strategic commissioners, and in realising the ambitions that will be set out in the 10 Year Health Plan. As ICBs need to develop plans to reduce their costs by the end of May, we committed to clarifying the role of ICBs by co-producing a Model ICB Blueprint and sharing the functional output of this work.

This Model ICB Blueprint has been developed by a group of ICB leaders from across the country, representing all regions and from systems of varying size, demographics, maturity and performance. It is a joint leadership product, developed and written by ICBs in partnership with NHS England. The group has worked together at pace to develop a shared vision of the future with a view to providing clarity on the direction of travel and a consistent understanding of the future role and functions of ICBs.

The delivery of the 10 Year Health Plan will require a leaner and simpler way of working, where every part of the NHS is clear on its purpose, what it is accountable for, and to whom. We expect the 10 Year Health Plan to set out more detail on the wider system architecture and clarify the role and accountabilities of trusts, systems, and the centre of the NHS.

We are sharing this blueprint with you today without the corresponding picture of what the future of neighbourhood health will look like or the role of the centre or regional teams.

We are also sharing this now without the benefit of the wide engagement with staff and stakeholders that will be required to get the detail and implementation right. Given the pace at which this work has been developed over recent weeks, our initial focus has been system-led design. We are now sharing it more widely for discussion and refinement and will be setting up engagement discussions over the coming weeks.

This blueprint document marks the first step in a joint programme of work to reshape the focus, role and functions of ICBs, with a view to laying the foundations for delivery of the 10 Year Health Plan. It is clear that moving forwards, ICBs have a critical role to play as strategic commissioners working to improve population health, reduce inequalities and improve access to more consistently high-quality care and we look forward to shaping the next steps on this together.

1. Context

In July 2022, Integrated Care Boards (ICB) were established with the statutory functions of planning and arranging health services for their population, holding responsibility for the performance and oversight of NHS services within their footprint. Alongside these system leadership and commissioning roles, they were also set up with a range of delivery functions, including emergency planning, safeguarding and NHS Continuing Healthcare assessment and provision.

As the Darzi review noted[1], since 2022, there have been differing interpretations of the role of ICBs, with some leaning towards tackling the social determinants of health, some focused on working at a local level to encourage services to work more effectively together, and some focused on supporting their providers to improve (in particular) financial and operational performance. The wider context, including performance measures focused on hospitals and the requirement for ICBs to ensure their Integrated Care System (ICS) delivers financial balance, mean that ICBs have found it hard to use their powers to commission services in line with the four ICS objectives. This has largely resulted in the status quo with increasing resources directed to acute providers, when the four objectives should have instead led to the opposite outcome.

As the Darzi review concludes, the roles and responsibilities of ICBs need to be clarified to provide more consistency and better enable the strategic objectives of redistributing resource out of hospital and integrating care. Crucial to this is a rebuilding of strategic commissioning capabilities, requiring "*as strong a focus on strategy as much as performance*" and a parallel investment in the skills required to "*commission care wisely as much as to provide it well*".

The 10 Year Health Plan will reinforce the criticality of this role and the Secretary of State is clear about his desire – and the need – to deliver the three shifts. The NHS needs to deliver better value for its customers – the population of England. This means increasingly focusing on prevention and reducing inequalities, delivering more services in a community/ neighbourhood based setting – and ensuring all services are delivered as efficiently and effectively as possible, in particular through the use of technology.

Across the NHS, these three strategic shifts form the foundation of the Model ICB's approach to transformation and redesign:

- **treatment to prevention:** A stronger emphasis on preventative health and wellbeing, addressing the causes of ill health before they require costly medical intervention and

[1] https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england

reducing inequalities in health. This involves proactive community and public health initiatives, working closely with local authorities, to keep people healthy.

- **hospital to community:** Moving care closer to home by building more joined-up, person-centred care in local neighbourhoods, reducing reliance on acute care.
- **analogue to digital:** Harnessing technology and data to transform care delivery and decision-making. From digital health services for patients, to advanced analytics (population health management, predictive modelling) for planners, the focus is on smarter, more efficient, and more personalised care.

These shifts set the direction for how ICBs need to operate going forward. The NHS needs strong commissioners who can better understand the health and care needs of their local populations, who can work with users and wider communities to develop strategies to improve health and tackle inequalities and who can contract with providers to ensure consistently high-quality and efficient care, in line with best practice.

This document, developed by a working group consisting of ICB leaders from across the country, sets out a blueprint for how ICBs can operate within a changing NHS landscape. It covers the following areas:

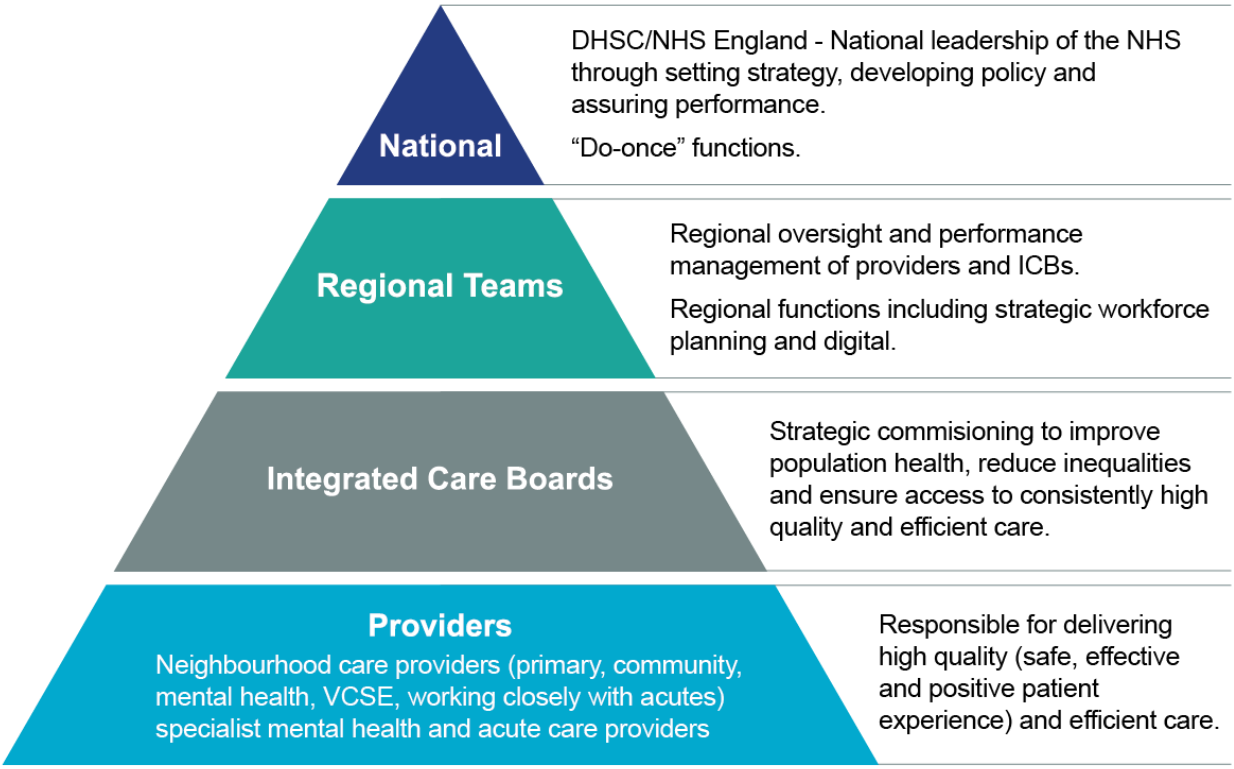
- **purpose** – why ICBs exist
- **core functions** – what they do
- **enablers and capabilities** – what needs to be in place to ensure success
- **managing transition** – supporting ICBs to manage this transition locally and the support and guidance that will be available.

2. Purpose and role: why ICBs exist

ICBs exist to improve their population's health and ensure access to consistently high-quality services. They hold the accountability for ensuring the best use of their population's health budget to improve health and healthcare, both now and in the future.

ICBs provide system leadership for population health, setting evidence based and long-term population health strategy and working as healthcare payers to deliver this, maximising the value that can be created from the available resources. This involves investing in, purchasing and evaluating the range of services and pathways required to ensure access to high quality care, and in order to improve outcomes and reduce inequalities within their footprint. ICBs not only commission services but also align funding and resources strategically with long-term population health outcomes and manage clinical and financial risks.

The refreshed role of ICBs has been developed through a set of assumptions about a refreshed system landscape, along the lines set out below:



3. Core functions: What ICBs do

To deliver their purpose, ICBs focus on the following core functions:

The following table summarises the activities that make up these core functions.

Model ICB core functions and activities	
Activity	**Detail**
1. Understanding local context: assessing population needs now and in the future, identifying underserved communities and assessing quality, performance and productivity of existing provision	
Population data and intelligence	• Using data and intelligence (including user feedback, partner insight, outcomes data, public health insight) to develop a deep and dynamic understanding of their local population and their needs and how these are likely to change over time • Leveraging real-time data and predictive modelling to identify risk, understand variation, and direct resources where they will have the greatest impact (allocative efficiency) • Segmenting their population and stratifying health risks • Dis-aggregating population health data to surface inequalities, generate actionable insights, inform service design and deployment and scrutinise progress towards equity
Forecasting and modelling	• Developing long-term population health plans using epidemiological, actuarial, and economic analysis • Forecasting and scenario modelling demand and service pressures • Understanding current and future costs to ensure clinical and financial sustainability • Convening people, communities and partners to challenge, critique and inform population health plans, demand modelling and cost forecasts
Reviewing provision	• Reviewing current provision using data and input from stakeholders, people and communities • Building a deep understanding of operational performance, quality of care (safety, effectiveness, user experience) and productivity/unit cost across all providers
2. Developing long term population health strategy: Long-term population health planning and strategy and care pathway redesign to maximise value based on evidence	
Developing strategy with options for testing and engagement	• Drawing on a variety of inputs (analysis of population health needs, evidence base on what works, national and international examples, user priorities, innovation and horizon scanning, bottom-up costing, principles of healthcare value, impact/feasibility analysis) to develop strategic options for testing and engagement with partners, people and communities • Developing and agreeing best practice care pathways with partners, people and communities, using national guidance and working closely with local clinical leaders to inform this

	• Aligning funding with need and impact using locally adapted actuarial models and bottom-up costing (“should cost” principles) • Ensuring efficiency and equity using value-based approaches to prioritisation, underpinned by public health principles
Setting strategy	• Setting overall system strategy to inform allocation of resources to maximise improved health and access to high quality care (safety, effectiveness, user experience), shifting focus from institutions to population outcomes, and targeting health inequalities by improving equity of access, experience and outcomes • Determining where change is required, the priority outcomes for improvement and population metrics to track • Co-producing strategy with communities, reflecting unmet needs and targeting inequalities • Designing new care models and investment programmes and co-ordinating major transformation programmes • Collaborating with local authorities, place-based partnerships, provider collaboratives, academia, think tanks, and analytics partners to develop and refine strategy
3. Delivering the strategy through payer functions and resource allocation: oversight and assurance of what is purchased and whether it delivers outcomes required	
Strategic purchasing	• Aligning funding to needs using data-driven models • Defining outcome-linked service specifications • Setting strategic priorities for quality assurance and oversight, developing policies and frameworks for quality improvement • Prioritising interventions to address health inequalities
Market shaping and management	• Understanding the different costs and outcomes of a range of providers • Building robust “should cost” and “should deliver” models to test against • Introducing and encouraging new providers where gaps exist in the market, for example, frailty models • Working with providers to understand factors necessary for sustainability, for example, the link between elective orthopaedics and trauma • Exploring a range of payment mechanisms
Contracting	• Negotiating and managing outcome-based contracts • Monitoring provider performance and benchmarking services with continuous review of impact, access and quality • Using performance frameworks, invoice validation • Establishing procurement governance, value-for-money checks

Payment mechanisms	• Designing incentives (blended payments, gainshare, shared savings) to improve equity, efficiency and productivity • Implementing risk mitigation strategies (for example, collaborative risk-pools) • Using financial stewardship tools (cost-effectiveness thresholds, return on investment) • Deploying payment models to improve equity (for example, blended payments linked to reducing inequalities)
4. Evaluating impact: day-to-day oversight of healthcare utilisation, user feedback and evaluation to ensure optimal, value-based resource use and improved outcomes	
Utilisation management	• Day-to-day oversight of service usage using real-time dashboards (admissions, urgent and emergency care attendances, prescribing, coding etc.) • Identifying unwarranted care variations utilising benchmarking tools and clinical audits and unwarranted over treatment, for example cataracts • Convening clinical reviews and managing complex cases • Optimising care pathways with providers
Evaluating outcomes	• Evaluating the outcomes from commissioned services • Rigorous monitoring of priority metrics, identifying unwarranted variation and clear feedback loops to inform commissioning adjustments and understand the return on investment • Establishing feedback loops for adaptive planning • Embedding feedback from people and communities, staff and partners into evaluation approaches
User feedback, co-design and engagement	• Evaluation, co-design and deliberative dialogue with people and communities, using design thinking methodologies • Ensuring user feedback mechanisms are embedded in how resource is allocated and evaluated
Governance and Core Statutory Functions: Ensures the ICB is compliant, accountable, and safe	
Ensuring the ICB is compliant, accountable and safe	• Establishing robust governance structures and processes to ensure legal compliance, transparency and public accountability • Fulfilling statutory duties (for example, equality, public involvement) and monitoring of equity outcomes alongside access, quality, and efficiency • Implementing strong clinical and information governance and effective financial and risk management systems • Maintaining business continuity and emergency planning • Overseeing delegated functions with proportionate assurance

ICB functional changes

To support the development of the future state, ICBs should consider the following assumptions about some of the functional changes that could happen. We are sharing this to provide an indication of the future state, however the detail and implementation will depend on multiple factors, including engagement and refinement with partners, the parallel development of provider and regional models, readiness to transfer and receive across different parts of the system and, in some cases, legislative change.

ICBs will need to work closely with their staff to ensure they are supported, to retain talent and to safely manage delivery across the wider system and public sector, including when functions move to different parts of the landscape.

Given the implications of these functional changes on different parts of the system, next steps will need to be developed by working closely with partners nationally and within local systems over the coming months. In light of this, no specific timeframes are provided at this stage.

ICB functional changes		
Change to manage	**Functions in scope**	**Guiding notes**
Grow: functions for ICBs to grow / invest in over time to deliver against the purpose and objectives	Population health management – data and analytics, predictive modelling, risk stratification, understanding inequalities	• Essential for core role and activities • Can be delivered within existing legislation • Will require investment in new capabilities over time
	Epidemiological capability to understand the causes, management and prevention of illness	
	Strategy and strategic planning including care pathway redesign	
	Health inequalities and inclusion expertise – capacity and capability to routinely dis-aggregate population and performance data to surface health inequalities, generate actionable insights, drive	

	evidence informed interventions and build intelligence to guide future commissioning and resource allocation decisions	
	Commissioning neighbourhood health	
	Commissioning of clinical risk management and intervention programmes (working with neighbourhood health teams to ensure proactive case finding)	
	Commissioning end-to-end pathways (including those delegated by NHS E: specialised services; primary medical, pharmacy, ophthalmic and dental services (POD); general practice, and further services that will be delegated by NHS England to ICBs over time) *Vaccinations and screening will be delegated by NHS England to ICBs in April 2026* *All remaining NHS England direct commissioning functions will be reviewed during 2025/26*	
	Core payer functions – strategic purchasing, contracting, payment mechanisms, resource allocation, market shaping and management, utilisation management	
	Evaluation methodologies and evidence synthesis using qualitative and quantitative data, feedback and insights	

	User involvement, user led design, deliberative dialogue methodologies	
	Strategic partnerships to improve population health (public health, local partners, VCSE, academia, innovation)	
Selectively retain and adapt: functions for ICBs to retain and adapt including by delivering at scale	Quality management – understanding drivers of improved health, range of health outcome measures, elements of high-quality care (safety, effectiveness, user experience); child death reviews	• Embed in commissioning cycle, monitoring of contracts • Avoid duplication with providers, regions and CQC • Use automated data sources and single version of the truth
	Board governance	• Look to streamline Boards to deliver core role as set out • Headcount should be reduced at Board level with the right roles and profiles to deliver core Model ICB functions
	Clinical governance	• Strengthen focus on embedding management of population clinical risk, best practice care pathways in commissioning approach
	Corporate governance (including data protection, information governance, legal services)	• Maintain good governance practice; look to deliver some functions at scale across ICBs
	Core organisational operations (HR, communications, internal finance, internal audit, procurement, complaints, PALs)	• Look to streamline and deliver some functions at scale
	Existing commissioning functions, including clinical policy and effectiveness – local funding decisions (individual funding	• Will be built into new commissioning/payer functions operating at ICB and pan-ICB level

	requests; clinical policy implementation)	
Review for transfer: functions and activities for ICBs to transfer over time, enabled by flexibilities under the 2022 Act for ICBs to transfer their statutory duties	Oversight of provider performance under the NHS performance assessment framework (finance, quality, operational performance)	• Performance management, regulatory oversight and management of failure to transfer to regions through the NHS Performance and Assessment Framework • Market management and contract management functions to be retained and grown in ICBs
	Emergency Preparedness, Resilience and Response (EPRR) and system coordination centre	• Transfer to regions over time
	High level strategic workforce planning, development, education and training	• Transfer to regions or national over time, retain limited strategic commissioning overview as part of strategy function
	Local workforce development and training including recruitment and retention	• Transfer to providers over time
	Research development and innovation	• Transfer to regions over time, with ICBs retaining and building strategic partnerships to support population health strategy
	Green plan and sustainability	• Transfer to providers over time
	Digital and technology leadership and transformation	• Transfer digital leadership to providers over time enabled by a national data and digital infrastructure
	Data collection, management and processing	• Transfer to national over time
	Infection prevention and control	• Test and explore options to streamline and transfer some activities out of ICBs

	Safeguarding	• Test and explore options to streamline and transfer some activities out of ICBs (accountability changes will require legislative changes)
	SEND	• Test and explore options to streamline and transfer some activities out of ICBs (accountability changes will require legislative changes)
	Development of neighbourhood and place-based partnerships	• Transfer to neighbourhood health providers over time
	Primary care operations and transformation (including primary care, medicines management, estates and workforce support)	• Transfer to neighbourhood health providers over time
	Medicines optimisation	• Transfer delivery to providers over time, retain strategic commissioning overview as part of strategy function
	Pathway and service development programmes	• Transfer to providers, retain strategic commissioning overview as part of strategy function
	NHS Continuing Healthcare	• Test and explore options to streamline and transfer some activities out of ICBs (accountability changes will require legislative changes)
	Estates and infrastructure strategy	• Transfer to providers over time, retain limited strategic commissioning overview as part of strategy function
	General Practice IT	• Explore options to transfer out of ICBs ensuring consistent offer

4. Enablers and capabilities: what ICBs need to ensure success

For an ICB to effectively perform the core functions set out in section 3, several key enablers need to be in place. A high-level summary of these is set out below:

- **Healthcare data and analytics –** to enable ICB decisions to be guided by population health data and insights, ICBs will need to develop strong population health management approaches underpinned by robust data capability. This will need to include developing the capabilities to segment the population and stratify risk and build a person-level, longitudinal, linked dataset integrating local and national data sources alongside public and patient feedback. There will need to be appropriate data-sharing and governance agreements to track individuals' journeys across health and care (to understand needs and outcomes holistically); and deploy predictive modelling to foresee future demand, cost and impact of interventions. ICBs will need to cultivate teams with the ability to analyse and interpret complex data (health economists and data-scientists) and deploy data-driven techniques (such as modelling the return on investment for preventative interventions). Data can be integrated reliably between services to provide real-time, accurate data enabling better decision-making and interoperability – the NHS Federated Data Platform (FDP) will be crucial to enable this work, and should be used as the default tool by ICBs.

- **Strategy –** ICBs will need to develop effective strategy capability, comprised of individuals with good problem solving and analytical skills. They will need to foster a greater understanding of value-based healthcare alongside the ability to synthesise a range of information (qualitative and quantitative) and develop actionable insights to support prioritisation. ICBs will need strategic leaders who can diplomatically and collaboratively work with a range of partners including by facilitating multi-agency forums and collaborative decision-making. They will also need the ability to navigate and synthesise complexity so that people and communities, staff and partners can understand the full picture, and be able to draw people together around the shared goal of improving population health.

- **Intelligent healthcare payer –** for ICBs to develop into sophisticated and intelligent healthcare payers, they will need to invest in their understanding of costs ('should cost' analysis) and wider finance functions, developing capabilities in strategic purchasing, contracting, design and oversight of payment mechanisms, utilisation management and resource allocation. This will need to include commercial skills for innovative contracting and managing new provider relationships. ICB staff will need to learn how to proactively manage and develop the provider market, using procurement and contracting levers to incentivise quality improvement and innovation. This should involve techniques that ensure effective use of public resources so that investment decisions are guided by

relative value, not just demand or precedent. This calls for deliberate use of tools such as programme budgeting and decommissioning frameworks to support allocative efficiency.

- **User involvement and co-design –** for services to truly meet communities' needs, people must be involved from the very start of planning through to implementation and review. Each ICB should have a systematic approach to co-production – meaningfully involving patients, service users, carers, and community groups in designing solutions. This goes beyond formal consultation and means working with people as partners. ICBs will need to ensure that focused effort and resources are deployed to reach seldom heard and underserved people and communities, working with trusted community partners to achieve this. Ultimately, this enabler is about shifting the relationship with the public from passive recipient to active shaper of health and care, with a particular focus on underserved communities.

- **Clinical leadership and governance –** ICBs will need effective clinical leadership embedded in how they work, ensuring they have a solid understanding of population clinical risk and of the best practice care pathways required to meet population needs and improve outcomes. Clinical governance and oversight will be crucial in ensuring that the decisions that ICBs make are robust, particularly regarding the prioritisation of resources. Contract management of commissioned services will need to include effective quality assurance processes.

- **System leadership for population health –** effective system leadership will be essential to driving improvements in population health. ICB leaders and staff need to be adept at system thinking, analytics, and collaboration. They will need to work diplomatically and be comfortable driving change and influencing without direct authority. ICBs should develop and foster strategic partnerships across their footprints with a range of partners (including academia, VCSE, innovation), alongside working together with providers and local government as they develop and implement their strategies.

- **Partnership working with local government –** recognising the critical and statutory role of local authorities in ICSs and as partner members of ICBs, engagement and co-design with local government will be critical to the next phase of this work. Linked to this, is the need for ICBs to continue to foster strong relationships with the places within their footprint, building a shared understanding of their population and working together to support improved outcomes, tackle inequalities and develop neighbourhood health. We will be working jointly with the Local Government Association to take this development work forwards.

- **Supporting ICB competency and capability development – national support offer and maturity assessment –** it is proposed that a national programme of work, including

a new commissioning framework, is developed to ensure ICBs have the necessary capabilities and competencies to discharge their functions effectively. This should be developed by learning from successful international models and World Class Commissioning and form the basis of future assessments of ICB maturity.

5. Managing the transition

The ask on ICBs is significant this year as they work to maintain effective oversight of the delivery of 2025/26 plans, build the foundation for neighbourhood health and manage the local changes involved with ICB redesign, including supporting their staff through engagement and consultation.

To support with this, the following sections set out some high-level principles around:

- delivering ICB cost reductions plans and realising the savings
- managing the impact on staff
- designing leadership structures of ICBs
- managing risk during transition through safe governance
- expectations for safe transition of transferred functions

Delivering ICB cost reductions plans and realising the savings

ICBs will need to use this guidance to create bottom-up plans which are affordable within the revised running cost envelope of £18.76 per head of population. More details on this are set out below:

- the calculations to derive the £18.76 operating cost envelope include all ICB running costs and programme pay (only excluding POD and specialised commissioning delegation)
- the reduction in ICB costs to meet this target must be delivered by the end of Q3 2025/26 and recurrently into 2026/27
- ICBs are encouraged to expedite these changes as any in-year savings can be used on a non-recurrent basis to address in-year transition pressures or risks to delivery in wider system operational plans and potentially sooner to mitigate and de-risk financial plans
- there will be flexibility at an ICB-level, as some inter-ICB variation may be warranted and will need to be managed within a region to account for hosted services, however we expect delivery of the target at an aggregate regional level
- generating savings cannot be a cost shift to a provider unless overall there is the saving, for example, a provider takes on an ICB operated service and therefore requires circa 50% less cost in line with the £18.76 running cost envelope

We recognise that not all functional changes to reach the Model ICB can be done this year as some changes will require legislation and any transfer arrangements will need to be

carefully managed to ensure safe transition. Recognising this, we anticipate that most savings will come from streamlining approaches, identifying efficiency opportunities – through benchmarking, AI and other technological opportunities and from at scale opportunities afforded through greater collaboration, clustering and where appropriate, eventual merger of ICBs. Principles to apply to footprints, clustering and mergers will be communicated and coordinated by regional teams.

NHS England is providing a planning template to facilitate the May 2025 plan returns. This will be issued in the week commencing 6 May 2025. Plans should be submitted to your regional lead by 5pm on **30 May 2025**. Plans will set out how each ICB intends to achieve the £18.76 operating cost envelope and will then go through a national moderation process (involving a confirm and challenge process) to support consistency of approach and sharing of opportunities. These plans should be informed at a high level by the vision set out in this blueprint.

Support for managing the impact on staff

A national support offer will be available to ensure fair and supportive treatment of staff affected by the transition. This includes advice on voluntary redundancy and Mutually Agreed Resignation Schemes (MARS), along with guidance on redeployment and retention where appropriate. Funding mechanisms to support these options will be clarified centrally ensuring local systems can manage workforce changes consistently. Emphasis will be placed on transparent, compassionate communication and engagement to retain talent and maintain morale through the change process. We will work in partnership with trade union colleagues to implement the change for staff.

Advice on leadership structures of ICBs

ICBs are expected to maintain clear, accountable leadership with effective governance during the transition and beyond. ICBs should look to streamline Boards and reduce headcount at Board level to deliver core purpose and role as described. Leadership structures and executive portfolios should also reflect the functions as set out above, including skills in population health data and insights, strategic commissioning (including strategy, partnerships and user involvement), finance and contracting and clinical leadership and governance. At Board level, a strong non-executive presence is encouraged to support both oversight and the delivery of transition priorities.

Managing risk during transition through safe governance

To ensure a safe and coherent transition, each ICB should establish a dedicated Transition Committee, including both executive and non-executive members. These committees will take responsibility for managing local risks, tracking progress, and overseeing the development of organisational design and implementation of change processes.

To support this work, a central NHS England programme team — under the leadership of an Executive SRO — will be set up to provide coordination, support and a check and challenge process on ICB plans. This will seek to ensure appropriate support guidance is developed to facilitate the transition, share best practices, and facilitate consistency across systems to deliver the vision set out here. This central support will also help ICBs navigate legal, operational, and workforce challenges while ensuring focus remains on delivery of statutory duties throughout the transition.

Expectations for safe transition of transferred functions

Safe transition of functions is critical to the success of the new Model ICB design and the future system landscape. To manage this transition effectively, an assessment of readiness is necessary for both the sender and the receiver. Implementing a gateway process will help verify readiness before transferring staff and functions underpinned by clear governance frameworks, outcome metrics, financial risk arrangements, and escalation protocols to ensure safe and effective delivery.

NHS England is currently developing the operating model for the Model Region. We will continue to work with ICBs as we develop the regional approach to ensure alignment with the Model ICB design and implementation. We have been clear that performance management of providers against the NHS Performance and Assessment Framework (NPAF) will transfer to Regions under the new design. It will be important to be clear on responsibilities as these functions transfer. Once transferred ICBs will oversee providers through their contracting arrangements but will not be responsible for leading the regulatory oversight of providers against the NPAF.

Frequently asked questions

FAQs covering all aspects of transition is being developed to support ICBs as they manage these elements locally.

Please direct any questions to england.Model-ICB@nhs.net and we will use these to inform future sets of FAQs.

NHS
Greater Manchester

NHS Reform
Organisational Design

Part of Greater Manchester
Integrated Care Partnership

May 2025

Purpose

- By the end of May the ICB needs to submit a response to the draft Model Integrated Care board blueprint
- The purpose of this presentation is to enable members of our extended leadership team (ELT) to share the current thinking and high-level modelling with teams
- The design groups will do the detailed design in June and July. The groups will include representative membership from across the system and will seek further engagement during that time from teams.
- This is part of our commitment to transparency and to engage you
- These are working drafts and are by no means the finished products
- All the models and proposals will be subject to change
- We thank you for your continued contributions, professionalism and commitment as we navigate these changes

Implementation of the GM model – DRAFT proposal

NHS Greater Manchester

NHS GM oversees £8.5bn budget to strategically commission services (once)

At place: maximise the impact locally

Live well	Integrated Neighbourhood Health	Population Health	Demand Management

- NHS GM will oversee the £8.5bn budget to strategically commission services (once). The role of localities will be to maximise the impact of this £8.5bn in Place - bringing local partners working together to deliver neighbourhood integrated care (like Live Well, preventative care, i.e. delivery of the "left shift")

- In Greater Manchester we work together with other public services and partners from across our city region to allocate our collective £80 billion resource to improve the health of our population

Core functions - What ICBs do

NHS Greater Manchester

1. **Understanding local context**
   Assessing population needs now and in the future, identifying underserved communities and assessing quality, performance and productivity of existing provision

2. **Developing long-term population health strategy**
   Long-term population health planning and strategy and care pathway redesign to maximise value based on evidence

3. **Delivering the strategy through payer functions and resource allocation**
   Oversight and assurance of what is purchased and whether it delivers outcomes required

4. **Evaluating impact**
   Day-to-day oversight of healthcare usage, user feedback and evaluation to ensure optimal, value-based resource use and improved outcomes

Grow

Population health data and analytics (incl. prevention, inequalities)

Strategy, pathway redesign, planning (incl. evaluation, user design, strategic partnerships

Commissioning and core payer functions

Retain/Adapt

Quality management

Governance: Board, clinical, corporate

Core operations: HR, comms, finance, audit, procurement, complaints, PALs

Clinical policy and local funding decisions

Review/Transfer

To NHS England

- Oversight of provider performance
- EPRR (emergency preparedness)
- Strategic workforce planning
- Research and innovation
- Data management

To providers

- Local workforce development
- Green plan
- Digital transformation
- Medicines optimisation
- Pathway development
- Estates and infrastructure
- Infection prevention and control (TBD)
- Safeguarding (TBD)
- SEND (TBD)
- NHS continuing healthcare (TBD)

To places

- Developing neighbourhoods and place-based partnerships
- Primary care (incl. GP IT)

ICB functional changes in Model ICB blueprint

NHS Greater Manchester

Functions of our strategic commissioning model

Clinical standards and governance	Strategic financial management	System improvement and delivery	Commissioning operations	Strategy and population health

NHS GM DRAFT Healthcare strategic commissioning model

NHS Greater Manchester

Our Mission – For the People of GM to Live Longer, Healthier Live

Our Goal – for people in GM to improve their healthy live years by x years (relative to England as a whole) and for the gap in healthy life years between the richest and poorest communities to reduce by y years.

£8.5bn

Children and maternity	Well people	People with Long term conditions	People with Mental Health and Learning disabilities/ autism	People with Cancer	People living with Frailty	People at the End of life
Prevention						
Primary care						
Planned care						
Unplanned care						
Specialist services						
Major service redesign						
Programme outcomes		***System performance metrics***			***Quality and experience of care***	

Strategic procurement function

A revised approach to integrated place based working in a reformed Greater Manchester system

NHS Greater Manchester

- Nationally agreed that GM will retain footprint co-terminus with GMCA
- NHS GM has reaffirmed its commitment to 10 places.
- However, a reset of these 10 places is needed, as this does not mean ten of everything. We need to be alert and active to where scaled delivery supports greater efficiency and consistency; and at the same time reduce the level of variation in the neighbourhood and place model
- Nine key changes are being proposed which will hopefully create clearer accountability, enhance efficiency, partnership competence and rigour, and will align NHS planning levels with local government (see next slide).
- These proposals will seek to improve the NHS's ability to plan, fund, oversee and transform services in a way that is more responsive to local needs while maintaining GM system- level oversight and strategic coherence.
- It is proposed the four core functions for place going forward will be: Live Well, Integrated neighbourhood health, population health and demand management

Proposed changes.....

NHS Greater Manchester

- Establish greater levels of consistency within the system by resetting ‘Localities’ as formal Place-based Partnerships and the new neighbourhood health and care provider vehicles
- Ensure consistency of the functions to be discharged through Place-based Partnerships
- The discipline of population health improvement must be the goal of all 10 places and its strategies and plans must articulate how it will achieve this
- Strengthen accountability for all 10 Place-based Partnerships
- Leadership and workforce - a workforce with a shared ambition for health, wellbeing and independence able to improve the delivery of shared outcomes
- Use the reform agenda to reset the relationship with citizens with Place-based Partnerships leading the work to deliver on that
- Each Place-based Partnership will deliver core features of a neighbourhood health model (Live Well)
- Measure success in outcomes, not outputs
- Finance - a clear line of sight to the total place spend on health and care, understand what aspects of that spend are influenceable and clarity of what spend the Place-based Partnership is directly charged with control of.

What this means for NHS GM

NHS Greater Manchester

- We need to reduce operating costs by at least 39%
- Around 90% of our operating cost are staff costs, therefore there will be a significant reduction in headcount
- The structures that we design need to align with the model ICB blueprint
- Not merging with any other ICBs

Next steps

- 20 May - Extended Leadership Team - *Share the plan from Chief Officer's Session for further engagement and discussion.*
- 22 May – Share presentation on plans with *ELT members for discussion with staff.*
- 23 May System - Leadership Group - *Engagement and discussion with providers across the system on NHS Reform plan so far and the impact on the workforce*
- 26 – 30 May Plan submission - *Triangulate all feedback from sessions across the month and check with final submission before sending on to NHSE*
- June onwards – *launch of design groups*
- End of July – *completion of design*

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Agenda Item 8

Classification:	Decision Type:
Open	Non-Key

Report to:	Cabinet	**Date:** 11 June 2025
Subject:	Adult Social Care Performance Quarter Four Report 2024/25	
Report of	Cabinet Member for Adult Care, Health and Public Service Reform	

Summary

1. This is the Adult Social Care Department Quarter 4 Report for 2024-25. The report outlines delivery of the Adult Social Care Strategic Plan, preparation for the new CQC Assessment regime for local authorities and provides an illustration and report on the department's performance framework.

Recommendation(s)

2. To note the report.

Reasons for recommendation(s)

3. N/A.

Alternative options considered and rejected.

4. N/A.

Report Author and Contact Details:
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Department: Health and Adult Care
E-mail: a.crook@bury.gov.uk

Background

5. This is the Adult Social Care Department Performance Report covering Quarter 4 of 2024-25.

Links with the Corporate Priorities:

6. The Adult Social Care is Department is committed to delivering the Bury 'LETS' (Local, Enterprising, Together, Strengths) strategy for our citizens and our workforce.

   Our mission is to work in the heart of our communities providing high-quality, person-centred advice and information to prevent, reduce and delay the need for reliance on local council support by connecting people with universal services in their local communities.

   For those eligible to access social care services, we provide assessment and support planning and where required provide services close to home delivered by local care providers.

We aim to have effective and innovative services and are enterprising in the commissioning and delivery of care and support services.

We work together with our partners but most importantly together with our residents where our intervention emphasises building on individual's strengths and promoting independence.

We ensure that local people have choice and control over the care and support they receive, and that they are encouraged to consider creative and innovative ways to meet their needs. We also undertake our statutory duties to safeguard the most vulnerable members of our communities and minimise the risks of abuse and exploitation.

Equality Impact and Considerations:

7. In delivering their Care Act functions, local authorities should take action to achieve equity of experience and outcomes for all individuals, groups and communities in their areas; they are required to have regard to the Public Sector Equality Duty (Equalities Act 2010) in the way they do carry out their work. The Directorate intends to drive forward its approach to equality, diversity and inclusion, ensuring that equality monitoring information is routinely gathered, and consider how a realistic set of S/M/L-term objectives may help to focus effort and capacity.

Environmental Impact and Considerations:

8. N/A

Assessment and Mitigation of Risk:

Risk / opportunity	Mitigation
N/A.	N/A.

Legal Implications:

9. This report demonstrates the Council's preparation for the new CQC inspection regime, its Care Act 2014 statutory duties and the strategic plan for Adult Social Care. This report demonstrates adherence to the law.

Financial Implications:

10. There are no financial implications arising directly from this report.

Appendices:

Data sources and what good looks like.

Bury MBC ASC Preparation for Assurance Peer Challenge Report

Background papers:

Adult Social Care Strategic Plan 2023-2026

Please include a glossary of terms, abbreviations and acronyms used in this report.

Term	Meaning	
CQC	Care Quality Commission	

Adult Social Care Performance Report for Quarter Four, 2024/25

1.0 Executive Summary

Quarter 4 marks the end of another year of our business planning cycle and gives us the opportunity to look back on the year and review our performance over the year as well as our progress against our objectives which excuses a larger executive summary this time.

1.1. Performance

24/25 has seen another year where demand has shown consistent growth over 23/24 with the number of people contacting our department up by 200 per month, a rise of 14%. A large part of this rise has been from the continued expansion of Rapid Response and Virtual Ward services that respond urgently to avoid unnecessary and premature admission to care services as well as avoid unnecessary hospital admission and support people at home. Without the expansion in these 2 services the increase in demand would have been much less and in line with population growth.

Despite these demand challenges we have still seen great progress in continued reduction in waiting lists over the year dropping from well over 100 people waiting to see a social worker this time last year to just 60 at the end of Q4. This has been delivered by increased productivity in our social work teams and can be seen in an increase in the number of assessments completed over the year with the average number of needs assessment each month growing by 25 compared to the previous year.

Greater reductions have also been seen in waiting lists for people needing the support of an occupation therapist following investment in additional staffing that reached a high 387 people wating for minor and major adaptation assessments in August 2024 but reduced to 267 by December and have now further decreased to 178 in March 2025. Within this those waiting for major adaptations has dropped to 92.

The biggest improvement in waiting list reduction has been seen in those waiting for review where a reduction from 1400 to 850 people, a drop of 39%, has been seen as the investment in additional staff to carry out reviews along with improvements in data quality and processes continue to embed.

The number of people using services in our borough continues to grow and rose by 4% overall in the last year. Some of this is explained by the work we have carried out to reduce waiting lists which sees more assessments completed. The biggest rises seen are in supported living and other community services. The other community services are explained by our new assistive technology services and supported living by our opening of mental health supported accommodation schemes. The numbers of people with a learning disability in supported living has not increased. However, we have also seen the use of residential care rise by 4.9% which is higher than population growth. This has been the result of a change in NHS processes for assessing continuing health care where patients are no longer funded by the NHS at the point of discharge from hospital, but rather funded as normal pending CHC assessment, this has seen a rise in the number of nursing home placements funded by the council that is responsible for this growth.

Overall, this suggests we still have more to explore over the coming year with increasing the use of our intermediate care services and a strengthening of our strengths based approach to care and support to ensure we are doing all we can to help our residents prevent, reduce and delay the need for care and support.

Our obsession to make safeguarding everyone's business saw the number of concerns rise from an average of 150 a month to over 200 per month as greater awareness was raised across our system. We have also been more successful in both asking and achieving outcomes with 90% now asked, compared to 74% a year ago, and 94% either fully or partially achieved, compared to 84% a year ago.

Of note throughout 24/25 has been the quality and sustainability of our care market. There have been no provider failures this year and no contracts have been handed back. We continued our focussed support to some providers who had previously been rated Inadequate or required improvement which following reassessment by the Care Quality Commission saw our quality ratings continue to improve. 90.9% of our care home beds are now rated Good or Outstanding which sees Bury's care home beds rated 12th highest in England and compares to an England average of 74%.

The remainder of our community services are rated 4th highest in Greater Manchester. We have only 1 supported living provider rated Requires Improvement and this year we will recommission our home care providers which will result in only care at home providers rated Good or Outstanding being commissioned.

Not seen in this data set but presented to our safeguarding board we have seen the number of acts of neglect or omission in our care services drop by half, which demonstrates the support we provide to our care providers really is making our services safer.

2024 to 2025 has been a great year for our social work workforce which has seen additional posts added in our reviewing team, our neighbourhoods, our intermediate care services and our safeguarding service. This year we have also supported more social work apprentices than ever before. Our vacancy rate has never been lower at only 3% and our staff engagement results from the pulse survey are the best across the whole council.

1.2. Objectives

For 24/25 these were to:

- Continue our transformation of learning disability services
- Continue our improvement of social work services
- Ensure we delivered superb intermediate care
- Make safeguarding everyone's business
- Deliver a local and enterprising care market
- And connect unpaid carers to quality support services

1.3. Transforming learning disability services

This year saw the full implementation of new preparing for adulthood team where we work with Children's services to ensure our younger residents a smooth transition into adult services. This team is now fully established and met its Q4 milestone of having every young person aged over 17 allocated to an adult's worker and having an assessment under the Care Act.

Our Together Towards Independence programme continued with staff being trained in the progression model ensuring our residents with a learning disability can be as independent as possible. In the coming year we will see the recommissioning our learning disability providers to ensure they are all working to this strengths-based approach designed to improve outcomes.

We have also formed the networks needed to develop our autism strategy and look forward to this being delivered in 25/26

1.4. Excellent Social Work

A large focus of this objective was to reduce our waiting lists and times which has been hugely successful, but we have also implemented a new progression policy and embedded our quality assurance system for case work which now involves the collection of feedback from our users.

We more than doubled the number of apprentices with the help of a grant from the Department of Health and Social Care and have recently joined the Think Ahead programme which supports the training of additional social workers to work in Mental Health.

We also welcomed a new Principal Social worker to our team who brings with her even more experience that will help us further improve the quality of our social work practice.

1.5. Superb Intermediate Care

A business case was prepared that saw additional investment in our Reablement Services to ensure even more people can benefit.

The home from hospital virtual ward service was implement and now supports up to 70 people every day who would otherwise be in hospital.

We have prepared a new intermediate care strategy for 2025 onward which will be ready for publication in the new financial year.

We finally took the plunge and purchased an electronic care record for our care services which will be in use from Q1 of 25/26.

Our work with our partners in the hospital as part of the front runner programme has seen our older residents and those with dementia in hospital supported to keep active and engaged whilst inpatients and as a result, we have seen demand for home based services rise and bed based services freed up to take more dependent patients. We have also supported more residents with dementia at home following hospital discharge. This programme called the 'Days Kept Away from Home Collaborative' went on to win a Health Service Journal Award for best partnership working as well as 2 highly commended in other categories.

1.6. Safeguarding in Everybody's Business

A multi-agency risk management protocol was developed and implemented by our safeguarding board partners.

We launched our safeguarding transformation programme for our operation teams and are well on with the design phase ready for implementation next year.

We have also improved our work implementing actions from safeguarding adult reviews and delivered a greater number of learning and improvement events.

Processes have been changed and improved within the safeguarding team that see enquiries being completed faster and more people fully or partially achieving their outcomes.

1.7. A Local and Enterprising Care Market

This programme saw the delivery of a brand-new quality assurance framework for our care providers. Our care workforce provider support offer was enhanced, and a new workforce strategy has been developed and is due to be agreed at cabinet in in Q1. This will see Persona grow to help us support our care market with attracting, retaining and training the care workforce in Bury.

In addition to seeing the continued delivery of our housing strategy which has delivered over £10m of inward capital investment in new accommodation schemes this programme has also developed an Extra Care Housing Strategy due for cabinet agreement in July 2025 and is now planning a refresh of our housing with additional needs strategy.

A Dementia and Ageing Well strategy have been developed, and work is almost complete on our prevention strategy.

We've also renewed our Internet Site and refreshed multiple parts of the Bury Directory making it easier to find information and advice. The Carers pages underwent huge transformation as part of our development of our new carers' strategy.

Underway now and due for delivery in 2025 is our new home care provision tender which will see all the borough's home care recommissioned.

1.8. Connecting Unpaid Carers to Quality Support Services

This priority saw the development of our new Carers Strategy and recommissioning of our carers' services. Developed with hundreds of our carers at large engagement events our strategy and its priorities were then co-produced with our co-production networks, a smaller group of carers and our carers service. We are now forming a carers co-production network who will help oversee the implementation of our strategy.

In addition to this, in partnership with Rochdale and Oldham our carers service N-Compass we utilised an accelerated reform grant to develop a new carers service for our residents who are in hospital.

1.9. And finally

Quarter 4 saw the department take part in a Local Government Peer Review where we hosted a group of health and social care professional for 3 days.

You can read a summary of their findings in the next section and the whole reported is appended to this report.

Whilst there is always more to do, they complimented the depth and breadth of our integration with our partners and praised our outstanding workforce for the difference they are delivery every day to our residents.

2.0 Delivery of the Adult Social Care Strategic Plan

2.1 Adult Social Care are committed to delivering the Bury 'LETS' (Local, Enterprising, Together, Strengths) strategy for our citizens and our workforce. Our mission is to work in the heart of our communities providing high-quality, person-centred advice and information to prevent, reduce and delay the need for reliance on local council support.

2.2 The Adult Social Care Strategic Plan 2023-26 sets out the Department's roles and responsibilities on behalf of Bury Council. It explains who we are, what we do, how we work as an equal partner in our integrated health and social care system and identifies our priorities for the next three years:

2.3 To build a health and social care system which will sustain our communities in the coming years within the funding available to us we need to look at providing support in different ways. Our journey over the next 3 years will be one of improvement and transformation, with the development of clear assurance mechanisms to enable transparency and accountability to the communities we serve. As we explore what social care delivery will look like 3 years from now, we will ensure that people who receive our support and their carers are at the heart of co-producing our social care delivery model and that their voice is central as we navigate through the financial and systemic changes we must make. The need for a new strategic priority to 'connect unpaid carers to quality support services' has been identified alongside the preparation of a new carers strategy in 2024/25 and progress will be included in future quarterly reports.

2.4 The 2023-26 Strategic Plan was refreshed in April 2025 supported by an updated annual improvement delivery plan which is monitored on a quarterly basis. Quarter 4 2024/25 delivery highlights include:

<u>Priority 1 – Transforming Learning Disabilities</u>

- Establishment of peer networks for autistic adults and families/carers.
- People with a learning disability and/or Autism a) taking up training opportunities saw an 18% increase on 23-24 and b) who have paid employment saw a 17% increase on 23-24.

Priority 2 – Excellent Social Work

- Q4 activity saw a review of our business plan following appointment of the new PSW with activity to be carried forward into a revised set of excellent social work improvement priorities for 2025/26.

Priority 3 – Superb Intermediate Care

- A review of reablement customer demand and capacity has been completed with additional staff being recruited to ensure the capacity of the service is sufficient to meet demand

Priority 4– Making Safeguarding Everybody's Business

- Multi-Agency MARM protocol implemented.
- Safeguarding Adults Board learning and development practice session delivered.

Priority 5– A Local and Enterprising Care Market

- Provider Quality Assurance and Improvement Policy has been signed off and implemented which will see further improvement and monitoring of our community care services

Priority 6 – Connect Unpaid Carers to Quality Support Services

- Bury Adult Carers Strategy 2025-29 was approved.

3.0 Update on Care Quality Commission (CQC) Assessment of Local Authorities

3.1 Since the CQC finalized its assessment guidance for local authorities in December 2023, it has now published 27 completed assessment reports (Local authority assessment reports - Care Quality Commission) with most of the 153 councils working through the assessment process.

3.2 The CQC indicated that all local authorities yet to be notified, would be contacted between March and September 2025. The first council in Greater Manchester (Bolton) was contacted as part of the April notifications. The next two upcoming notification dates are 12th May and 9th June 2025.

3.3 Local progress in terms of CQC Assessment readiness activity includes:

- Reviewing the draft CQC Information Return.
- Updating the Self-Assessment of Adult Social Care in Bury.
- Confirming all local key contacts for the CQC for the site visit.
- A 'Getting the Call' plan for pre-assessment site visit planning is in place.
- Case tracking information preparation is underway.

3.4 In February 2025, an LGA Adults Peer Challenge took place at the request of the Adult Social Care Department, to support preparation planning for CQC inspection. A copy of the full report is attached as an appendix to this report.

3.5 Key messages from the Peer Challenge are summarised as follows:

Passionate and Committed Workforce. Staff across the adult social care directorate in Bury demonstrate a passion and positivity for their work.

A Clear and Well-Articulated Improvement Journey. Staff members are highly engaged in the ongoing improvement journey and can clearly articulate how strengths-based practice has been embedded within service delivery.

Resources and Team Support. Staff reported feeling well-equipped to carry out their roles effectively, with access to the necessary resources and support.

Strong and Self-Aware Leadership. The leadership of the directorate demonstrates a high level of self-awareness and is committed to creating an environment where staff can thrive.

Visible and Approachable Leadership. Staff consistently highlighted the visibility and accessibility of senior leadership within the service.

Financial Commitment to adult social care. In a challenging financial climate. The commitment to reinvesting in adult social care through additional staff resources demonstrates a proactive approach to sustaining the quality-of-service provision.

Effective Management of Waiting Lists. Significant progress has been made in reducing waiting lists for new assessments, reviews, and occupational therapy.

Exemplary Integration with Health Services. The integration of health and social care services at both operational and strategic levels in the council is commendable and serves as a model of best practice.

Strong Provider Relationships and Quality Assurance. The service's teams have established robust relationships with care providers, underpinned by a well-structured quality assurance framework.

Effective Safeguarding Partnership Working. The relationships within the Safeguarding Adults Board (SAB) are described by partners as robust suggesting effective multi-agency collaboration.

Commitment to Co-Production. The council demonstrates a genuine commitment to co-production, particularly among senior leadership and commissioning management.

Robust Oversight of Data, Quality, and Finance. The directorate was able to demonstrate to the peer challenge team clear oversight in data management, quality assurance and financial control.

3.6 A number of areas for consideration were also raised, these are summarised below, with improvement actions being undertaken by the Council:

Embedding Safeguarding Awareness Across All Teams. While safeguarding structures are in place, there is a need to ensure that safeguarding practice and referral pathways are consistently understood by all staff.

Action: A priority intervention within the Adult Safeguarding Programme is to agree a revised internal referral pathway for adult safeguarding from start to closure with referral routes out.

Enhancing Support and Engagement for Carers. Further work is required to ensure that carers fully understand the support available to them, how to access services, and how they can contribute to strategic planning.

Action: Work is planned for 2025/26 to establish a new carers' service, coproduction network and to develop a young adult carers' charter.

Embedding Equality, Diversity, and Inclusion (EDI) Across All Teams. While the Integrated Neighbourhood Teams (INTs) have made significant progress in considering ethnicity and religion in service delivery, other teams and aspects of EDI require further attention.

Action: Work has commenced on the preparation of an EDI plan for Adult Social Care to understand and address barriers to care and support, meet the diverse needs of communities and representation in our workforce.

Improving Website Accessibility and Communication Clarity. There is recognition that the accessibility of the corporate and adult social care webpages needs improvement to ensure residents can easily access information and support.

Action: Improved website content for adult social care is live following its redevelopment that had commenced prior to the Peer Challenge.

Expanding Commissioning Beyond Accommodation-Based Support. Currently, commissioning is largely focused on accommodation-based support. There is an opportunity to broaden this approach in partnership with the Voluntary, Community, Faith and Enterprise (VCFE) sector and with Persona.

Action: A refreshed set of commissioning intentions for 25/26 are being developed.

4.0 Highlight Report for Quarter 4, 2024/25

Adult Social Care - Quarterly Highlight Report - Quarter 4

Obsessions	Performance Measures	Frequency	Polarity	Sparkline	Lastest Data	Direction of Travel	Rank (higher is better) Peers (16) 23/24	Rank (higher is better) NW (24) Q3 24/25	Rank (lower is better) GM (10) Q4 24/25
Reduce the number of people waiting for a social work needs assessment	Number of people on waiting list for ASC needs assessment	Q	L		54				3
	Median number of days waiting for an ASC needs assessment	Q	L		26				4
Increase the number of people who have their safeguarding outcomes partially or fully met	Proportion of people that were asked about their outcomes	Q	H		85%			11	
	Of those who expressed outcomes the proportion of people who have their safeguarding outcomes fully or partially met	Q	H		100%			7	
Increase the number of people leaving intermediate care services independently	The proportion of people who received short-term services during the year where no further request was made for ongoing support	Q	H		85%		3	8	
	The proportion of older people (65+) who were still at home 91 days after discharge from hospital	A	H		92%		7		
Increase the number of people with a learning disability who are provided with the opportunity to live more independently	Number of people trained in the progression model	A	H		58				
	Number of customers who have had an assessment or review using the progression model	A	H		275				
Increase the number of people accessing care and support information and advice that promotes people's wellbeing and independence.	The proportion of people and carers who use services who have found it easy to find information about services and/or support	A	H		65%		10		
	The proportion of people who use services, who reported that they had as much social contact as they would like	A	H		47%				
Increase the number of people with lived experience who provide feedback	Number of feedback provided	Q	H		124				
Increase the number of unpaid carers identified	Total number of new carers registered with Bury Carers' Hub	Q	H		84				

Annual Measures: ASCOF 24/25
Quarterly Measures: updated Q4 24/25

The Department has adopted an outcome-based accountability framework to monitor performance and drive improvement. Several outcomes have been chosen that will change if the objectives of our strategic plan are met, we call these our obsessions. An obsession is a key part of an outcome-based accountability framework where focus on these areas have positive knock-on effects right across our areas of work

In Quarter 4 we saw a small but anticipated increase in days waiting for assessment following the Christmas period, but this was quickly resolved in the following months, and we have maintained our positive performance standing in relation to this obsession, remaining 3rd in Greater Manchester for this measure.

Safeguarding outcomes continue to be strong, and further detail is available later in this report,

Quarter 4 showed a very small dip in the numbers of people leaving our short-term services independent at 85% but this continues to be above the England average of 83% and was only 1% lower than last quarter

One of our priorities is transforming learning disability services by implementing a strengths-based progression model throughout our services that support people with learning disabilities. This focuses on maximizing independence for individuals with learning disabilities by providing tailored support to gradually develop life skills, allowing them to progress towards greater autonomy in their daily lives, often through small, achievable steps and personalised goals based on their individual strengths and needs; it emphasizes a focus on increasing independence rather than relying on long-term care services.

So far, we have trained 58 social workers and care providers in this new model and 275 of our learning disability users have benefited from this new model of care and support planning.

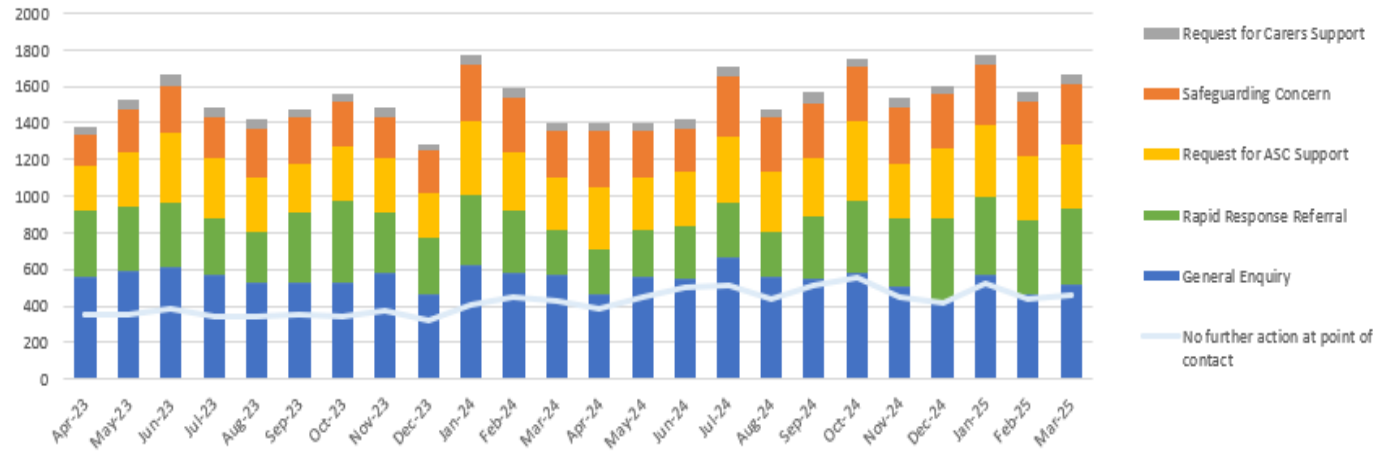
Improving the number of people accessing information is only collected annually as part of a national survey so this number will not change regularly. However, to ensure we can improve this we have been developing the council intranet and internet sites which went live in Q4, you can see them here Health and Adult Social Care - Bury Council or https://www.bury.gov.uk/social-care-and-support/health-and-adult-social-care

Our efforts to collect feedback from our users continues to embed and we are now collecting it regularly as part of our assurance processes for care services and case files audits. So far 386 people have provided feedback which will be used to inform the development of our services and service plans for 25/26.

4.1 Contacts

The primary means of public contact to request support, information and advice is through our care, connect and direct office (CAD). A higher proportion of contacts resolved by CAD means that people's enquiries are being dealt with straightaway and not passed on to other teams.

Number of Adult Social Care (ASC) Contact Forms recorded each month.



How does Bury Compare?

Contacts by Outcome | February 2025

	Safeguarding adults	Deprivation of liberty safeguards	Link to existing case	Progress to new case	Resolved at contact - equipment / adaptations /telecare to be provided	Resolved at contact - other	Unknown
Bolton	3.2%	7.6%	21.4%	19.9%	30.2%	17.7%	
Bury	22.1%	2.0%	5.7%	38.8%		23.8%	7.7%
Manchester	14.4%	7.5%	41.5%	14.7%	0.6%	21.3%	
Oldham	12.6%		1.9%	29.3%		56.2%	
Rochdale				35.5%	34.3%	30.2%	
Salford			72.7%			27.3%	
Stockport	13.1%	9.4%	26.1%	26.8%	3.3%	21.2%	
Tameside	29.2%	2.0%	12.8%	30.7%		25.3%	
Trafford	2.4%	4.8%	47.0%	12.7%		33.2%	
Wigan	21.6%	11.9%	33.1%	17.0%		16.4%	

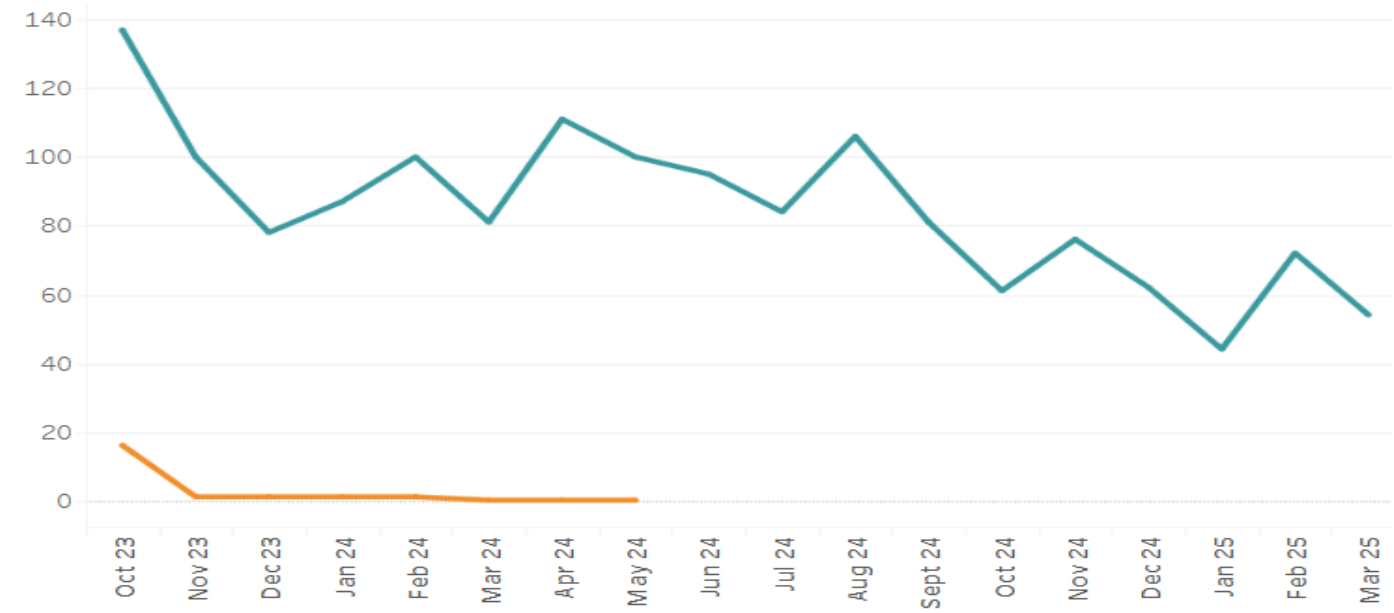
Contacts – Q4 commentary

This shows the number of contacts the department receive each month and what they were about. It also illustrates the number resolved by our contact centre.

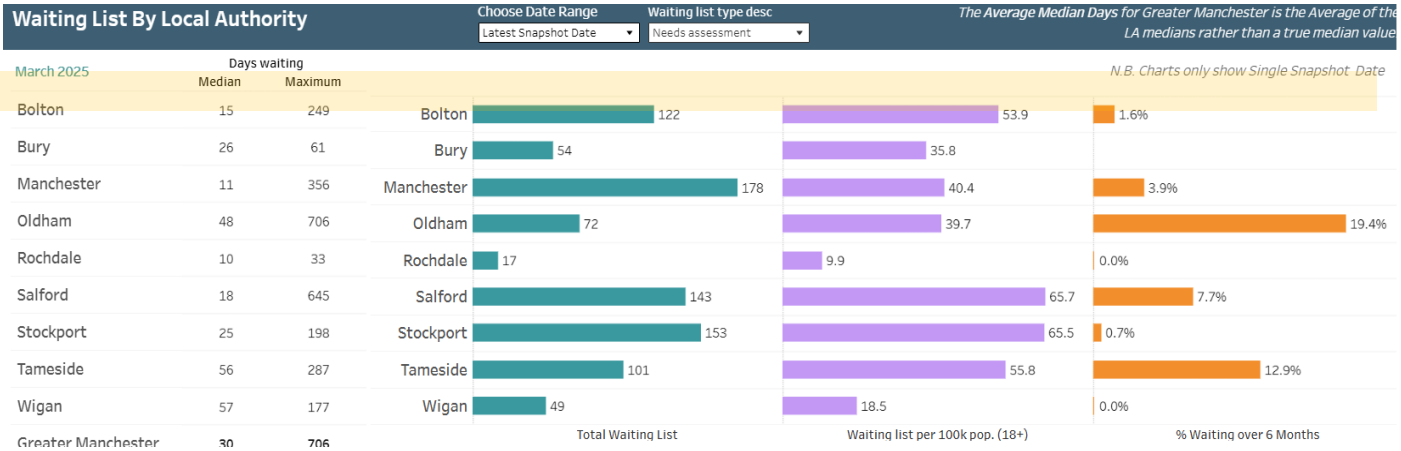
Q4 showed volumes remaining at a busier level, January showed increased activity and is traditionally the most active month for all contacts. Activity returned to average levels during February and rose again in March but is now consistency 100 contacts per month higher than it was 2 years ago.

4.2 Waiting Times for Assessments and Reviews

People awaiting an assessment or review of their needs by social workers, occupational therapists, or deprivation of liberty safeguards assessors. Reduced waiting times lead to improved outcomes for people because they are receiving a timelier intervention.



How does Bury Compare – Needs Assessment?



Waiting list – Q4 commentary

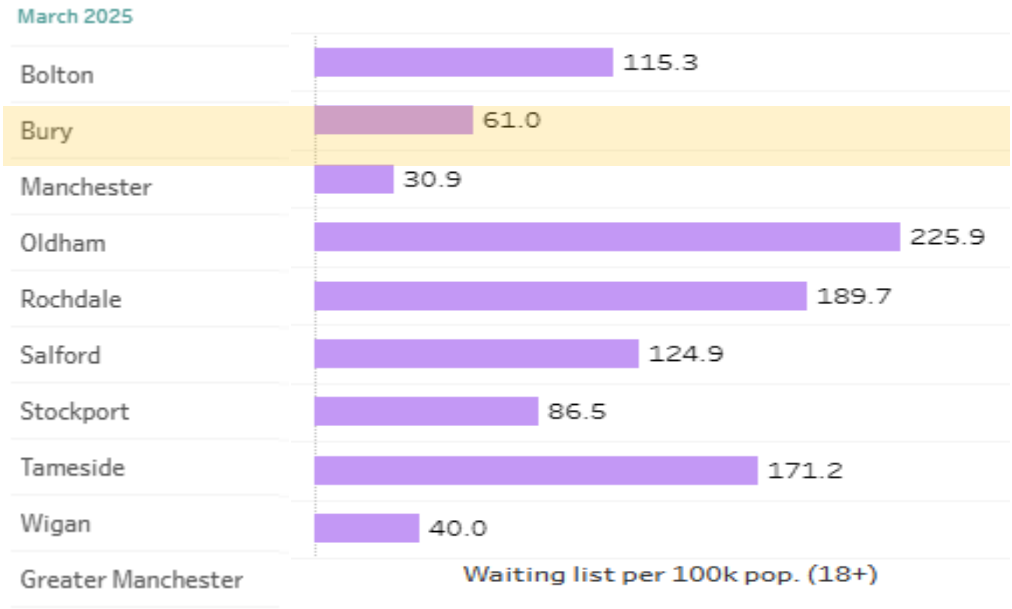
Progress continues to be made in reducing the numbers of people awaiting allocation for Care Act assessment through our targeted initiatives under the oversight of the Performance and Improvement Board. After a slight increase in days waiting in January (as is expected due to post holiday period demand) we have been successful in maintaining our position as 3rd in Greater Manchester against this metric. We remain in a strong position on cases awaiting allocation and our recent LGA Peer Review identified that staff and managers are supporting the reduced number of people awaiting allocation with focus to managing any residual risk and with appropriate

attention to prioritisation. Waiting well principles are being adhered to providing assurance that the reducing number of people awaiting assessment are 'waiting well'.

We continue to use data analysis to focus our performance strategies overseen by robust governance. Our vacancy rates in social work remain at an all-time low with continued and concerted effort towards further reductions in waiting times. Through the Adult Social Care Performance and Improvement Board managers across the department continue to focus on monitoring trends and themes in demand with continued refresh of the data recording and dashboards to evidence work undertaken and support efficiency in service delivery.

Efforts continue to focus on reducing the number of people waiting for an Occupational Therapy assessment, supported by the investment in two additional Therapists. This increased capacity has continued to show positive impact. After reaching a high of 387 people in August 2024, numbers reduced to 267 by December and have now further decreased to 178 in March 2025.

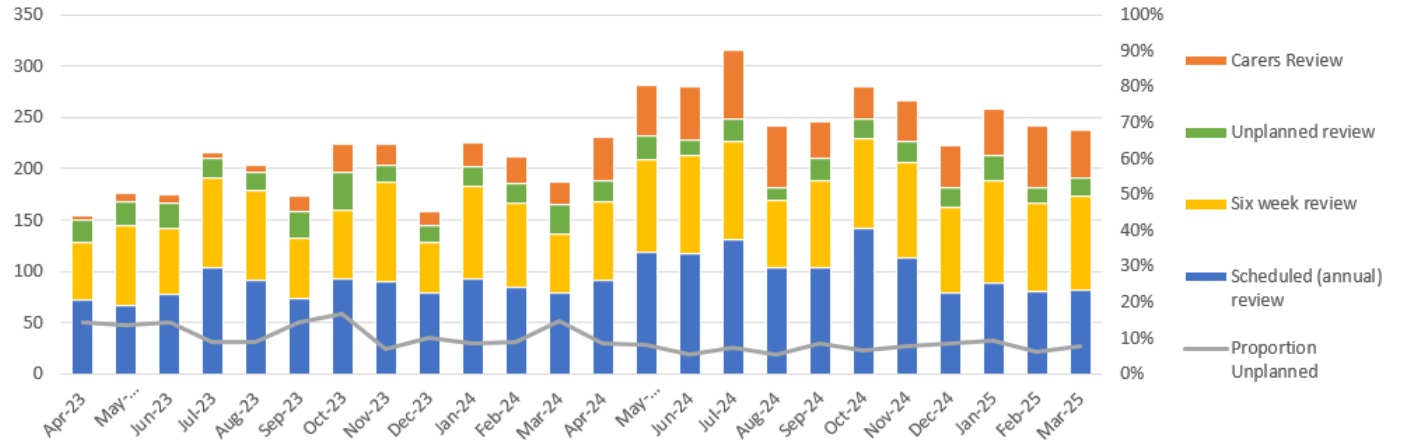
How does Bury Compare – OT assessment?



4.3 Reviews

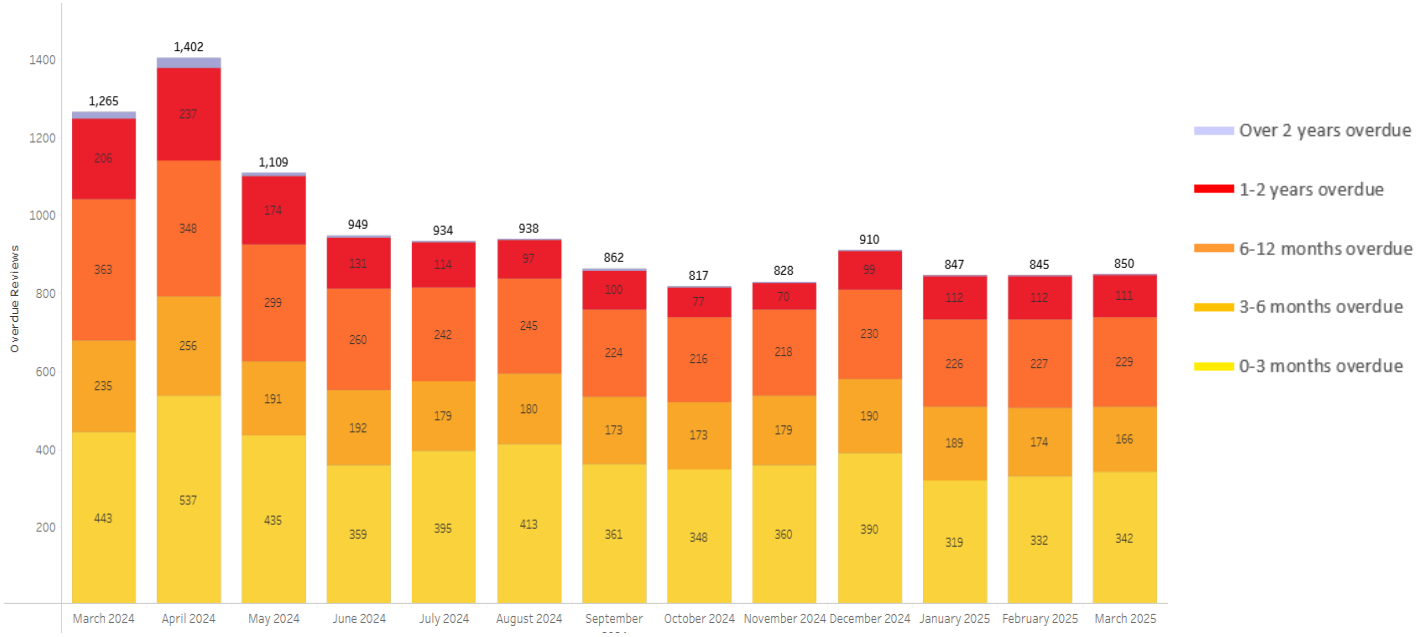
Adult Social Care reviews are a re-assessment of a person's support needs to make sure that they are getting the right support to meet their needs. Needs may change over time, and new services and technology may give someone more independence and improve their wellbeing. A lower proportion of unplanned reviews means that people are support through scheduled reviews of their support needs rather than when a significant event has occurred requiring a change in support. Support packages should be reviewed every 12 months. It is important to note that it not just the adult social care reviewing team who undertake reviews, however, most of the planned review activity is completed by this team.

Number of Adult Social Care Reviews Completed each month.



Note - the % axis references the grey line which is the proportion of unplanned reviews.

Number of Overdue Adult Social Care Reviews on the last day of each month



Reviews – Q4 commentary

This shows the number of people who have had a review of their care and support and those who are overdue an annual review. All the 3000+ people receiving long term services should receive an annual review each year and those new or in short term services should receive an initial review in the first 6 to 8 weeks of service commencing.

A review is an opportunity to ensure someone's care and support is meeting their assessed needs and their support is personalised to them. It is also an opportunity to ensure care is not resulting in dependence and provides an opportunity to reduce care to increase a person's independence. This also releases care back into the market to be used by others.

At the end of Feb 2025, 850 people were overdue a review. This is a significant reduction compared to the position 12 months ago when the average number of overdue reviews was 1200-1450, however, there is still further progress to be made given that the number of overdue reviews appears to be fairly stable over the past 6-9 months, though reassuringly, these figures are not increasing to the levels from 12 months ago.

This is significant progress when compared to the position 12 months ago and is down to several factors, including: the expanded adult social care reviewing team continuing to be fully staffed, as well as a continued push on data quality across the system and ensuring that reviews are not incorrectly showing as overdue. The graphs also reflect the extra efforts which have been taken to target carers reviews, with the adult social care reviewing team now being in a position where all carers' reviews identified as due to become overdue in a particular month are allocated across the team at the beginning of the month, meaning that all unpaid carers are reviewed yearly.

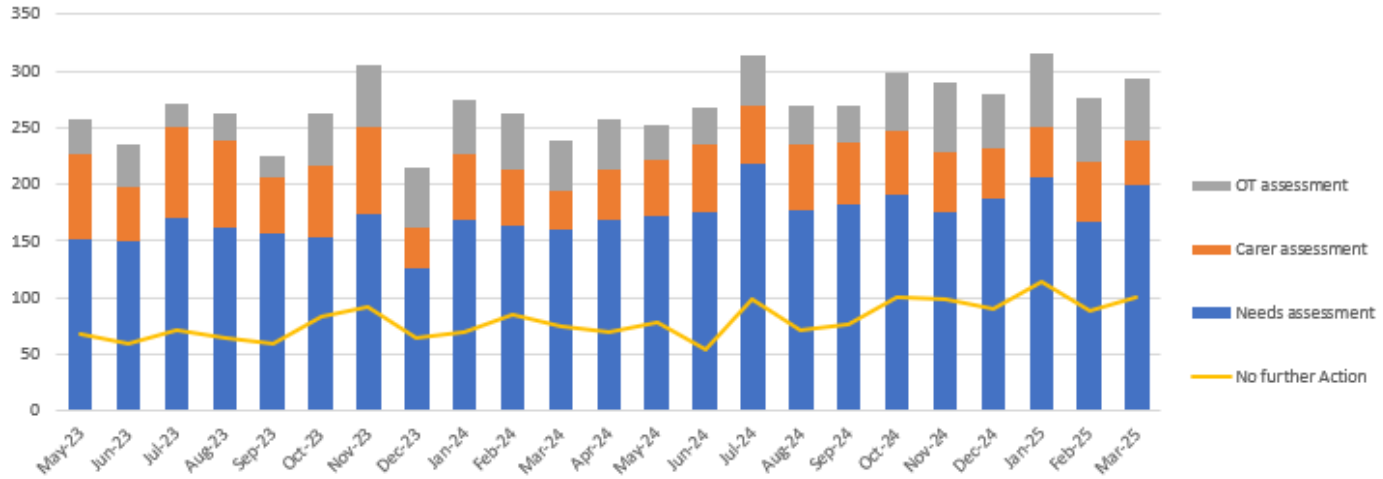
Identifying and supporting unpaid carers is a departmental target and we have achieved our target set out in Q1 of being in a position where unpaid carers are now no longer overdue their reviews. At present, the team are now maintaining this position and take great pride in doing so.

This is a very positive achievement for the department and further demonstrates where adopting an obsession drives positive performance.

4.4 Assessments

Local Authorities have a duty to assess anyone who appears to have needs for care and support, regardless of whether those needs are likely to be eligible. The focus of the assessment is on the person's needs, how they impact on their wellbeing, and the outcomes they want to achieve. Assessments where there was no further action are where there were no eligible needs identified or a person with eligible needs declined services. A lower number means that operation teams can focus their time on those people with identified needs.

Number of Adult Social Care (ASC) Assessments Completed each month.



Assessments – Q4 commentary

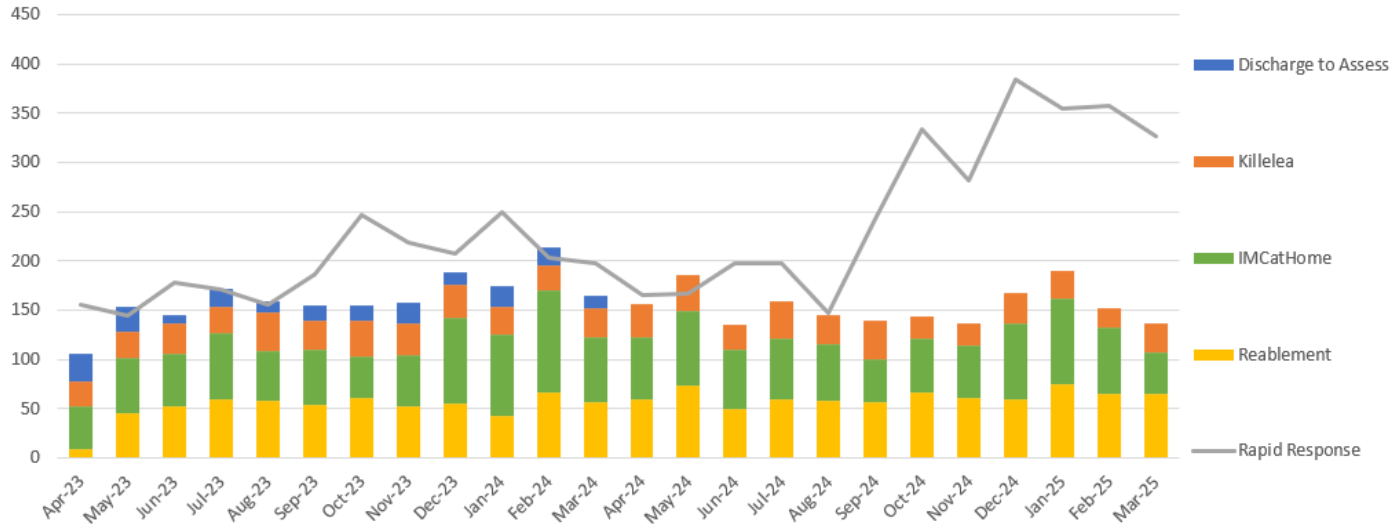
In Quarter 4, the demand for assessments remained high, with average monthly numbers exceeding 200, compared to just over 150 two years ago. This increase in demand has been addressed by optimising workflows through prompt allocation of casework, the implementation of short-term assessments for urgent cases and maintaining a focus on caseload reviews. The department's efforts to improve efficiency and workforce capacity have resulted in a stable assessment completion rate, with the time taken to complete assessments improving compared to the Greater Manchester average. Moving forward, the department will continue to monitor demand and make necessary adjustments to staffing and processes to ensure that high standards of service are maintained.

The focus on efficiency and workforce capacity has resulted in a stable assessment completion rate, with the time taken to complete assessments improving compared to the Greater Manchester (GM) average.

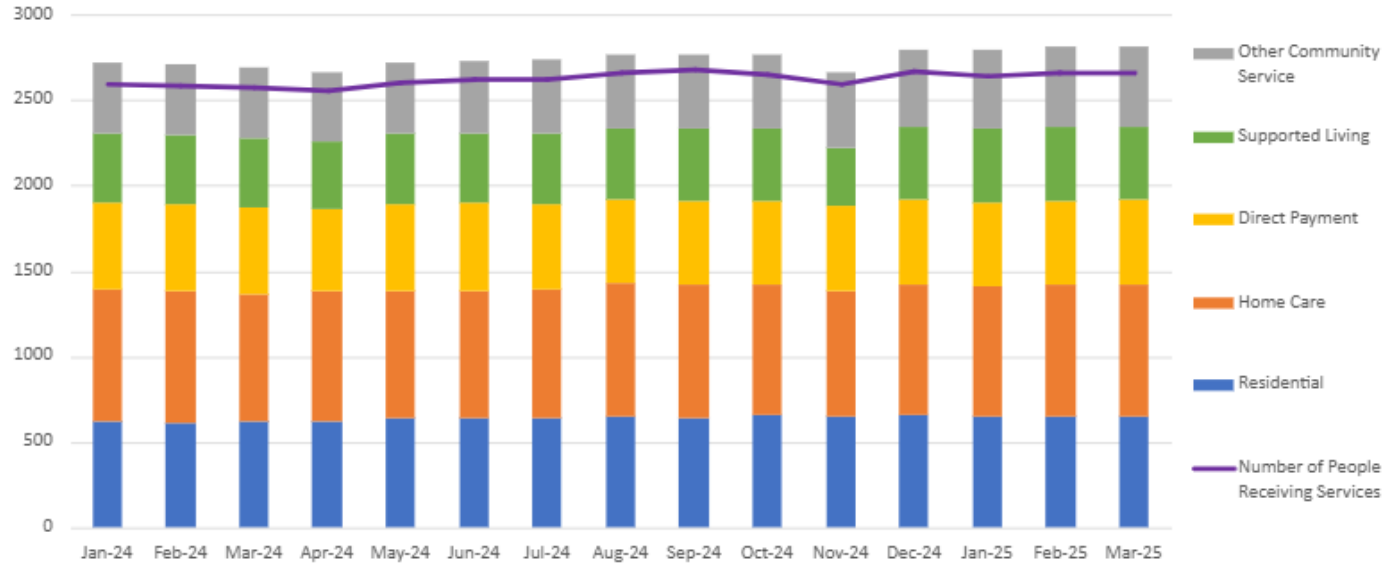
4.5 Services

Adult Social Care services may be short-term or long-term. Short-term care refers to support that is time-limited with the intention of regaining or maximising the independence of the individual so there is no need for ongoing support. Long-term care is provided for people with complex and ongoing needs either in the community or accommodation such as a nursing home. It is preferable to support people in their own homes for as long as it is safe to do so.

Number of Intermediate Care (short-term) services completed each month.

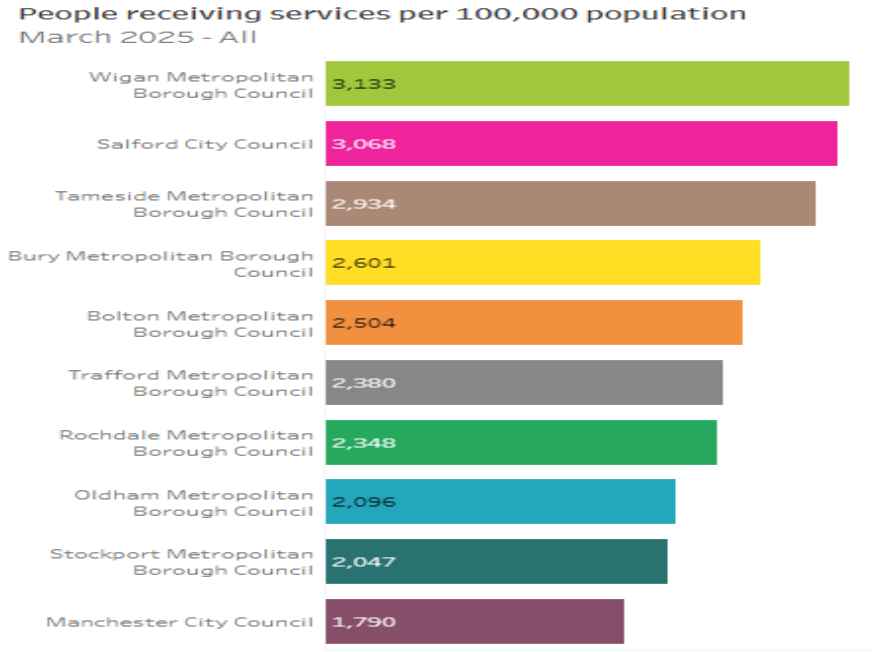


Number of Long-term Adult Social Care services open on the 1st of each month.



	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Residential	618	639	640	640	645	644	658	650	656	649	648	648
Home Care	764	746	748	757	782	779	760	737	769	766	776	775
Direct Payment	485	509	510	497	496	488	488	494	491	490	489	492
Supported Living	387	408	409	407	413	419	424	341	429	432	431	428
Other Community Service	408	417	424	440	434	438	440	445	451	453	468	471
Residential Placement	618	639	640	640	645	644	658	650	656	649	648	648
Supported at Home	1940	1965	1984	1988	2014	2041	2000	1945	2021	1996	2014	2013
Number of People Receiving Services	**2558**	**2604**	**2624**	**2628**	**2659**	**2685**	**2658**	**2595**	**2677**	**2645**	**2662**	**2661**

How does Bury Compare?



Services – Q4 commentary

This shows the number of people we support in our various service types.

The first chart shows the number of people supported in our intermediate care services. These services aim to prevent, reduce, and delay the need for long term care and support so the busier they are the better.

There have been a reduced number of people through Killelea due to the high acuity over the winter months (quarter 4). Whilst it was envisaged the number would increase from quarter 3, there were also a reduction in referrals into the service. Whilst a drop in flow through our intermediate care bed based services is concerning, the referrals to the home based service (Reablement) increased significantly to the highest recorded in Q4, it did not impact on flow out of the hospital as the department purchased alternative domiciliary capacity from the independent sector to mitigate this. Quarter 4 has shown to have increased dependency, within the bed-based service, due to the local hospital ensuring people do not decondition when admitted, this has led to more people returning home with Reablement and IMC@home and the more dependant people requiring a bed base.

Although many services have remained stable you will see from the graph that Rapid Response activity has stabilised on the increased activity, this has not fallen to levels previously seen in Q1 and Q2. This is caused by the increasing success of the hospital at home service continuing to support even more people and avoiding hospital admissions, thus maintaining people in the community ensuring they do not escalate to require ongoing Social Care services, whilst also recovering at a much quicker rate. Significant work has taken place with primary care colleagues and local care homes, to refer to Rapid Response as a first port of call, prior to calling an ambulance. I addition to this, the Northwest Ambulance Service (NWAS) has utilised Rapid Response more often, including utilising them for falls within the Bury location.

Overall service use is shown in the second and third charts which shows service use increasing with larger growth in other community services and supported living. The other community services are explained by our new assistive technology services and supported living by our opening of mental health supported accommodation. The numbers of people with a learning disability in supported living has not increased. However, we have also seen the use of residential care rise by 4.9% which is higher than population growth. This has been the result of a change in NHS processes for assessing continuing health care where patients are no longer funded by the NHS at the point of discharge from hospital, but rather funded as normal pending CHC assessment, this has seen a rise in the number of nursing home placements funded by the council that is responsible for this growth.

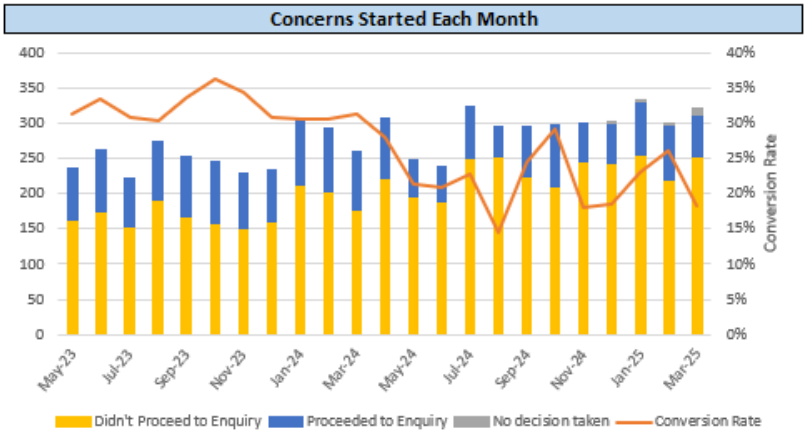
4.6 Safeguarding

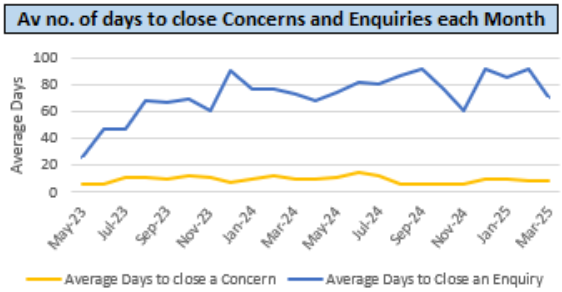
Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working **together** to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action.

Safeguarding and DoLS Activity Summary

Obsession	Increase the number of people who have their safeguarding outcomes met		Mar-25
	Percentage of people who were asked what outcome they would like		85%
	Of the people that expressed outcomes, were the outcomes achieved?	Not Achieved	
		Partially Achieved	42%
		Fully Achieved	58%

Open Safeguarding Enquiries	*Number*	*Av. Days*	*Max Days*
ACS Safeguarding Team	96	95	637
Hospital Social Work Team			
Learning Disability Team	16	37	188
OPMHT	5	31	67
Community Mental Health Team			
Strategic Adults Safeguarding Te			
Operation Crawton			
Total	**117**	**86**	**656**





Active DoLS Requests	*Urgent*	*Standard*	*Total*
Waiting for Assessment	1	81	**82**
Processing	1	10	**11**
Total	**2**	**91**	**93**

How does Bury Compare?

Metric	Bury	Rank in Northwest (out of 22)
Conversion Rate	16%	5th
Making Safeguarding Personal – Asked	90%	6th
Making Safeguarding Personal - Outcomes	94%	10th

Last Updated: Q4 2024/25

Safeguarding – Q4 commentary

A continuing picture of good performance for Bury Adult Safeguarding. Last quarter we saw a marked increase in asking people their outcomes and either fully or partially achieving those outcomes. This has continued in practice with outcomes being asked in 90% of cases and 94% of these cases having their outcomes met or partially met. It is unlikely that we will ever meet everybody's outcomes all the time. However, we continue to be happy with this level of outcome data.

The conversion rate as stated in the chart has dropped to 16% which is a continuation of the previous quarter. We continue to monitor this change this against our safeguarding concerns being received to ensure that we are not receiving an unusual amount of inappropriate safeguarding concerns. The

social workers continue to work with and education providers and partner agencies on this issue. Whilst our Head of Adult Safeguarding has raised this issue with his peers across the partnership, through the Safeguarding Adults Board.

We have moved up in the last 12 months at a regional level in Making Safeguarding Personal. Now we are in the top 10 local authorities in the Northwest. We are now also 6th in the region in asking people their outcomes showing that we are focusing on our obsessions. Both regional data points have been held since the last quarter, so we hope that this good practice continues.

S.42 enquiry length times have remained consistent over the last two quarters and is showing a good picture. This is partially due to reviewing how allocations have been taking place and focusing the front-line staff in completion of paperwork where the risk has already been managed. We continue to undertake reflective sessions; we held the last one in March and focused on duty systems and safeguarding concerns and the next booked for July which will focus on our incel ideology and link to our work in the Channel (radicalisation) space.

We have recently held our safeguarding away day, focusing on team development, CQC preparedness and safeguarding transformation and started rolling out the mandatory S.42 enquiry training for all adult social care staff.

Deprivation of Liberty Safeguards (DoLS) continues to perform well with no concerns from a supervisory body perspective.

4.7 Complaints and Compliments

Complaints

Period 2024/25	Number of complaints received	Decision			20 working day timescale	
		Upheld	Partially Upheld	Not Upheld	Within	Outside
Q4	26	3	10	5	10	14

2 complaints closed – consent not provided

6 complaints ongoing

Compliments

Period 2024/25	Number of compliments received	Source		
		Person receiving or had received services	Relative of person receiving or had received services	Other (incl. various survey responses/thank you cards)
Q4	173	6	15	152

Complaints and Compliments – Q4 Commentary

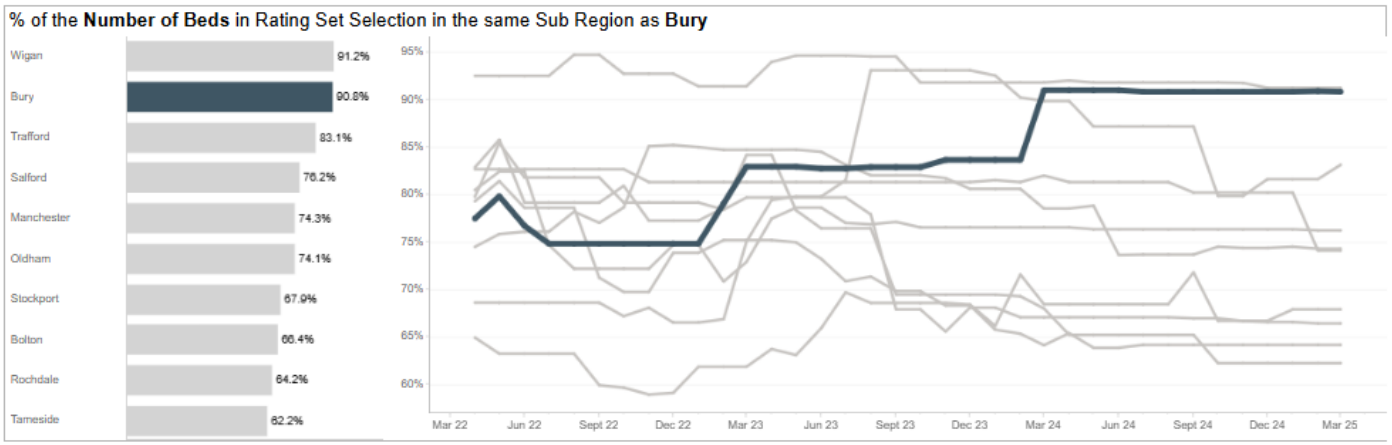
Complaints have shown a small increase from this time last year, 18 in Q4 2023/2024. Although there has been an increase it has not highlighted any areas of concern and appears to be in line with the extra assessment and review activity being undertaken by the department. The total number of complaints for the year is 92 which is very slightly above last year's numbers.

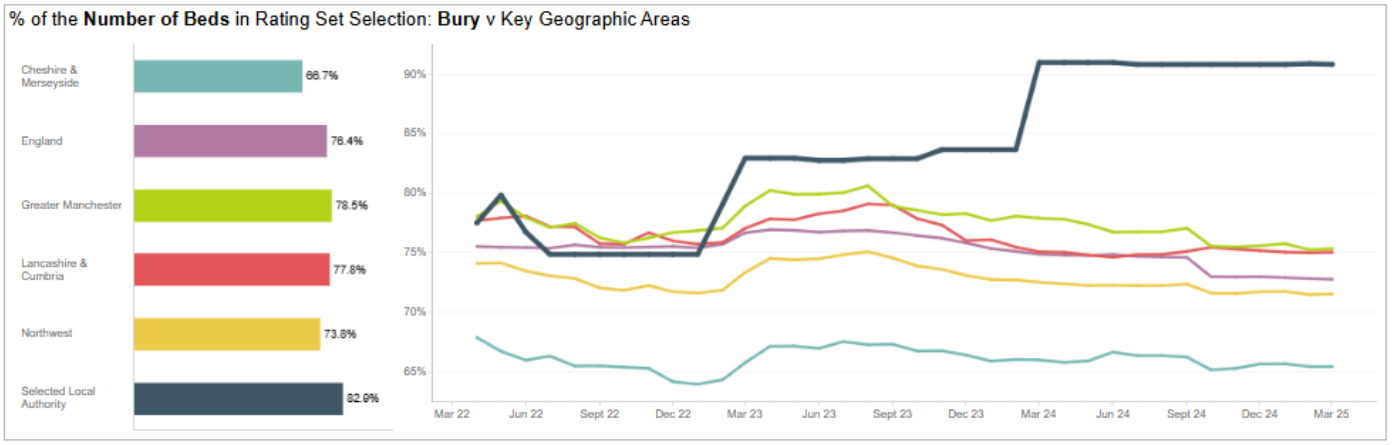
Compliments are showing a decrease from this time last year, 222 in Q4 2023/2024 and are 850 for the year although very slightly lower than last year remains nearly 10 times greater than the number of complaints.

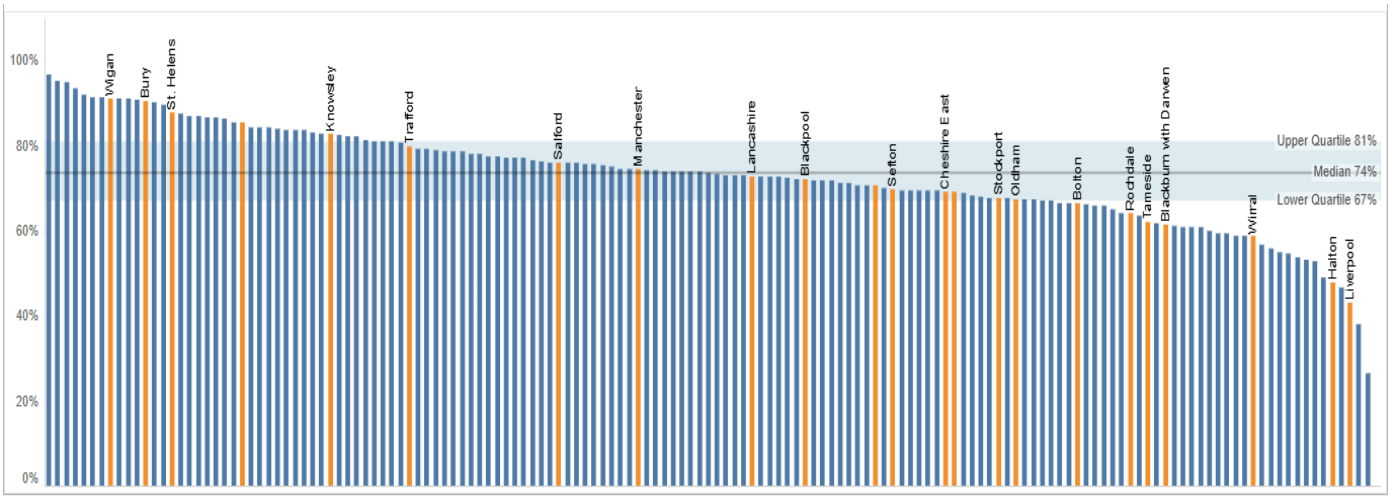
Further information on numbers, themes and teams will be available soon in the annual complaints report which will be tabled at Health Overview Scrutiny Committee later in the year.

4.8 State of the Care Market

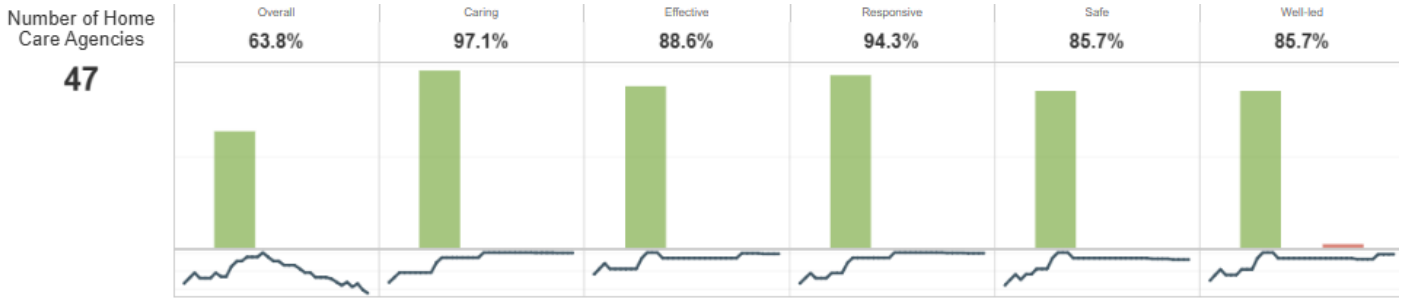
Number of care home beds rated good or outstanding.







Quality Ratings of Bury's Home Care Agencies



Last Updated: Q4 2024/25

State of the Care Market – Q4 commentary

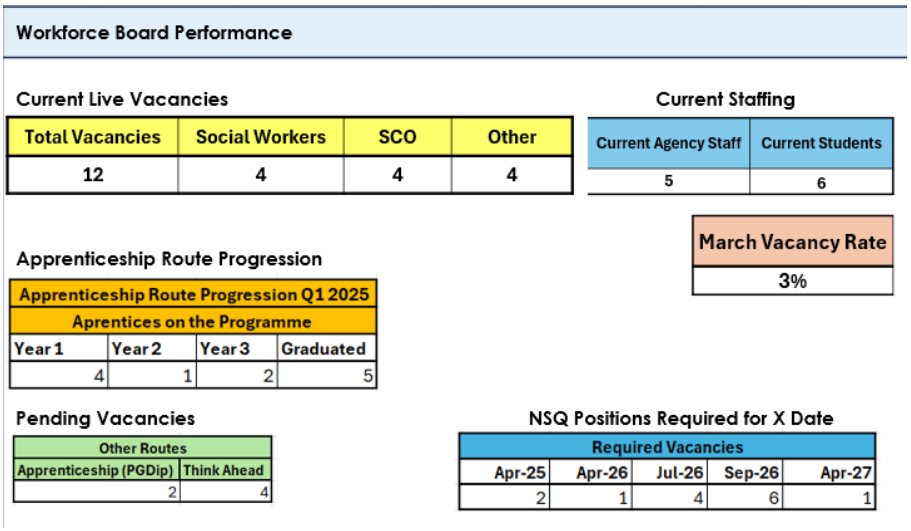
The top charts show the quality ratings of care homes in Bury compared to the rest of Greater Manchester showing the % of beds rated good or outstanding. The second chart shows Bury, and in turn Great Manchester compared to the other regions in England and the Northwest. The third chart shows the % of care home beds rated Good or better across the whole of the country with Bury being at number 12.

The final chart shows the rating of home care agencies operating in Bury. For both charts the nearer to 100% the better. The overall quality of our care homes continues to increase with Bury now joint 1st amongst its GM Neighbours and performing well above the England average and the average of all Northwest regions.

Bury is ranked 4th in GM for community providers including care at home and supported living, however, it should be noted that this considers all providers active in our locality. Of those providers that the Council commission

- The upcoming care at home retender will result in only care at home providers rated Good or Outstanding being commissioned
- Only one supported living provider rated Requires Improvement, the rest are Good or Outstanding.

4.9 Workforce Development



Workforce Board Performance

Current Live Vacancies

Total Vacancies	Social Workers	SCO	Other
12	4	4	4

Current Staffing

Current Agency Staff	Current Students
5	6

March Vacancy Rate
3%

Apprenticeship Route Progression

Apprenticeship Route Progression Q1 2025			
Aprentices on the Programme			
Year 1	Year 2	Year 3	Graduated
4	1	2	5

Pending Vacancies

Other Routes	
Apprenticeship (PGDip)	Think Ahead
2	4

NSQ Positions Required for X Date

Required Vacancies				
Apr-25	Apr-26	Jul-26	Sep-26	Apr-27
2	1	4	6	1

The chart above illustrates the favourable workforce position. Currently, we have a low level of vacancies within the operational department, which enhances team performance, practice consistency, and overall service stability.

The internal social work apprenticeship programme has been revised to improve the learning journey. Positively, five apprentices qualified in March and are now contributing to teams across the department. Our external social work programme has also been reviewed, with a postgraduate route approved, alongside the Mental Health social work fast-track route designed to support the community mental health transformation programme over the next year.

Appendix - Data sources and what good looks like

Section	Chart	Data Source	What does good look like?
Contacts	Number of Adult Social Care (ASC) Contact Forms recorded each month.	Contact Records in LiquidLogic: Contact Type Contact Outcome	Six Steps to Managing Demand in Adult Social Care: ≈ 25% of contacts go on to receive a full social care assessment.
	GM Comparison		
Waiting Lists	Waiting List Summary	Professional Involvement in LiquidLogic: Awaiting allocation work trays Brokerage Work trays Overdue Review Tasks DoLS data from the database.	Lower is better
	Needs and Carers Assessments: No of Cases Waiting for Allocation		
	GM Regional Comparison		
Assessments	Number of Adult Social Care (ASC) Assessments Completed each month	Assessment forms in LiquidLogic	
	GM Regional Comparison	Av. number of days from the contact start date to the assessment end date	Lower is better
Services	Number of Intermediate Care (short-term) services completed each month	All IMC Service data from four data sources	
	Number of Long-term Adult Social Care services open on the 1st of each month.	Service data from Controcc Grouped by Service Type Count of service types, not people	
	Proportion of Home Care vs Nursing and Residential Care Services compared against 2 years ago		Lower Residential & Nursing Care is better
	Northwest Regional Comparison		
Reviews	Number of Adult Social Care Reviews Completed each month	Review forms completed in LiquidLogic	Higher number of completed reviews. Lower proportion of Unplanned reviews.
	Number of Overdue Adult Social Care Reviews on the last day of each month	Review Tasks in LiquidLogic past the due date	Lower is better
	Regional Comparison	As above	
Safeguarding	Percentage of people who have their safeguarding outcomes met	Completed safeguarding enquiries: Making Safeguarding Personal questions	Higher is better
	Outcomes were achieved		
	Open Safeguarding Enquiries	Safeguarding enquiry forms on LiquidLogic and CMHT/EIT spreadsheets	Target: Enquiries closed in 56 days or less
	Concerns Started Each Month	Contact Forms on LiquidLogic: form type safeguarding concerns	
	Average number of days to close Concerns and Enquiries each month	As above	Targets: Concerns closed in 3 days or less. Enquiries closed in 56 days or less
	Regional Comparison	As above	Higher is better

Preparation for Assurance

Peer Challenge Report

Bury Metropolitan Borough Council

Final Report

February 2025

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Background

Bury Metropolitan Borough Council (the Council) asked the Local Government Association (LGA) to undertake an Adult Social Care Preparation for Assurance Peer Challenge at the Council, and with partners.

The council commissioned an independent peer challenge to assess the ability of the adult social care service to deliver good services to people, as well as preparedness of the adult social service for a Care Quality Commission (CQC) assessment.

The purpose of a peer challenge is to help an authority, and its partners assess current achievements, areas for development, and capacity to change. Peer challenges are improvement focused and are not an inspection.

The peer team used their experience and knowledge of local government and adult social care (ASC) to reflect on the information presented to them by people they met, and material that they read.

Prior to being onsite, the LGA peer challenge team undertook a six case file audits, lived experience interviews, a review of data, and held 1-1 calls between members of the peer team and their counterparts at Bury MBC. The team were then onsite for three days holding interviews, focus groups, and discussions to fully understand the adult social care department to develop feedback and recommendations through triangulating the evidence presented.

All information collected was on a non-attributable basis to promote an open and honest dialogue.

The members of the peer challenge team were:

- **Jill Britton**, (DASS), Director of Adult Social Care, Luton Borough Council
- **Councillor Joanne Harding**, Executive Member for Finance, Change and Governance, Trafford Council
- **Alun Davis**, Expert by Experience Peer
- **Ruth Harrington**, Director of Adult Social Care, Adults with Disabilities and SE Essex, Essex County Council
- **Christine Conway**, Head of Adult Safeguarding and Principal Social Worker, Dudley Council
- **Sue Whetton**, Head of Commissioning, Derbyshire County Council
- **Sarah Morris**, Principal Social Worker for Adults, North Northamptonshire Council

- **Marcus Coulson**, Peer Challenge Manager, Local Government Association

The team were on-site at Bury MBC for three days from the 11th –12th February 2025. In arriving at their findings, the peer team:

- Held around fifty interviews and discussions with 190 different people including Councillors, officers, partners, people with lived experience, and carers.
- Had access to the full suite of the 38 CQC information return documents, which included multiple files in each return, plus the self-assessment., and other information was provided by request whilst on site.
- Completed six case file audits and spoke to people with lived experience during the onsite review.

The peer challenge team spent approximately 250 hours with Bury MBC the equivalent of twenty-five working days. Invariably, this is still a snapshot of the Council's adult social care service rather than being a comprehensive picture.

Specifically, the peer team's work focused on the Care Quality Commission (CQC) framework four assurance themes for the up-coming adult social care assurance.

They are:

Care Quality Commission Assurance themes

Theme 1: Working with people. This theme covers:	**Theme 2: Providing support.** This theme covers:
Assessing Need Supporting People to Live Healthier Lives Equity in Experiences and Outcomes	Care Provision, Integration, and Continuity Partnerships and Communities
Theme 3: How the local authority ensures safety within the system. This theme covers:	**Theme 4: Leadership.** This theme covers:
Safe Pathways, Systems, and Transitions Safeguarding	Governance, Management, and Sustainability Learning Improvement and Innovation

All information was collected on a non-attributable basis. The peer challenge team would like to thank to thank councillors, staff, people with a lived experience, carers, partners, and providers for their open and constructive responses during the challenge process.

Initial feedback was presented to the council on the last day of the peer challenge and gave an overview of the key messages. This report builds on the presentation and gives a more detailed account of the findings of the peer team.

Key Messages

There are observations and suggestions within the main section of the report linked to each of the CQC themes and the nine quality statements. The following are the peer team's key messages to the council:

Strengths

Passionate and Committed Workforce. Staff across the adult social care directorate in Bury demonstrate a passion and positivity for their work. Their dedication to supporting residents is evident in their daily practice, and they take immense pride in their roles within the local authority. This sense of purpose translates into high levels of motivation and a commitment to continuous improvement and continuous personal development. Staff members consistently expressed a strong connection to the values and mission of the directorate, reinforcing a positive and supportive working culture.

A Clear and Well-Articulated Improvement Journey. Staff members are highly engaged in the ongoing improvement journey and can clearly articulate how strengths-based practice has been embedded within service delivery. They understand and embrace the importance of focusing on individuals' capabilities rather than deficits, ensuring that care and support services promote independence, choice, and control for residents. The impact of this approach is evident in improved resident outcomes, greater service user satisfaction, and increased staff confidence in delivering high-quality care.

Resources and Team Support. Staff reported feeling well-equipped to carry out their roles effectively, with access to the necessary resources and support. This includes not only financial and material resources but also a culture of peer support across teams and support from direct line managers. The collaborative working environment fosters knowledge-sharing, problem-

solving, and resilience, ensuring that staff can deliver services despite ongoing pressures.

Strong and Self-Aware Leadership. The leadership of the directorate demonstrates a high level of self-awareness and is committed to creating an environment where staff can thrive. Leaders actively seek feedback, reflect on practice, and engage with frontline workers to ensure continuous development. Opportunities for professional growth, training, and career progression are available, empowering staff to develop their skills and advance in their careers.

Visible and Approachable Leadership. Staff consistently highlighted the visibility and accessibility of senior leadership within the service. Leaders engage regularly with teams, providing encouragement, guidance, and a direct link to strategic decision-making. This approach has fostered a culture of openness and trust, ensuring that staff feel valued and supported in their roles.

Financial Commitment to adult social care. In a challenging financial climate,. The commitment to reinvesting in adult social care through additional staff resources demonstrates a proactive approach to sustaining the quality of service provision. Despite budgetary pressures, the council has strategically prioritised adult social care, ensuring that residents receive the support they need.

Effective Management of Waiting Lists. Significant progress has been made in reducing waiting lists for new assessments, reviews, and occupational therapy. Staff and team managers can clearly articulate their approach to prioritisation, ensuring that those with urgent needs are seen promptly while maintaining contact with all individuals awaiting support. This proactive approach enhances resident safety and service efficiency.

Exemplary Integration with Health Services. The integration of health and social care services at both operational and strategic levels in the council is commendable and serves as a model of best practice. Collaborative working between the service and health partners has led to streamlined pathways, improved coordination of care, and better outcomes for residents. Staff provided clear examples of how this integration has had a tangible impact, including more efficient hospital discharges and enhanced community-based support. It was noted that there had been a reduction in hospital attendance of 1.5%, at a time when the adjacent borough had a 4% rise.

Strong Provider Relationships and Quality Assurance. The service's teams have established robust relationships with care providers, underpinned by a well-structured quality assurance framework. Commissioners work closely with providers to ensure high standards of care, with a clear ambition to embed the resident voice at the heart of quality discussions. This collaborative approach fosters a culture of trust and continuous improvement and ensures that services remain

responsive to residents' needs.

Effective Safeguarding Partnership Working. The relationships within the Safeguarding Adults Board (SAB) are described by partners as robust suggesting effective multi-agency collaboration. This partnership ensures that safeguarding responsibilities are well understood and that appropriate structures are in place to protect vulnerable residents.

Commitment to Co-Production. The council demonstrates a genuine commitment to co-production, particularly among senior leadership and commissioning management. This commitment is embedded in strategic planning and operational practices, ensuring that co-production is not merely a policy statement but a principle guiding service development and delivery. There is a strong framework in place and progress has been made, there is also recognition that further work is needed to embed co-production more consistently across all service areas. The commitment to listening to the lived experience is a strength that will continue to drive service improvements.

Robust Oversight of Data, Quality, and Finance. The directorate was able to demonstrate to the peer challenge team clear oversight in data management, quality assurance and financial control. This enables informed decision-making, effective resource allocation, and continuous service improvement. The ability to track key performance indicators and respond to emerging trends positions the service well for ongoing service enhancement.

Areas for Consideration

Embedding Safeguarding Awareness Across All Teams. While safeguarding structures are in place, there is a need to ensure that safeguarding practice and referral pathways are consistently understood by all staff. This includes providing ongoing training, enhancing internal communication, and reinforcing the importance of safeguarding responsibilities at every level of service delivery.

Enhancing Support and Engagement for Carers. Further work is required to ensure that carers fully understand the support available to them, how to access services, and how they can contribute to strategic planning. Strengthening communication channels and co-production with carers will help to ensure they receive the support they need while having a meaningful role in shaping future services.

Embedding Equality, Diversity, and Inclusion (EDI) Across All Teams. While the Integrated Neighbourhood Teams (INTs) have made significant progress in considering ethnicity and religion

in service delivery, other teams and aspects of EDI require further attention. A more consistent approach to inclusivity, ensuring that all aspects of diversity are embedded in practice, will strengthen service provision and responsiveness to diverse community needs.

Improving Website Accessibility and Communication Clarity. There is recognition that the accessibility of the corporate and adult social care webpages needs improvement to ensure residents can easily access information and support. This includes ensuring compliance with accessibility standards, simplifying navigation, and clearly identifying residents' communication needs. Digital inclusion initiatives should also be explored to support residents who may struggle with online access.

Expanding Commissioning Beyond Accommodation-Based Support. Currently, commissioning is largely focused on accommodation-based support. There is an opportunity to broaden this approach to include more preventative services in partnership with the Voluntary, Community, Faith and Enterprise (VCFE) sector and with Persona (a social care provider in Bury created in 2015). Strengthening prevention initiatives will help to reduce crisis interventions and promote greater independence for residents.

Co-production and the Lived Experience

Strengths

Commitment to Co-production. The council demonstrates a strong and genuine commitment to co-production, particularly among senior leadership and commissioning management. This commitment is embedded in strategic planning and operational practices, ensuring that co-production is not merely a policy statement but a principle guiding service development and delivery. Senior leaders actively champion co-production, fostering a culture where the voices of individuals with lived experience are valued and incorporated into decision-making processes.

Co-production Networks. The peer team were interested to see that substantial resources are dedicated to supporting co-production networks, with a focus on older people and individuals with learning difficulties. The council has established and maintained key partnership boards, such as the Mental Health Board and Learning Disability Partnership Boards, which provide structured platforms for ongoing engagement and co-production efforts. These boards play a pivotal role in shaping service design and delivery, ensuring that the needs and perspectives of those who rely on social care services are at the forefront of policy development.

Bury Co-production Commissioning Charter. One of the council's most notable best practices is the implementation of the Co-production Commissioning Charter. This document serves as a framework for embedding co-production into commissioning processes. It includes a range of best practice initiatives, such as:

- The inclusion of individuals with lived experience in quality assurance visits to service providers, ensuring services meet the needs and expectations of the people they are intended to support.
- The active involvement of people with lived experience in recruitment panels for key social care positions, ensuring that the workforce is selected based on an understanding of service user needs. Workers told the team that they were planning to involve people with lived experience in a forthcoming recruitment process.
- The engagement of people with lived experience in procurement processes, providing valuable insights into the commissioning and contracting of services. The peer team met with people with lived experience who have been involved in quality reviews of providers; they told the team that there are plans for a paid position to undertake these reviews.

The council's approach to co-production reflects a structured and thoughtful integration of service users into the broader governance and oversight of adult social care services, reinforcing a commitment to transparency, inclusivity, and continuous service improvement.

Voluntary, Community, Faith, and Enterprise (VCFE) Sector

Positive Directorate Relationships. The adult social care directorate has established a productive and collaborative working relationship with the VCFE sector. Partnership working is well embedded, with regular engagement mechanisms ensuring that the sector is involved in discussions on service delivery, transformation, and emerging priorities. These relationships provide a strong foundation for continued collaboration, ensuring that the diverse expertise within the sector is effectively harnessed to support communities.

Healthwatch Involvement. Healthwatch plays a crucial role in shaping service delivery, acting as a key conduit between service users and commissioners. As a commissioned partner, Healthwatch has undertaken a range of projects that provide valuable insight into user experience and system performance. This intelligence is used to inform service improvements and to ensure that user voices influence decision-making. There is an opportunity to further integrate Healthwatch's findings into strategic planning processes to enhance responsiveness to local needs.

Sector Challenges. Despite the positive contributions of the VCFE sector, it is facing increasing pressure due to rising staffing costs and resource constraints. These challenges have the potential to impact service sustainability, particularly for smaller organisations that play a vital role in community-based provision. Exploring opportunities for additional support, including capacity-building initiatives and funding stability measures, will be important to ensure the sector remains resilient and able to continue delivering essential services.

Sensory Impairment Service (SIS)

Bury Blind Society Partnership. The partnership between the council and Bury Blind Society for the delivery of the SIS is well established, with positive feedback from both service users and providers. The commissioned service is reported to be highly responsive, with effective communication channels facilitating strong joint working. The ongoing collaboration ensures that people with sensory impairments receive tailored support that meets their specific needs.

Co-Produced Service Delivery. The recent redesign of SIS was developed through a comprehensive co-production process, ensuring that individuals with sensory impairments played an active role in shaping the service model. This approach has led to a service that is both user-centred and aligned with best practices. Continued investment in co-production methodologies will support the ongoing refinement and adaptation of services in response to evolving needs.

Stable Service Provision. The service continues to operate effectively, with no reported waiting lists for mobility support and stable vision impairment (VI) registration numbers. This indicates a well-managed and demand-responsive service model. Maintaining this level of stability will be important, particularly in the context of potential future demographic changes and increased service demand.

Deaf Community Engagement. While the SIS is performing well overall, there is an identified need to enhance engagement with the local deaf community. A key organisation supporting this community has encountered difficulties in maintaining links, which may have impacted access to support and representation in service planning. Strengthening outreach efforts, fostering new partnerships, and exploring targeted engagement strategies will be important to ensure that the needs of deaf individuals are effectively addressed within the wider sensory impairment service landscape.

Considerations.

While significant progress has been made, there are opportunities to further embed co-production and the lived experience across all areas of adult social care. Key considerations for strengthening the council's approach include:

Establishing a Task and Finish Group. A dedicated task and finish group, comprising relevant stakeholders including service users, carers, voluntary sector representatives, and commissioning leads, could be established to develop a directorate-wide co-production framework. This framework should provide a clear definition of co-production, outline its principles, and set measurable outcomes to assess effectiveness.

The group should also consider best practice from other local authorities and national guidance to ensure alignment with wider sector expectations.

Raising Awareness Among Frontline Staff and Carers. Frontline staff and carers play a crucial role in implementing co-production principles. Awareness-raising activities, including training sessions, workshops, and case study presentations, could enhance understanding and buy-in.

Carers Co-Production Clarity. While carers are engaged in service planning activities, there is an opportunity to further clarify and formalise their role in co-production and decision-making. Embedding co-production into staff induction and ongoing professional development will help create a workforce that values and consistently applies co-production in day-to-day practice.

Securing Resources for Co-production Processes in Underrepresented Groups. While existing co-production networks support older people and individuals with learning difficulties, there is a need to allocate funding and resources to extend co-production opportunities for people with physical impairments and autism. Investment in accessible engagement methods, including assistive technology and tailored communication approaches, will ensure that co-production is truly inclusive.

Developing a Policy for Paying People with Lived Experience. Meaningful involvement in co-production should be recognised and valued appropriately. Developing a clear policy on reimbursing individuals with lived experience for their time and contributions is essential. This policy should include guidance on payment structures, reimbursement for expenses, and non-monetary incentives where appropriate, ensuring a fair and transparent approach.

Embedding the Voice of Lived Experience into Key Documentation. People with lived experience should be actively involved in shaping the council's self-assessment documentation and other key reports. Their insights should be integrated into publicity materials and service improvement plans, reinforcing a commitment to genuine co-production and reflecting the real

experiences of service users. By addressing these considerations, the council can further enhance its ability to deliver high-quality co-production, ensuring that adult social care services are shaped by and for the people they support. This will not only strengthen preparedness for assurance processes but also improve outcomes for service users and communities.

Case File Audit

Prior to the onsite visit six cases files were reviewed. The **strengths** that were identified in these cases were:

- A flexible use of carers personal budgets
- The recording templates demonstrate the voice of the person
- There was an example of clear understanding of legal frameworks and full involvement of a young person arranging her support with the team around her
- There was an example of risk enabling practice with a person who had complex needs including mental health issues, and with the young person moving into adulthood.

The **areas for consideration** identified in these cases were:

- The carers assessments did not include analysis of the carer's situation
- The voice of the relative was sometimes stronger than the voice of the person
- The opportunities to work in a person-centred way were sometimes missed
- The council should consider providing guidance on the use of the first person narrative in cases as this was sometimes inconsistent
- The case summaries provided could include a more balanced evaluation including areas for development.

This was a small cohort of case files audits, but in line with the number that is likely to be undertaken by CQC.

Theme 1: Working with People

This relates to assessing needs, planning, and reviewing care, arrangements for direct payments and charging, supporting people to live healthier lives, prevention, wellbeing, information, and advice, understanding, and removing inequalities in care and support, and people's experiences and outcomes from care.

Quality Statement One: Assessing Needs

Strengths

Culture of Support. A strong culture of support exists among staff, with managers and leaders providing clear guidance and encouragement. Staff described a workplace where employees feel valued and equipped to deliver quality services. In conversations with the peer team staff demonstrated a commitment to strengths-based working and actively engaging with individuals to co-develop care plans that focus on personal outcomes.

Use of Population Data. The strategic use of population data plays a key role in understanding and addressing the specific needs of individual neighbourhoods. By leveraging this data, the service ensures that local nuances are reflected in the care planning process.

Practice Framework. The continuous development of the practice framework has been well received by practitioners, who acknowledge its role in shaping effective service delivery. The integration of Liquid Logic into this framework has further streamlined processes, improving workflow efficiency and record management.

Assessment of Need. Innovative tools such as Canary are being utilised to enhance the assessment of needs, providing valuable insights into service users' requirements. Trusted assessors within Integrated Neighbourhood Teams (INTs) contribute significantly by ensuring timely access to basic equipment.

Carers Hub Feedback. Feedback from carers engaging with the Carers Hub was overwhelmingly positive. A key strength of the service is that all carers who have sought support through the hub have received a carers assessment. The table below illustrates the significant positive trends from August 2023 to February 2025:

		Aug-23	Feb-25
Care assessments	People on waiting list	154	72
	Average wait time	58	26
	Maximum wait time	449	86
Carer's assessments	People on waiting list	11	10
	Average wait time	38	14

	Maximum wait time	220	25
Care reviews	People on waiting list	1148	841
	Average wait time	180	172
	Maximum wait time	791	722

While all carers reported receiving a carers assessment, there remains a need to address the number of overdue reviews to ensure a continuity of support, which the director and his colleagues are aware of.

Considerations

Access to Occupational Therapists (OTs). The service should ensure consistent and equitable access to occupational therapists (OTs) across different service areas to enhance the efficiency of interventions. Improving the accessibility of the Directory of Services, including the council's website, is a recognized priority to ensure individuals and carers can easily navigate available support options. Advocacy services should be given a greater profile to empower individuals in making informed decisions about their care.

Quality Statement Two: Supporting People to Live Healthier Lives

Strengths

The responsive equipment service ensures timely support, allowing individuals to maintain independence.

Technology Enabled Care. Technology is well integrated into care provision, with new innovations being piloted successfully. Good examples and user perspectives have highlighted the positive impact of these initiatives. The expansion of the Shared Lives program is also noteworthy, and it is recommended that a select number of case studies be included in the self-assessment to showcase successful implementations.

Preventative Pathway. The presence of a robust preventative pathway—including Staying Well, Social Prescribing, and community assets demonstrates a proactive approach to wellbeing. INTs have proven highly effective in supporting individuals and improving outcomes, while the Intermediate Tier services and Reablement pathways are well-embedded within community teams.

Bury Employment and Support Team. The Bury Employment and Support Team's work, including initiatives such as a café, workshop and garden run by service users, exemplifies an outstanding model of engagement, social inclusion and support to develop skills towards employment opportunities.

Considerations

Individuals with Autism. Alternative strategies should be explored to better address the needs of individuals with autism. Enhancing the information available at the referral stage of the reablement service would improve user experience and expectation management.

An All-Age Prevention Pathway. The introduction of an all-age prevention pathway could further streamline and integrate support services. Additionally, concerns have been raised about limited access to mental health support for individuals who do not meet the threshold for secondary services.

Referrals into Adult Social Care. A clearer pathway for referrals into adult social care is needed, ensuring a seamless and efficient process. Referral processes to Persona should also be reviewed to ensure they are outcomes focused.

Quality Statement Three: Equity in Experiences and Outcomes

Strengths

People with Learning Disabilities. A housing strategy is in place for people with learning disabilities to ensure that sufficient and appropriate accommodation is made available. The learning disability team is proactively addressing digital exclusion and working towards greater accessibility for service users.

Interpreters and Translation Services. Staff report good access to interpreters and translation services, ensuring that language barriers do not hinder service engagement. Cultural and religious competence training is widely available, enhancing the ability of staff to provide inclusive care. The INTs actively consider the needs of diverse communities, with strong links established with Jewish and Asian communities, ensuring culturally appropriate support.

Considerations

Articulating Outcomes. While there is awareness of seldom-heard communities, it is important to better articulate the outcomes achieved for these groups.

Demographic Data Collection. Demographic data collection should be improved to enable a more detailed analysis of service impact and effectiveness. Signing up to the Workforce Race Equality Standards may help in further embedding inclusivity within staff recruitment and development processes and demonstrating this commitment to staff. Expanding staff networks will provide additional peer support and development opportunities.

Equity of Access. The Staying Well Team appear to only work with people aged fifty plus. It may be beneficial to extend the offer to include all adults to ensure equity of access to early support for all people aged eighteen plus.

Theme 2: Providing Support

This relates to market shaping, commissioning, workforce capacity and capability, integration, and partnership working.

Quality Statement Four: Care Provision, Integration and Continuity

Strengths

Home Care Market. There is a stable and resilient home care market with commissioning arrangements appearing to work well on a locality basis, minimising travel times and costs and waiting times for new packages of care.

Ensuring quality of local services. The peer team heard evidence of a recently developed and robust quality assurance framework, with staff teams demonstrating a sense of pride in maintaining high standards and local providers having higher than average CQC ratings when compared across Greater Manchester (GM). This has been supported by effective monitoring, feedback mechanisms, and an open culture of continuous improvement.

Managing Provider Failure. The peer team heard and read evidence of robust policy and procedures to manage provider failure. Although provider failure appears to be a rare event, the close relationships with provider organisations in the market have contributed well to this process in ensuring all people impacted had a swift and positive outcome.

Service sustainability. The Bury Flex initiative has been highly effective in supporting recruitment and training for both permanent and relief staff within the adult social care sector and providers told the peer team how much they valued this free offer of support. This initiative is proactively addressing workforce challenges by developing a sustainable pipeline of skilled professionals, ultimately improving service continuity and stability.

Exemplary Integration with Health Services. The integration of health and social care services at both operational and strategic levels in the council is commendable and serves as a model of best practice. Staff reported their ability to work well as multi-disciplinary teams and were extremely proud of their improvement journey.

Workforce. There is a comprehensive Integrated Care Partnership Locality Workforce Strategy in place which is closely aligned to the Greater Manchester Integrated Care Strategy and the 'Let's Do It' Strategy for the Borough. The peer team heard about good examples of a strong local training offer for commissioned providers as well as well supported progression opportunities for council staff.

Technology-Enabled Care (TEC) Advancements. The TEC team provided evidence of positive outcomes for individuals supported by innovative technology solutions. People have benefitted from assistive technology that promotes independence, safety, and well-being. The integration of TEC within the broader care framework demonstrates the council's commitment to modern, sustainable, and person-centred approaches.

Accommodation. There is robust evidence of supporting the development of new appropriate accommodation for older people, people with mental ill health and those with a learning disability and/or who are autistic. The commissioning led 'Living Options' group was highly regarded by the INTs to support them to explore housing and accommodation options available to people they were supporting.

Staying Well and Connect and Direct. The council led Staying Well and Connect and Direct (CAD) teams presented evidence of holistic assessment and person-centred approaches that achieve positive outcomes for people delaying the need for increased statutory support.

Considerations

Voice Of People. Increase the visibility of the voice of people who draw on care and support and their carers in your evidence of co-production and outcomes achieved by commissioned service provision, perhaps by utilising an outcomes framework aligned to Think Local Act Personal's Making It Real.

Ensure sufficient capacity in local services to meet demand. The council recognises that there are several market position statements outlining activity in the directorate which are not fully understood by providers. Commissioners should support the provider market further so that they are more able to engage with the council's vision and the ambitions that are outlined, particularly in relation to the need to increase nursing care, specialist dementia nursing care and care and support for younger adults with complex needs. It would also be helpful to create just one or two market position statement documents.

Home Care Monitoring System. The peer team heard that the implementation of the Home Care Monitoring System had meant that payment of fees was sometimes not achieved on time for some

commissioned providers. However, the council was responsive to any escalation of payment issues and were carrying lessons learned forward into the forthcoming re-procurement process.

Development Of Bespoke Accommodation. Whilst choice of accommodation has improved or is improving for older people and people with a learning disability, further development of bespoke accommodation for those with complex needs, including for those who are living out of area would provide more choice and improved outcomes for people. Alongside this, consideration should be made for growing the workforce alongside an enhanced fee rate/structure to consider the requirement for enhanced skills and support for those with complex needs including advanced complex dementia.

Outputs and Outcomes. When speaking to staff there was some confusion between the ideas and reality of outputs and outcomes and therefore the ability of staff to describe the difference services were making to people's lives. The council should seek to promote a clearer understanding for staff of the difference between outputs and outcomes so that they can better describe their performance and achievements to the regulator when they arrive.

Quality Statement Five: Partnerships and Community

Strengths

Person-Centred Approaches and Positive Outcomes. The Staying Well and Connect and Direct (CAD) teams demonstrated a commitment to person-centred care. Evidence presented highlighted a range of positive outcomes achieved through tailored approaches that consider individual needs and preferences. Service users have reported enhanced well-being, improved independence, and greater access to community-based support. These person-centred approaches align with national best practices and reinforce a culture of responsive and adaptable care.

Integrated Working with Health Partners. Collaborative integrated working with health partners has led to streamlined pathways, improved coordination of care, and better outcomes for residents. Staff provided clear examples of how this integration has had a tangible impact, including more efficient hospital discharges and enhanced community-based support.

Effective Safeguarding Partnership Working. The relationships within the Safeguarding Adults Board (SAB) are strong, demonstrating effective multi-agency collaboration. This partnership ensures that safeguarding responsibilities are well understood and that appropriate structures are in place to protect vulnerable residents.

Maturing Partnership with the Voluntary, Community, Faith, and Enterprise (VCFE) Sector. The council has fostered a growing and maturing partnership with the VCFE sector, enhancing service integration and community-based care provision. Collaborative working has led to increased accessibility of services, improved pathways for service users, and strengthened community resilience. The development of a Memorandum of Understanding (MoU) between the VCFE sector and the council further underlines the commitment to transparency, mutual support, and shared strategic priorities.

Carers Service Improvements. The Carers Service has made significant strides in identifying and supporting carers, resulting in increased referrals from a diverse range of agencies. These improvements ensure that more carers are receiving timely assessments, access to essential support services, and opportunities for respite. Feedback from carers highlights improved awareness of available support and enhanced collaboration between health and social care teams.

Strong Provider Relationships. Service providers have reported a positive and respectful relationship with the council, with one provider describing the current partnership as “the best it’s been in Bury.” This collaboration has contributed to a high level of trust, improved service quality, and a shared commitment to continuous improvement.

Accommodation and Housing Initiatives. Positive progress has been made in the development of accommodation options to support individuals with a range of care needs. This includes increased provision of supported living arrangements, ensuring people can live independently with the necessary support in place.

Considerations

Fee Differentials for Complexity of Need. Current fee structures may not fully account for the varied complexity of individuals' care requirements, leading to potential inequities in resource allocation. A structured review of funding mechanisms should explore how payment models can better reflect the intensity and specialisation of care required. This includes developing tiered funding frameworks that align with assessed need, incentivising providers to offer services that cater to individuals with higher acuity needs while maintaining financial sustainability across the care sector.

Evidencing Commissioning for Outcomes. A clearer framework for demonstrating how commissioning decisions contribute to measurable improvements in people’s lives is essential for

accountability and strategic planning. This requires refining data collection processes, establishing robust key performance indicators (KPIs), and embedding impact measurement within commissioning cycles.

Lived Experience Partnerships. While existing initiatives have enhanced service user involvement, further steps are required to embed co-production as a standard practice across adult social care. Strengthening the role of individuals with lived experience in service design, evaluation, and governance structures will help ensure that policies and practices reflect the realities of those receiving care. Establishing formalised co-production frameworks and expanding training opportunities for both staff and service users will reinforce meaningful engagement.

Home First Data Presentation. The Home First approach, which prioritises supporting individuals in their own homes rather than institutional settings, lacks clear visibility within existing data reports. Enhancing data disaggregation by categorising service users by nursing care, supported living arrangements and self-funded placements will provide greater clarity on service effectiveness.

Comparative Performance Analysis. Regular reference to internal performance data is evident, yet expanding comparative analysis with other GM councils could enhance strategic insights. Utilising regional benchmarking tools and national datasets will offer a more nuanced understanding of best practices and areas for development.

Theme 3: Ensuring Safety

This area relates to Section 42 safeguarding enquiries, reviews, safe systems, and continuity of care.

Quality Statement Six: Safe Systems, Pathways and Transitions

Strengths

Preparing for Adulthood (PFA). Significant progress has been made in ensuring that young people transitioning from children's services to adult social care receive the support they need. Early involvement with young people and their families has led to stronger relationships between children's and adult services staff, creating a more seamless transition. The establishment of a dedicated virtual PFA team has further strengthened communication and collaboration, ensuring that families receive clear guidance and support.

Financial Services in the PFA Team. Financial services in the PFA team have been restructured to better accommodate transitioning individuals, including enhanced welfare benefits advice for families. However, there remains scope for improvement in PFA data collection and analysis to inform service planning and delivery. The council should explore ways to enhance access to both the children's services and adult social care recording systems to streamline information-sharing and support continuity of care.

Hospital Discharge and Rehabilitation. A well-defined hospital discharge pathway is in place, supported by technological solutions that facilitate timely and effective transitions from hospital to home or other care settings. 84% of people now leave these services managing independently and the service has moved to 8th in the Northwest region from 11th with 6,500 people benefiting from the rapid response and intermediate care services. The INTs are proactively managing waiting lists, ensuring that individuals receive the necessary support without unnecessary delays.

Person-Centred Rehabilitation. Person-centred rehabilitation approaches are yielding positive outcomes, with good examples of tailored interventions that promote independence and recovery, staff talked about how they, in partnership with health colleagues, could escalate or step-down through a clear pathway to avoid hospital admission. Partnerships with key stakeholders, including Community Safety and the SAB, have been instrumental in enhancing service delivery and ensuring coordinated responses to complex cases.

Quality Statement Seven: Safeguarding

Strengths

Safeguarding and Risk Management. A culture of safeguarding as a collective responsibility is taking hold, with staff increasingly recognising its importance across the workforce. Strategic partners within the SAB are working well together, leading to improved outcomes. An example is that there has been a steady reduction in the time it takes to complete a section.42 enquiry and there has been in increase in meeting or partially meeting people's safeguarding needs. However, there is recognition that further progress is needed to strengthen safeguarding practices and ensure consistency.

The Multi-Agency Risk Management process. The Multi-Agency Risk Management process appears robust with clear evidence of its effectiveness. Staff described feeling more confident in supporting people in risky situations. Leadership within the service is making a tangible difference, driving improvements in areas such as hoarding interventions and the understanding of self-

neglect. The Deprivation of Liberty Safeguards (DoLS) framework is well-regarded, with staff expressing pride in their achievements in this area of keeping waiting lists for standard authorisations to a minimum.

Safeguarding Transformation Plan. Team managers have demonstrated confidence in articulating risk management approaches, underscoring a culture of accountability and proactive intervention. The head of service is driving the necessary changes outlined in the safeguarding transformation plan. Plans to implement a hub and spoke safeguarding model could further enhance service coordination and responsiveness.

Despite these positive developments, challenges remain. The service recognises that the existence of multiple routes into safeguarding can create confusion and inefficiencies. A review of referral pathways could help streamline processes and improve access to timely interventions. Additionally, strengthening feedback mechanisms for individuals and organisations that raise safeguarding concerns would reinforce transparency and trust in the system.

Staff Awareness of Quality Assurance Processes. Raising staff awareness of quality assurance processes and their links to the broader risk management framework is another key area for development. The ongoing efforts to establish multi-agency auditing within the SAB should continue, ensuring that safeguarding practices are rigorously assessed and continuously improved.

Theme 4: Leadership

This relates to strategic planning, learning, improvement, innovation, governance, management, and sustainability.

Quality Statement Eight: Governance, Management, and Sustainability

Political Support for Adult Social Care. There is clear political and senior officer support for adult social care at Bury MBC. The Cabinet Member is skilled and competent and understands the detail of the directorate, without veering into the operational. He is keen to ensure there is collective responsibility and oversight of the performance and budget position of the directorate. As a result there is an added governance structure and Cabinet are sighted in a quarterly performance dashboard and a financial letter. There is also evident learning being taken from recent children's services issues at Bury MBC.

Political support includes opposition councillors who support the council leadership vision for adult

social care and they receive regular briefings. Overview and Scrutiny appears to work well and the Chair is well regarded. The politicians have trusted relationships with the director and they report that adult social care related councillor casework is responded to swiftly.

Leadership by the Adult Social Care Director. In the view of the peer team the leadership of the Adult Social Care Director is exemplary, visible and proactive. Nothing in the feedback from the peer team to him was a surprise demonstrating his comprehensive knowledge of his service and the people in it. He promotes collective responsibility and oversight of performance, quality and finance, which the peer team saw evidenced across the directorate management layers demonstrating positive governance and accountability.

Leadership that is Accessible and Supportive. The director and his senior leadership colleagues are seen by many staff to be accessible and supportive. These staff say they are proud of the improvement journey they have been on and keen to develop it further where needed.

Quality of the Health and Care Partnership. From speaking with key stakeholders it was clear to the peer team that the quality of the health and care partnership is exceptional and is a joint force that is really visible. The council is wedded to integration with health and the VCFE sector and this is evident from strategic perspectives through to operational delivery. All council and health staff the peer team spoke with are rightly proud of what has been achieved. There appeared to be good cohesion across the council departments such as housing, finance and transformation.

Integrated Neighbourhood Teams. The council structure has five Integrated Neighbourhood Teams (INTs) which are developing in maturity as they start to identify priorities for specific areas, using data and knowledge of the local community. One member of the LGA peer team with many years' experience said, *"I always knew integrated teams were a good idea, now I've been to Bury I can see it actually working really well for the staff and local people."*

Senior Adult Social Care Management Capacity. When looking at the management structure of adult social care it appears complex with the director managing a large span of people, across a range of levels of seniority and there are two groups of senior leadership meetings described. There may be a rational for bringing in an additional assistant director and to simplify the structure and give greater support to the director to focus on strategy and partnerships.

Key Performance Indicators. To support delivery of activity across the integrated teams the council should increase the visibility of the joint health and care KPIs for staff so they can more effectively direct their work. This was a direct ask from staff.

Health Economy. The health economy situation is a real risk to adult social care and the integration achievements delivered thus far. The integration of health and care for the children's sector will need to be accelerated for it not to impact the wider system.

Quality Statement Nine: Learning, Improvement, and Innovation.

Relationship with GM health. The peer team wish to recognise the value of the relationship between Bury MBC adult social care directorate and the health structures in GM and the support received for the council. This includes the value of the ten GM DASS's working collaboratively.

Training for Cultural Change. There is a recognition by the director and his colleagues that cultural change takes time, but change is happening and staff feel supported in their development and their well-being. There are real and tangible examples of staff having formal development opportunities and access to resources to achieve this. The peer team heard some fantastic examples of whole workforce training across health and care frontline staff, such as strength based training, which was frequently referenced in the conversations the peer team had with staff.

GM Social Work Teaching Partnership. As part of the GM social work teaching partnership social workers have access to a wide range of training and development opportunities, provided by the partners across GM. There are innovative integrated teams with health and care leadership, leading to tangible improvements in hospital attendance and rehabilitation. New technology is being piloted and decisions made based on evaluations.

Consistency of Social Work Practice. The senior leadership of the directorate recognises that there is work to be done on consistency of social work practice. The strengthening of the implementation of the quality assurance framework would support this. Senior leaders are aware that the support to staff and particularly local people need to improve so they understand what services are available. There are plans to revise the corporate and adults website and the adult social care directory of services to make it easier for people to access services and increase choice.

Innovation. There are opportunities to involve the arm's length trading body Persona to test and support innovation in service delivery. For example, learning from piloting and prototyping TEC in extra care and residential care could support roll out in the wider sector to maximise outcomes and efficiencies.

Voice of the Lived Experience. There are greater opportunities to bring the voice of the lived experience and co-design into development of services including those integrated with health. As

these things are achieved ensure there is clear publicity for those with a lived experience and staff to be able to confidently describe their narrative of success to each other that drives your cultural change and the stories told to the regulator.

General Top Tips for Assurance Preparation

- Appoint an adult social care lead.
- Political briefings.
- Secure corporate support and buy-in.
- Maximise the Council's adult social care business intelligence capacity to inform the self-assessment.
- Get health partners and integrated services leadership on board.
- Compare and learn from children's inspections.
- Gather insights from partners and providers.
- Be clear on approaches to co-production and responding to diverse needs.
- Encourage organisational self-awareness.

Lessons learned from other peer challenges.

- Councils need an authentic narrative for their adult social care service driven by data and personal experience.
- The narrative needs to be shared with those with a lived experience, carers, frontline staff, team leaders, middle managers, senior staff, corporate centre, politicians, and partners in health, the third sector and elsewhere.
- Ideally this story is told consistently, is supported by data, and personal experience - do not hide poor services.
- This will probably take the form of:
    - What are staff proud to deliver, and what outcomes can they point to?
    - What needs to improve?

  - What are the plans to improve services?

- In the preparation phases, consider putting it on all team agendas asking staff what they do well, what is not so good and to comment on the plans to improve. Collate the information from this process and add to the self-assessment. Ensure the self-assessment is a living document that is regularly updated.
- Immediately prior to CQC arriving, ask staff what they are going to tell the regulator. How is their experience rooted in observable data and contributes to the overall departmental narrative? These stories drive the understanding of yourselves and others.
- The regulator is interested in outcomes and impact from activity. The self-assessment needs to reflect this as do other documents.
- The conversation with the regulator is not therapy! For those interviewed it should be a description of what they do and the impact they have had in people's lives. Case examples written in the authentic voice of those with a lived experience bring this alive.

Immediate Next Steps

We appreciate the senior political and managerial leadership will want to reflect on these findings and suggestions to determine how the organisation wishes to take things forward.

Whilst it is not mandatory for the council to publish their report, we encourage councils to do so in the interests of transparency and supporting improvement in the wider sector. The LGA would like to publish this Preparation for Assurance Peer Challenge Report on the Association's website but will only do so once we have been advised that is has been put in the public domain by the council through its own internal governance processes.

As part of the peer challenge process, there is an offer of further activity to support this. The LGA is well placed to provide additional support, advice, and guidance on several the areas for development and improvement and we would be happy to discuss this.

Clare Hogan is the **LGA Principal Adviser for the North West Region** and main contact between your authority and the Local Government Association. Clare's contact details are:

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In the meantime, we are keen to continue the relationship we have formed with the council throughout the peer challenge. We will endeavour to provide signposting to examples of practice and further information and guidance about the issues we have raised in this report to help inform ongoing consideration.

Contact Details

For general information about Adult Social Care Preparation for Assurance Peer Challenges please contact:

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For more information on the programme of adult's peer challenges and the work of the Local Government Association please see our website: Adult social care peer challenges | Local Government Association.

Agenda Item 9

Classification Open	Item No.

Meeting:	Health Scrutiny
Meeting date:	19th June 2025
Title of report:	**Development of a work programme for 2025/2026**
Report by:	**Josh Ashworth** Senior Scrutiny Officer
Decision Type:	**For Information**
Ward(s) to which report relates	**All**

1. Purpose

This paper outlines the forward plan for the Health Scrutiny Committee, ensuring statutory responsibilities are met, conventional areas of focus are maintained, and recent commitments are followed through. It also reflects on the topics covered in the previous year to inform future planning.

2. Statutory Responsibilities

- Scrutiny of NHS and Public Health Services
- Review of Substantial Variations in Health Services
- Oversight of Complaints and Patient Feedback

3. Conventional and Partnership Commitments

- Healthwatch Engagement
- Public Health Priorities
- Joint Working with Adult Social Care and ICS Partners

4. Topics Covered in 2024/25

The Committee received updates and reports on the following:

- Health and Care Update
- Elective Care Updates
- Health Inequalities Strategy Updates
- Workforce Updates
- Urgent Care and Winter Preparedness
- Adult Social Care Provider Workforce Support
- Bury ICP Locality Performance

- Updates from Bury Healthwatch
- Adult Social Care Updates
- Women's Health Update
- Local Government Association Update
- Your Medicines Matter Campaign
- Locality Plan Update
- Pharmacy First Update

The Chair of the Health Scrutiny Committee also highlighted the strong partnership between the GMCA Overview & Scrutiny Committee and the GM Joint Health Scrutiny Committee, introducing a standing agenda item which the Chair provided regular updates on developments at a Greater Manchester level these updates will continue going forward into this municipal year.

These discussions could inform the development of the 2025/26 work programme.

5. Proposed Areas for 2025/26

Building on last year's work, the Committee may wish to focus on for discussion

- Access to Services (GPs, Dentistry, Urgent Care, NHS 111)
- Health Inequalities (Deep dive into local disparities and strategy implementation)
- Workforce Pressures (Recruitment, retention, and wellbeing across health and care)
- ICS Governance and Locality Performance (Transparency, outcomes, and integration)
- Public Health Focus (Mental health, substance misuse, prevention strategies)
- Women's Health and Maternity Services (Follow-up and further exploration)

6. Terms of Reference

A dedicated Health Scrutiny Committee was set up to scrutinise partner organisations on issues relevant to the residents of the Borough. Full terms of reference are:

- Adult social care (including adult safeguarding)
- Health and wellbeing board
- Housing
- Public health
- Adults and Communities budget and policy framework
- Statutory health scrutiny powers including the review and scrutiny of any matter relating to the planning provision and operation of health services for children and young people, including transitional health care services, affecting the area and to make reports and recommendations on these matters

7. Work Programme 2025/26

7.1 The Health Scrutiny Committee is required to set a work programme for 2025/2026

7.2 A well thought out and effective Work Programme will allow work to be time-tabled to ensure completion and help determine when and what resources may be needed.

7.3 Within the Programme it is important to ensure that there is the capacity to provide an urgent response to issues that arise during the year and need to be dealt with at short notice. Scrutiny of Key Executive decisions will form a large element of the Committee's work during the year, and it is important that flexibility is built into the Work Programme to allow for this to take place.

7.4 To assist in the development of an outcome focussed, measurable, realistic and timely Work Programme, a Prioritisation Protocol is set out below. The Protocol sets out some initial questions to be

asked of proposed topics and includes further questions and filters to help achieve a prioritised and deliverable work programme.

8. Conclusion

The information contained in this report provides an outline of the terms of reference for the Health Scrutiny Committee along with a Work Programme Prioritisation Protocol to assist in setting an outcome based, focussed, balanced and deliverable work programme based on the priorities of Bury Council and its residents.

Appendix 1

Prioritising Topics for Scrutiny

When deciding which items to include on the Scrutiny Work Programmes it can sometimes become confusing and difficult to identify the topics which are most important or worthy of scrutiny.

Section 1 - At the outset

When topics have been identified as possible Scrutiny Work Programme items, Members and their support Officers should ask the following of each topic identified;

- **Does the issue have a potential impact for one or more sections of the population?** Yes – Leave on Work Programme
- **Is the issue strategic and significant?** Yes – Leave on Work Programme
- **Is there a clear objective for scrutinising this topic?** Can objective be identified – Yes leave on Work Programme
- **Is there evidence to support the need for scrutiny?** Yes – Leave on Work Programme
- **What are the likely benefits to the Council and its customers? What do we hope to achieve?** If identifiable – Leave on Work Programme
- **Are you likely to achieve a desired outcome?** Can benefits to Council and customers be achieved?
- **What are the potential risks?**
- **Are there adequate resources available to do the activity well?**
- **Is the Scrutiny activity timely?** Yes – Leave on Work Programme

Section 2 – Criteria to Reject

Once the questions above have been answered and the topics are still included on the Work Programme, Members should move onto the following rejection filters:-

Reject if;

- The issue is being examined elsewhere e.g. officer group, other Councillor group.
- Issue was reviewed less than 2 years ago
- New legislation or guidance expected within the year
- No scope for scrutiny to add value/make a difference
- The objective cannot be achieved in the specified timescale
- Changes are currently being /have recently been implemented

Section 3 – Prioritisation of Topics

The following questions should be asked when looking to prioritise potential work programme items.

Public interest

- Has the issue been identified by Members through surgeries and other contact with constituents?(on how many occasions – more occasions warrants a higher score).

- Has a user dissatisfaction with the service been identified? (complaints).
- Topic identified through Market Surveys/Citizens Panel.
- Has the issue been covered in the local media?

Internal Council priority

- Council Priority area?
- There is a high level of budgetary commitment to the service/policy area (as percentage of total expenditure)
- There has been a pattern of budgetary overspends
- The service is a poor performer (evidence from performance indicators/benchmarking).

External Factors

- Central Government priority area
- Issues raised by External Audit Management Letter/External Audit Reports.
- Key reports or new evidence provided by external organisations on key issue.

Community impact/links with Community Strategy

Equality Impact and considerations:

Assessment of Risk:

The following risks apply to the decision:

Risk / opportunity	Mitigation

Consultation:

Legal Implications: N/A

Financial Implications: N/A

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