# AGENDA FOR

# HEALTH AND WELLBEING BOARD

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**To: All Members of Health and Wellbeing Board**

Dear Member/Colleague

**Health and Wellbeing Board**

You are invited to attend a meeting of the Health and Wellbeing Board which will be held as follows:-

| | |
|---|---|
| **Date:** | Tuesday, 17 March 2026 |
| **Place:** | Council Chamber |
| **Time:** | 4.30 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 the Health and Wellbeing Board 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 PUBLIC QUESTION TIME**

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

Approximately 30 minutes will be set aside for Public Question Time, if required.

**4 MINUTES OF PREVIOUS MEETING** *(Pages 5 - 10)*

The minutes of the meeting held on 15th January 2026 are attached.

**5 MATTERS ARISING**

**6 WIDER DETERMINANTS OF POPULATION HEALTH**

**7 THE OPERATION OF THE HEALTH AND CARE SYSTEM**

**a BETTER CARE FUND UPDATE Q3 26-27** *(Pages 11 - 18)*

Report attached

**b HEALTHWATCH ANNUAL REPORT** *(Pages 19 - 54)*

Reports attached from Andrew Griffiths Chief Operating Officer Healthwatch Bury

**8 BEHAVIOUR AND LIFESTYLE DETERMINANTS OF HEALTH**

**a PHYSICAL ACTIVITY UPDATE** *(Pages 55 - 88)*

Report and presentation attached from Lee Buggie Public Health Specialist and Lucy Fitzsimon Neighbourhood Wellness Lead

**9 THE EFFECT OF PLACE AND COMMUNITY ON HEALTH AND WELLBEING**

There are no items for consideration under this quadrant.

**a NEIGHBOURHOOD PLANS** *(Pages 89 - 158)*

Report and Slides attached from Kath WynneJones NCA-NHS

## 10 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 4

**Minutes of:** Health and Wellbeing Board

**Date of Meeting:** 15 January 2026

**Present:** Councillor T Tariq (in the Chair)
Councillors A Arif and J Southworth

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

**Apologies for Absence:** Councillor L Smith, Councillor S Walmsley, Councillor T Pilkington, Councillor S Arif and Councillor E FitzGerald

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## HWB.134 APOLOGIES FOR ABSENCE

Apologies for absence are noted above.

## HWB.135 DECLARATIONS OF INTEREST

There were no declarations of interest made at the meeting.

## HWB.136 PUBLIC QUESTION TIME

There were no public questions asked at the meeting.

## HWB.137 MINUTES OF PREVIOUS MEETING

**It was agreed:**

That the minutes of the meeting held on 11th November 2025 be approved as a correct record.

## HWB.138 MATTERS ARISING

There were no matters arising.

## HWB.139 WIDER DETERMINANTS OF POPULATION HEALTH

### a HOMELESS PREVENTION STRATEGY

Sian presented an overview of the Homelessness Prevention Strategy, outlining the vision for homelessness to be rare, brief and non-recurring. She highlighted key targets including reducing the use of bed and breakfast accommodation, halving rough sleeping, improving supported accommodation pathways and supporting people into settled homes. She noted the wider national housing context, planned investment, changes to allocations policies and the strategy's five-pillar prevention model.

Sian also summarised the pressures of the housing crisis, increased demand for temporary accommodation, and the impact of poor housing conditions on health. Links were made to the Child Poverty Strategy, and the Board noted the continued rise in both presentations to the service and rough sleeping.
The Board discussed the need to strengthen governance arrangements around homelessness.

Councillor Tariq welcomed the ambition and emphasised system-wide collaboration and alignment with public service reform. Jon confirmed the action plans could be brought together for Board oversight, and Will Blandamer highlighted the importance of connecting this work to locality boards and the Bury Partnership's health inequalities agenda.
Councillor Arif asked about confidence in achieving the six-week B&B target; Sian reported improvements but noted ongoing challenges due to limited temporary accommodation, particularly larger homes. He also queried provision for disabled residents, and Sian confirmed accessible accommodation remained limited but was being developed.

The Board agreed that a future reporting mechanism should be developed, with Jon to explore how updates can feed into wider action planning. The discussion also acknowledged recent national research on temporary accommodation and ongoing work to strengthen safeguarding, communication, and practice.

**It was agreed**

- The Chair thanked Sian for the presentation and the Board noted the update.

## HWB.140 THE OPERATION OF THE HEALTH AND CARE SYSTEM

### a SAFEGUARDING ANNUAL REPORT

Rachael Strutz adult safeguarding manager provided the Committee with an overview of the Safeguarding Annual Report and reflected on the work undertaken throughout the year. She explained that the Partnership had continued to make progress following its commitment to strengthening the use of Adult Social Care Advanced Practitioners, who now play a more visible role in supporting practice and improving the quality of decision-making. In addition, she noted that the Partnership's approach to data had been strengthened, with improvements in the way information is captured, analysed and compared both regionally and nationally. This has enabled a clearer understanding of safeguarding activity and how Bury's performance aligns with wider trends.

Rachael confirmed that the actions identified in the previous cycle had been completed, but emphasised that the key question now was how the Partnership demonstrates the difference this work is making. She explained that the focus moving forward is on showing impact, strengthening strategic priorities, and ensuring that the learning identified is influencing future practice and partnership working.

Adrian Crook echoed Rachael's comments and welcomed the continued improvement in safeguarding arrangements. He highlighted that under the leadership of Jeanette Richards, the overall quality of reporting and analysis presented to the Partnership has significantly improved. Reports now draw out learning more clearly, provide stronger evidence, and ensure that the implications for partners are well understood.

Adrian went on to expand on the mechanisms in place to support both delivery and scrutiny. He described how the Partnership now has a specific multi-agency group responsible for establishing actions, tracking progress and monitoring whether actions are being delivered effectively across the system. This group ensures that partners are not only agreeing to actions but also demonstrating how improvements are implemented in practice.

He also explained that an additional layer of scrutiny has been developed through the Partnership's Scrutiny Group, which provides more robust challenge. This group tests whether partner organisations can evidence the improvements they report and holds them to account for maintaining safeguarding standards. Adrian stressed that this represents a shift towards a

more rigorous and transparent assurance process. He also recognised the important contribution of Jan France, noting that her leadership and attention to detail have been invaluable in strengthening scrutiny arrangements.

**It Was agreed**

- The update be noted

## HWB.141 BEHAVIOUR AND LIFESTYLE DETERMINANTS OF HEALTH

### a CULTURE STRATEGY UPDATE

Jackie Veal, Head of Wellness provided a brief overview of the Culture Strategy and the key pillars within the accompanying slides. She outlined the role of culture in supporting wellbeing across Bury and highlighted ongoing work with cultural partners, primary and secondary schools, and SEND communities. She explained that although the strategy currently does not include performance indicators, work is underway to define what will be measured and how culture can be used as a vehicle to deliver health and wellbeing outcomes.

Councillor Tariq asked about the link between culture and health inequalities, particularly how the strategy aligns with the remit of the Health & Wellbeing Board from both adult and children's perspectives. He emphasised the importance of engaging the older people's network and understanding the lived experience of different communities. Jackie acknowledged these points, noting increased SEND engagement, and confirmed culture has a significant role in supporting this community.

Helen Tomlinson asked about the involvement of the VCFE sector in tackling health inequalities and suggested closer alignment with Live Well and the social cohesion sub-group. Jackie agreed and committed to linking with relevant colleagues, including Chris Woodhouse, to explore opportunities for cohesion-focused work. She noted that around 450 cultural and community groups are active across the borough, and the team is keen to support activity across all five neighbourhoods.

Adrian Crook welcomed the strategy and encouraged consideration of long-term, sustainable performance measures. He cautioned against short-term approaches such as arts-on-prescription without creating lasting participation. He stressed the importance of developing self-sustaining community assets that reduce inequalities over time. Jackie agreed and noted ongoing work to engage creative industries in partnership activity.

**It Was Agreed:**

- The update be noted

## HWB.142 THE EFFECT OF PLACE AND COMMUNITY ON HEALTH AND WELLBEING

Jon Hobday and his team were thanked for his ongoing work in relation to reducing health inequalities, an update on which had been circulated via email.

### a PUBLIC HEALTH ANNUAL REPORT

Jon Hobday, Director of Public Health provided a summary of the statutory Public Health Annual Report, explaining that its purpose is to spotlight key public health issues and drive system-wide action. This year's report focuses on the commercial determinants of health and

how the environments in which people live, work and shop influence health inequalities across the borough.

Jon highlighted how factors such as high concentrations of fast-food outlets, advertising, and targeted marketing disproportionately affect people living in poverty, making unhealthy choices more likely. He explained that 73% of ill-health is linked to non-communicable diseases, which are strongly shaped by wider environmental and commercial influences. The report outlines tactics used by industries and the importance of regulation and policy to create healthier environments, including national developments such as extended smoke-free zones for tobacco and vapes.

Jon stressed the need to shift away from narratives that blame individuals for poor health, recognising how industries influence norms, including through sponsorship, education materials and social media. He drew attention to increasing alcohol-related mortality, high levels of obesity, and rising food poverty locally. Work underway includes the Bury Food Strategy, transforming food procurement and catering, and the Healthy Stadia work promoting non-alcohol and healthier food options. Spatial planning work, including the Supplementary Planning Document, supports this approach in areas with high obesity rates. Smoking prevalence remains at 10%, supported by enforcement and prevention work.

Key recommendations include promoting healthy environments, regulating harmful practices, empowering communities and businesses, advocating for system change and ensuring fair taxation. Jon issued a call to action for the system to champion a whole-systems approach and align policy.

Councillor Tariq asked about alignment with the Marmot approach and the latest position on the Cabinet motion. Jon confirmed he would share the action plan with the committee and that the motion, including an enhanced equality impact assessment process, would be brought back with further detail.

Adrian Crook welcomed the structure of the report and highlighted the opportunity to track planning policy implementation and capture success stories that demonstrate impact. Jon agreed that building a portfolio of case studies would strengthen future reporting.

**It Was Agreed:**

- The Board noted the update.

## HWB.143 GM POPULATION HEALTH BOARD FEEDBACK

Jon Hobday, Director of Public Health, provided an update from the Greater Manchester Population Health Board.

**It was agreed:**

That the update be noted.

## HWB.144 URGENT BUSINESS

There was no urgent business.

**COUNCILLOR T TARIQ**
**Chair**

**(Note: The meeting started at Time Not Specified and ended at Time Not Specified)**

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Agenda Item 7a

**Bury Health and Wellbeing Board**

| | |
|---|---|
| **Title of the Report** | Better Care Fund (BCF) 2025/26 Quarter 3 (Q3) Reporting Template |
| **Date** | 17th March 2026 |
| **Contact Officer** | Hannah Dixon – Commissioning Manager |
| **HWB Lead(s) in this area** | Will Blandamer Executive Director Health and Adult Care and Place Based lead<br><br>Adrian Crook – Director Adult Social Care<br><br>Lynne Ridsdale, Chief Executive |

| **Executive Summary** | | | |
|---|---|---|---|
| Is this report for? | Information | Discussion | Decision Y |
| Why is this report being brought to the Board? | To seek Health and Wellbeing Board retrospective sign off for the Bury Q3 reporting template for the Better Care Fund 2025/26. The deadline for submission to the NHSE Better Care fund team was 30th January 2026. | | |
| Please detail which, if any, of the Joint Health and Wellbeing Strategy priorities the report relates to. (See attached Strategy) www.theburydirectory.co.uk/healthandwellbeingboard | The Better Care Fund primarily focuses upon:<br>• Living Well with a Long-Term Condition<br>• Reducing Length of Stay in hospitals<br>• Improving and supporting Hospital Discharges<br>• Prevention & Early Intervention | | |
| Please detail which, if any, of the Joint Strategic Needs Assessment priorities the report relates to. (See attached JSNA) http://jsna.theburydirectory.co.uk/kb5/bury/jsna/home.page | • Living Well with a Long-Term Condition<br>• Reducing Length of Stay in hospitals<br>• Improving and supporting Hospital | | |

| | |
|---|---|
| | Discharges<br>• Prevention & Early Intervention |
| Key Actions for the Health and Wellbeing Board to address – what action is needed from the Board and its members? Please state recommendations for action. | (1) Note the content of the report.<br><br>(2) Agree the retrospective submission of the Q3 reporting template to BCF 2025/26 as per the attached full reporting submission |
| What requirement is there for internal or external communication around this area? | None |
| Assurance and tracking process – Has the report been considered at any other committee meeting of the Council/meeting of the CCG Board/other stakeholders....please provide details. | The Q3 reporting template has been collaboratively populated by relevant colleagues from within Bury Council and NHS GM Bury ICB. |

## Introduction / Background

### 1 Introduction and background

1.1 The final Better Care Fund (BCF) 2025/2026 Policy Framework and Planning Guidance can be found at: BCF Better Care Fund policy framework 2025 to 2026 - GOV.UK

This policy framework confirms the conditions and funding for the Better Care Fund (BCF) for 2025 to 2026.

1.2 For 2025 to 2026, the objectives of the BCF reflect the government's commitment to reform via a shift from sickness to prevention and from hospital to home. These shifts are also consistent with commitment to reform by developing a 'neighbourhood health service', based on more responsive, preventative and co-ordinated care in people's homes and local communities.

1.3 The BCF achieves this by requiring local authorities and integrated care boards (ICBs), to develop and agree plans in collaboration with other local partners to meet the overall objectives of the BCF.

1.4 The plan is owned by the Health and Wellbeing Board (HWB) and governed by an agreement under section 75 of the NHS Act (2006). This continues to provide an important framework in bringing local NHS services and local government together to

tackle pressures faced across the health and social care system and drive better outcomes for people.

1.5 In line with the government's vision for health and care, the Better Care Fund policy framework sets out the vision, funding, oversight and support arrangements, focused on 2 overarching objectives for the BCF in 2025-26:

- reform to support the shift from sickness to prevention
- reform to support people living independently and the shift from hospital to home

1.6 At the same time, NHS England and the LGA published the Planning Requirements for the BCF. These can be found at: BCF Planning Requirements 25-26

## 2 BCF 2025/2026 Conditions, Objectives and Metrics

Better Care Fund policy framework 2025 to 2026 - GOV.UK.

2.1 National Conditions

Both local authorities and ICBs must comply with the BCF national conditions. Grant conditions for local authorities of each component grant of the BCF will reflect these national conditions. The national conditions outline steps HWBs must take to deliver on the BCF objectives.

The national conditions for the BCF in 2025/2026 are:

- jointly agreeing a plan
- implementing the objectives of the BCF
- complying with the grant conditions and the BCF funding conditions
- complying with the oversight and support processes

2.2 Objectives

The two objectives for the BCF in 2025 to 2026 are:

- **Objective 1**: To support the shift from sickness to prevention – including timely, proactive and joined-up support for people with more complex health and care needs; use of home adaptations and technology; and support for unpaid carers.
- **Objective 2**: To support people living independently and the shift from hospital to home – including help to prevent avoidable hospital admissions; achieve more timely and effective discharge from acute, community and mental health hospital settings; support people to recover in their own homes (or other usual place of residence); and reduce the proportion of people who need long-term residential or nursing home care.

2.3 BCF metrics for 2025 to 2026

The three metrics to be reported on are below. All 3 metrics are reporting as on track to meet goals:

Metric 4.1: Emergency Admissions **-** Emergency admissions to hospital for people aged 65+ per 100,000 population – the goal for this target is to be below the target rate set in the plan.
Table 1 shows that metric 4.1 is on track to meet goals – projected data has been used to inform quarter 3 reporting for this metric as data has not finalised for months October 25 onwards at the time of submission.

**Table 1 - Metric 4.1: Emergency Admissions**

| | Q1 | Q2 | Q3 |
|---|---|---|---|
| **Target: Rate** | 1488.6 | 1461.2 | 1516 |
| Performance | 1397.26 | 1351.6 | 1340.9 |
| Variance | -91.34 | -109.6 | -175.1 |

Metric 4.2: Delayed Discharge - Average length of discharge delay (LDD) for all acute adult patients (calculates the % of patients discharged after their DRD, multiplied by the average number of days - the goal for this target is to be below the target rate set in the plan.
Table 2 shows that metric 4.2 is on track to meet goals overall – Q3 data is based on months October and November data as December is not available at the time of submission.

**Table 2 - Metric 4.2: Delayed Discharge**

| | Q1 | Q2 | Q3 |
|---|---|---|---|
| **Target: Rate** | **1.30** | **1.49** | **1.00** |
| Performance | 0.94 | 0.80 | 1.09 |
| Variance | -0.36 | -0.69 | 0.14 |

Metric 4.3: Residential Admissions **-** Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population. The actual number of residential admissions has been used in Table 3, the goal for this target is to be below the number of admissions target set in the plan.
Table 3 shows that metric 4.3 is on track to meet goals.

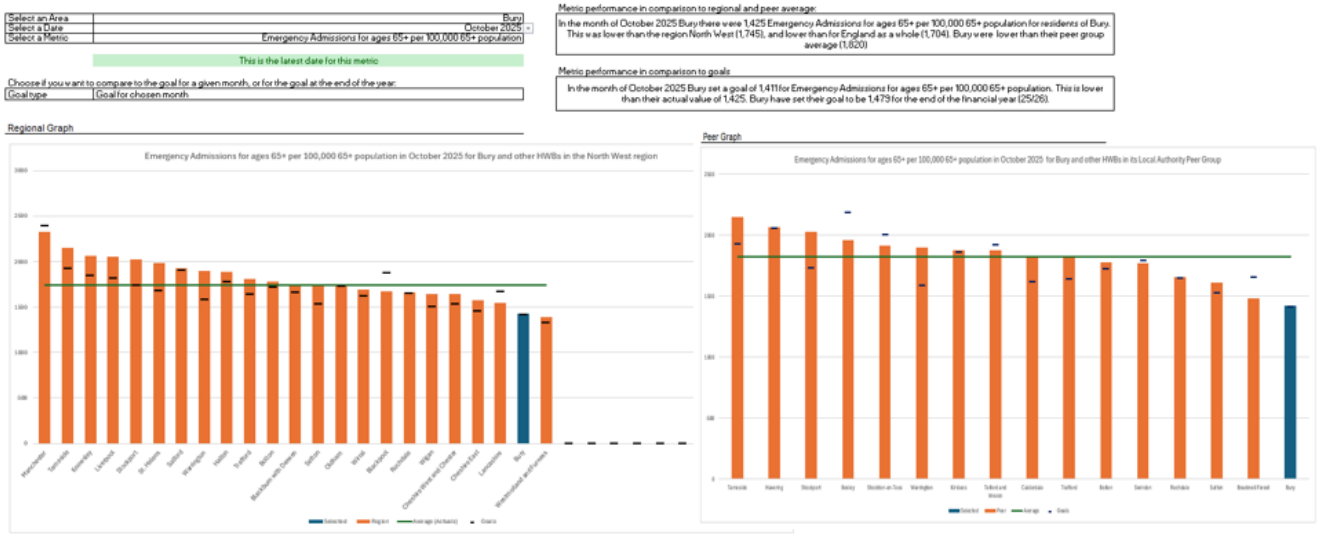
**Table 3 - Metric 4.3: Residential Admissions**

| | Q1 | Q2 | Q3 |
|---|---|---|---|
| **Target: Number of Admissions** | **62.0** | **62.0** | **62.0** |
| Performance | 40.0 | 46.0 | 58.0 |
| Variance | -22.0 | -16.0 | -4.0 |

## 2.4 Metric Performance Comparison

Emergency Admissions for ages 65+ per 100,000 65+ population – Graph 1 shows for the month of October 25, Bury was lower than the region North West, England as a whole and their peer group for this metric.

**Graph 1 - Emergency Admissions for ages 65+ per 100,000 65+ population**




Average days for discharge ready date to date of discharge (including 0 days) – Graph 2 shows for the month of November 25, Bury was higher than the region North West, England as a whole and their peer group average for this metric.

**Graph 2 - Average days for discharge ready date to date of discharge (including 0 days)**

Long-term admissions to residential care homes and nursing homes for people aged 65+ per 100,000 population – Graph 3 shows for the month of September 25, Bury was higher than the region North West, England as whole and their peer group average for this metric.

**Graph 3 – Long term admissions to residential care homes and nursing homes for people aged 65+ per 100,000 population**

**Data Source** - DHSC Better Care Fund & Discharge Dashboard - DH eXchange

## 3.0 Finance Report

3.1 Table 4 demonstrates that 72% of the planned BCF income has been spent up to Q3 25-26.

**Table 4 – Income and Expenditure**

**Better Care Fund 2025-26 Q3 Reporting Template**

**5. Income & Expenditure**

Selected Health and Wellbeing Board: Bury

| | 2025-26 | | |
|---|---|---|---|
| **Source of Funding** | Planned Income | Updated Total Plan Income for 25-26 | DFG Q3 Year-to-Date Actual Expenditure |
| DFG | £2,576,737 | £2,576,737 | £1,109,517 |
| Minimum NHS Contribution | £19,577,112 | £19,577,112 | |
| Local Authority Better Care Grant | £9,410,943 | £9,410,943 | |
| Additional LA Contribution | £0 | £0 | |
| Additional NHS Contribution | £2,136,317 | £2,136,317 | |
| **Total** | **£33,701,109** | **£33,701,109** | |

| | Original | Updated | % variance |
|---|---|---|---|
| **Planned Expenditure** | **£33,701,109** | £33,701,109 | **0%** |

| | | % of Planned Income |
|---|---|---|
| **Q3 Year-to-Date Actual Expenditure** | £24,421,199 | **72%** |

## 4.0 Reporting and checkpoints

4.1 It is expected that performance on spend and the metric goals aligned to the BCF programme will be reported on a quarterly basis. The reporting requirements have now been finalised for Q3 and have been submitted to NHSE Better Care fund Team.

## 5.0 Links to the Bury Locality Plan

5.1 The Better Care Fund proposals should not be read in isolation but should be seen as a constituent part of the Bury Locality Plan and ''Let's Do It' 2030 Bury Strategy which sets out the entirety of the local approach to Health and Social Care transformation.

## Recommendations for action

- That the Health and Wellbeing Board note the content of the Q3 reporting submission

- That the Bury Health and Wellbeing Board retrospectively approve the attached Better Care Fund 2025/2026 Q3 reporting submission and ratify the decision to submit to the national Better Care Fund team for assessment.

**Financial and legal implications (if any)**

- These proposals relate to the use of financial resources
- These proposals have been developed in partnership with the Bury Council s.151 Officer and the Bury Director of Finance.

**Equality/Diversity Implications. Please attach the completed Equality and Analysis Form if required.**

- None

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CONTACT DETAILS:

**Contact Officer**: Hannah Dixon

**E-mail address:** h.dixon@bury.gov.uk

**Date: 17th March 2026**

Bury HWB Q3 25-26.xlsx

**END**

Agenda Item 7b

| Classification<br><br>Open / Closed | Item No. |
|---|---|

| | |
|---|---|
| **Meeting:** | Bury Health and Wellbeing Board |
| **Meeting date:** | 17th March 2026 |
| **Title of report:** | Healthwatch Bury Annual Report 2024-25 |
| **Report by:** | Andrew Griffiths – Chief Operating Officer for Healthwatch Bury |
| **Decision Type:** | **Information / Discussion** |
| **Ward(s) to which report relates** | **All wards in Bury** |

**Executive Summary:**

1. Overview

   Healthwatch Bury strengthened its role as the independent champion for people using local health and social care services, expanding engagement and influencing system decisions across Bury and Greater Manchester. Key focus areas included inequalities, navigation, and amplifying seldom-heard voices.

2. Key Highlights

   Leadership & Infrastructure

   - New Chief Officer, Andrew Griffiths, appointed — driving visibility, sustainability, and community reach.
   - Opened a new accessible town centre office, now functioning as a community hub for drop-ins and partner events.

Community Reach

- 400+ residents shared direct feedback.
- 1,300+ engagements via events, drop-ins, and outreach.
- 5,435 website visits for information and signposting.
- Extensive outreach with seldom-heard groups: asylum seekers, homeless residents, carers, veterans, sensory impairment groups.

3. Major Projects & Impact

Women's Health

- Identified significant barriers across life stages.
- Outcomes: GM Women's Health Steering Group established; GP training increased; menopause support expanded.

Dementia

- Highlighted gaps in diagnosis and post-diagnosis support.
- Led to re-establishing the Dementia Steering Group and informing a new boroughwide dementia strategy.

Prescriptions

- Captured patient challenges with digital access, delays, and GP pathways.
- Informed the ICP and triggered a follow-up study on patient-led prescribing.

Clearer Communications

- Feedback from >140 patients led to standardised, clearer NCA appointment letters, improving accessibility and reducing non-attendance.

Eye Care (National Project Contribution)

- Local insights informed Healthwatch England's A Strain on Sight national report.

4. Support for Vulnerable Residents

Healthwatch directly supported individuals with:

- Delayed Continuing Healthcare decisions
- Domestic abuse–related communication risks
- Unmet social care needs
- Long waits for surgery

- Digital exclusion affecting access to prescriptions and GP services

These interventions resulted in improved care coordination, safety, and access.

5. Finance

- Core Local Authority funding: £122,000 (unchanged for 11 years).
- Additional income: £12,700 plus ICS collaborative funding.
- Total expenditure exceeded income, indicating future sustainability considerations.

6. Priorities for 2025–2026

1. Reducing inequalities, especially in deprived communities.
2. Identifying unmet needs, including focused work with veterans.
3. Improving health and care navigation across the system.

Cross-cutting theme: Visibility
Increasing reach, recognition, and engagement across all communities in Bury.

**Recommendation(s)**

**That:**

The report is noted and the work of Healthwatch Bury be recognised as valuable and effective in supporting people reaching appropriate outcomes when they need it.

**Key considerations:**

**Introduction/ Background:**

Healthwatch Bury has been the independent voice of patients and service users in Bury since 2013, providing support to individuals who need it across a range of topics.

**Key Issues for the Board to consider:**

The changing landscape following the Dash Report and what the future may look like for the independent public voice going forward.

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**Community impact/links with Community Strategy**

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**Equality Impact and considerations:**

*Under section 149 of the Equality Act 2010, the 'general duty' on public authorities is set out as follows:*

*A public authority must, in the exercise of its functions, have due regard to the need to -*

(a) *eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;*

(b) *advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;*

(c) *foster good relations between persons who share a relevant protected characteristic and persons who do not share it.*

*The public sector equality duty (specific duty) requires us to consider how we can positively contribute to the advancement of equality and good relations, and demonstrate that we are paying 'due regard' in our decision making in the design of policies and in the delivery of services*.

| **Equality Analysis** | *Please provide a written explanation of the outcome(s) of either conducting an initial or full EA.* |
|---|---|
| | |

**Please note: Approval of a cabinet report is paused when the 'Equality/Diversity implications' section is left blank and approval will only be considered when this section is completed.*

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**Legal Implications:**

*To be completed by the Council's Monitoring Officer*

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**Financial Implications:**

*To be completed by the Council's Section 151 Officer*

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**Report Author and Contact Details:**

**Background papers:**

Healthwatch Bury Annual Report 2024 - 25

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

| Term | Meaning |
| --- | --- |
| | |

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healthwatch Bury



Annual Report 2024–2025

# Unlocking the power of people-driven care

Healthwatch Bury

# Contents



"The feedback local Healthwatch hear in their communities and share with us at Healthwatch England is invaluable, building a picture of what it's like to use health and care services nationwide. Local people's experiences help us understand where we – and decision makers – must focus, and highlight issues that might otherwise go unnoticed. We can then make recommendations that will change care for the better, both locally and across the nation."

**Louise Ansari, Chief Executive, Healthwatch England**

# A message from our Chair

## Healthwatch Bury 2024–25: A Year of Meaningful Advocacy

In 2024–25, Healthwatch Bury continued to engage with local people and communities —ensuring that lived experience helps shape health and social care services across the borough. Amid growing pressures on the NHS and deepening inequalities, our staff, board, and volunteers remained committed to listening, amplifying, and influencing, particularly on behalf of those too often unheard.

We've maintained a strong and visible presence, from Bury Pride and local health centre listening events to informal "park bench surgeries." Through projects such as Women's Health, Prescriptions, and Clearer Communications, we enabled people to speak up about the issues that mattered to them—from barriers to accessing contraception, to concerns about medication delays and the clarity of information from service providers. These initiatives offered safe and inclusive spaces for diverse voices to be heard and shaped our recommendations for system improvements. Inclusion and accessibility have been central—meeting people where they are, particularly those who might not otherwise seek us out.

Tackling health inequalities has remained a core focus. We've deepened our engagement with communities who are seldom heard and amplified the voices of marginalised people, supporting those unsure of their rights, rebuilding trust after poor care experiences, and helping people navigate a complex system.

As a statutory body, Healthwatch Bury brings insight from these conversations directly into decision-making forums, ensuring local voices are heard and acted upon by those with the power to make changes. We've shared detailed feedback with system leaders, commissioners, and regulators like the CQC, highlighting both service gaps and examples of excellence.

Our priorities for the coming year are clear: expand our reach—particularly through platforms like Healthwatch Bury Live—while maintaining strong face-to-face engagement in neighbourhoods and local spaces. We'll support more people to understand their rights and navigate services with confidence. And we'll ensure real-life experiences continue to inform decision-making at every level, keeping the patient voice central to system reform.

This year's report reflects not just the challenges people face in accessing care, but also the vital role Healthwatch Bury plays in listening, responding, and driving improvement.

# A message from our Chair

Looking ahead and building for 2025-26 with energy and renewed focus, we are enjoying our new, more accessible office which strengthens our community presence and enhances opportunities for collaboration. We have welcomed Andrew Holland as our new Chief Officer, bringing fresh insight and passion for making our organisation financially sustainable and broadening our reach—ensuring more people across all Bury communities know who we are and how we can help.

**Ruth Passman, Chair of Healthwatch Bury**

# A message from our new Chief Officer

"First of all, let me start by saying how excited I am to lead Healthwatch Bury.

Having only been in role a very short time, one thing is clear and that is the team are incredibly keen to ensure the voices of the people of Bury are heard loud and clear.

I have been taken aback by the passion and enthusiasm within this team, and I'm looking forward to us all working together to ensure that we make Healthwatch Bury famous by making sure that we are seen and heard in all of our localities and that we continue to champion our people and be their voice wherever and whenever they need us."

**Andrew Holland, Chief Officer of Healthwatch Bury**

# About us

## Healthwatch Bury is your local health and social care champion.

**We ensure that NHS leaders and decision-makers hear your voice and use your feedback to improve care. We can also help you find reliable and trustworthy information and advice.**

### Our vision

A world where people who live, work, volunteer, study and use services in Bury can all get the health and care they need.

### Our mission

To make sure Bury people's experiences help make health and care better.

### Our values are:

- **Listening to people and making sure their voices are heard.**
- **Including everyone in the conversation – especially those who don't always have their voice heard.**
- **Analysing different people's experiences to learn how to improve care.**
- **Acting on feedback and driving change.**
- **Partnering with care providers, Government, and the voluntary sector – serving as the public's independent advocate.**

# Our year in numbers

**We've supported more than 400 people to have their say and get information about their care. We currently employ 6 (3.8 full time equivalent) staff and, our work is supported by 9 volunteers.**

## Reaching out:

Over 400 people shared their experiences of health and social care services with us, helping to raise awareness of issues and improve care. We engaged with nearly **1300** people via our drop ins, park bench surgeries and community events.

**5,435** people came to our website for clear advice and information on topics such as **mental health support, food banks** and **finding an NHS dentist.**

## Championing your voice:

We published **4** reports about the improvements people would like to see in areas like **Women's Health**, **Prescriptions, Clearer Communications and CAMHS Enter and View Report.**

Our most popular report was **Women's Health Report**, highlighting people's experiences of accessing support for menopause, sexual health and any other health concerns.

In addition to above we published 4 activity reports showcasing what we have been up to and highlighting issues to the health and care commissioners and services. We also contributed towards Healthwatch England reports around **Pharmacy Services** and **Eye Care services.**

## Statutory funding:

We're funded by **Bury Local Authority**. In 2024/25 we received £122,000 which is the same as the previous 11 years.

# A year of making a difference

**Over the year we've been out and about in the community listening to your stories, engaging with partners and working to improve care in Bury. Here are a few highlights.**

## Spring

We highlighted concerns of people in Bury around access to dementia services and changes in provision

Our team actively kept track of all vacancies to register with NHS dentists to help people that were struggling to get one themselves

## Summer

Healthwatch Bury participated in Healthwatch England's eye care research by conducting in-depth local engagement at eye clinics, and the findings have now been submitted and published in the final reports.

We explored women's health issues in Bury, focusing on menopause awareness, and published a report based on community feedback and group engagement.

## Autumn

We gathered patient feedback on prescription issues, shared findings with key stakeholders, and supported clearer communication on patient-led prescribing.

We raised safeguarding concerns about patient belongings at the hospital, prompting policy review with the Northern Care Alliance and action to improve patient safety and staff accountability.

## Winter

We supported Rock Healthcare's patient engagement, gathering feedback on the proposed Radcliffe branch relocation and reporting insights to ensure patient voices informed decision-making.

We supported Public Health's Community Pharmacy Services Survey by promoting it, gathering community feedback through local group visits, and reporting insights to inform the upcoming Pharmaceutical Needs Assessment.

# Working together for change

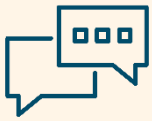
**We've worked with neighbouring Healthwatch to ensure people's experiences of care in Greater Manchester are heard at the Integrated Care System (ICS) level, and they influence decisions made about services at Greater Manchester ICS**

This year, we've worked with 9 Healthwatch across Greater Manchester to achieve the following:

## A collaborative network of local Healthwatch:

We have progressed into the second year of our partnership agreement with the ICS, as part of a network of 10 local Healthwatch to amplify the voices of people across the region. We've contributed to regional strategies, produced GM-wide reporting, and launched shared platforms to strengthen our insight. Our representative ensures lived experience is heard and influences decisions across the ICS.

## Voices from our communities:



We listened to thousands of people across Greater Manchester on topics like ADHD, Menopause, Pharmacy, Urgent Care and CAMHS. These insights were shared with the ICS and used to inform strategy, consultations, and influence service design. By working together across the region, we've made sure the experiences of individuals and communities are central to how health and care services are planned and delivered.

## Building strong relationships to achieve more:

In November, Healthwatch in Greater Manchester hosted a conference, bringing together ICS leaders, Healthwatch staff, the VCSE sector and communities. We presented our work across the network, the importance of Healthwatch work and explored new ways of working, including stronger patient representation and co-production at ICS level.

We've also summarised some of our other outcomes achieved this year in the Statutory Statements section at the end of this report.

# Making a difference in the community

**We bring people's experiences to healthcare professionals and decision-makers, using their feedback to shape services and improve care over time.**

Here are some examples of our work in **Bury** this year:

## Creating empathy by bringing experiences to life

**Hearing personal experiences on dementia and their impact on people's lives helps services better understand the issues people face.**

Healthwatch Bury gathered experiences from dementia patients and carers, highlighting challenges in diagnosis and support. Our 2024/25 report identified inconsistencies and provided recommendations, leading to the re-establishment of a Dementia Steering Group and a new strategy aligned with 'The Well Pathway for Dementia.' Greater Manchester developed a Dementia Care Pathway with quality standards for diagnosis, community support, and end-of-life care. Bury reviewed services against these standards, identifying key improvements. A delivery plan, created with Voluntary Community and Faith Alliance members, aims to improve care and support for those affected by dementia.

## Getting services to involve the public

**By involving local people, services help improve care for everyone.**

Earlier this year we supported Rock Healthcare with patient engagement regarding the proposed relocation of their Radcliffe branch to Moorgate Primary Care Centre. We actively contributed to the consultation process, helping ensure patients' views were heard. By collecting and summarising feedback, we provided Rock Healthcare with a clear and concise overview of local perspectives to inform their next steps. This support helped promote inclusive decision-making and strengthened the involvement of local people in shaping service changes.

## Improving care over time

**Change takes time. We work behind the scenes with services to consistently raise issues and bring about change.**

Over the years, we have steadily pushed for meaningful change in children and young people's mental health services. Our 2019 report laid the groundwork, highlighting key challenges. Greater Manchester CAMHS report amplified regional voices, exposing systemic barriers. Most recently our Enter and View visit to Bury CAMHS captured current experiences and best practices. Together, those pieces of work reflect on our ongoing commitment to listening, learning and influencing improvements.

# New Office Launch

**We are delighted to share the successful launch of our new town centre office, developed in partnership with Irwell Valley Housing in 2024/25.**

- This new space has become a community hub for local residents, offering regular drop-in sessions and making it easier for people to access the support they need.
- We began by welcoming the public to a lively open event in October that brought together residents, local partners, and new faces. With wellbeing-focused activities and an inviting atmosphere, the day helped introduce our services to a wider audience and laid the foundation for ongoing community involvement.
- Soon after in November, we brought together representatives from a wide range of local organisations to celebrate our new space. This event sparked new relationships and strengthened existing ones, highlighting the importance of collaboration in addressing local needs.
- Additionally, in collaboration with Bury Live Well Service, we delivered a Menopause Awareness session that offered useful insights and signposted further support. More sessions are planned to meet growing interest.
- Overall, this year has been one of growth and connection—expanding our reach, improving partnerships, and opening more doors to meaningful engagement across the community.

# Listening to your experiences

**Services can't improve if they don't know what's wrong. Your experiences shine a light on issues that may otherwise go unnoticed.**

This year, we've listened to feedback from all areas of our community. People's experiences of care help us know what's working and what isn't, so we can give feedback on services and help them improve.

**This year we have reached different communities by:**

- Attending events in our local community including Collabor8 and Bury Pride Holding park bench surgeries across all townships and parks to widen our reach.
- Holding regular drop-in sessions/visiting groups for the seldom heard, vulnerable and facing stark inequalities in the community including homeless people, carers, veterans, asylum seekers, refugees and people with sensory impairment.
- Publishing information and advice articles on our website for topics such as arthritis, floating support and carers groups.
- Publishing videos on our YouTube channel in regards to various topic including gambling awareness, cancer support, smell and taste disorders and hate crime

# Listening to your experiences

## Championing community voices to improve women's health

**Last year, we listened to experiences of local women and highlighted their concerns about accessing health and social care services.**

Through direct engagement and research, we uncovered barriers in adolescent, reproductive, and post-reproductive healthcare that needed urgent attention. Women, clinicians, and community leaders emphasised the importance of clear information, choice, and being heard when seeking care. This feedback shaped our Women's Health Project Report, driving action to improve services and awareness across Bury.

### What did we do?

We engaged with local women to understand their experiences with health and social care services throughout different life stages. This work was driven by concerns raised in the Women's Health Strategy (Department of Health & Social Care, 2022). A report published in May 2024 outlined key findings and recommendations.

### Key things we heard:

**34%** **of women reported they were satisfied or very satisfied with the help and support they had received**

**88%** **of women rely on GP practices for health care advice and support**

**A number of women reported having their symptoms dismissed as 'too young for menopause' or it's normal for your age' or diagnosed with anxiety with little or inappropriate treatment offered**

Our work highlighted how fragmented communication and complex healthcare processes can prevent women from accessing essential health and social care services. By engaging with local women, we identified key challenges in adolescent, reproductive, and post-reproductive care.

### What difference did this make?

Our work raised vital awareness of gaps in women's healthcare, influencing local decision-makers to improve training, access, and communication. The Since then the GM Women's Health Steering Group has been established, three GPs are now training in women's health across Bury, and four local staff are becoming Menopause Coaches. Boroughwide menopause drop-in sessions are underway. Healthwatch Bury also hosted a session attended by 18 women, offering a space for open discussion and shared experiences.

# Listening to your experiences

## Improving hospital communication by making patient letters clearer and more accessible.

**Healthwatch Bury ran a research project to explore the methods of communications sent to patients from the Northern Care Alliance (NCA).**

We spoke with over 140 local patients to gather feedback on existing NCA letter templates. Patients emphasised the need for clear, consistent, and easily understandable communication. Many also expressed that information about alternative communication options would greatly improve accessibility. Their insights have helped shape recommendations for enhancing patient letters, ensuring they provide essential details in a more inclusive and user-friendly format.

### Key things we heard:

**47%** **of respondents told us they had a choice of their preferred method of contact.**

**59%** **of respondents preferred to receive a letter about their appointment.**

> 'Too much information on the letter, not relevant to me about the car park, non-smoking policy and the Trust policy information. It was just for an MRI Scan'

As a result, NCA patients now receive standardised, clear, and concise letters that provide all the essential information for their appointments, ensuring better understanding and engagement with healthcare services.

### What difference did this make?

Our report played a key role in the Northern Care Alliance (NCA) project to streamline and standardise letter templates across Bury, Rochdale, and Oldham. By improving communication and consistency, the initiative has enhanced patient experience and reduced appointment nonattendance. It also helped address inequalities by directing patients to better communication tools when needed. The report was shared with the NCA Outpatient Excellence Programme Steering Group (OPex), and we have been assured that its recommendations will inform ongoing improvements to outpatient services.

# Listening to your experiences

## Gathering patient insights on prescription experiences

**We carried out a research project to examine patient experiences with the prescription process, aiming to highlight key challenges, identify local best practices, and assess the usability of digital platforms like the NHS App.**

Through community group visits, engagement activities, and one-on-one interviews, we gathered insights from over 120 people. In addition, questionnaire responses were collected, providing valuable data to shape improvements in accessibility and support within prescription services.

### Key things we heard:

**54%** **of respondents told us they were very satisfied, experiencing no problems in collecting their prescriptions**

**39%** **of respondents said they used the NHS app for ordering repeat prescriptions**

> "It took me three days and numerous attempts to get in touch with a GP. Then I had to do an over the phone appointment only to be told by the GP that they needed to see me before prescribing, so had to wait a further two days to get in for a face to face. One week later I was able to get the medication I needed."

We've worked with patients and social prescribers in the community to support patients with signing up to the NHS App to enable better and quicker access to prescriptions.

### What difference did this make?

Through this project, we have strengthened our relationship with Bury Integrated Care Partnership, enabling regular collaboration to keep patients informed about key health initiatives. As a result, we are now conducting a follow-up project on Prescriptions, assessing the impact of the patient-led prescribing pilot in Bury North. Additionally, we are working closely with the local social prescribing team to support patients in accessing digital healthcare by helping them sign up for the NHS App, improving engagement and ease of access to essential services.

# Hearing from all communities

**We're here for all residents of Bury. That's why, over the past year, we've worked hard to reach out to those communities whose voices may go unheard.**

Every member of the community should have the chance to share their story and play a part in shaping services to meet their needs.

**This year, we have reached different communities by:**

- Listening to those with visual impairment to understand the barriers they face in getting an appropriate eye care services.
- Provided hands-on support to individuals facing digital exclusion by assisting them with registering for the NHS App and connecting them with local health services.
- Working with asylum seekers, refugees, Hong Kong and South Asian communities (such as ADAB ladies' group) to ensure they can understand their rights and what care is available to them.
- Attended Bury Red Door to support homeless people with any queries related to health and care services and registering with the GP practices.

# Hearing from all communities

## Supporting the National Eye Care Project

### We listened to eye care patients to improve services

Healthwatch Bury was selected to support Healthwatch England's national eye care research. We secured funding to carry out in depth local engagement and held drop-in sessions at Fairfield General Hospital and Rochdale Infirmary eye clinics. We also worked with Bury Society for the Blind to reach people with lived experience. All survey responses contributed valuable local insight to the national evidence base.

### What difference did this make?

Our engagement ensured that the voices of local patients—especially those waiting for or recently treated in secondary eye care—were heard at a national level. By gathering real stories from clinics and community groups, we helped highlight the emotional, physical, and practical impact of long waits. Our findings fed into Healthwatch England's report A Strain on Sight, which calls for better use of community optometrists and improved patient support. The report's recommendations aim to reduce waiting times, improve communication, and ensure patients with the most urgent needs are prioritised—changes that could significantly improve outcomes for people in Bury and beyond.

## Helping refugees and asylum seekers understand and access NHS care

### Supporting asylum seekers and refugees to navigate the health and social care system

Healthwatch Bury continued with monthly drop-in sessions for asylum seekers and refugees. These sessions provide vital support with GP appointments, housing, women's health, and interpreter bookings. Recognising broader community needs, we've expanded access to other vulnerable groups on an ad hoc basis like homeless groups. Our commitment ensures continuity of care and support for those who need it most.

### What difference did this make?

By continuing these sessions, we've created a trusted space for vulnerable individuals to access vital services and support. We've helped people navigate complex systems, such as booking hospital interpreters for non-English speakers and clarifying surgery waiting times for a child, while sharing updated NHS dental care information. Expanding the sessions to engage wider community groups has reduced isolation and strengthened local support networks. Our ongoing presence has built lasting trust, ensuring those most in need receive accurate information and support to access healthcare, housing, and other essential services with greater ease and confidence.

# Information and signposting

**Healthwatch Bury provides free, confidential support to help people navigate health and social care services. Whether it's finding an NHS dentist, raising a concern, or choosing a care home, we're here to listen, guide, and empower individuals to make informed decisions.**

**"We're now based in the town centre, offering weekly drop-in sessions that make it easy for people to access our support. Over the past year, we've supported individuals by:**

- Providing up-to-date information people can trust
- Helping people access the services they need
- Supporting people to look after their health
- Signposting people to additional support services like housing, food banks and mental health support.

# Information and signposting

## Helping a Carer Navigate Delays in Healthcare Decisions

**Healthwatch Bury supported a carer awaiting a Continuing Healthcare decision, helping secure an outcome and connecting him with financial advice—bringing clarity during a difficult time.**

A carer contacted Healthwatch Bury after months of waiting for a Continuing Healthcare decision for his wife, who has dementia and complex health needs. The delay and lack of communication caused significant stress. We contacted the Complex Care Team, who acknowledged the delay and agreed to follow up. We referred the carer to Age UK Bury for financial advice. The patient was granted CHC, and the carer expressed deep gratitude for our support. The outcome brought much-needed clarity, reduced stress, and empowered the carer to plan ahead with confidence.

> "Healthwatch Bury's involvement has made so much difference going forward with this for my wife"

## Supporting a Patient in Crisis to Access Follow-Up Care

**Healthwatch Bury helped a domestic violence survivor update hospital records, ensuring safe communication and access to follow-up care without compromising her new location.**

A patient, recently relocated to a women's refuge after fleeing domestic violence, was concerned about missing a hospital follow-up. She had no appointment details and couldn't access her old phone or address. Healthwatch Bury contacted the Northern Care Alliance, eventually reaching the relevant department. We provided her new contact details and a safe postal address. Her records were updated, including removal of her former partner as next of kin, and a local follow-up appointment was arranged. This ensured her safety, restored access to care, and gave her control over her healthcare journey.

> "I am so relieved that Healthwatch Bury has helped me to sort this out. I was worried about missing my appointment and my ex-partner finding out my new details.'

# Information and signposting

## Supporting people with unmet social care needs

**Thanks to Tanya's experience, a spotlight has been shone on the real-life impact of unmet social care needs for disabled adults.**

Tanya, who lives with multiple physical and emotional health conditions, lost her care package due to rising costs, leaving her without vital support. Her home still has unsuitable adaptations, leading to repeated falls and a growing sense of fear and isolation. Despite exploring local options, Tanya emphasised the need for tailored home adaptations and hands-on care. With her consent, we contacted Adult Social Care and referred her to Healthwatch England, who were collecting stories for their campaign on unmet social care needs. Tanya's experience is now part of their "Exposing the unmet need in social care" series.

> "I'm isolated because I can't get help. Ask yourself something; would you want one of your relatives to live like that?"

## Supporting a Family to navigate the system and access accurate information

**Thanks to support from Healthwatch Bury, a family's long wait for their daughter's surgery was resolved.**

The family, whose first language is not English, had waited nine months for hernia surgery at Royal Bolton Hospital, affecting the child's development and making toilet training difficult. Healthwatch Bury contacted the GP and discovered a referral had been made to Manchester Children's Hospital with a shorter wait time. Using an interpreter, we updated the family and advised follow-up if needed. At six weeks, they received an appointment for the next day, and their daughter has since had successful surgery. bringing relief and reassurance.

> We're so grateful to Healthwatch Bury for following up and keeping us informed about our daughter's surgery wait times. It brought such relief during a very worrying time, and we really appreciated the reassurance and support.

# Showcasing volunteer impact

**Our fantastic volunteers have given up their time to support our work. Thanks to their dedication to improving care, we can better understand what is working and what needs improving in our community.**

**This year, our volunteers:**

- Visited communities to promote our work and what we have on offer.
- Collected experiences and supported their communities to share their views
- Carried out enter and view visits to local services to help them improve

# Showcasing volunteer impact

## At the heart of what we do

**From finding out what residents think to helping raise awareness, our volunteers have championed community concerns to improve care.**

My experience in hands-on support and leadership equips me with empathy and strategic insight to drive positive change. As Director at Healthwatch Bury, living with sight loss empowers me to lead with compassion, understanding, and a deep commitment to inclusion and accessibility. I want to bring a strong, compassionate voice to Healthwatch Bury, one that represents the lived experiences of individuals navigating health and social care services, particularly those affected by neurological conditions and sight loss.

Katie

When I retired, I wanted to be involved in health and social care similar to my work role. With Healthwatch I can put in as many or as few hours as I wish to fit around other commitments. My involvement with Healthwatch has been interesting and varied ranging from reviewing national reports, contributing to panel meetings and taking part in face-to-face data collection. It's been really nice to meet and work with fellow volunteers.

Caroline

**Be part of the change.**

If you've felt inspired by these stories, contact us today and find out how you can be part of the change.

www.healthwatchbury.co.uk

0161 253 6300

info@healthwatchbury.co.uk

# Enter and View authorised representatives

**These are our Healthwatch Bury volunteers that have gone through our thorough Enter & View training processes and have passed the relevant Disclosure and Barring checks, enabling them to conduct visits on behalf of Healthwatch Bury.**

- **Caroline Sutcliffe**
- **Florence Sokol**
- **Alison Slater**
- **Alan Norton**

In addition to the above, our staff team have also undergone the training and checks and are authorised to conduct Enter & View visits.

# Our Board

Healthwatch Bury is proud to be guided by a dynamic and diverse Board, whose members generously volunteer their time and expertise to strengthen our mission. Each brings a wealth of lived experience and professional insight that shapes our work and impact:

- **Tan Ahmed** has over a decade of leadership at ADAB, with deep expertise engaging Black, Asian, and minority ethnic communities, refugees, and asylum seekers.
- **Gita Bhutani**, an NHS clinical psychologist with more than 30 years of experience, has led national initiatives around workforce and staff wellbeing, championing inclusive access to healthcare.
- **Alan Norton** is a nationally recognised advocate for disabled people and a respected leader in accessible living, drawing on a successful business background to drive systemic change.
- **Ruth Passman** brings over 20 years of high-level experience in the Department of Health and NHS. She is passionate about making Healthwatch Bury an accessible and trusted voice for all communities.
- **Katie Price**, Healthwatch Bury's Director, combines front-line experience with strategic leadership. Living with sight loss, she leads with empathy and a strong commitment to accessibility and inclusion.
- **Masoud Sanii** provides the invaluable perspective of a service user and sits on national NHS reference groups representing lived experience. He brings expertise in equality, diversity, and inclusion, particularly around race and disability in the public sector.
- **Alison Slater,** a retired NHS professional, ensured high-quality environments for patient care throughout her career and brings that same dedication to our work.
- **Florence Sokol** has a rich background in both paid and voluntary roles across social care—from frontline support to training future professionals—and brings detailed knowledge of CQC standards and policies.

# Finance and future priorities

**We receive funding from Bury Local Authority under the Health and Social Care Act 2012 to help us do our work.**

## Our income and expenditure:

| Income | | Expenditure | |
|---|---|---|---|
| Annual grant from Government | £122,000 | Expenditure on pay | £117470 |
| Additional income | £12,700 | Non-pay expenditure | £22,784 |
| | | Office and management fee | £16,321 |
| **Total income** | **£134,700** | **Total Expenditure** | **£156,575** |

## Additional income is broken down into:

- £1,000 received from Healthwatch England for work on a project
- £2,000 received from the GM Healthwatch network rebate
- £7,000 received from the GM Healthwatch network for hosting the function
- £2700 from the Irwell Valley Foundation Grant

### Integrated Care System (ICS) funding:

Healthwatch across Greater Manchester also receive funding from our Integrated Care System (ICS) to support new areas of collaborative work at this level, including:

| Purpose of ICS funding | Amount |
|---|---|
| Greater Manchester Network funding for single point of contact and administrative hub. | **£99,000** |

# Finance and future priorities

## Next steps:

### Over the next year, we will keep reaching out to every part of society, especially people in the most deprived areas, so that those in power hear their views and experiences.

We will also work together with partners and our local Integrated Care System to help develop an NHS culture where, at every level, staff strive to listen and learn from patients to make care better.

### Our top three priorities for the next year are

1. Tackling inequalities – Helping improve the outcomes for those that the system isn't working well for even further.

2. Uncovering unmet needs – Amplifying the voices of those who are missing out on vital support by engaging with veterans and ensuring they are able to access the support and services they require.

3. Improving navigation – Helping people find their way around the complex world of health and social care to get the help they need.

Underpinning these key priorities is one main theme – visibility. We will strive this year to build on the number of people supported last year, increasing those numbers and doing as much as we can to reach more of our local community. This will make us more visible, increase our demand, and ensure that our community get the best out of the services available to them.

# Statutory statements

**Healthwatch Bury CIC, 56-58 Bolton Street, Bury, Greater Manchester, BL9 0LL**

**Healthwatch Bury uses the Healthwatch Trademark when undertaking our statutory activities as covered by the licence agreement.**

## The way we work

**Involvement of volunteers and lay people in our governance and decision-making.**

Our Healthwatch Board consists of 7 members who work on a voluntary basis to provide direction, oversight and scrutiny of our activities. Our Board ensures that decisions about priority areas of work reflect the concerns and interests of our diverse local community.

Throughout 2024/25, the Board met 6 times and made decisions on matters such as our future public engagement plans, our contract with Bury Council and its specifications as well as the future of our premises. In addition, the Board hosted three drop-in sessions, including a public event that welcomed local councillors and the MP, an opportunity to strengthen relationships and explore collaborative ways of working..

We ensure wider public involvement in deciding our work priorities by using public feedback, consulting with representatives and patient groups, involving volunteers and lay people in our Enter & View panel and inviting participation in our AGM.

## Methods and systems used across the year to obtain people's experiences

We use a wide range of approaches to ensure that as many people as possible can provide us with insight into their experience of using services.

During 2024/25, we have been available by phone and email, provided a web form on our website and through social media, and attended meetings of community groups and forums.

We ensure that this annual report is made available to as many members of the public and partner organisations as possible. We will publish it on our website and will also have copies available at our engagement events as well as our AGM.

## Responses to recommendations

We had no providers who did not respond to requests for information or recommendations. There were no issues or recommendations escalated by us to Healthwatch England Committee, so no resulting reviews or investigations.

# Statutory statements

## Taking people's experiences to decision-makers

We ensure that people who can make decisions about services hear about the insights and experiences that have been shared with us.

In our local authority area, for example, we take information to Health Scrutiny Committee, Social Care Risk Escalation Group, the System Assurance Committee, Public Health Delivery Partnership, Elective Care and Cancer Recovery Board and several more.

We also take insight and experiences to decision-makers in the Greater Manchester Integrated Care System. For example, we have a representative on the GM System Quality group. We also share our data with Healthwatch England to help address health and care issues at a national level.

## Healthwatch representatives

Healthwatch Bury is represented on the Bury Health and Wellbeing Board by Ruth Passman, Chair of Healthwatch Bury.

During 2024/25, our representative has effectively carried out this role by providing strategic input, constructive challenge and using influencing skills to ensure that the voice of services users, carers, patients and the public is heard. Working in collaboration with leaders from the healthcare system, the public, voluntary and community sector and a range of local stakeholders, this has enhanced our strategic impact last year, in close alignment with our input into the broader Greater Manchester (GM) programme of work to secure Healthwatch representation at all levels as we moved to an Integrated Health System.

Healthwatch Bury is represented on Healthwatch Bury is represented on Greater Manchester Integrated Care Partnerships by Danielle Ruane –Chief Coordinating Officer of the Healthwatch in Greater Manchester Network, and Greater Manchester Integrated Care Boards by Heather Etheridge – Independent Chair of the Healthwatch in Greater Manchester Network. Ruth Passman represents Healthwatch in Greater Manchester on the Population Health Committee; a committee of the NHS Greater Manchester Integrated Care Board. In addition to being responsible for discharging the statutory organisational responsibilities of NHS GM, the Committee provides wider system leadership in relation to population health in Greater Manchester, with a primary focus on improving health outcomes and reducing health inequalities.

# Statutory statements

## Enter and view

| Location | Reason for visit | What you did as a result |
|---|---|---|
| Bury Children and Adolescent Mental Health Service | Responding to complaints and wider work of Greater Manchester around Childrens mental health services. | Created report and associated recommendations to feed into future planning work. |

## 2024 – 2025 Outcomes

| Project/activity | Outcomes achieved |
|---|---|
| Dementia Project | Recommendations from the Dementia project report are being used to design the local dementia strategy and to shape the future services. |
| Women's Health Project | Improved engagement, menopause event, women's health clinic |
| Prescriptions Project | Regular ongoing conversation with the Integrated Care Partnership. Conducting a follow up project to explore how patient led prescribing has impacted people's experiences. Raising awareness of the pilot locally. |
| Clearer Communications Project | Assisted in redesign and standardising of patient letters from hospital trust, ensuring accessibility and comprehension of many groups. |
| Dentistry | Monitored availability of places on NHS dentist patient lists and helped people get registered with an NHS dentist when they have not been able to themselves |
| Pharmaceutical Needs Assessment survey | Engaged with people who are digitally excluded to support patients to have their say about future pharmacy services. |

healthwatch Bury

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**Briefing Note**

| | |
|---|---|
| To | Bury's Health and Wellbeing Board |
| From | Lee Buggie & Lucy Fitzsimon |
| Subject | Driving Physical Activity through the "LET'S Get Bury Moving" (LGBM) Framework |
| Purpose | Information / Discussion |
| Decision required | No |
| Status | Live |

**Briefing Paper: Tackling Physical Inactivity and Inequalities in Bury**

**Subject:** Driving Physical Activity through the "LET'S Get Bury Moving" Framework

**1. Executive Summary**

Physical inactivity remains a critical driver of health inequalities in Bury. While national activity levels have seen record highs, local data and demographic gaps—particularly among women, girls, and lower-income families require a coordinated, whole-system response. This paper aligns Bury's local "LET'S Get Bury Moving" physical activity strategy with Sport England's "Uniting the Movement" and the "Greater Manchester Moving" strategies to propose recommendations for the Board.

Please find below links to the LGBM landing page and the digital mapping of Bury's physical activity, whole systems approach.

- **LET'S Get Bury Moving:** LETS Get Bury Moving | Bury Directory

- **LETS Get Bury Moving Mapping:** LETS Get Bury Moving • LETS Get Bury Moving Complexities • Kumu

**2. Latest Physical Activity Trends & Inequalities**

**Adults:**

- 66% of adults are Active (150 minutes) an increase of 4.3% from the last monitoring period
    - Moving in the right direction towards the 3-year LGBM Physical Activity Strategy's ambition of 70% by 2028
- 24.6% are Inactive (Less than 150 minutes of moderate physical activity per week) a reduction of 2.2%
- 9% are Fairly Active (30-149 minutes per week) a reduction 2%

**Children and Young People (CYP):**

- 60.6% Active (60+ of moderate physical activity per day ) this has increased by 11.4% and activity levels both in and out of school are increasing
    - Bury are already above the LGBM strategy aims of 52% active over 3 years
- 17% Inactive (less than 30 minutes per day) Reduced by 3.3%
- 22.6% are Fairly Active, Reduced by 7%
- **Persistent Inequalities:**
    - **Ethnicity:** Black (41%) and Asian (43%) children remain significantly less active than their White British (51%) peers.
    - **Socioeconomic:** Children from the least affluent families (45%) are less active than those from the most affluent (58%).
    - **Intersectionality:** Activity levels drop further for those with multiple inequality characteristics, such as Asian girls or those from low-income Black backgrounds.

**3. Strategic Alignment**

Bury's approach is anchored in three key tiers of strategy:

- **National:** Sport England's Uniting the Movement focuses on "Place-based" working to dismantle barriers in the 20% most inactive areas.
- **Regional:** GM Moving in Action sets the blueprint for Greater Manchester, prioritising active travel and "moving as a natural part of everyday life".
- **Local: LET'S Get Bury Moving** is the borough's framework and we aspire to move away from "one-off" interventions and focus on long-term system change.

**4. Focus on Women and Girls: Bury Place Partnership**

The **Bury Place Partnership** identifies women and girls as a priority group, noting they are historically less likely to be active.

- **Safety & Design:** Actions focus on "taking back our streets" by ensuring public realms are designed with women's safety and needs in mind.
- **Empowerment:** Leveraging the Lionesses' legacy (which saw 176,000 more girls playing football since 2017) to create inclusive, "judgment-free" local environments.

**5. Recommendations for Board Action**

1. Endorse a system wide and targeted approach to increasing physical activity, ensuring collective action across partners and focused support for communities with the greatest need.

2. Advocate for and contribute to the borough's physical activity agenda, championing initiatives, sharing resources and supporting collaborative efforts that help residents become more active.

**For a deeper understanding of Bury's Physical Activity data sets please see the below:**

Bury 23-24 Active_Lives.pdf

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# Driving Physical Activity through the "LET'S Get Bury Moving" Framework

## Tackling Physical Inactivity Inequalities.

Lee Buggie – Public Health Specialist and Lucy Fitzsimon – Neighbourhood Wellness Lead

"If physical activity were a drug, we would refer to it as a miracle cure, due to the great many illnesses it can prevent and help treat". *UK Chief Medical Officers, 2019*


Bury Council

# LET'S Get Bury Moving (LGBM) Physical Activity Strategy

LET'S Get Bury Moving

System Partner Framework

Anchored in infrastructure and improved place's

Inequalities Focus on Index of Multiple Deprivation (1-2 )

"Marmott" aims around Universal Proportionalism

Landing Page & Padlet

LGBM EIA

LET'S Get Bury Active Schools

LET'S Get Bury Active Early Years

Working up a Physical Activity finder

Bury Council

# Data Limitations

- **Active Lives**
- 175,000 national respondents (Aged 16+)
- **Random probability based on post codes**
- Variety of schools selected
- **Data weighted and matched to Office of National Statistics (ONS)**
- **Limitations to consider**
- **Self bias reporting**
- **Excludes SEND schools**
- **Only 1-2 Bury Schools take part**
- **Difference between Fingertips and Active Lives**
- **Fingertips define adults as 19+, Sport England (SE) use 16+**
- Fingertips recognises gardening as physical activity SE don't !
- **Bee Survey**
- Physical Activity trends follow SE data sets
- Breakdown at Ward level which we don't get from the above sources
- Used to populate Neighbourhood Profiles

SPORT ENGLAND

Office for Health Improvement & Disparities

#BEE WELL

Bury Council

# Headlines linked to LGBM Physical Activity Strategy

Adults:

- 66.4% of Adults are Active (150 minutes) Increased by 4.3%
  - Moving towards 3-year LGBM Physical Activity Strategy ambition of 70%
- 24.6% are Inactive (Less than 150 minutes per week) Reduced by 2.2%
- 9% are Fairly Active (30-149 minutes per week) Reduced by 2%
- IMD (1-3) next slide


Children and Young People (CYP):

- 60.6% Active ( 60+ per day ) Increased by 11.4%
  - Above the LGBM strategy aims of 52% over 3 years
- 17% Inactive ( less than 30 minutes per day ) Reduced by 3.3%
- 22.6% are Fairly Active, Reduced by 7%

*Source: Active Lives 2025*

Bury Council

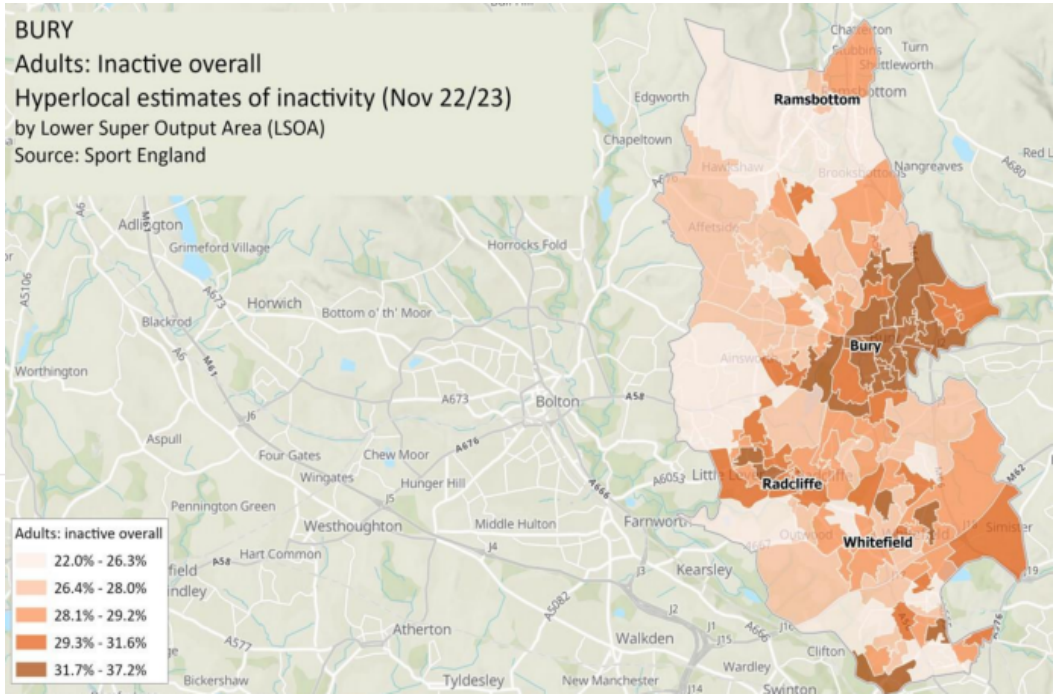
# Physical Activity Inequalities

**Adult Activity Levels:**

- **Insight: Deprivation** is the single largest predictor of inactivity in Bury.

**Children and Young People & The Gender Gap**

- **61%** of children are active daily.
- **Gender Split:** Boys (52%) vs. **Girls (46%).**
- **Inequality:** Activity levels are significantly lower for **Asian and Black youth** compared to White British peers.

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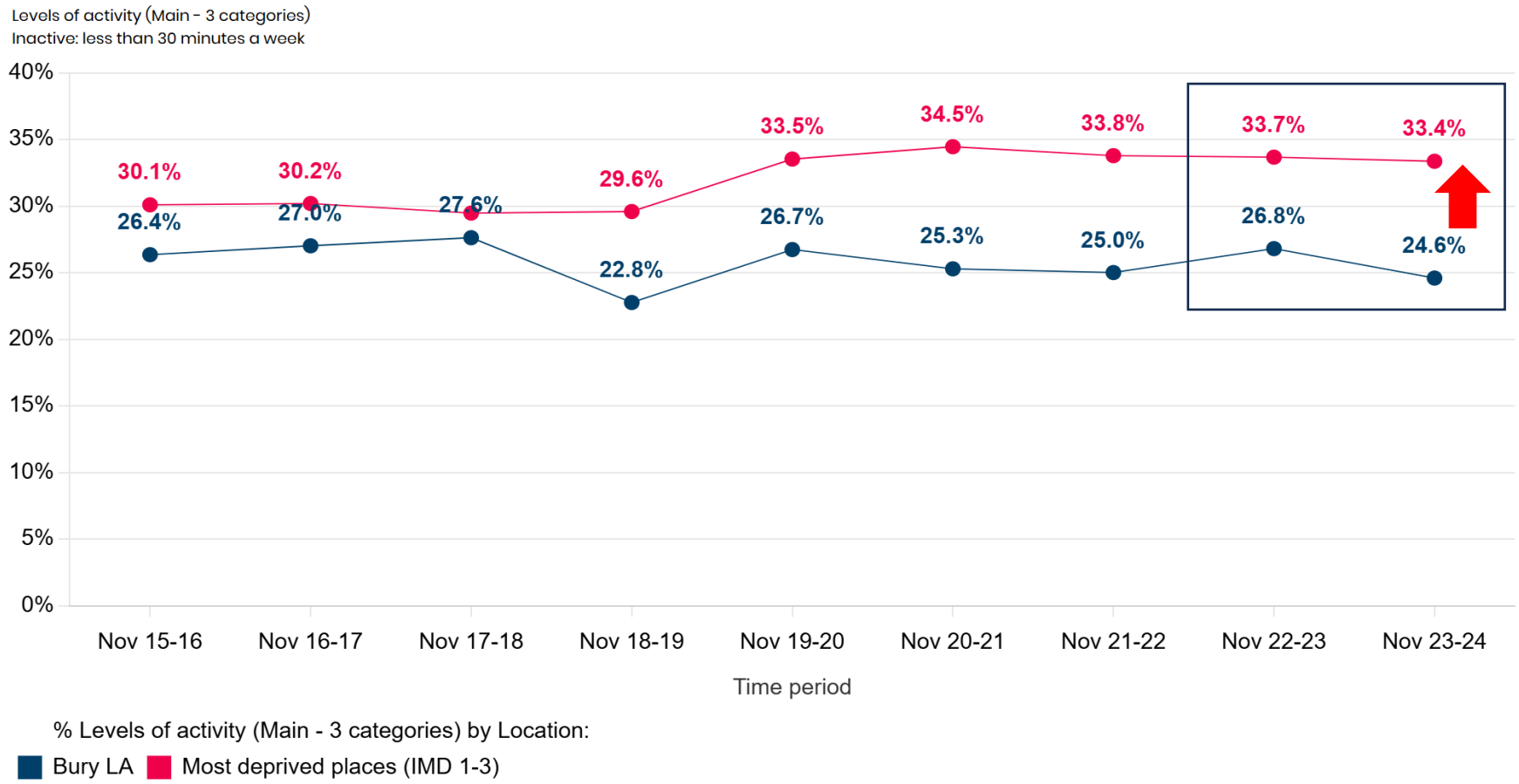
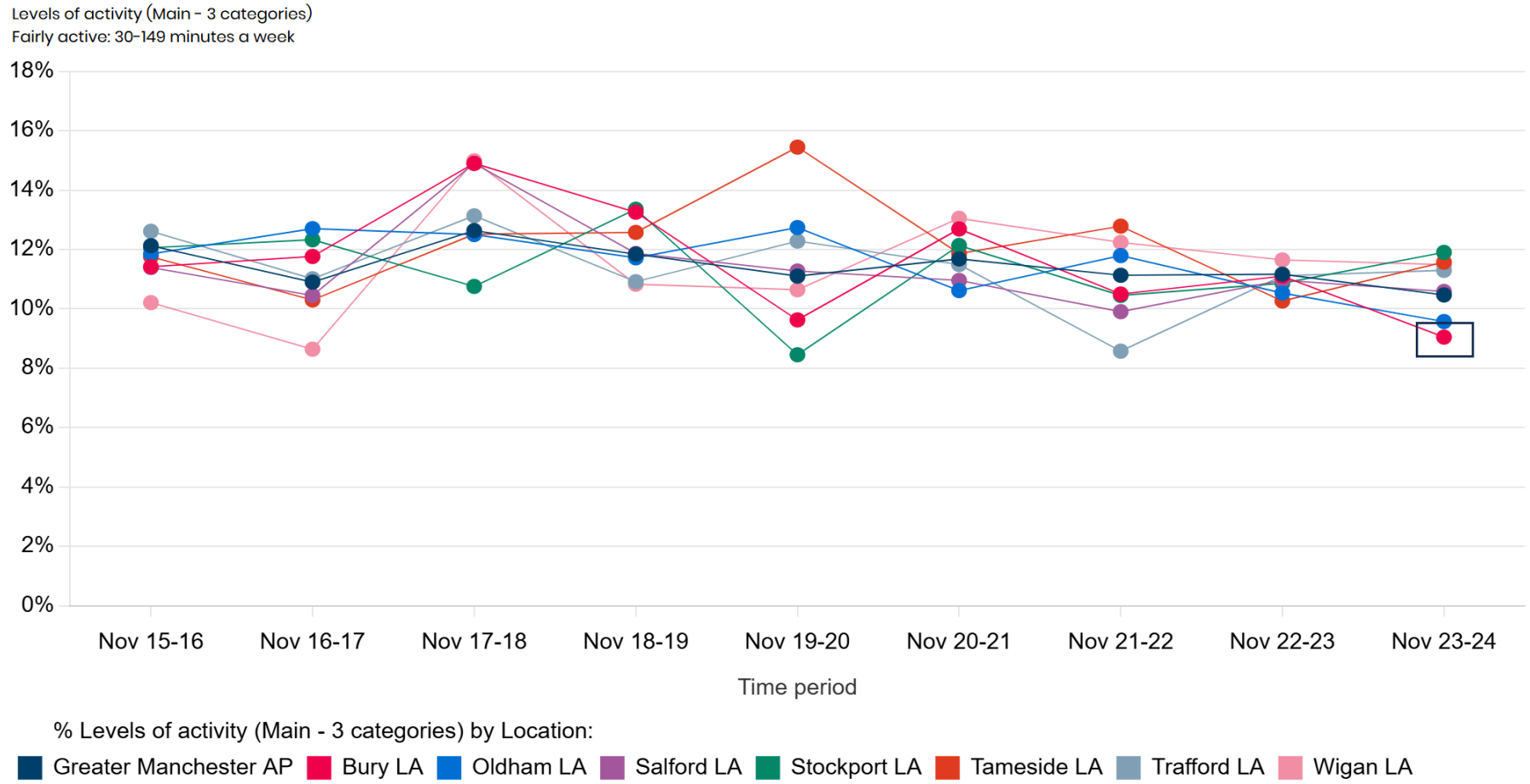
# Index of Multiple Deprivation (IMD /1-3)




Source: *Sport England, Active Lives.(2026)*

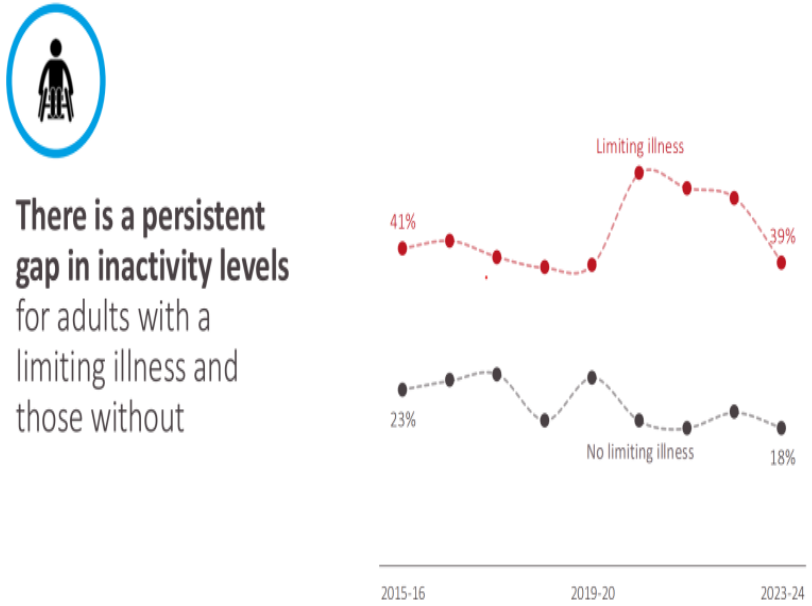
# Comparisons with Greater Manchester – Active / Inactive / Fairly Active




Source: *Sport England, Active Lives.(2026)*

# Disability and SEND

- We know about activity levels for children and young people but **SEND specific patterns are missing from local reporting**
- National Evidence suggests children with SEND are **typically less active**




Source: *Sport England, Active Lives.(2026)*

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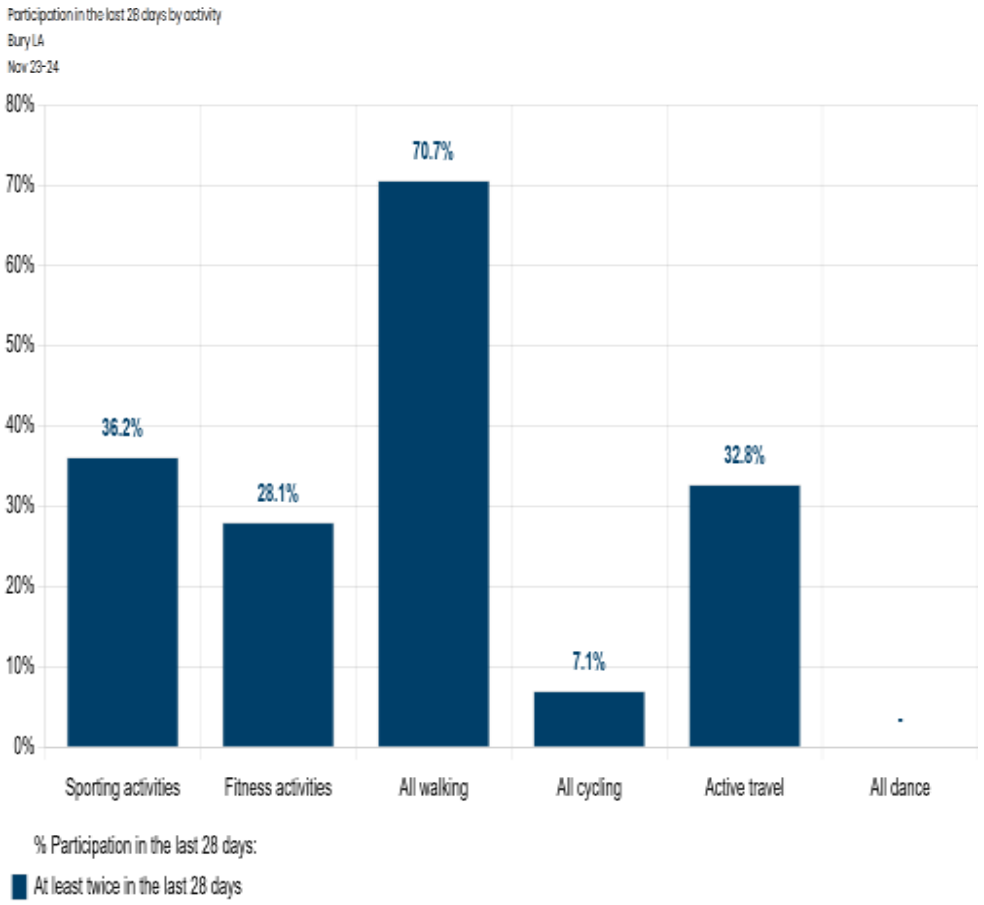
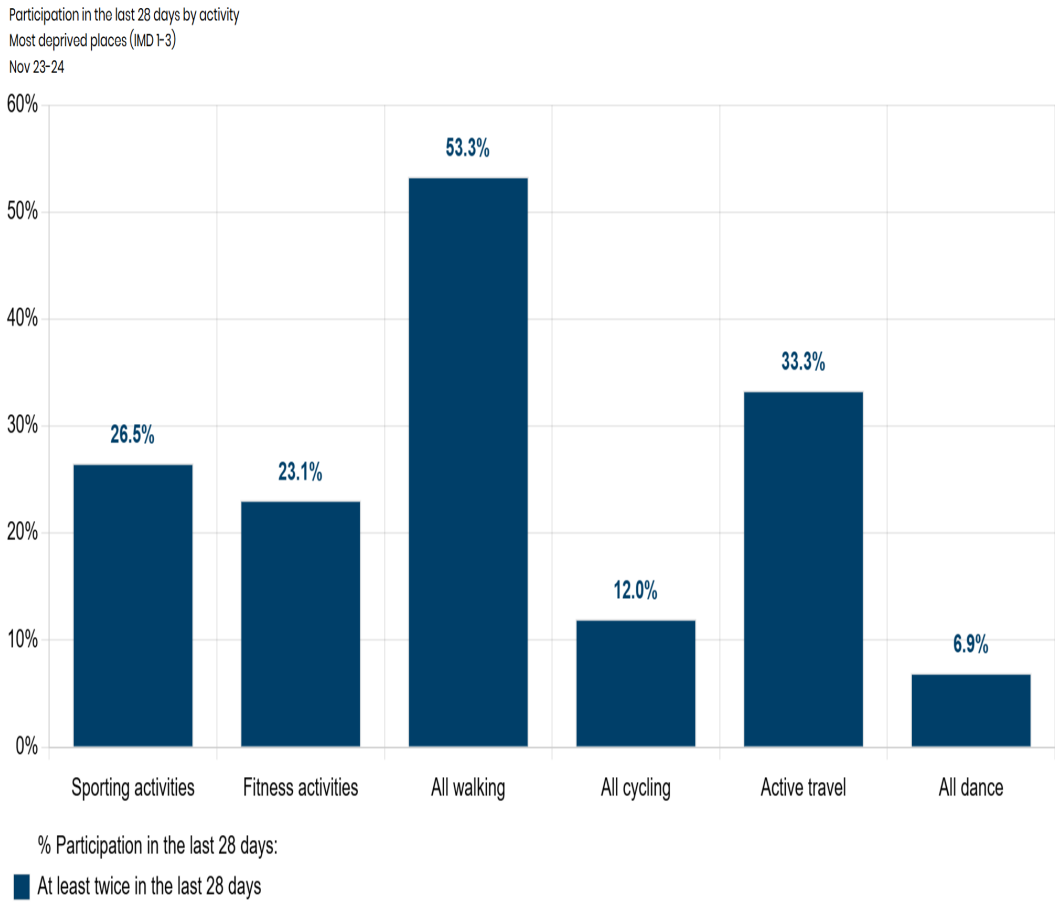
# What are our communities doing ?




Source: *Sport England, Active Lives.(2026)*

# Where and how do Bury communities become active ?

- There are 80 Gyms registered in Bury
- Bury Council has 13 Green Flag Parks and 2 Green Flag cemeteries
- A range of 3G pitches in and out of school settings
- A wide range of Golf courses across the borough
- Blue networks including sailing and open water swimming facilities at Elton Reservoir
- New Padel facilities & 10 Swimming Pools at a range of facilities
- Grass roots clubs and alternative facilities

Counts of sports facilities across Local Authority Districts (LAD) per 10,000 people

| | | | | |
|---|---|---|---|---|
| E08000001 | Bolton | 427 | 693 | 14.43 |
| E08000002 | Bury | 309 | 627 | 15.94 |
| E08000003 | Manchester | 568 | 972 | 10.29 |
| E08000004 | Oldham | 273 | 887 | 11.28 |
| E08000005 | Rochdale | 306 | 731 | 13.67 |
| E08000006 | Salford | 348 | 776 | 12.89 |
| E08000007 | Stockport | 486 | 607 | 16.49 |
| E08000008 | Tameside | 267 | 865 | 11.55 |
| E08000009 | Trafford | 461 | 510 | 19.61 |
| E08000010 | Wigan | 515 | 639 | 15.64 |

Source: *Office for National Statistics.(2023).*

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# What do we know – the basics

- Adults are becoming more active
- Less adults are inactive
- Need to do more with adults on the point of becoming active
- Further targeted work in IMD 1-3
- Compare very well to Greater Manchester Neighbours
- Deprivation is the key contributor

- CYP significantly more active in and out of school settings
- Active School's Radcliffe and East
- Gender and Ethnicity focus

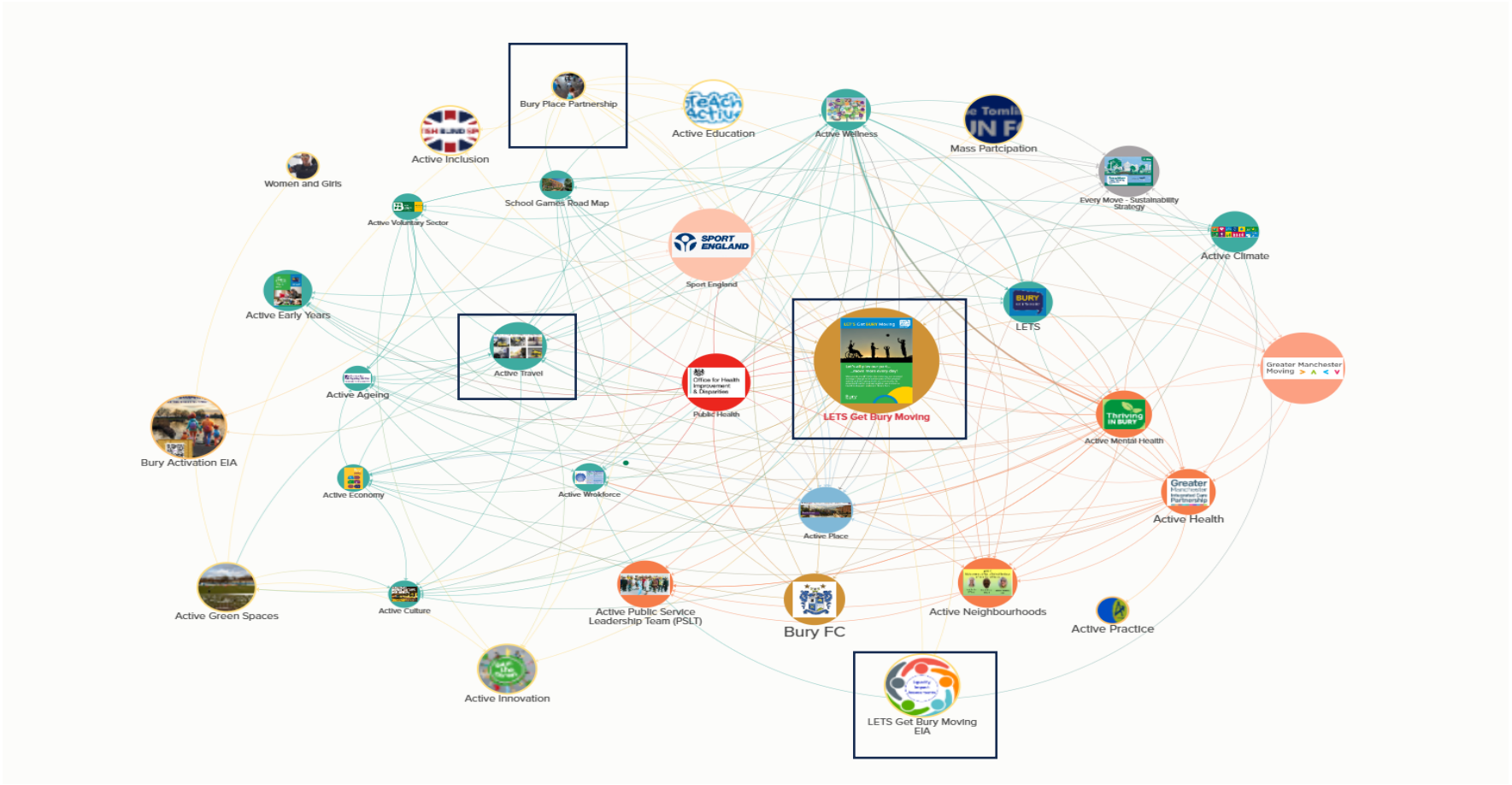
Bury Council

# What else do we know ?

- **11,000** children and young people are not active enough
- Inequality metrics show activity rates are much lower for **young people with two or more characteristics**
- Children and young people from our **low affluence families** are the least likely to be active
- Young people who report they do not have **access to outdoor space** as less likely to be active
- Our **least affluent households** are more likely to be inactive (NS Sec 6-8). There is a clear inequality gap between our least and most affluent households.
- There is a **persistent gap** in inactivity levels for **adults with a limiting illness** and those without.
- **Inactivity rates are higher for those outside of the workforce** and for adults in our most deprived communities.

Bury Council

# So, LETS have a look at the Bury Physical Activity System



# Policy and Strategy Levers

- Sport England and GM Moving – Women and Girls, Men's Health, Stigma , System Change
- LGBM – 3 key drivers and HIA
- **Best Start in life and Economic Growth – Corporate priorities**
- **Public Service Leadership Teams – Thematic Leads & Dashboards**
- **Wellness – Leisure Provision, Culture, Live Well Services**
- Climate – Active Travel KM's mapped, investment into safer sustainable travel
- Economy and Working Well programmes linked to wellness
- **Mental Health Framework to underpin refreshed Mental Health strategy**
- Transport – Active Travel - Activation resource supporting communities
- **Age Friendly Bury – walking route audits, disability friendly walks and cycling provision**
- **Local Plan & Supplementary Planning** – National Planning policy Framework


Bury Council

# LGBM Equality Impact Assessment (EIA)

Teach Active

WOW the WALK TO SCHOOL challenge



Bury Early Years Physical Development Pathway


junior parkrun

**Showdown**

Showdown is a fast-moving sport, with similarities to table tennis and air hockey. It was designed for people with a visual impairment, but anyone can play!

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# Active Travel & Place

- **School Streets & Play Streets**
- WOW – Active Travel Tracker
- Modeshift Stars
- Activation
- Dr Bike Days
- **Wheels for all**
- Road Traffic Calming
- **Bike Hospital**
- Buggy Storage
- Fit For Purpose
- **Activation inequalities & Equality Impact Assessment**
- Older Adult's walk audits
- Bikeability
- Bury's Walking and Cycling Forum
- Bury Bee Board




Bury Council

# Whole System Contributors

**Early Years:**

- Focus on Good Level of Development
- **Physical Development Pathway**
- Physically Active Spaces
- **Legacy programmes**
- Growing and outdoor provision
- Holiday and Food ( HAF )

**Primary Care:**

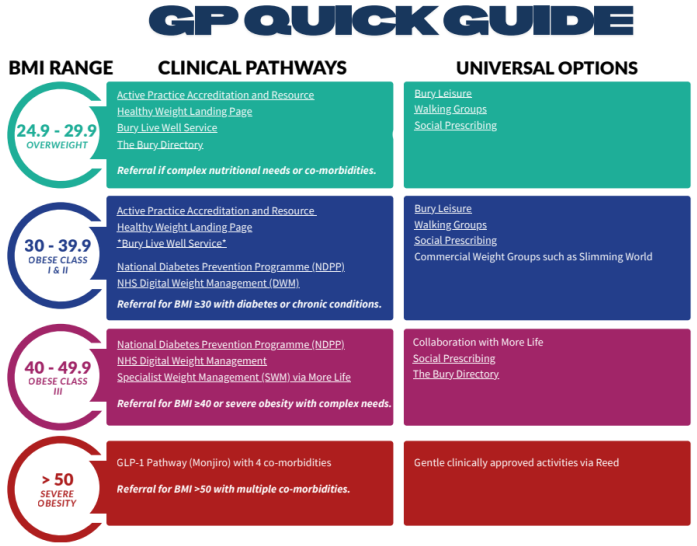
- **Active Practices**
- Weight Management Contributions
- Park Run Practices
- **BMI pathways**
- Campaigns and resources

**Bury VCFA:**

- Link Grants and Investment to **IMD and system focuses**
- Support Originations to become active, BID writing
- **System Navigation**

**Bury FC:**

- Walking Sports
- **Sporting Memories**
- Glob**al Majority Outreach**
- Schools
- **Working Well**




**CIC's and Charities:**

- Sunnywood Project Supporting Volunte
- Growing Together Radcliffe Youth Activities
- National Cycling Academy lead walks and cycle provision

**Global Majority Communities:**

- **Micro Grants linked to activation**
- **Breaking Barriers and Community Cohesion**

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# You Said – We Did !




Bury Council

# Case Study

## A Partnership with Purpose

Through Let's Get Bury Moving, Teach Active is delivering a **comprehensive borough-wide programme** that provides every primary school in Bury with training and resources to **embed movement into Maths and English lessons**. We're tackling some of the biggest challenges facing schools today — **inactivity, health inequalities, and rising SEN needs — while simultaneously raising educational standards.**


**42 schools / 328 teachers / 1676 plans** downloaded in the first week !

***"We're proud to see Greater Manchester leading the way in active learning—and Bury at the heart of this movement. This borough-wide project is an example of how collaboration between education and health partners can transform education and wellbeing for children."*** — Jess Simons, Greater Manchester Moving

***"This project is a game-changer for children's health and education in Bury."*** — Lee Buggie, Public Health Specialist – Live Well and Healthy Place

Bury Council

https://vimeo.com/1157523364?fl=pl&fe=sh

# Case Study -Bury FC Comets Group

- Improved confidence and willingness to participate in group activities
- Improved listening and engagement skills
- Making new friends
- Increased physical activity and fitness
- Inclusive football for children who previously struggled to access sport

| Metric | Value |
|---|---|
| Programme started | 13 February 2025 |
| Sessions delivered | 50 |
| Total children attended | 17 |
| Age range | 5–11 |
| Average attendance | 7 per session |
| Coaching team | 1 lead coach + 2 helpers |

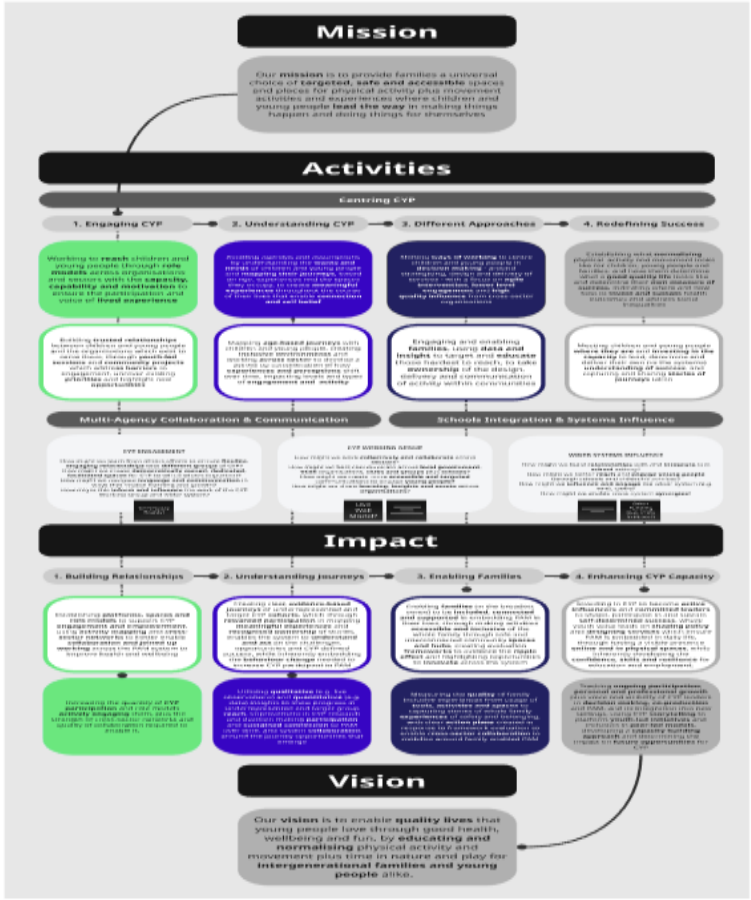
"My Child struggled to find a suitable football group before finding Comets."

"The coaches are patient and encouraging and my child feels welcome every week."

"Since starting more physical activity I have noticed my childs health has improved. We experience far less respiraratory issues."

# Place Partnership
# Children, Young People and Families

- *"Our mission to provide **families** a universal choice of targeted, safe and accessible **spaces and places** for **physical activity**, plus movement **activities** and **experiences** where children and young people **lead the way** in making things happen and doing things for themselves"*
- Engaging with CYP – Youthwatch
- Multi agency Collaboration and Communication – System wide
- Impact – out come – what have we heard

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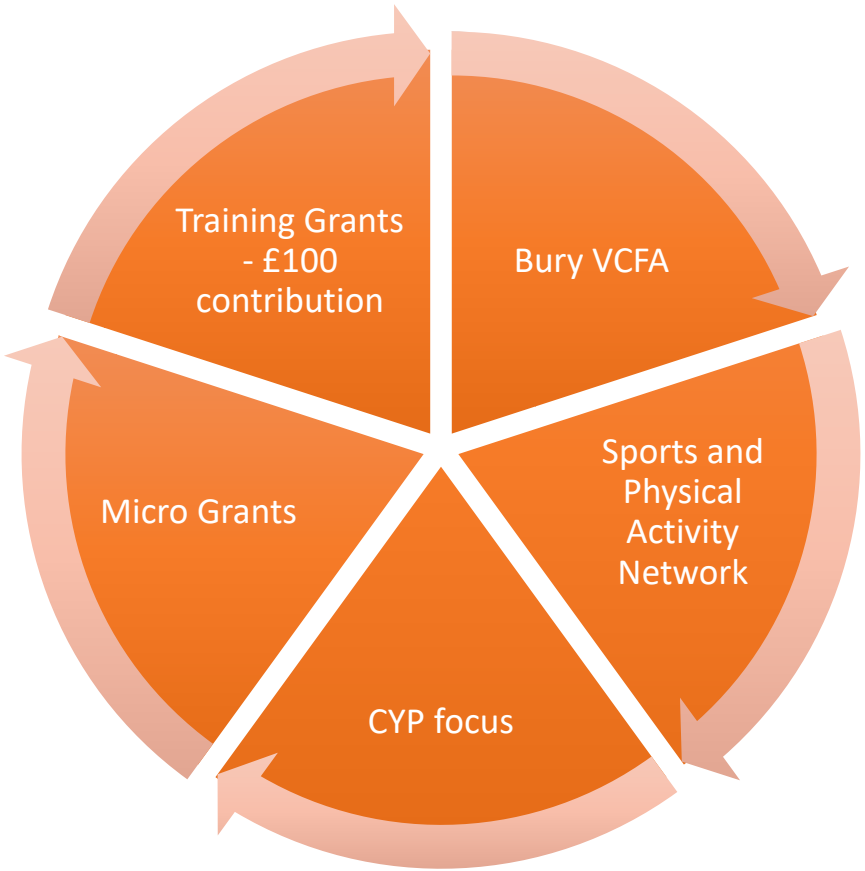
# Place Partner




- Leadership Skills Foundation
- JUMP – Join Us Move Play Training
- WOW
- BEAT the Street
- Playstreets
- Teach Active

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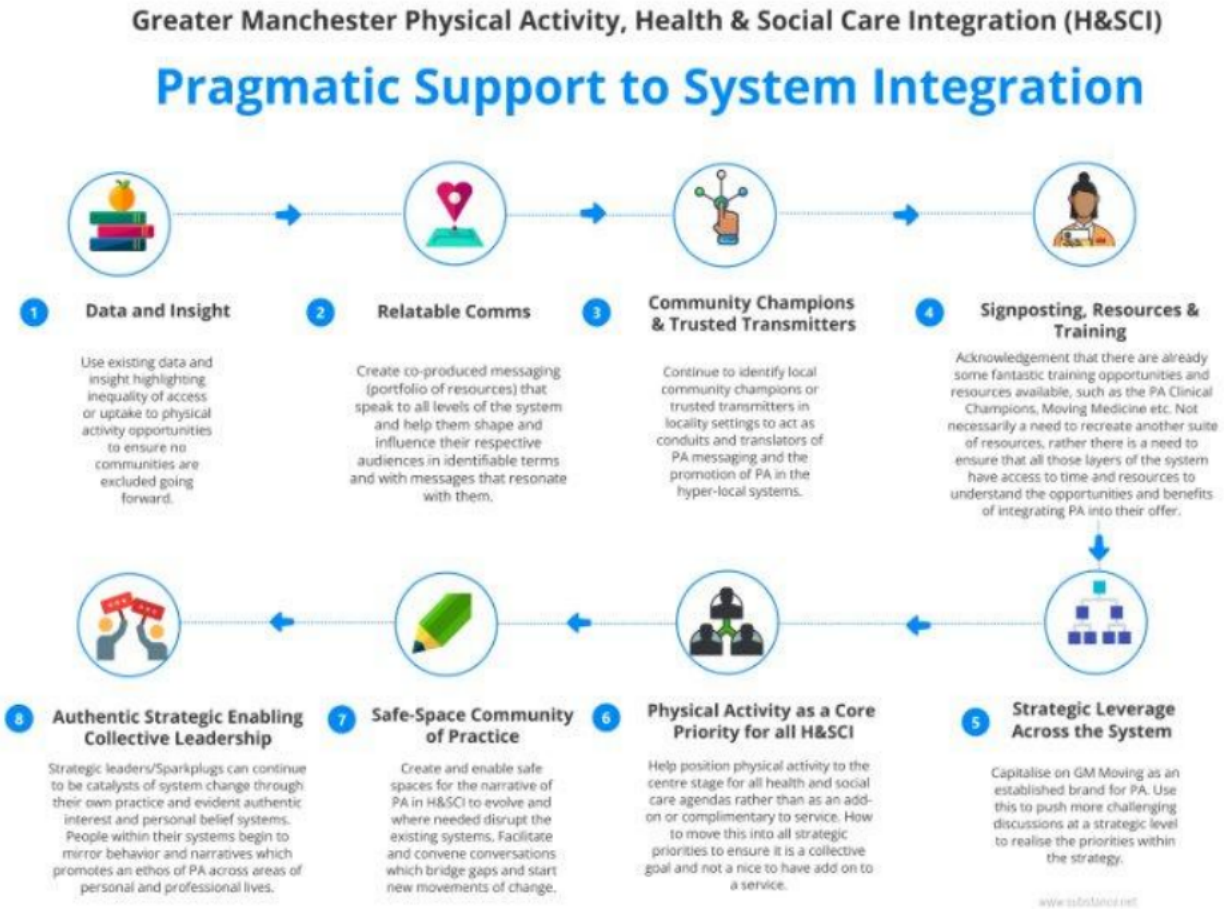
# GM Moving Population Health Deep Dive
# Fernhill & Pimhole and Radcliffe.




- Test a new evaluation approach
- Asses and measure population health of our collective place based and WSA
- Local Workshops
- Scoping Local Data
- Interviewing
- Future progress updates

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# Case Study

Bury Relics, formed in 2017, provide both community and competitive walking football for people from the Bury area and beyond.

Community walking football is provided for the over 50's and The Relics have five teams in the Greater Manchester Walking Football League, two over 60's teams, an over 65's team, an over 70's team, and new for 2025 an over 75's team.


Ken Buggie

[Bury Relics – Walking Football]

Bury Council

# Mass Participation

- Glad to Bee Rad & Folk Tales and Fables
- QR codes walks
- Trail and Rail
- WOW – Active Travel Tracker & **Teach Active**
- **Bury Running Festival**
- Park run and Junior Park Run / Primary Park Runs
- GM / & Bike Hospital
- **Bury Walking Festival**
- Toddle Treks
- **Encourage unstructured play**
  - **Everyone's role, safe, well lit, community cohesion**
- Ghost Story Walks
- **BEAT the Street**
- **“2000 – 4000” steps – evidence-based approaches**




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# Unsung Hero's


BT

**Free Shaun the Sheep art trail comes to Bury town centre**

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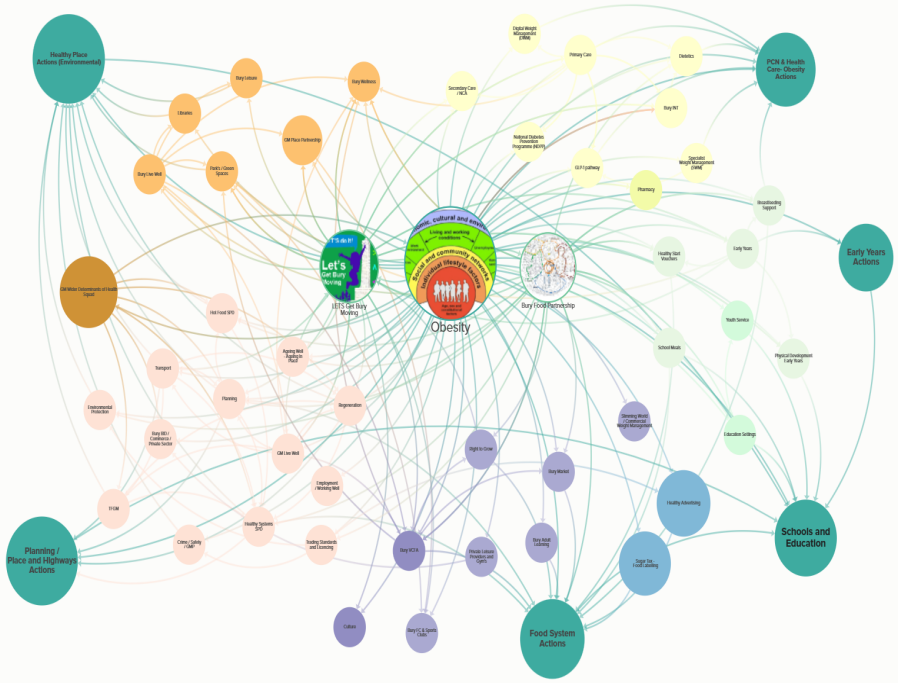
# Naturally linked to Bury's Obesity Alliance

- Physical Activity for Health not Weight
- Early Years and Schools
  - NCMP showing increases in Obesity Rates
  - Physical activity showing increases
- Prevention focus
  - 0-5 years
  - 6-11 years
- Data dashboard created
- Action Plan Live
- Infrastructure & Place focus
- GP pathways in development
- Listening to youth voice and peers as next steps

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# Asks of the board !

**1. Endorse a system-wide and targeted approach to increasing physical activity**, ensuring collective action across partners and focused support for communities with the greatest need.

**2. Advocate for and contribute to the borough's physical activity agenda**, championing initiatives, sharing resources, and supporting collaborative efforts that help residents become more active.

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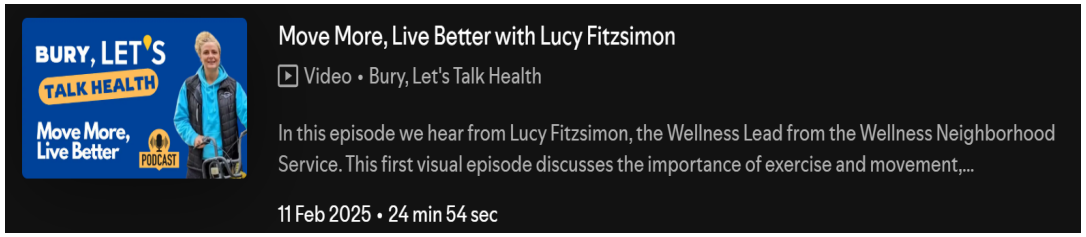
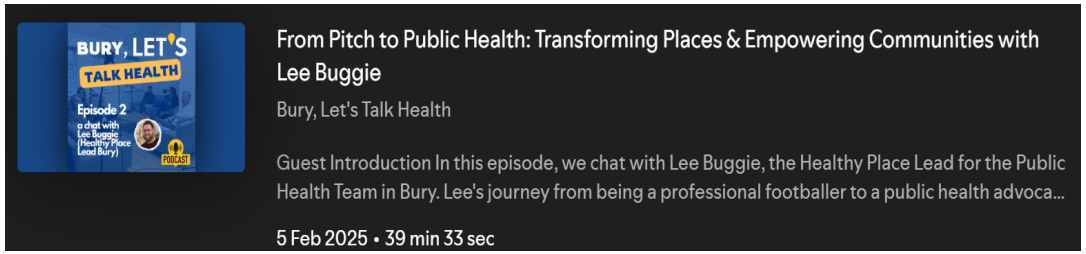
# Thank you as always




https://open.spotify.com/episode/1D2fI1QRrd17Pbnh0bh7bh?si=-t2aA8PfR-WF_9mb6kHq0Q




https://open.spotify.com/episode/45DECHGGPcIOZtMlQvbpmy?si=40f8f260db1940ef



Bury Council

# Neighbourhood Health Plans in Greater Manchester

## Part of Greater Manchester Live Well

Draft Template v0.3

November 2025

Part of Greater Manchester Integrated Care Partnership

## 1.0 Introduction

### 1.1 Profile of locality – demographics & JSNA

Bury is a Borough in Greater Manchester with a population of c195,000 residents and a GP registered population in excess of 205,000. The population of Bury is growing and ageing. The proportion of the population aged 65 and over is projected to grow from 18% to 21% (a relative increase of 16%) by 2040, and the proportion of the population aged 80 and over is projected to from 5% to 7% (a relative increase of 40%) by 2040. Over the same time the proportion aged under 20 is projected to fall from 25% to 23%.

The five neighbourhoods are North, East, West, Whitefield, and Prestwich. North neighbourhood is the most affluent, with the highest average household income (c£46,600). Conversely, East and West neighbourhoods are far more deprived, with parts of these neighbourhoods (particularly Bury town centre, Radcliffe, and the M66 corridor) within the most deprived ten percent of areas in England. Average household income in East and West neighbourhoods is around £36,900 – almost £10,000 less than in North neighbourhood. Whitefield and Prestwich neighbourhoods sit roughly in the middle of these figures, although there are still pockets of relatively high deprivation, particularly in Whitefield.

The demographics of the neighbourhoods vary significantly. North neighbourhood has the oldest age profile, with around 10% of residents over the age of 75. East and Prestwich neighbourhoods have a much younger age profile, with more than 20% of residents in these neighbourhoods under the age of 15.

Life expectancy in North neighbourhood is around 82 years, four years longer than the 78 years in East neighbourhood. In terms of healthy life expectancy, the average resident of North neighbourhood is expected to reach age 67 in good health, whereas in East neighbourhood this figure is only 59 years. West, Whitefield and Prestwich neighbourhoods are closer to the borough-wide average of 63 years of healthy life expectancy.

Note that this data was last reviewed in 2023. New neighbourhood profiles are currently being developed and will be available as part of the refreshed Bury Joint Strategic Needs Assessment (JSNA) shortly.

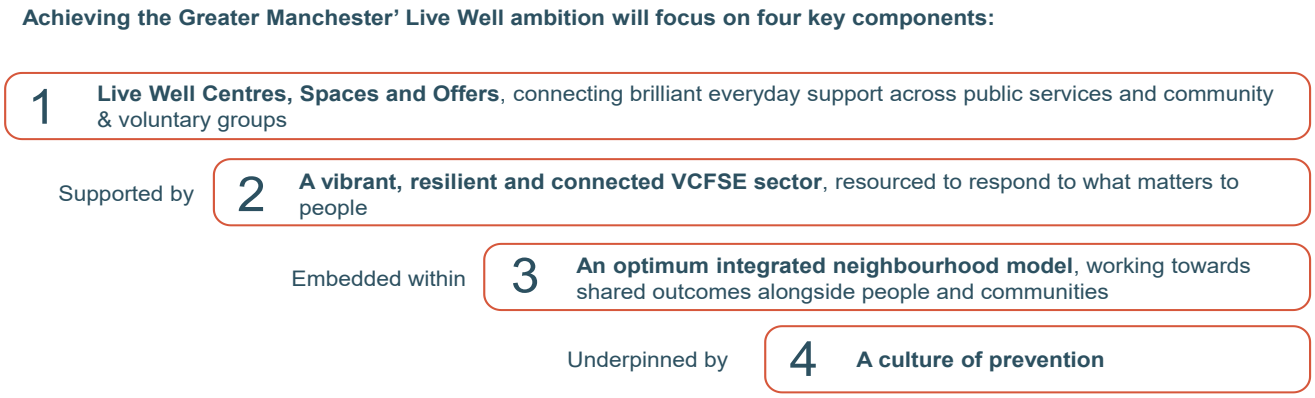
The leading causes of death in Bury are cardiovascular diseases and cancers. The main causes of disability are musculoskeletal conditions and mental illness. Diabetes and liver disease are increasing as causes of disability and death. Health outcomes across Bury are somewhat less equal than across England as a whole. This likely reflects the diversity of population that Bury contains, ranging from urban to rural and affluent to deprived.

According to the 2021 census results, the majority of Bury's resident population identified their ethnic group within the high-level “White” category, which is 1.9% higher than the national figure of 81% for England. However, this is changing with a trend towards non-white ethnic groups making up a higher proportion of the population. This is broadly consistent with the national trend. The proportion of people identifying as “Asian” has seen the highest increase from 7.2% in 2011 to 10.6% in 2021. The East Neighbourhood has a comparatively higher proportion of Asian residents. The South of the borough has a significant Jewish community which is fairly geographically concentrated whose community spans Salford and Manchester.

Bury has a strong and diverse voluntary sector with over 26,229 volunteers and 1,249 voluntary, community and faith sector groups. The (VSCE) comprises mainly small and micro groups with comparatively few medium scale VCSE organisations in the Borough.

There are positive examples of partnership working between the public and VCSE sectors and across health and social care. A recent Local Government Association peer review described integration between health and social care at operational and strategic levels, and our current model of neighbourhood working as “both enviable and exemplary”, and “the best any of us have seen and something to promote beyond Greater Manchester”. We have a history of high-quality partnership working between public services, with business, with the voluntary, community and faith sectors, and with residents. We call this ‘Team Bury’ who are responsible for delivering our locality ‘Let’s Do It’ strategy (appendix 1a).

## 2.0 Live Well and the Neighbourhood Model in Greater Manchester

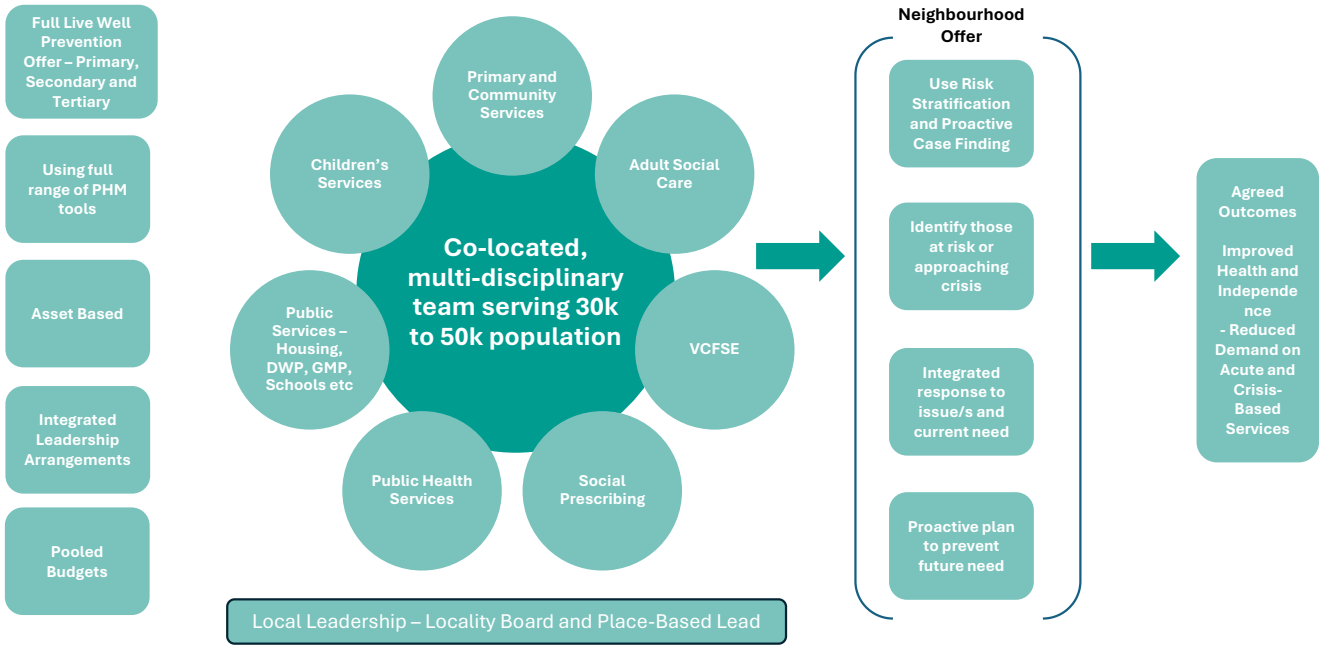



Neighbourhood working in Greater Manchester is based on a different relationship between public services and residents. It is the establishment of multi-agency teams working on geographical footprints of 30-50k population where front-line public service staff know each other, can work collaboratively, and can understand the strengths and assets of residents.

We are creating models of integrated and person-centred services with a focus on the delivery of joined up multi-agency working addressing segmented cohorts of the population to reduce, delay, or eliminate risk of escalated harm, poor outcomes, and unnecessary use of costly, reactive public service spend.
It is an all-age, all public and voluntary service model. It includes integrated health and care teams: primary care, community care, adult and children's care, mental health services, and aspects of secondary care delivered in neighbourhoods

And representatives from the:
- Council
- DWP
- Voluntary Services
- GMP
- GMFRS
- Housing providers

The **key features** of the neighbourhood model are shown below:




The neighbourhood model in Greater Manchester is based on **these conditions.**

| | |
|---|---|
| 1. Strong Relationships | These are the foundation – based on trust, mutual support and leadership for people and place (not organisation) |
| 2. A Clear Vision | A vision for neighbourhood and place that articulates the benefits and enables 'buy in' |
| 3. A Community Led, Shared Approach – Pride in Place | A partnership of equals –community leadership and participation – based on strengths and different conversations |
| 4. A Shift in Power and Resources | As close to those affected by decisions as possible – empowering people and neighbourhoods with greater autonomy and agency – backed up by resources |
| 5. A Culture of Permission to Lead and Act | Built on relationships, shared learning and psychological safety |
| 6, Alignment and Co-Working | Aligned boundaries, co-location, joined up strategic and operational conversations |
| 7. Based on Intelligence, Impact and Insight | Drawing on the insight, experience and expertise of communities; the right intelligence and insight architecture and systems in place and neighbourhood |
| 8. Continuous Improvement | Through systematised approach to learning across GM and 10 localities – and feedback on successes and challenges |

Enabled by a strategic centre pursuing a vision for prevention and Live Well

Partners in Greater Manchester have also developed a set of Live Well Hallmarks – including those relating to the neighbourhood model. These are intended to support local areas in shaping and strengthening their own approaches. They can be found here: https://gmpcca.wordpress.com/wp-content/uploads/2025/09/hallmarks-version-1.pdf

For the first time, the NHS requires each place to develop Neighbourhood Health Plans in 2026/27. The strengthened role of Place Partnerships in Greater Manchester gives us the opportunity to accelerate the implementation of neighbourhood working.

## 3.0 Locality Neighbourhood Structure

### 3.1 Neighbourhood Geographies – including alignment with PCNs

Within Bury, there are 5 neighbourhoods, North, East, West, Prestwich and Whitefield. Whitefield and Prestwich neighbourhoods have coterminous boundaries of PCN's whereas North, East and West neighbourhoods are not coterminous and have 2 PCNs serving the 3 towns/neighbourhoods. The working relationship across the PCN's and neighbourhoods is underpinned by a memorandum of understanding, regular communication, and a shared ambition of working together more efficiently, and improving health outcomes . The Clinical Directors of the neighbourhoods and PCN's are all currently undertaking a bespoke leadership development programme together to strengthen our clinical system leadership capability across the Borough.

Figure 1 shows the neighbourhood geography in the Bury Locality.


*Figure 1: Bury Neighbourhoods*

### 3.2 Location/s of Live Well Centres and spaces

Bury's new exemplar Live Well Centre will be The Ark, a former Pupil Referral Unit (PRU) located in Whitefield. It has many advantages as a Live Well centre:

- Its proximity to an area of social economic disadvantage
- Its proximity to the children's centre at Ribble Drive Primary School
- The availability of an existing building and site available for conversion, including a reception area, classroom sized rooms, kitchen, sports hall, green space and parking.

The Bury Public Service Reform Steering Group considered the potential location for the exemplar Live Well implementation and Whitefield was chosen for the following reasons:

- Whitefield is relatively under resourced in terms of voluntary, community and faith sector enterprise (VCFSE) capacity.
- Parts of Whitefield (especially Besses which is the more deprive part of the neighbourhood) has limited public service presence.
- Area of higher deprivation and associated challenges.
- Community Safety challenges but with an established partnership action already happening in response including GMP's in Operation VARDAR.
- An established and mature Public Service Leadership Team.
- There is a coterminous Primary Care Network and examples of positive joined up working across health, care and the VCSE including recent work on improving responses to people who have co-occuring mental health and drug and alcohol problems.
- Support from Bury social housing providers.
- In its social economic make up – with areas of poverty close to areas of affluence – it is a microcosm of the borough as a whole.
- The opportunity to connect public service reform and the Live Well development to economic regeneration through the Whitefield masterplan.

The GM commitment is to have a Live Well centre in each neighbourhood across GM, including the 5 in the borough of Bury, by 2030. The Ark is first phase of delivering this and will inform the development of a live well offer in each of the other 4 neighbourhoods Bury.

### 3.3 Scope of the Neighbourhoods

In April 2019, we established 5 Integrated Health and Social Care Neighbourhood Teams (INTs) made up of Adult Social Care and Adult Community Nursing teams being co-located under single leadership arrangements. Each Neighbourhood has a part-time GP Clinical Lead, a full-time professionally registered Neighbourhood Lead (Social Worker, Nurse or Therapist) and a Neighbourhood Support Officer.

These teams represent the core health and care organisational and delivery structure at a neighbourhood level but each Neighbourhood has a wider partnership (including for example: GP practices, MH services, palliative care, adult therapies, community pharmacy, housing, care providers and VCSE organisations) which meet regularly.

Community-based mental health provision through the Living Well model is established on a neighbourhood footprint with Neighbourhood huddles established and PCN Mental Health Practitioners linking with GP practice neighbourhood clusters and MDTs and taking an active role in the wider Neighbourhood partnerships.

Each Neighbourhood also has a Public Service Leadership Team which connects the INTs with wider public service partners including housing, the local authority, public health, Greater Manchester Police (GMP), the Fire and Rescue Service (GMFRS) and the voluntary sector.

At present INTs have an adult focus but there are developing links with children and family services. Schools are clustered on a neighbourhood footprint and work is ongoing to plan how children's and family services can align with the neighbourhood model including the development of Family Hubs and children's multi-disciplinary teams.

## 4. Neighbourhood Governance

### 4.1 Neighbourhood governance and connection with Locality / Place Partnership

The strategic plan for Bury at place level is set out in the Bury's "Let's Do It!" strategy (Bury 2030). Let's Do It! is a strategic plan for economic growth, reducing deprivation, and boosting community power by fostering collaboration, building on local strengths, and putting people first to create a resilient, inclusive borough with better life chances for all residents. It focuses on areas like health, work, housing, and tackling inequalities. It's a framework for "Team Bury" (Council, partners, communities) to work together to achieve shared goals, using neighbourhood-focused approaches, innovation, and a strengths-based perspective.

Bury has two key partnership boards in the Locality with responsibility for health and care - the Integrated Delivery Collaborative Board and the Bury Locality Board. Both include senior leadership from all partner organisations.

The Integrated Delivery Collaborative Board is the vehicle for the delivery of the health and care priorities on behalf of the Locality Board and oversees the localities main health and care transformation programmes.

The Public Service Reform Steering Group, chaired by the Deputy Place Based Lead, drives the development of the neighbourhood model including the Live Well agenda.

There is an integrated approach, across the Council and Northern Care Alliance NHS Foundation Trust (NCA), to the operational management of the INTs and the Neighbourhood Development and Delivery Group coordinates the work of the INT and Neighbourhood partnerships in delivering neighbourhood health and care priorities in the context of the Locality Plan and agreed health and care transformation programmes.

The INTs connect with wider public service partners through the Neighbourhood Public Service Leadership Teams (see section 3.3)

Figure 2 describes the neighbourhood governance structure in the Bury Locality. This structure is designed to ensure:

- Effective management of operational services (INTs etc).
- Connectivity between neighbourhood working and the Borough's strategic health and care transformation programmes.
- More effective communication and information sharing between partners to support our locality ambitions.
- More joined up planning and delivery across public services and the VCSE both at place and neighbourhood level.
- Strategic leadership of the development of Bury's wider Neighbourhood model through the Public Service Reform Steering Group.

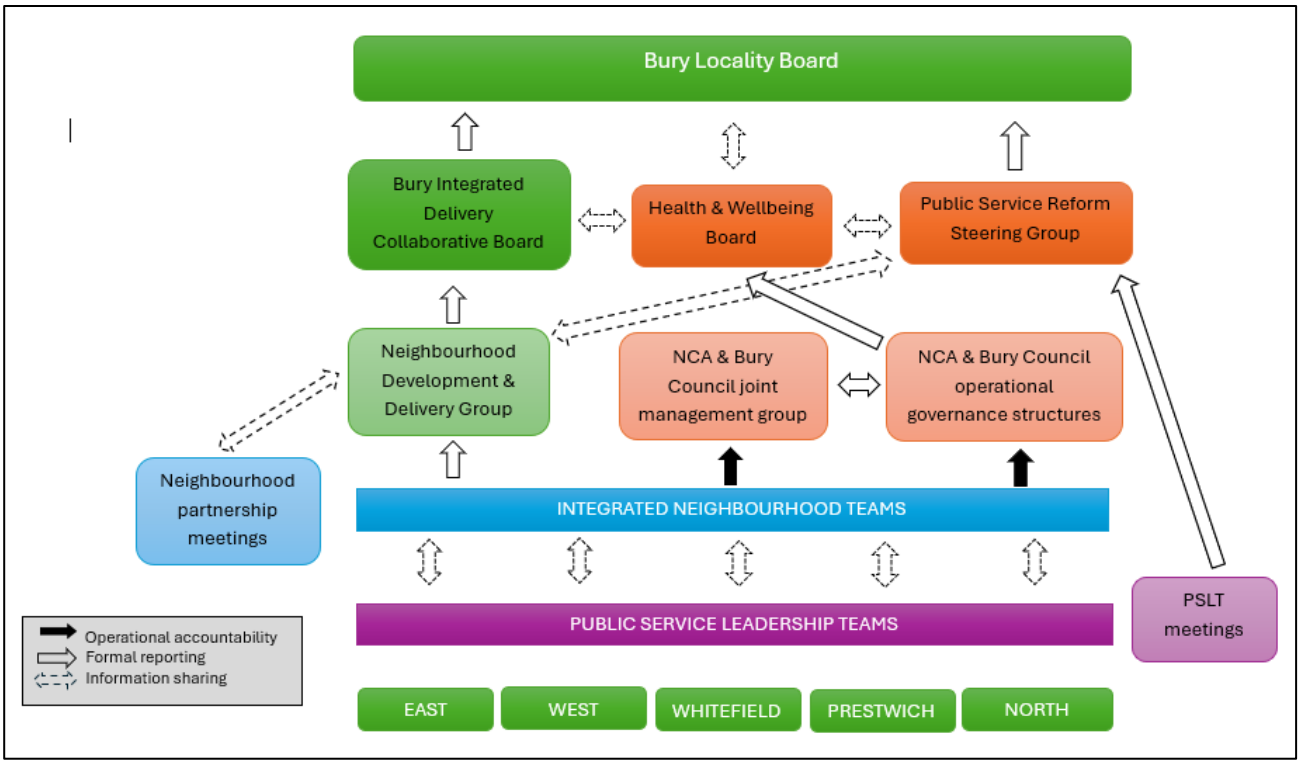



*Figure 2: Bury Locality Neighbourhood governance structure*

## 4.2 Neighbourhood clinical & professional leadership

Strategically we have two GPs who hold clinical leadership roles in health and care governance:

- Dr Cathy Fines - Associate Medical Director (GMICB Bury)
- Dr Kiran Patel – Medical Director (Bury GP Federation and Integrated Delivery Collaborative)

Each Neighbourhood has a part-time GP Clinical Lead, a full-time professionally registered Neighbourhood Lead who manages the Integrated Neighbourhood Team and a Neighbourhood Support Officer.

| Neighbourhood | GP Lead | Neighbourhood Lead |
|---|---|---|
| Prestwich | Dr Richard Deacon | Clare Rayson |
| Whitefield | Dr Alistair Webley | Jane Wilson |
| North | Dr Wissam el Jouzi | Linda Prescott |
| West | Ade Rotowa | Janet Stanton |
| East | Dr Fazel Butt | Gemma Iliadis |

*Table 1: INT Leadership*

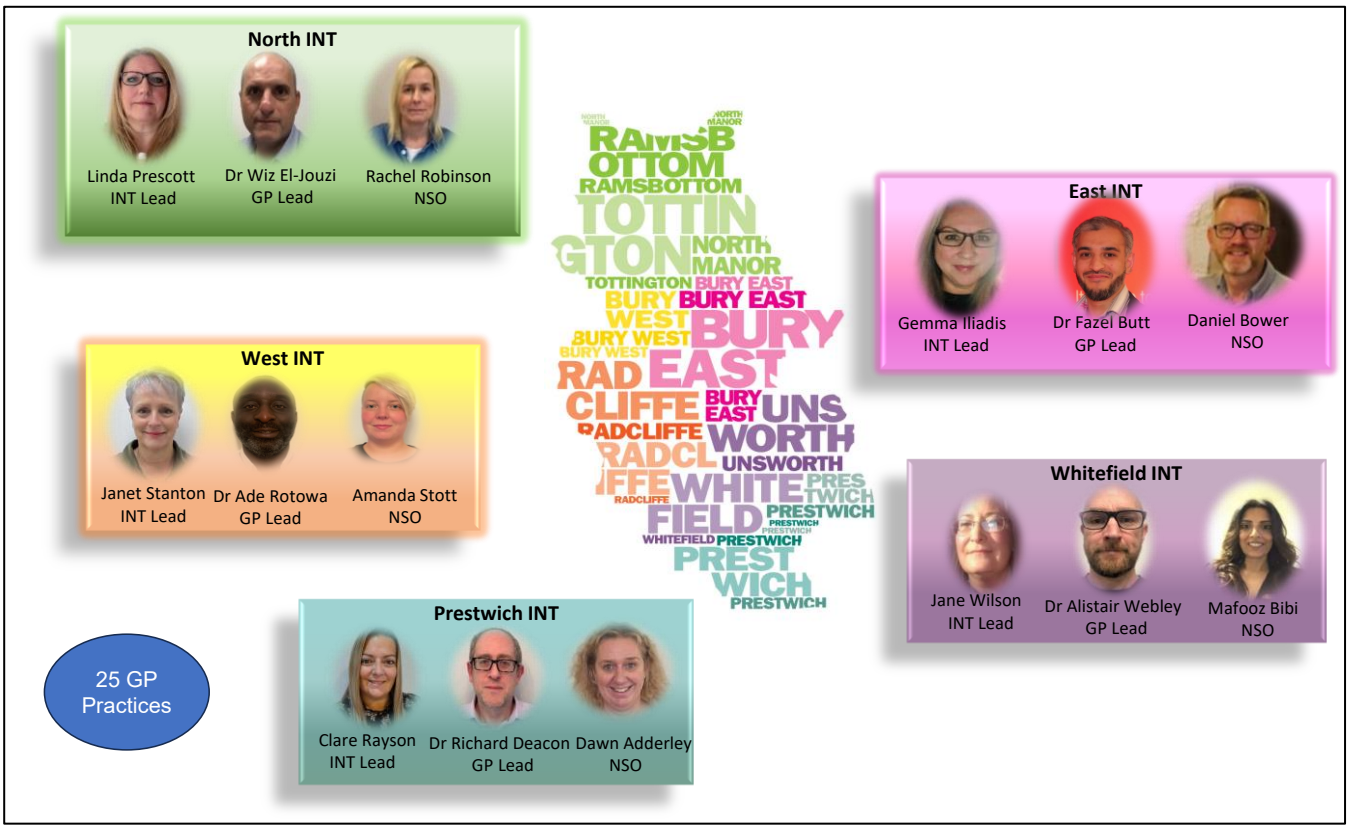



*Figure 3: INT Leadership*

The GP leads engage with their practice clusters, PCN managers and 4 PCN Clinical Directors through representation on the Bury GP Board, and informal networks.

Collaborative working with PCNs is supported by a memorandum of understanding between the PCNs and Neighbourhoods.

### 4.3 Primary Care leadership roles

Each health and care transformation programme also has a clinical lead:

- Dr Cathy Fines –Women and Children
- Nigget Saleem (Pharmacist) - CVD/Diabetes
- Dr Sanjay Kotegaonkar – Elective and Community
- Dr Simon Minkoff – Palliative & End of Life Care

The Bury Clinical & Professional Senate provides a forum for our Neighbourhood GP and clinical leads to work collaboratively with clinical and professional representatives from secondary care, mental health services and social care. For example, proposed new pathways of care or key provider policies and strategies are reviewed by the Clinical & Professional Senate.

### 4.4 Wider Neighbourhood partnership

There are monthly or bi monthly partnership meetings in all of the neighbourhoods. These

include: GP practices, MH services, ASC, District Nursing, adult therapies, community pharmacy, housing, care providers and VCSE organisations and provide an opportunity for information sharing, shared learning and contribution to planning at a Neighbourhood level. The intention is to strengthen these Neighbourhood partnerships to extend the breadth and depth of integrated working as set out in figure 8.

### 4.5 Public Service Leadership Teams

Each Neighbourhood also has a Public Service Leadership Team which connects the INTs with wider public service partners including housing, the local authority, public health, Greater Manchester Police (GMP), the Fire and Rescue Service (GMFRS) and the voluntary sector. Through the involvement of Council Policies offices these teams maintain links with Elected Members.

### 4.6 Alignment of other services and teams

Many services are delivered at a place level (e.g. specialist community heather services) because the teams are too small to be configured at neighbourhood level. However, some do connect with the Neighbourhoods e.g., the Specialist Community Palliative Care the team has identified a link worker for each Neighbourhood who attends the neighbourhood partnership meeting and acts as a point of contact.

### 4.7 How the VCSE, communities and those with lived experience are involved

#### 4.7.1 VCSE

There is a local MoU with the VCSE in place – co-produced with the sector and public service commissioners and partners.

The MoU builds on both existing commitments of the national Civil Society Covenant and the GM Accord and is based on a shared principle of mutual trust, working together, and sharing responsibility. The MoU aims to develop further how Bury works together to improve outcomes for communities and citizens, acknowledging that there are power imbalances in relationships between the sectors and taking active and transparent steps to consider these to build trust and ensure progress as equal partners. The MoU also acknowledges that a single system approach to enabling the best outcomes for local people may require change in how services are delivered and that organisational boundaries should not be a barrier to this process.

The MoU is built on a Bury first approach, utilising the skills, experience and expertise within the locality and broader VCSE sector before bringing in external agencies and supporting spaces to deepen a shared understanding between the sectors by engaging in forums, networks, peer learning opportunities, shadowing and knowledge exchange schemes.

We have identified a number of key enablers to ensure the success of the MoU including:

- Communication and culture - ensuring all partners and their workforce feel valued and respected.
- Improved data and intelligence sharing - to improve planning, design and outcomes for residents.
- Ensuring a financially resilient and appropriately resourced VCSE sector.
- Recognising and capturing learning to build best practice and ensuring the voice of the

VCSE sector and local communities are heard and valued in strategic governance and decision-making boards and groups in Bury.

The work includes ongoing involvement of the VCSE sector in the delivery, monitoring and future revisions of the Bury “Let's Do It Strategy” and the Bury Locality Plan; representation on a number of partnerships including Locality Board (which also includes a focused agenda item at each meeting from a VCSE organisation), PSR Board, IDC, Community Safety Partnership, Children’s Safeguarding Board, Health and Wellbeing and Mental Health Programme Boards, to name a few.

Strategic representation of the VCSE is predominantly through the Local Infrastructure Organisation (LIO), Bury VCFA, however the Live Well programme in Bury offers the opportunity to explore wider representation and increase VCSE leadership opportunities in local governance arrangements.

### 4.7.2 Neighbourhoods and Live Well

As has already been described, each Neighbourhood has a partnership group made of representatives from health, care and local VCSE providers. These groups are a space for building relationships, sharing information and insight about the needs of the communities and informing the identification of health and care priorities in the Neighbourhoods.

In planning and developing the proposal we need to be true to the principles of LET’S Do It! and Live Well and work with the local community to understand their needs, hopes and expectations. This is essential – to operate as a Live Well centre it needs to be ‘owned’ by the community. There has already been some engagement with residents on what Live Well could mean in Whitefield via insight work delivered through the VCFA (Voluntary, Community & Faith Alliance).

Local people have been involved people in a number of ways – through roundtable conversations, working with existing networks such as Community Connectors, through VCSE sector pulse check surveys and engaging through existing community events. Residents’ surveys and engagement sessions have also been facilitated by local elected members and Onward Homes, a key housing provider in the area.

As Live Well progresses, our ambition is to create a number of community representative places on the neighbourhood leadership teams in addition to a Live Well ‘reference group’ of VCSE leaders from each neighbourhood with the aim of ensuring existing strengths and assets are being utilised, developed in response to need, and are connected into Live Well Hubs/Spaces and vice versa. In addition, we will involve those with lived experience or community groups representing them, in our Bury Fund grant making panels with the intention that 50% of panel members are community reps (including a young persons’ rep), aligning to our MoU commitment of ensuring the voice of the VCSE sector and local communities is heard and valued in the development of neighbourhoods.

In September 2025 Bury held an inaugural Armed Forces Covenant Conference with a specific focus on Live Well through the lens of the armed forces communities and veterans. This was to also consider alignment with the national VALOUR programme of support for these groups (to align VALOUR nationally, with Live Well regionally and LETS into neighbourhoods).

### 4.7.3 Wider engagement and co-production work

In addition to this recent programme-specific engagement work, other engagement work includes:

- An extensive range of engagement and co-production work with Parents, carers and children & Young people as part of the SEND improvement programme.
- Listening events with people with lived experience to inform the development of the new Bury mental health strategy.
- An active Older People's Network which informs the development of policy and strategy.
- The development of the Bury Council LD strategy with People First.
- The establishment of a new autism co-production network.
- The development of a new dementia co production network.

Speakeasy, originally part of Sport England's *I Will If You Will* pilot supporting women and girls in 2016, works with people diagnosed with aphasia resulting from conditions such as stroke, brain injury and dementia. The group first co-designed an accessible walking route in Clarence Park, ensuring features like surface quality, inclines, toilets and health-literacy needs reflected what mattered most to service users' wellbeing and ability to be active. In 2025, Speakeasy and Bury Public Health partnered again to expand this approach, mapping two additional park-based walks, supported by wider system investment from Transport for Greater Manchester and the Department for Transport. The programme will now extend across multiple neighbourhoods in Bury, with potential for Greater Manchester-wide aphasia-friendly walking routes. The resulting maps will be shared with health and community partners to support broader use and promote inclusive, accessible activity.

Bury Council and housing staff highlighted the lack of menopause support available for women in the workplace and local communities, leading to a co-designed approach to improve provision. A mapping exercise confirmed limited existing support, prompting senior leadership—including the Chief Executive—to join listening events and shape a new model of menopause wellbeing. Bury Live Well staff were trained to deliver tailored daytime and evening drop-ins covering HRT, sleep, nutrition, hormones, physical activity and peer support, which quickly gained strong interest from both council staff and local GP practices. Growing community demand led the Live Well service to expand from two to five trained menopause coaches and move delivery into neighbourhood venues, widening access for residents. GP-focused webinars are now being developed to extend support further across Primary Care Networks, with an average of 12 women from diverse backgrounds attending each session, demonstrating a sustainable and community-led approach to health creation.

### 4.8 Finance

The locality has a budget of £70m devolved from GMICB, which is encompassed within a section 75 agreement with Bury Council. The Locality Board is a delegated sub-committee of the NHS GM board (as well as operating as the apex of senior partnership leadership in the health and care system, jointly chaired by the Leader of the Council and the Senior GP in the borough) and receives monthly budget updates and formal quarterly reporting. The budgets cover Community Services including the Better Care Fund, inpatient and community Mental Health services, Continuing Healthcare and Primary Care.

At a Neighbourhood level the INTs are operationally resourced through the NCA and Bury Council. We have no plans at this stage to delegate budgets to neighbourhood level.

Work on neighbourhood health and care priorities is partly supported through the locality GP contract – Locally Commissioned Services Framework. This has provided targeted funding to GP practices to meet agreed Neighbourhood level targets, typically in relation to secondary prevention and reducing health inequalities.

### 4.9 Risk management

Individual provider organisations are responsible for the management of their own organisational risks in line with their own standard governance procedures. Where providers are commissioned by the NHS risks are routinely reported and reviewed as part of standard contract reporting and management arrangements. Locality programme, system and strategic risks are managed in line with the NHS GM Risk Management Policy.

In Bury, all the health and care transformation programmes maintain a risk register which includes key risks to programme delivery and where relevant operational risks relating to service provision. These are regularly reviewed by the relevant programme board, committee or group. For the Neighbourhood programme the responsible group is the Neighbourhood Development & Delivery Group.

A consolidated locality risk register is regularly reviewed by the Bury Risk and Scrutiny Group to ensure consistency and compliance with the NHS GM Risk Management Policy. Risks scoring 12 or more are routinely reported to Bury Integrated Delivery Board and the Bury Locality Board. Local risk management procedures are described in the Bury Risk Management Standard Operational Procedure. Where required risks are escalated to GMICB programme board or executive in line with the NHS GM Risk Management Policy.

### 4.10 How implementation, monitoring and evaluation of the plan will be overseen

The table below outlines the governance for the 5 pillars of the neighbourhood Portfolio, which will ensure implementation and evaluation of it's own delivery plan and outcomes.

| Programme | Lead | Governance |
|---|---|---|
| Live Well | Will Blandamer | Public Service Reform Board/Locality Board |
| Neighbourhood Leadership Teams | Chris Woodhouse | Public Service Reform Board |
| Integrated Health and Care Adult Teams | Kath Wynne-Jones | Neighbourhood Design and Delivery Group and IDC Board/Locality Board |
| Neighbourhood approaches to supporting Children's and Families | Jeanette Richardson | Public service Reform Board/Childrens Strategic Partnership Board |
| Estates strategy | Claire Postlethwaite | Strategic Estates Group |

*Table 2: Neighbourhood programme governance*

A quarterly Portfolio Board will be established to ensure alignment of the strategic ambition of the 5 neighbourhood programmes

Quarterly neighbourhood delivery collaborative workshops are already in place to bring together teams working on the delivery of different the components at an operational level.

We have 3 key priorities with regard to outcomes set development:

1. Work with key partners to agree the main ‘neighbourhood’ indicators which will be monitored to inform planning and evaluate impact with specific reference to population health through a Neighbourhood dashboard (developing list above) in the context of the outcomes set in development at GM
2. The development of indicators and targets for GP practice clusters to monitor delivery against Neighbourhood level priorities that form part of the locality GP contract – Locally Commissioned Services Framework.
3. Work with GMICB and NCA data and intelligence teams to develop an integrated dashboard to track activity at a patient level to understand the impact of active case management through Neighbourhood MDTs mirroring work that has been done in Bolton.

We are aware that an outcomes framework is in development at GM relating to neighbourhood delivery, connected to the National Neighbourhood Health Implementation Programme. Our local framework will be finalised once we have seen the outputs of this work.

## 5.0 Operating Model

### 5.1 Introduction

The Model of Neighbourhood working is a cornerstone of the Locality plan – the strategy for the health and care system in the Borough.

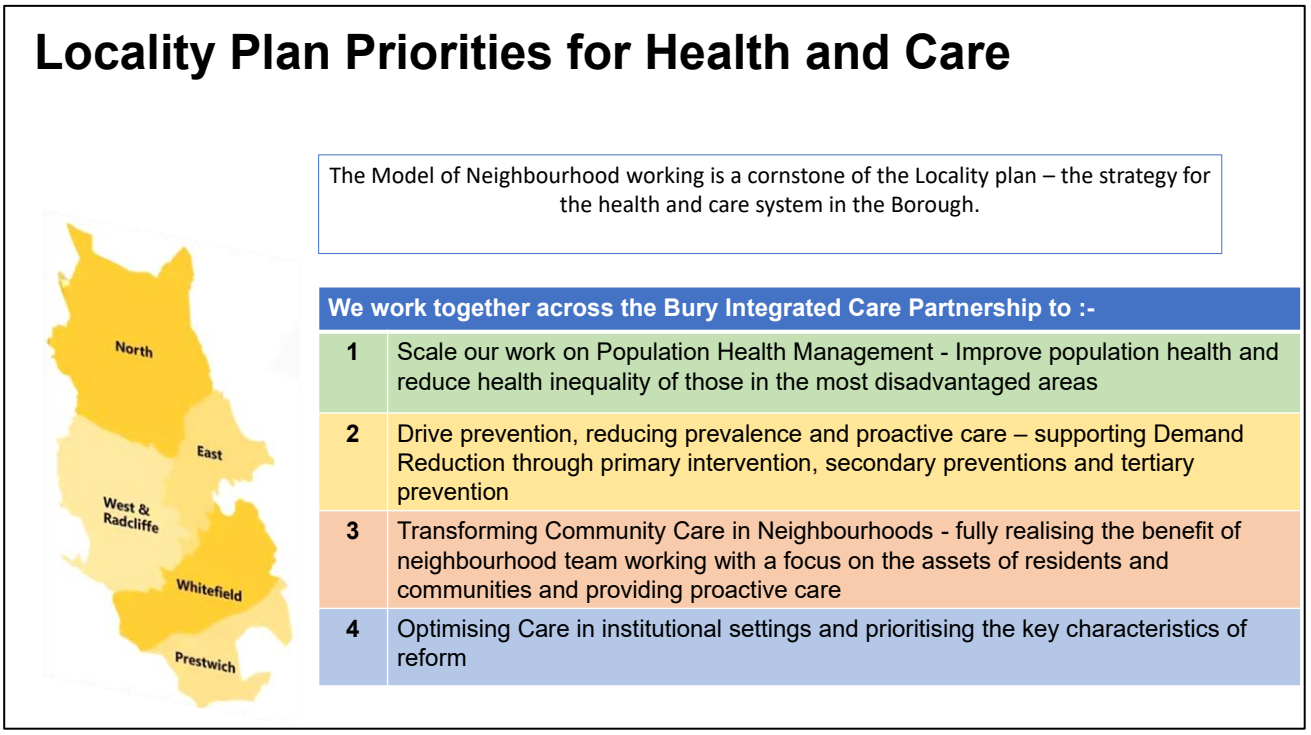



*Figure 4: Locality Plan priorities*

We have developed a number of key principles with regard to neighbourhood working which include:

- The neighbourhood level is the **building block** for organisations to work together and the **foundational unit for delivery** recognised across public service organisations and working with the voluntary sector
- There is a **look and feel of one public service workforce functioning together and with the voluntary and community sector**, unrestricted by role titles or organisational boundaries – working for the place and people.
- **Aligning services** within and around neighbourhood areas allows partners to have a **shared understanding of the strengths of communities and people** in that place – because our 5 places are different.
- The benefits to our populations are both **better integrated and joined up delivery, which is what the public expect of us and is a precondition for prevention and early intervention.**
- Neighbourhood working also allows the identification of particular risks and harms to people in places, and provides mutli-agency and **targeted approaches to enable early intervention** to prevent future problems.

- This approach will **help to reduce pressure on a range of public services characterised by unplanned, expensive intervention,** allowing them to focus their resources on those who need it most.
- It relies on a level of **integrated leadership, accountability, performance and governance structures**.

Our approach to neighbourhood working includes:

- Reflective of the **5 main towns in the borough – Whitefield, Prestwich, Radcliffe, Bury and Ramsbottom** – each of which has its town centre masterplan thus connecting reform to growth.
- Creating opportunities for front line staff to know each other and problem solve and not just refer to each other.
- Multi-agency teams having a shared appreciation of the strengths and assets of the community.
- Co-location of teams and partner agencies where possible. Shared resources, skills and strengths.
- Huddles and MDTs – bringing partners together to get to the root cause of issues and support those in the community most at risk.
- Combining models of risk stratification to identify cohorts of avoidable risk, harm and cost, with the knowledge and experience of people in the place.
- A more strategic approach to investment– for example scaled up investment in housing with care. Investing in prevention and community resilience – including through VCFSE partners (see VCSE MOU).
- Improving economic activity and participation – for example, DWP trailblazer opportunity
- Better organised public services but with a shared approach to engaging communities and residents differently.
- A mechanism to allow us to respond to Borough, GM, or national priorities – e.g. how to improve school readiness.

We have 5 pillars to our neighbourhood plan which are outlined below.

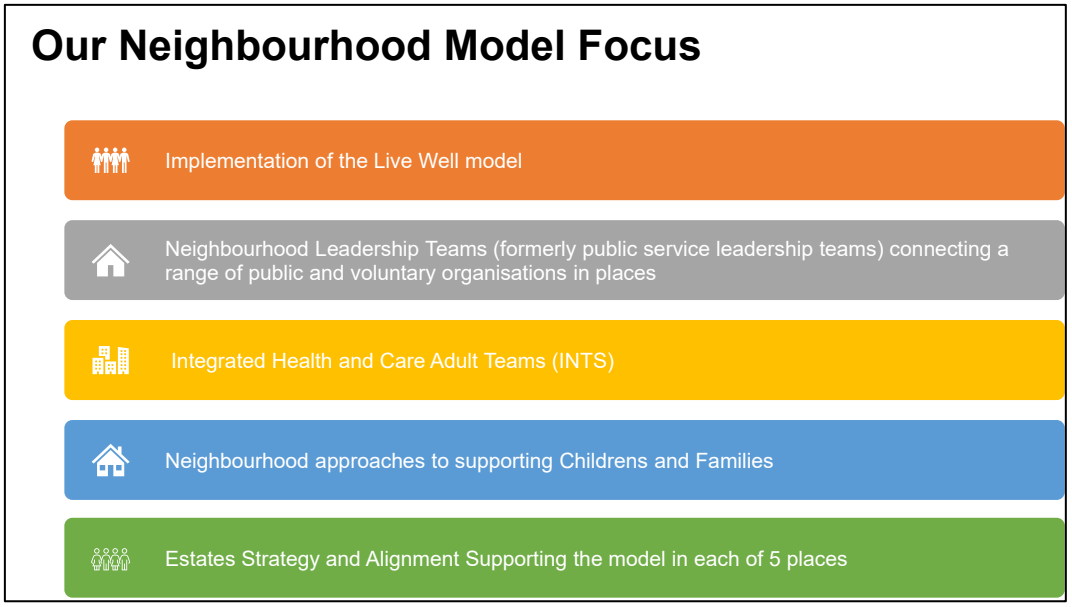



*Figure 5: Neighbourhood model components*

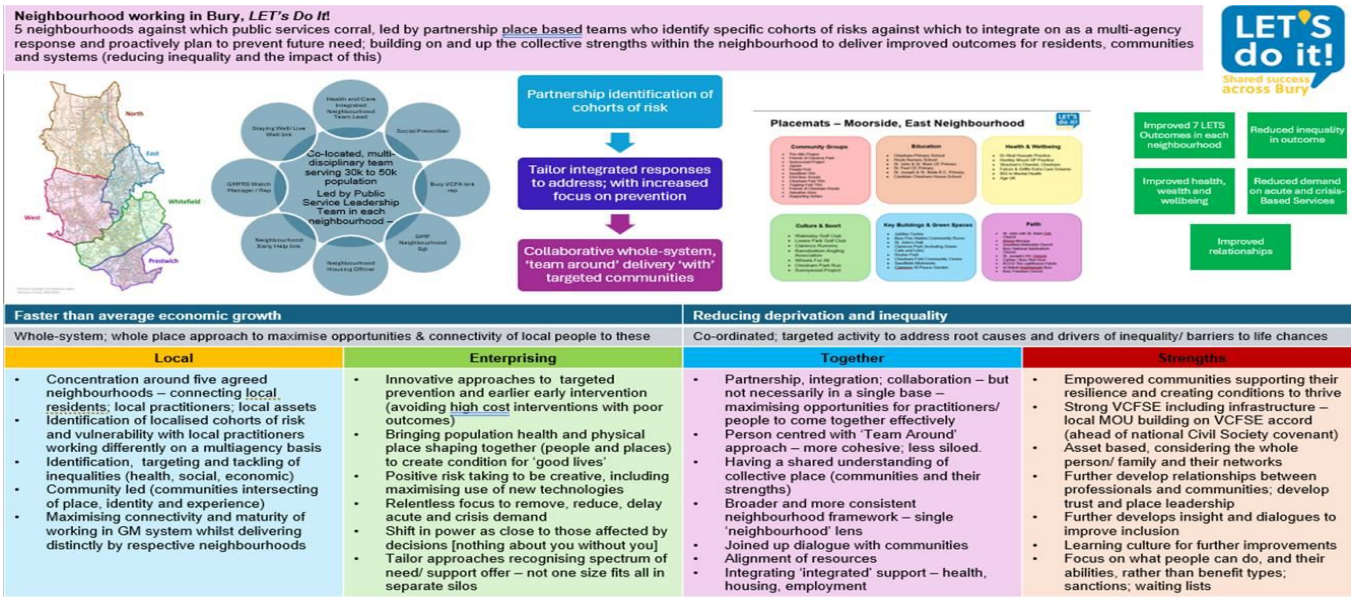



*Figure 6: Bury's approach to neighbourhood working*

## 5.2 How neighbourhoods interact with/relate to Live Well Centres and Spaces and the broader neighbourhood offer

Starting with Whitefield and the development of our exemplar Live Well Centre it is envisaged that Live Well centres and spaces will be an integral part of our Neighbourhood ecosystem in line with the GM Live Well and Neighbourhood model. The aim is to develop live well offers in out neighbourhoods aligned with Integrated Neighbourhood Teams to provide an offer to our communities based on the thrive model. See figure 7 below.

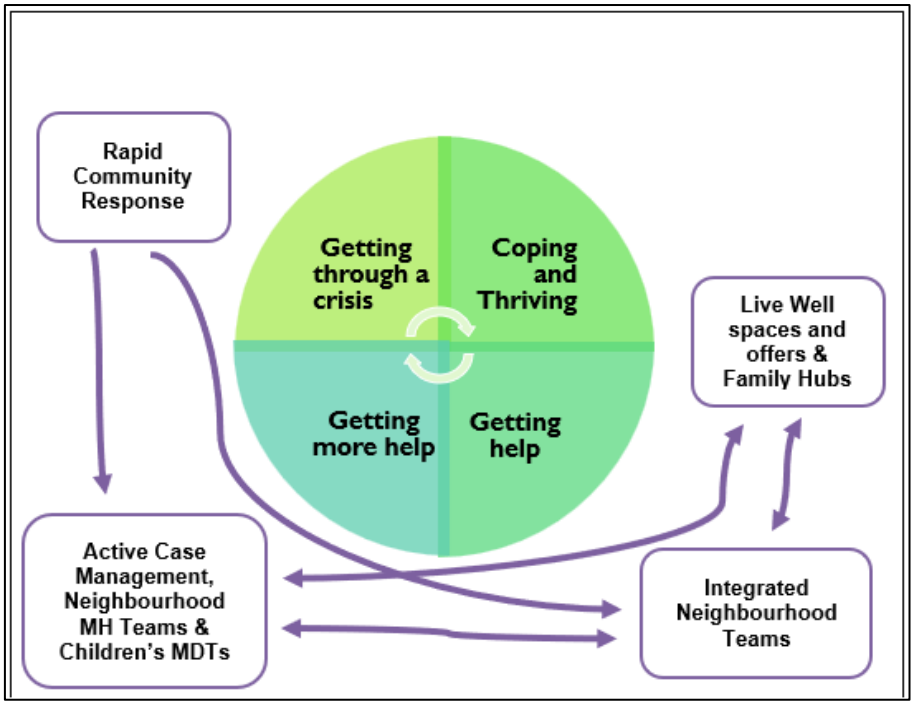



*Figure 7: Thrive model in neighbourhoods*

We have Public Service Leaderships Teams in each of the 5 Neighbourhoods, creating relationships between public services and voluntary and community capacity in the place and working to address particular cohorts of risk and harm.

Schools are clustered on a Neighbourhood footprint and there are for example Neighbourhood based SENCO communities of practice. We also have the model of family hubs in development, predicated on the 5-neighbourhood footprint but in practice delivered at a much more local community level (for example Chesham).

This work – to join up public services, to create opportunities for public services to know each other and work more effectively together, and for public services to have a shared knowledge of the assets and voluntary and community capacity in the place is one of the key pillars of public service reform in Bury. A core component of this work is the leadership provided by the Bury Voluntary Community and Faith Alliance (Bury VCFA) - creating the conditions for a movement, administering investment capacity, and challenging public services in the way they work. But it is also about the incredible array of community and voluntary groups in the borough, some large some small, and the contribution they make to people's lives. The VCSE sector and the community work of faith groups and organisations is integral to Bury's Live Well neighbourhood model of working, demonstrated through the commitments in the Bury VCSE/Public Sector MoU, signed by the Bury VCSE Leadership Group and Locality Board partners in September 2025.

### 5.3 Health and care in neighbourhoods: The national ambition

Our principles and current ways of working align with recent national neighbourhood planning guidance outlining 6 components for neighbourhood working:

- Population health management using risk stratification
- Modern General Practice
- Standardising community health services
- Neighbourhood Multi-disciplinary Teams
- Integrated intermediate tier with a 'home first ' approach
- Urgent neighbourhood services

All of which are to be supported by secondary care contributions to neighbourhood health.

In Bury, we have all of the building blocks in place, but need to do more to systematise, scale and spread our work.

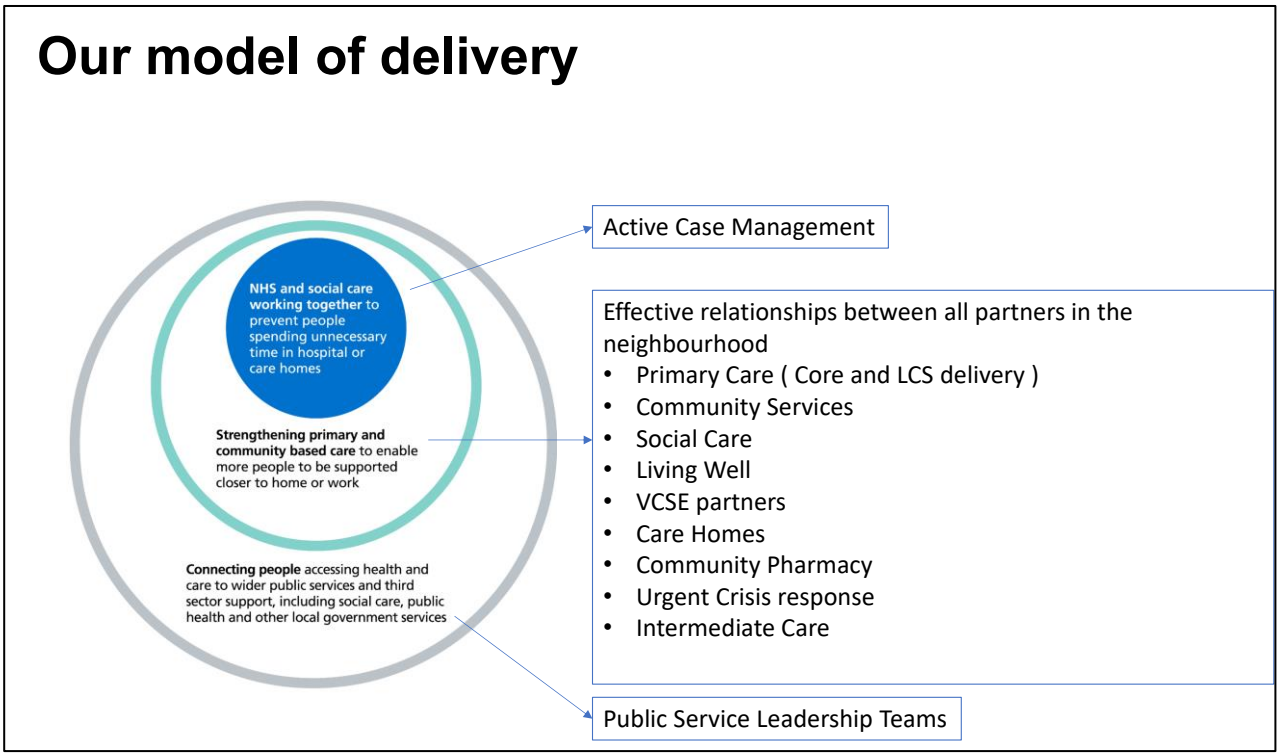



*Figure 8: National neighbourhood model*

### 5.3.1 Population Health management using risk stratification and supporting vulnerable populations to reduce health inequalities

Bury's LET'S Do It strategy is a health inequalities strategy. A major aim is to improve quality of life as measured by inequalities in life expectancy. Other aims address many of the building blocks of health, such as improving educational outcomes or economic growth that benefits everyone. Bury's Health and Wellbeing Board acts as a standing commission on health inequalities in the borough. It uses the Greater Manchester Population Health Framework to organise its work.

Bury's Prevention Framework (Appendix 1c) is designed for everyone—residents, professionals, and partners—to work together in preventing illness, promoting wellbeing and reducing inequalities. It focuses on taking early action to help people stay healthy and safe, reducing demand on urgent care and tackling health inequalities by addressing factors like housing, education and employment. The framework aligns with national, regional and local strategies, including Bury's LETS Do It! 2030 vision and is built around three types of prevention: primary (stopping problems before they start), secondary (detecting and treating issues early) and tertiary (managing long-term conditions to prevent complications). Prevention happens at both individual and population levels and follows a life course approach—Start Well, Live Well, Age Well, to ensure opportunities for health improvement at every stage of life. Guided by principles of being Local, Enterprising, Together, and Strengths-based, the framework highlights current initiatives such as anti-poverty strategies, smoking cessation, cancer screening, and heart disease management.

Work is going on to refresh the JSNA, including neighbourhood profiles, to inform planning and prioritisation based on need and inequality.

There is work going on across the borough to reduce inequalities continues through:

- Ongoing delivery of the anti-poverty strategy, including food support, digital inclusion, support with bills and employment programmes.
- Launch of the Bury Tobacco Control Alliance which focuses on prevention, supporting smokers to quit, reducing HIs and effective enforcement, with priority cohorts identified e.g. routine and manual workers, those with serious and enduring mental health and mothers smoking at time of delivery.
- Improving diet through the Sustainable Food Places Framework.
- Improving vaccine uptake.
- Improving sexual health services for sex workers through ongoing outreach, screening and contraceptive support in sex work settings.
- Improving care for coronary heart disease.
- Expanding neighbourhood-level support through Live Well hubs.
- Refresh of the JSNA to guide future decision making.

Next steps include developing detailed plans for each life stage to deliver neighbourhood and borough-wide actions that help all residents live healthier, happier lives.

To improve outcomes for the 20% most deprived populations identified by the Index of Multiple Deprivation (IMD), as a Locality we have already started to adopt a targeted, community-led approach, in part through the development of the Live Well programme which includes:

1. Mapping and understanding need using IMD data and layering it with health, housing, and access data to identify local challenges and assets in neighbourhoods.
2. Strengthening trust through local partnerships by building on relationships with community groups, faith networks, and voluntary sector organisations. Community connectors and health champions are supporting co-design and delivery for selected conditions e.g. CVD and diabetes.
3. Delivering tailored services in familiar, accessible settings such as schools and community centres which are culturally appropriate and also address wider issues like housing, employment, and food insecurity.
4. Empowering communities through co-production and investing in leadership, skills, and capacity with support from the VCSE infrastructure body. This is at the heart of the GM Live Well model.
5. Monitoring, evaluating, and adapting solutions using real-time data and feedback. Outcomes will be shaped around what residents value, not just traditional service metrics.

This approach will ensure equitable, locally informed solutions that reflect and respond to the needs of communities.

The public service leaderships teams (PSLTs) have identified cohorts of need / risk / vulnerability in each of the 5 neighbourhoods. This is based on data and insight from PSLT partners Plans in relation to these are at different levels of maturity.

Table 4 details these cohorts for each neighbourhood.

| Neighbourhood | Priority cohorts / needs identified |
|---|---|
| East | • Individuals susceptible to cuckooing and hoarding.<br>• Victims of Domestic Abuse particularly under 21 and repeat victims.<br>• Individuals struggling with poor mental health.<br>• High intensity service users and Frequent ED attendance. |
| | • High number of single-family households (compared to Borough average) and one-persons households of those aged 65+ struggling with social isolation/ vulnerability.<br>• Digital exclusion especially among older people in Hawkshaw & Shuttleworth wards.<br>• Low-income households including those vulnerable to debt in Elton Ward |
| Prestwich | • Financially and medically vulnerable older adults (85+) facing isolation and chronic health risks.<br>• Low-income households with young children. |
| West | • Households with long-standing addictions, including older adults.<br>• Individuals who are at risk of isolation because of concerns about drug use and criminality in the community (and risk of such individuals being susceptible to exploitation e.g. through cuckooing).<br>• Younger individuals moving into the area with multiple existing needs around alcohol and mental health. |
| Whitefield | • Socio-economically vulnerable families, particularly in Besses and Southern Unsworth.<br>• Older teenagers without local, inexpensive youth-related offer who become involved with criminality including e-bikes and associated robbery and burglaries (particular focus on Besses).<br>• Smoking rates, particularly in routine and manual labourers and those residing social housing, plus working with children and young people on prevention (including vaping). |

*Table 4: priority cohorts identified by PSLTs*

Bury has a Major Conditions Board (MCB) that meets monthly with representatives from the Neighbourhoods, NHS GM ICB, Public Health and providers. The Board has oversight and provides assurance of the delivery of the cancer, CVD, dementia, diabetes, falls/frailty and respiratory programmes.

In 2026-27, the cancer programme in Bury will focus on 2 tumour groups where Bury has been identified as an outlier for early diagnosis - lung and colorectal. As a Locality and through neighbourhoods we will focus on patient and clinician education to increase awareness of signs and symptoms of all cancers, but with a particular focus on these priority tumour groups. Through connections with our PSLTs we will amplify GM Cancer Alliance comms campaigns and target these where we know we have unwarranted variation for late-stage diagnoses.

The CVD/diabetes work programme will continue to build on work related to structured diabetes education, Hybrid Closed Loop, diabetes care processes and the optimisation of hypertension and lipid management. Where work would benefit from a neighbourhood approach, as it has done with diabetes, we will target activity as appropriate.

Bury's Public Health Team published a paper in September 2025 with the purpose of critically

examining the role, limitations, and appropriate use of risk stratification in healthcare. The paper sets out some of the limitations of predictive risk stratification and potential risks including: false negative and false positive results resulting in over treatment, waste, and harm. It highlights the need for proper technical and ethical appraisal of any potential risk stratification tool before adoption and ongoing assessment of benefit, harm, and costs. We are currently exploring what this means for our risk stratification approach.

In Bury some practices have access to the Ardens GEM risk stratification tool. The GP record (EMIS) can be used to identify cohorts of need by applying tools such as the Electronic Frailty Indec (eFI) and EARLY (patients who require palliative care). QRISK is used with individual patients.

### 5.3.2 Modern General Practice

As a Borough we have created a local General Practice Strategy which is delivered through the Bury GP Board and is delivering improved access for patients.

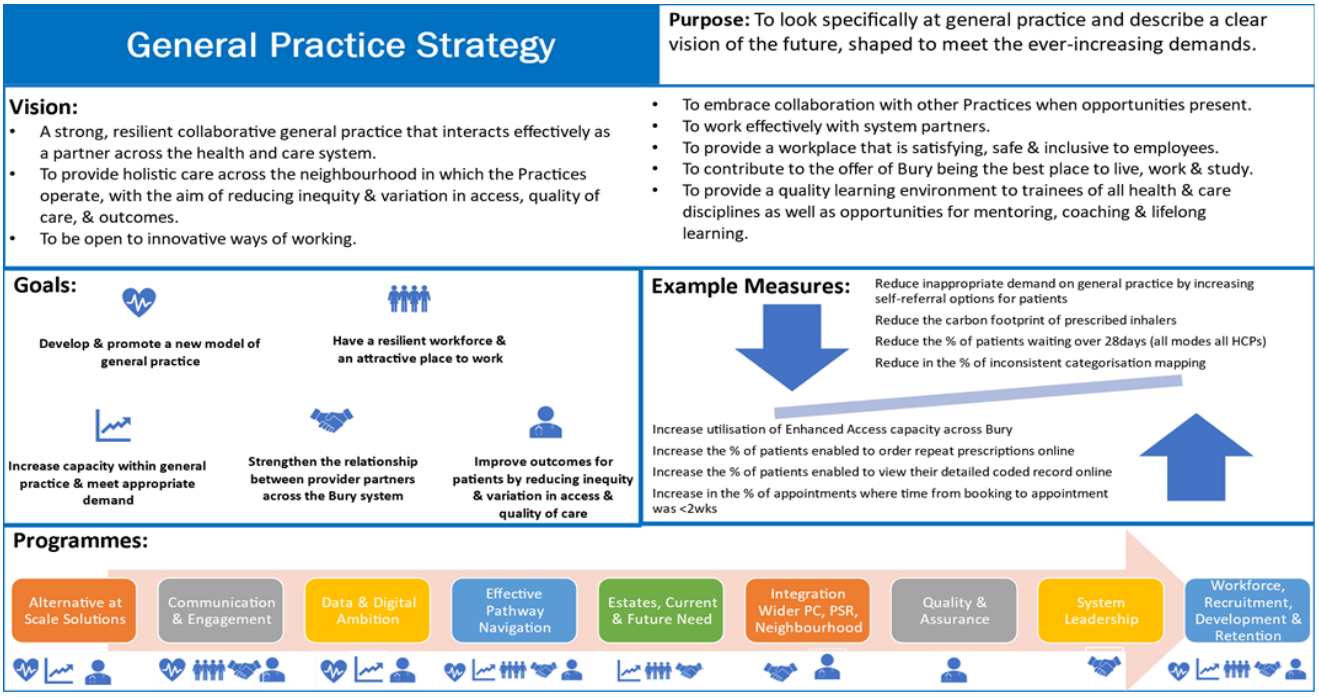


*Figure 9: National General Practice Strategy*

A range of services have been developed offering additional accessible appointments including:

- Women's Health Hub – 277 appointments offered to Whitefield patients requiring LARC's (addressing an identified inequality in access issue).
- Nearly 15,000 additional appointments offered through winter via Surge and Acute Respiratory Hubs (ARH). Evidence suggests that these clinics reduced attendances across A&E and BARDOC and released pressure on Primary Care in the process.
- Enhanced Access – nearly 40,000 appointments offered across the borough.

Patients are now accessing services differently:

- 65% of 13yo+ are now registered for the NHS App, an increase of 6%.

- Prescription requests via this method have increased by 50%, driven by the phased roll out of Patient Led Ordering. This work also supports embedding the GM GP Practice & Community Pharmacy Interface principles document intended to improve communication and reduce the administrative burden of repeat prescription requests. (214,956 in 2023/24 to 323,327 in 2024/25)

We have implemented the capacity and access improvement programme:

- As part of the Modern General Practice - Digital telephony, simpler online requests and faster care navigation, assessment and response 100% of practices are now enabled for online patient registration.
- It's easier for a patient to register with a GP surgery (moving house, new baby) and reduces administrative burden on practices.

Utilisation of wider primary care provision

- Referrals to pharmacy increased by 192% (2193 in 2023/24 to 6418 in 2024/25).
- Community Urgent Eye Service activity increased by 18%.

There are a range of roles now employed through ARRS including Clinical Pharmacists, First contact physiotherapists, Physician associates, Social Prescribers, Mental Health Practitioners Nursing Associates, General Practice Assistants, Digital and Transformation Leads and also General Medical Practitioners.

GP collective action has prompted positive inroads to reduce bureaucracy. However, ongoing work is needed to continue to progress required changes through Primary Care/Secondary Care Interface.

We are expanding our cross working across organisational boundaries with GP's providing cover supporting intermediate care facilities and Consultants reaching into the community and care homes.

Bury has historically delivered neighbourhood level interventions designed to reduce unwarranted variation between GP practices thereby contributing to a reduction in health inequalities via The Bury Locally Commissioned Service (LCS). Under the LCS model, all practices within a neighbourhood are required to meet a minimum threshold of achievement for the neighbourhood to receive payment, strengthening collective responsibility and shared outcomes.

For 2025–26, the LCS focused on two priority areas: Chronic Obstructive Pulmonary Disease (COPD) and frailty. Previous years priorities have included: bowel cancer screening, dementia care, dual diagnosis, frailty, falls prevention, respiratory disease and adverse childhood experiences. In the current year the focus is on reducing the risk of exacerbation among patients with COPD, identification and management of frailty and roll-out of EPaCCs.

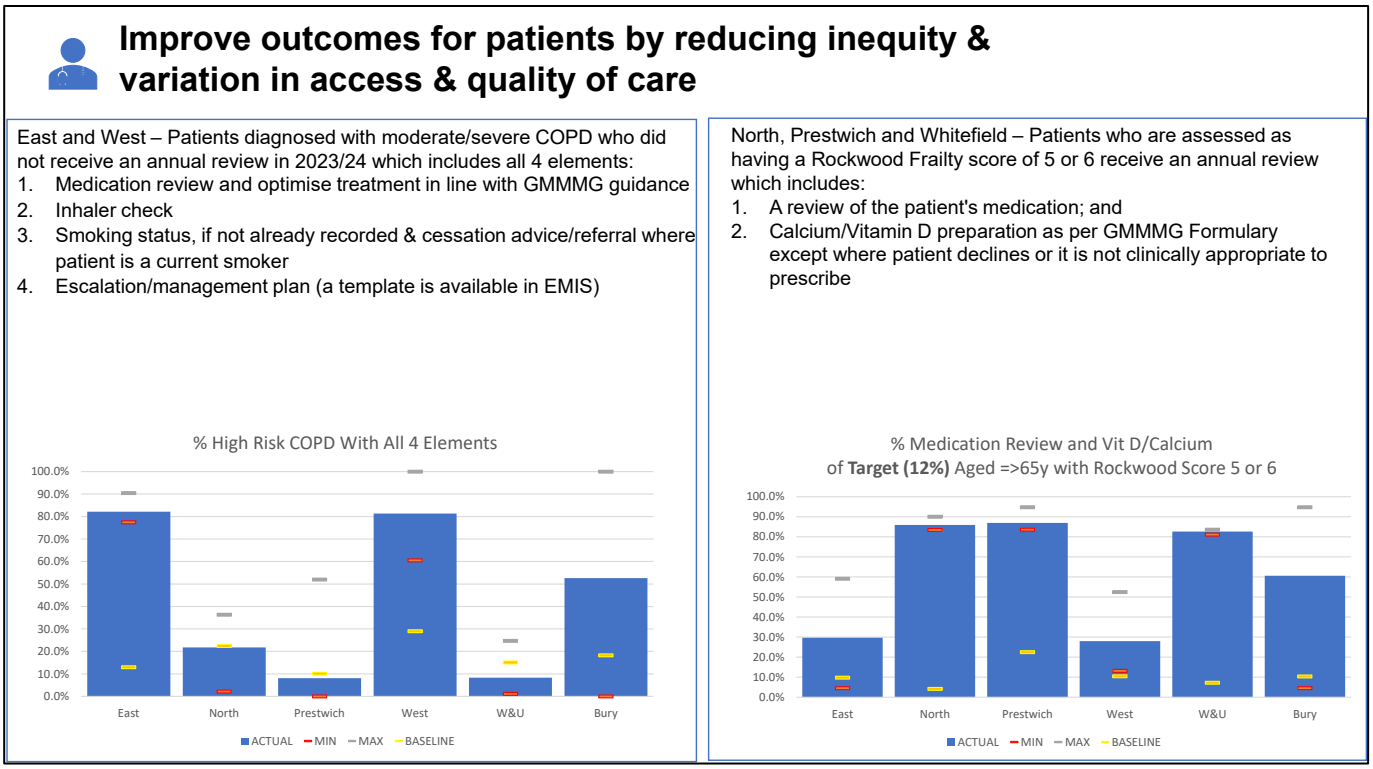



*Figure 10: LCS impact*

The future of our neighbourhood-based, primary care-led work in this area is dependent on GMICB decisions on the form and funding of BeCCoR Phase 3 and specifically whether there will be the ability to fund general practice to focus on agreed local and neighbourhood level priorities in relation to (secondary) prevention and reducing inequalities and unwarranted variation as we have done in recent years.

### 5.3.3 Standardising community health services

There are several programmes of work developing for Community Services across the Greater Manchester System. Bury Locality is committed to ensuring a cohesive collaborate approach with NHS Greater Manchester Integrated Care Board (NHS GMICB) and across providers of Community Services to ensure strategic alignment to the NHS GM ICB Strategy and identify opportunities to improve delivery, provide cost effective care in the community closer to home and support admission avoidance with Bury Locality Partners, whilst driving high quality care.

Early work has commenced to review and align Locality services across the NCA FLP. This work is focusing on contract alignment across NCA FLP footprint to reduce variation and address inequalities and will support service transformation. The NCA has commenced a series of Community Services Reviews looking at demand management and pathway improvement. Aiming to standardise service delivery and reduce any variation. Six reviews have been completed to date on - Dietetics, Paediatric Speech and Language Therapy (SALT), District Nursing, Community Diabetes, Adult SALT, Intermediate Care and a planned future review for Muscular Skeletal Services (MSK).

Realising a ‘neighbourhood health service’ that delivers more care at home or closer to home is a key national and local priority. Standardising community services is identified as one of the 6 key components to deliver. We are taking every opportunity to ensure that community

services are connected into the neighbourhood delivery model where appropriate, with some services such as District Nursing already organised on a neighbourhood footprint alongside adult social care.

As part of our neighbourhood health programme we will continue our transformation of community health services to support our locality ambitions.

### 5.3.4 Standardising community mental health services

Bury priorities for Mental Health align to the GM Mental Health and Wellbeing Strategy. Core to this is the transformation of community services and the creation of Neighbourhood Mental Health Teams (the 'Living Well model'). The aim is to support more people with serious mental health problems to have their needs met in a holistic way and lead fulfilling lives by strengthening community-based mental health provision. In Bury we are doing this through the establishment of Neighbourhood MH teams (based on the Living Well model) comprising PCFT clinical staff and VCSE link and peer support workers aligned to our Neighbourhoods.

**Living Well offers**:
- Community mental health support for adults that focuses on people's strengths, to help them recover and stay well as part of their community.
- A connected front door to community service, offering mental health and practical support (such as housing, employment, financial support).
- Support for people who may have previously been excluded from services because their needs are too complex for primary care and not complex enough for traditional secondary care services.
- A multi-disciplinary neighbourhood approach, with additional mental health expertise and support for primary care professionals.
- An approach to fulfilling the expectations of the National Community Mental Health Framework, adopted from Lambeth who launched the model 15+ years ago.

Key features of the neighbourhood mental health team include:
- Jointly delivered by the VCSE and PCFT.
- Aligned to the Neighbourhood model with huddles aligned to neighbourhoods.
- Workforce model includes PCN MH Practitioners who attend Neighbourhood MDTs and can pick up referrals directly from the MDT.
- VCSE link workers and peer support workers can connect people with a wide range of community support including VCSE, employment, housing, benefits etc. Links with Social Prescribing are developing.
- Have initial conversations rather than clinical assessments, involving people in their care.
- Hold dedicated consultant-led clinics for new patients, providing early access to psychiatric assessment and intervention.
- Provides an older age adults offer in NMHT's preventing the need for assessment in specialist older adult services.
- Provides a single point of access for all referrals into secondary care MH services – streamlining referral pathways for GPs.
- Enables patients to be stepped up into CMHTs and specialist services and stepped down.
- GP Connect – provides GPs with direct access to advice from psychiatry.

So far the CMHT restructure has been implemented. Bury are the first Living Well Team within PCFT to provide the following:
- Operate huddles across all neighbourhoods

- Provide an older age adults offer
- Have initial conversations as recommended in the LW Handbook
- Transferred our CMHT Assessment Team into LW to improve patient journey & experience
- Commenced a step up / step down pathway to ensure seamless transition between services

### 5.3.5 Neighbourhood Multi-disciplinary Teams

Bury has 5 Integrated Neighbourhood Teams (INTs) made up of Adult Social Care and Adult Community Nursing teams co-located under single leadership arrangements. Each Neighbourhood has a part-time GP Clinical Lead, a full-time professionally registered Neighbourhood Lead and a Neighbourhood Support Officer.

In addition, a AHP and Nurse liaison worker work across the Neighbourhoods. They have the flexibility to take on a key worker role for people who have been referred into active case management and also play a key role in liaising with wider secondary care services and developing referral pathways into Active Case Management. For example, they have been involved in:

- Working with Fairfield General Hospital (FGH), wards and departments to promote Active Case Management which has resulted in increased referrals. Meetings are arranged with the medical directorate to promote the INTs and ACM.
- Working with North Manchester General Hospital (NMGH) wards and departments to promote Active Case Management.
- Developing responses to high intensity service users and particularly people who have high numbers of attendances at FGH ED – working with the ED Team and MH Liaison.
- Working with Ambulance Services**,** meetings completed with Hatzola and NWAS to promote the INTs and ACM. There is a pilot ongoing with the North West Ambulance Service to establish a referral pathway to ACM for identified high intensity service users.

### 5.3.6 Active Case Management MDTs

As part of the Active Case Management (ACM) process there are MDT meetings linked to each GP practice in the Neighbourhoods (figure 11). Together the MDT coordinates care for individuals to improve independence, prevent, reduce and delay by improving access to the right service at the right time ensuring a person-centred and strength-based approach.

Patients referred for ACM are discussed at an MDT which supports care planning, identifies a key worker and agrees the most appropriate intervention(s) based on the needs and goals of the patient.

The MDT includes:

- The GP or clinical representation from the patient’s registered practice.
- Neighbourhood GP Lead
- Neighbourhood Lead
- PCN MH practitioner
- PCN Social Prescriber
- District nurse
- Adult Social Care
- Nurse and / or AHP Liaison Practitioner
- GP practice or PCN pharmacist

Other services may be invited where appropriate including:

- Housing
- Drug / Alcohol services
- Representative from the Council's Live Well and Staying Well Teams.

Around 100 people per month are referred into Active Case Management. The cohorts include:

- Older people with frailty
- People with poorly managed long-term conditions
- Complex adults with multiple health and social needs
- High intensity service users

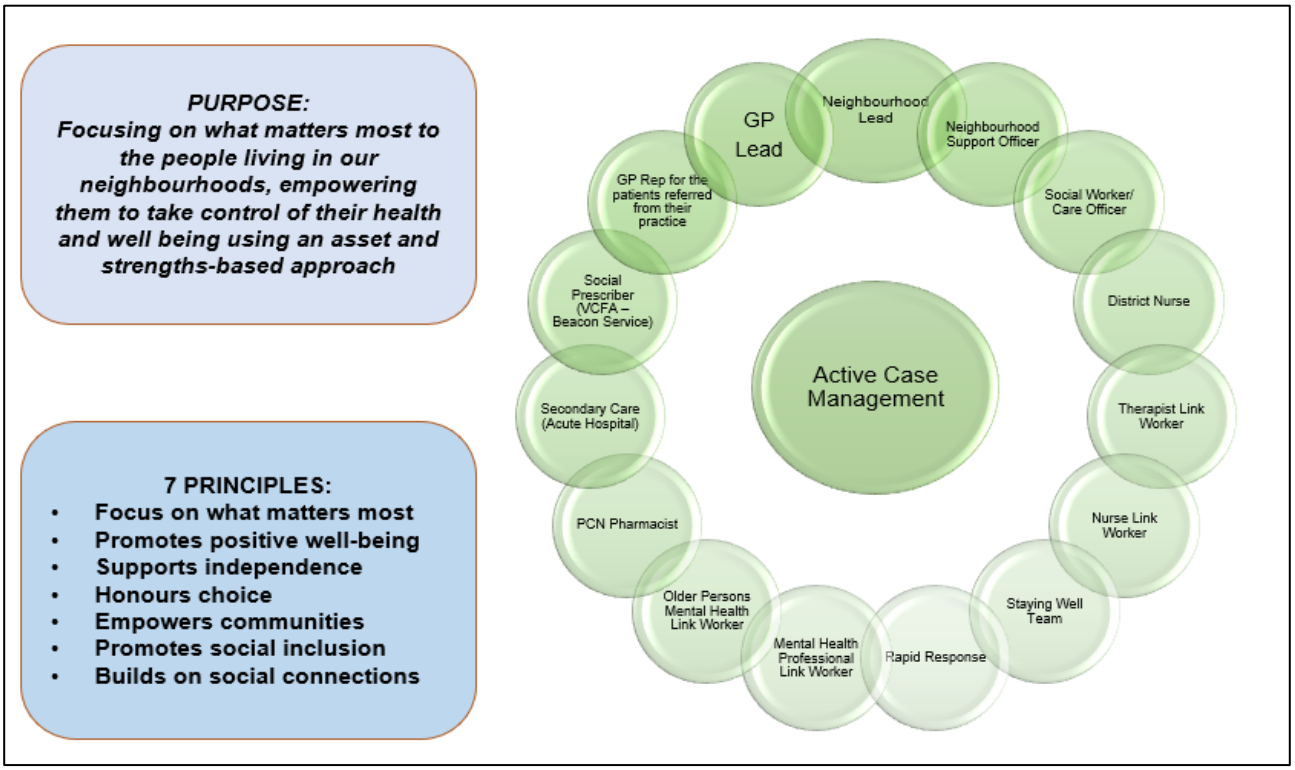
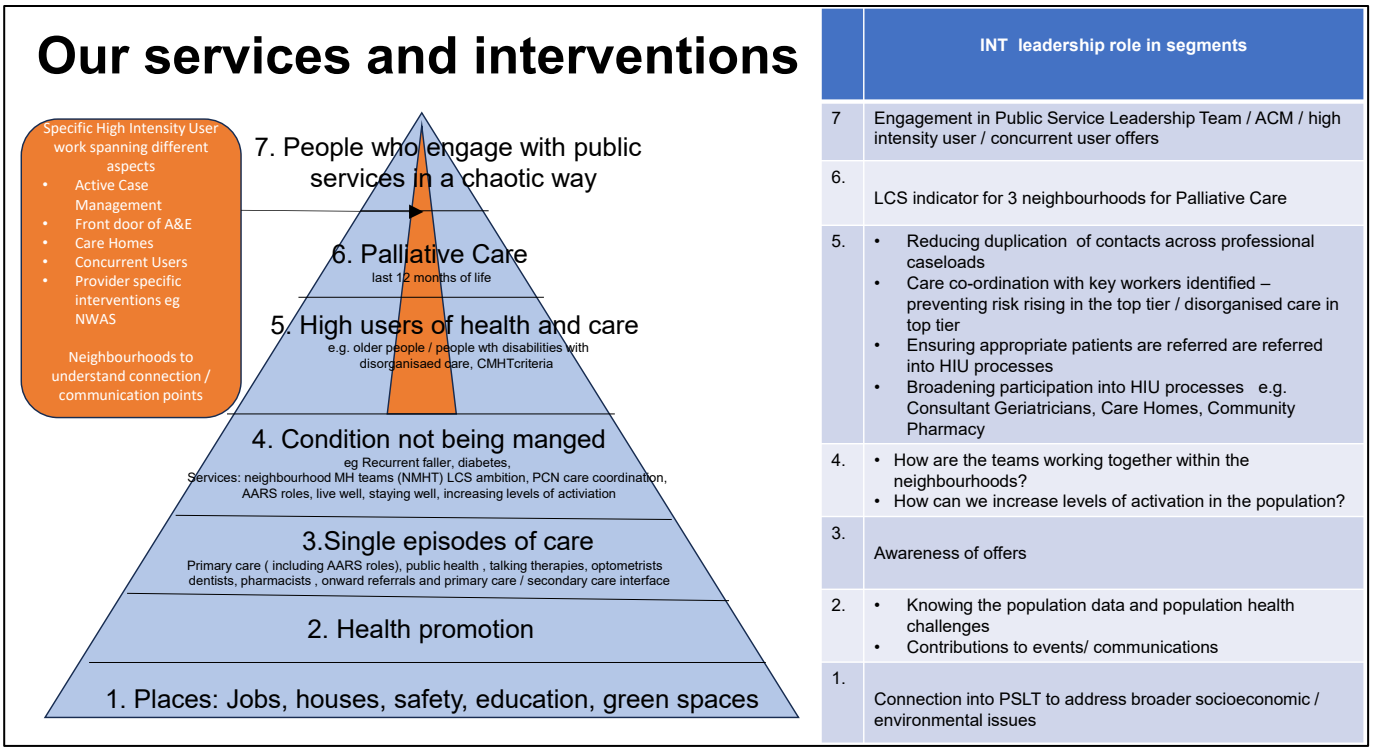



*Figure 11: Active case Management*

Whilst the INT's are focused on health and care delivery, the INT leads play a role throughout all the pyramid of need (figure 12).




| | INT leadership role in segments |
|---|---|
| 7 | Engagement in Public Service Leadership Team / ACM / high intensity user / concurrent user offers |
| 6. | LCS indicator for 3 neighbourhoods for Palliative Care |
| 5. | • Reducing duplication of contacts across professional caseloads<br>• Care co-ordination with key workers identified – preventing risk rising in the top tier / disorganised care in top tier<br>• Ensuring appropriate patients are referred are referred into HIU processes<br>• Broadening participation into HIU processes e.g. Consultant Geriatricians, Care Homes, Community Pharmacy |
| 4. | • How are the teams working together within the neighbourhoods?<br>• How can we increase levels of activation in the population? |
| 3. | Awareness of offers |
| 2. | • Knowing the population data and population health challenges<br>• Contributions to events/ communications |
| 1. | Connection into PSLT to address broader socioeconomic / environmental issues |

*Figure 12: Services and interventions*

### 5.3.7 Integrated intermediate tier with a 'home first ' approach and Urgent neighbourhood services

Through the Greater Manchester Transformation Fund in 2018, enhanced clinical support was embedded into the social care rapid response service and the totality of intermediate tier services were integrated within a single line management arrangement. The partnerships developed across the Borough and these platforms have been the key base on which transformation of the integrated intermediate tier and urgent crisis response has been formed and has continued to build our success.

Prior to our focused work on reducing the number of days kept away from the patients home (patients who are clinically ready to go home), the process was very reactive, communication was poor across organisational boundaries, there were several versions of the truth, and few people were taking responsibility for discharge – it was someone else's responsibility.

Through strong leadership engaging all professions and all parts of the system in a shared purpose and ensuring open and honest communication and promoting *Home First*, we have seen a significant reduction in the number of patients awaiting discharge who are clinically ready to go home. The Integrated Discharge Team has created new roles (including Age UK – Home from Hospital serivce) to ensure that the team has a truly Multidisciplinary Home First approach.

Outcomes between April 2024 and now include:

- Numbers on DKAFH: Reduced from 60 to 44
- Total Days on DKAFH list: Reduced from 1000 to 534
- 95% to be discharged to their own home - over 65 years from medical wards: increased from 91% to 93%

- % of beds occupied by patients with a LoS over 21 days : reduced from 23.5% to 12.5%

In Bury we have a strong foundation of an urgent neighbourhood service within our intermediate tier of services. Our Rapid Response Team provide our Urgent Crisis Response (UCR) service, which incorporates Hospital at Home, Rapid Response and the Falls pick-up service. December saw the highest number of referrals come into UCR (Rapid Response and Hospital at Home) with circa 500 referrals. Of the circa 500 referrals, nearly 50 came from Care Homes. The ability to receive referrals via Adastra has now been activated, and the team are consistently overachieving the GM and National 2-hour response measure. The team are continuing to work with NWAS to improve referral activity via Adastra and will explore further options for reducing the variation in service usage between mid-week and weekends. This work is also supported by the NCA Call B4 Convey and SPOA.

The new Falls pick-up Service established in line with national planning guidance is now fully operational. The falls pick-up service responded to 103 referrals in December 2024 for Bury residents impacted by a low-level fall.

Since October 2022, Burys Hospital at Home (H@H) service has supported over 3,000 patients in their own residences, avoiding an equivalent number of hospital attendances or admissions. This has been especially valuable for frail patients, who face greater risks from hospitalisation including deconditioning, falls, and hospital-acquired infections and are often subject to longer stays or discharge to care settings.

A patient shared:

"*I feel fortunate to receive care at home. Hospitals can be overwhelming when I'm unwell. Being treated in my own space allows me to feel at ease and reassured by the skilled professionals looking after me."*

The Consultant Practitioner role was newly introduced within the Hospital at Home service and has played a pivotal role in shaping the service. In addition to managing a growing caseload, the team operates across both hospital and community settings, establishing strong, collaborative relationships with hospital teams, Same Day Emergency Care (SDEC), and consultants.

This integrated approach has enabled the safe management of patients with higher acuity needs in their own homes, individuals who would previously have required hospital admission. The Hospital at Home model offers clinical care at home through face-to-face visits, remote monitoring, and virtual consultations with healthcare professionals, including consultants.
Our Hospital at Home Consultant Practitioner released a national publication on "The importance of a comprehensive geriatric assessment for older people admitted onto a virtual ward."

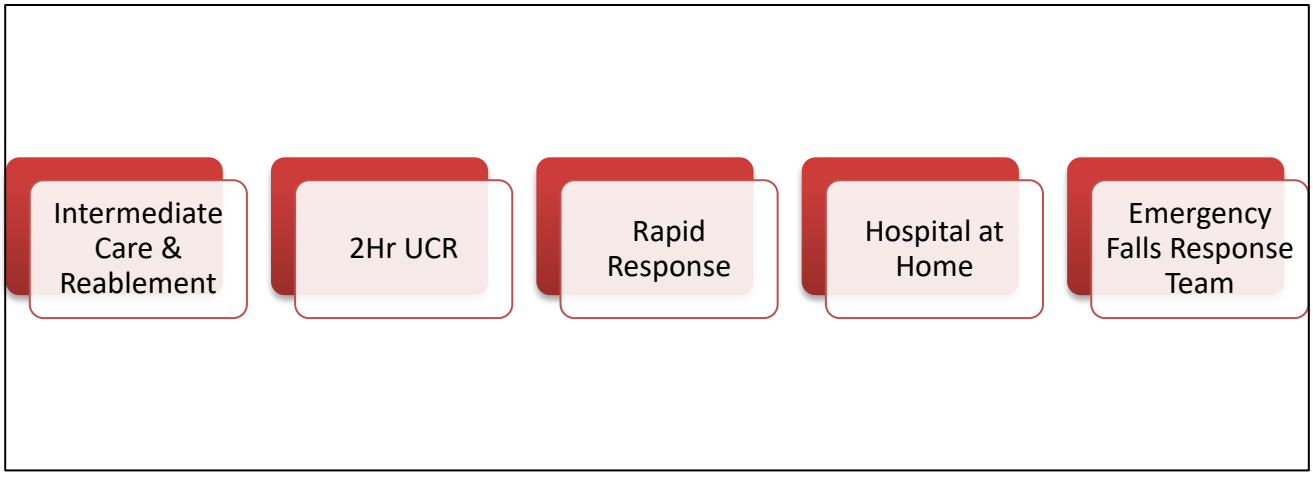


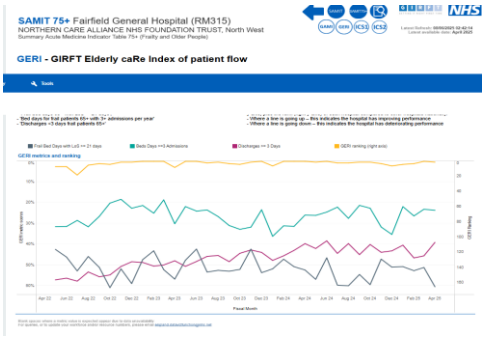

*Figure 13: The intermediate tier*

The Geriatrician consultants based at Fairfield General Hospital have and continue to play a key part in a series of new initiatives, reaching out into the community to provide a system wide 'Home First' approach and cultural change, to facilitate patients remaining in their homes. This, in turn, eases pressure within Urgent Care and, most importantly, ensures people can receive the right care, at the right time, in the right place. This work also underpins the UEC Planning Guidance for 2025-26, emphasising the shift from hospitals to community to improve patient outcomes and system efficiencies.

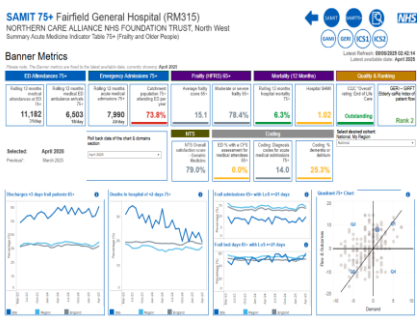
Some examples of this are:

- ☑ The Consultant geriatricians provide clinical expertise and oversight for the Hospital at Home patients, through collaborating in MDTs to develop care plans and providing expert advice and interventions contributing to improved patient care.
- ☑ A care home test of change has been established as an integrated approach with FGH consultants and healthcare professionals in-reaching into two Bury care homes, supported by primary care, Mental Health and Community service colleagues.
- ☑ An offer of Geriatrician in-reach into Neighbourhoods to improve links and integrated working.
- ☑ Support provided to community teams to manage more acutely unwell patients via Frailty SDEC.

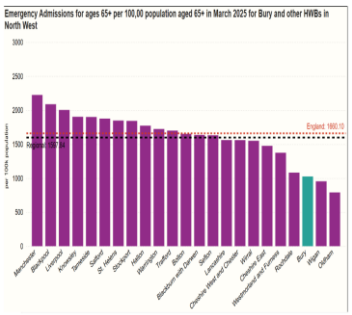
# Hospital Data/ Performance




Data taken from the SAMIT 75+ (GERI – GIRFT Elderly care Index of patient flow) from April 22 the ranking has risen so that from Dec 22 FGH has been consistently at the top of the GERI ranking, and even when there are slight drops is able to recover this to be consistently no.1 of the participating Trusts.




This data shows FGH currently 2nd in the country however the big data news is that frail people discharged within 3 days has consistently increased over the past 2 years, and deaths in hospital have reduced enormously.




**Comparison to regional and England Average.**

In the month of March 2025 there were 1025 emergency admissions for ages 65+ per 100,000 population aged 65+ for residents in Bury. This was lower than the region Northwest (1598) and lower than England as a whole (1660). Bury were lower than their local authority peer group average (1554).

Caveat: Until July 2025, SDEC activity is inaccurately being coded as an admission when it may not be, so the ranking could be much better than recorded.

*Figure 14: Outcomes*

One of our local priorities has been to enhance the provision of health and care services within care homes. This initiative aligns with the Enhanced Health in Care Homes (EHCH) Framework, aiming to ensure residents receive the right care, at the right time, in the right place. Our approach includes strengthening community-based services and delivering proactive, in-reach and support from healthcare professionals directly into care homes.

In addition, we are committed to equipping care home staff with the appropriate training and competencies to improve skill sets. This upskilling aims to reduce pressure on the broader health system, including Community Services, NWAS conveyances, Emergency Department attendances, and hospital admissions.

What have we done?

- ☑ Developed a one-page document for Care Home Staff advising them who to contact in the first instance when a resident becomes unwell.
- ☑ Bury care homes and primary care participated in a proof of value led by Health Innovation Manchester Re: SafeSteps Falls prevention app and Restore. This work has been referred to as the blue-print in GM and also received a “Health Tech Award 2024 for “Best use of digital for Social Care for achieving a 57% reduction in ambulance call outs.
- ☑ System workshop held on 30th October 2024 represented by FGH consultants, care home managers, commissioning, general practice, community and HMR and NMGH colleagues. This workshop was scheduled to enable colleagues to come together to build relationships, connections and strengthen system thinking/ working in relation to the enhanced health in care homes framework [EHCH]. Highlighting any potential collaborative opportunities to strengthen our current system model, supporting people in our care homes. A test of change has been completed with two care homes to improve pro-active and personalised care and provide training and development support for care home staff in line with the EHICH framework, working with the education facilitator and NCA Learning and Development Team.

### 5.4 Development priorities for our health and care integrated neighbourhood teams

The NHS 10 year plan is reflective of our local ambition. We have made progress made on integrated neighbourhood working through our active case management approach and single line management arrangements, connected to the reform of wider public services. We have had a relentless focus on addressing population health and health inequalities and will continue to so. We will also focus on increasing connectivity across the age spectrum.

We have strengthened primary care capacity and enabled a shift of services from hospital to the community. Where possible we have utilised technology – as evidenced in our adoption as a GM pilot of dementia care planning records using the GM Care Record, though we still have more to do.

Moving forwards, we will deepen our processes and relationships that enable integration, and have a stronger focus on the shift of diagnostic capacity and outpatient provision out of hospital, supported by digital and estates strategies.

We will build on the existing Neighbourhood infrastructure of Integrated Neighbourhood Teams and Public Service Leadership Teams to work with our partners to deliver implement the NHSE Neighbourhood health guidelines and GM Neighbourhood model. The emphasis will be on:

- Providing better care close to or in people's own homes, helping them to maintain their independence for as long as possible.
- Promoting self-care, supporting early intervention and reducing health deterioration or avoidable exacerbations of ill health.
- Identifying opportunities for greater use of digital infrastructure and solutions to improve care.
- Supporting further service integration and joined up working between services including the VCSE.

**Priorities:**

1. Review the existing model of Active Case Management and MDTs and implement recommendations including the development of improved approach to impact evaluation.
2. Development and delivery of the Neighbourhood plans aligned to the local GP contract and agreed population health priorities with an emphasis on proactive personalised care and secondary prevention for CVD, respiratory and frailty, maintaining active input from health and care partners into the Public Service Leadership Teams and development and delivery of Neighbourhood People & Communities Plans.
3. Strengthen communication and integrated planning and delivery between key neighbourhood partners including GP Practices, PCNs leadership, community health services, acute services, adult social care, public health, care homes, community pharmacy and the voluntary sector.

# Connecting System Partners

Over the last six months we have strived to bring local system partners together as well as colleagues from neighbouring localities (HMR, NMGH) to strengthen partnership working and to promote our service offers at a local level, obtaining and sharing good practice, amongst considering opportunities for further improvements. This has been done via a series of community cafes and system workshops including, Prevention, Hospital at Home, High Intensity Service Use and Care Homes.


*Figure 14: connecting our system partners*

## 5.5 How community engagement will take place to enable continuous improvement.

As Live Well progresses, the ambition is to create a number of community rep places on the neighbourhood (Public Service) leadership teams in addition to a Live Well 'reference group' of VCSE leaders from each neighbourhood with the aim of ensuring existing strengths and assets are being utilised, developed as need demands, and are connected into Live Well Hubs/Spaces and vice versa.

In addition, we will involve those with lived experience or community groups representing them, in our Bury Fund grant making panels with the intention that 50% of panel members are community reps (including a young persons' rep), aligning to our MoU (as described in section 4.2 commitment of ensuring the voice of the VCSE sector and local communities is heard and valued in the development of neighbourhoods.

## 5.6 Neighbourhood enablers

### 5.6.1 Estates plan

We have Borough wide estates strategy, which is supportive of our ambition of neighbourhood working. A lead officer has been identified to complete the estates framework on behalf of the Borough. The programme of work and timelines are currently being determined.

### 5.6.2 Digital maturity, integration and data sharing

Bury is aiming to deliver a digitally enabled, neighbourhood-led model of integrated care. 65% of people aged 13+ are now registered for the NHS App and Bury is ranked eighth out of 27 localities within the Northwest for uptake. On the back of this we have an active programme of rolling out patient led ordering of medication across our Neighbourhoods.

However, we recognise that digital exclusion is a limiting factor for some parts of our population – for example, this has been identified by our North neighbourhood Public Service Leadership Team as a priority area to address for parts of the community in that area.

We have a good track record of digital innovation and recent examples include:

- Working with Health Innovation Manchester on the prove of value project for the Electronic Dementia Care Plan.
- Roll-out of SafeSteps, a digital falls prevention app piloted with care homes and Primary Care, that supports early detection of deterioration in older people. Integrated into ward rounds, it reduced ambulance callouts by 57% and won a digital health award.

It is envisaged that promoting increased use if the Greater Manchester Care Record (GMCR) will be an important in supporting integrated working and we are aware that further work is required with our key system partners to optimise its potential. For example, we have an active programme of work to implement the use of EPaCCS across health and care partners involved in palliative care and Bury was one of the localities that worked with Health Innovation Manchester on the prove of value project for the Electronic Dementia Care Plan

**Our current priorities include:**

1. Working with GMICB and NCA data and intelligence teams to develop an integrated dashboard to track activity at a patient level to understand the impact of active case management through Neighbourhood MDTs, mirroring work that has been done in Bolton.
2. Promoting the wider use of GMCR including the shared care planning tools.
3. Further roll-out and embedding of EPaCCS.
4. Completing the roll-out of patient-led ordering of repeat prescriptions.
5. Working with Safesteps to submit a bid to the National Institute for Health and Care Research (NIHR) to evaluate the effectiveness and cost-effectiveness of Safe Steps in preventing falls and avoidable hospital use while capturing practical insights to inform future adoption.
6. Refresh of the JSNA Neighbourhood profiles.
7. Strengthen data sharing arrangements to support the operation of our existing Neighbourhood MDTs.

Our key Trusts (NCA and PCFT with GMMH) have started the process of commissioning new EPRs and this provides an important opportunity for improving data sharing and integration. However as with optimising the use of GMCR, achieving this will require support from the GMICB and Trusts to ensure that the opportunities are realised as decisions will be made at Trust level.

We are aware that NHS GM ICB has S251 approval to process GP and Social Care records to national secondary care and mental health datasets from Secondary Uses Service. This has been used to build a longitudinal patient record which can segment the GM population into various groups e.g. adults with multiple long-term conditions. NHS GM ICB have implemented tools such as the Combined Predictive Model, QRISK, Cambridge Multi Morbidity Score and the eFI. Work is underway to use the Analytics and Data Science Platform to support a Population Health Management approach.

We are keen to work with the GMICB DII team and learn from other localities to identify suitable approaches to risk stratification.

To support integrated working including at a neighbourhood level the following data sharing agreements are in place:

- Between the Bury GP Federation and Northern Care Alliance NHS Foundation Trust (NCA) to support the delivery of the Hospital at Home (virtual ward) services.
- Between the NCA and Bury Council covering the delivery of a range of integrated services including intermediate care, the hospital discharge team and Integrated Neighbourhood Teams.
- Between the GP Federation and all GP practices.

### 5.7 Alignment with Family Hubs

A model of family hubs is in development, predicated on the 5-neighbourhood footprint but in practice delivered at a much more local community level (for example Chesham). This programme of work is currently being finalised.

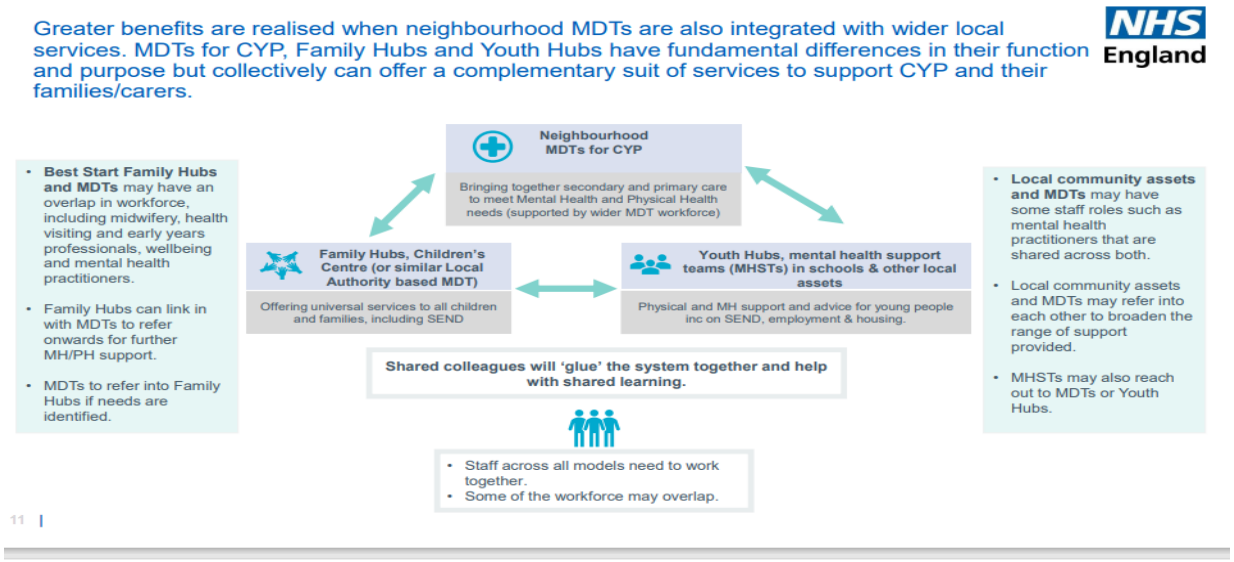



*Figure 15: Children's MDTs – the national vision*

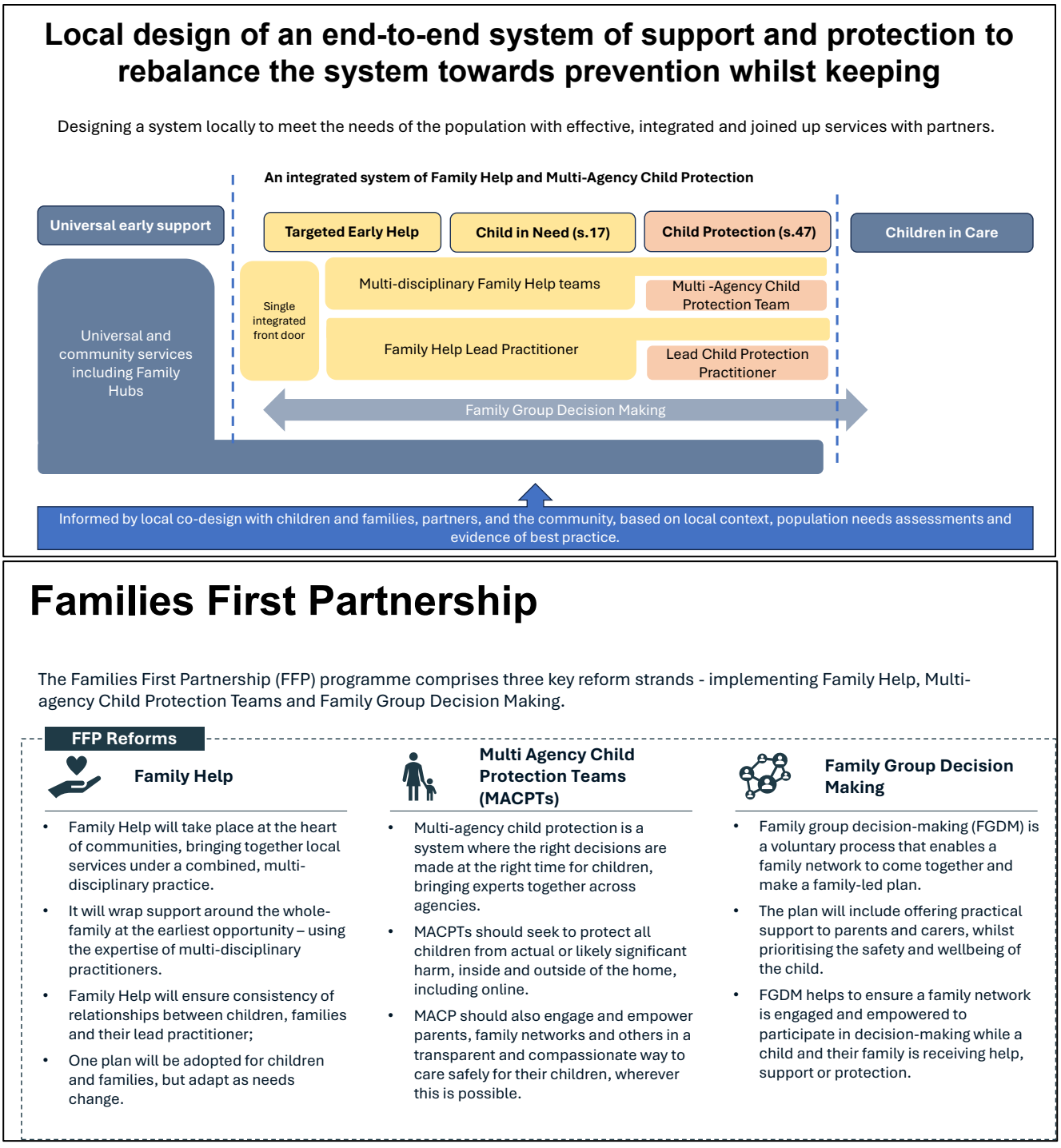



*Figure 16: developing an end-to-end system of family support and safeguarding*

## 5.8 Approach to enabling community led health creation

The scale and spread of a strengths-based approach is integral to the Bury Let's Do It! strategy and our VCSE sector plays a key role in promoting and delivering a community development approach to the health challenged in the Borough.

Bury has a vibrant VCSE with many organisations working at a grassroots level to improve the health and wellbeing of our communities. Our VCSE infrastructure body, the VCFA, provides a key role in supporting these organisations and our neighbourhood partnership group provide

an opportunity to build relationships and share learning.

The development of co-production networks like those described in section 4.7.3 have an important role to play in giving residents and people with lived experience a voice in shaping both strategy and services.

We are seeking to put a community led approach into practice in the development of the Whitefield Live Well Hub at the ARK (section 3.2). The intention is that this will be community-owned and led – via a successful asset transfer and its own staff and volunteer workforce.

### 5.9 How is learning and best practice shared across neighbourhoods in the locality

At a neighbourhood level learning and best practice are shared through Neighbourhood multi-agency partnership meetings and Public Service Leadership Team meetings.

Specific education programmes have been delivered linked to Neighbourhood health and care priorities. In some cases these have been targeted at specific professional groups but in most cases have been open to staff across all sectors. Examples from the last 3 year have included:

- End of life care for people with dementia.
- Dementia awareness.
- Co-occuring conditions [part facilitated by people with lived experience].
- Bowel cancer awareness.
- ACEs and trauma informed practice.
- Frailty awareness.
- EpaCCs.

The VCSE sector is represented across all 5 neighbourhood leadership teams (PSLT) via the local infrastructure organisation, Bury VCFA. Mechanisms are in place to share the two-way flow of information through hyper-local networks such as the Community Connectors and the wider VCSE sector through the Bury VCSE Leadership Group (both facilitated by Bury VCFA).

At place level Bury has established communication and engagement mechanisms for sharing learning and good practice including:

- Monthly GP webinars
- Quarterly GP engagement events
- Community café events
- A programme of themed system Neighbourhood workshops (recent themes include prevention and high intensity service users)
- Themed programmes of training and education – most recently on frailty and falls prevention.

### 5.10 The role of Neighbourhoods in emergency planning and winter preparedness

The neighborhood infrastructure in Bury plays a critical role in emergency planning and winter preparedness. Each year the Bury locality convenes a system-wide Winter Planning Sub-group (of the Bury Locality UEC Board). Which provides oversight and leadership in planning for winter and the Christmas holiday period.

The Neighbourhood Leads on the group provide updates on real time winter pressures being

experienced, provide a neighborhood perspective on locality plans and help to cascade the winter planning arrangements across the neighborhoods.

Neighbourhood Leads also contribute to NCA (community) and Bury Council (Adult Social Care) emergency preparedness, resilience and response (EPRR) and business continuity plans.

## 6 2026/2027 – Local Delivery of GM Commissioning Priorities

| GM Commissioning Priority | Local Implementation Arrangements | Impact | | | | |
|---|---|---|---|---|---|---|
| | | Pop Health Improvement | Activity | Finance | Performance | Quality |
| *Example – BeCCor Year 2, Housing, Population Health* | | | | | | |
| | | | | | | |

This section will be populated throughout February / March as the GM planning assumptions relating to commissioning intentions become clearer.

## 7 2026/2027 – Local Delivery Priorities

| Local Delivery Priority | Rationale – e.g. ROI, Local Need etc | Impact | | | | |
|---|---|---|---|---|---|---|
| | | Pop Health Improvement | Activity | Finance | Performance | Quality |
| | | | | | | |
| | | | | | | |

This section will be populated throughout February / March as the GM planning assumptions relating to commissioning intentions become clearer.

## Appendices

| | |
|---|---|
| 1a. Bury LETs Strategy | lets-do-it-strategy.pdf |
| 1b. Public Service Leadership Terms of Reference (TORs) | PSLT_ToR_v5.docx |
| 1c. Prevention Framework | Bury Prevention Framework 2025.pdf |

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BURY INTEGRATED CARE PARTNERSHIP

# The Bury Whole System strategy for Neighbourhood Working

Part of Greater Manchester Integrated Care Partnership

# The Strategy for Borough – Lets Do It

BURY INTEGRATED CARE PARTNERSHIP



The Let's Do It vision for 2030 recognises the considerable strengths people and communities in the borough and to collectively tackle deep-rooted issues by giving everyone the encouragement and support to play their part, joining together the delivery of all public services and voluntary services as if as one and delivering an ambitious plan for both social and economic infrastructure.

- Lets Do it sees us deliver services ***Locally*** and targeted to the needs to the local population.
- It ensures we use ***Enterprise*** to develop an economic strategy, a skills strategy and ambitious regeneration plans for our towns.
- We have also committed to deliver these ***Together*** with our population and our public sector partners. This sees us deliver joined up health and social care services in our Integrated Partnership, alongside wider public sector reform.
- And finally, we are committed to always taking a ***Strengths*** approach. Our vision is for a place in which people are helped to make the best of themselves, by recognising and building on strengths, not deficits.

The Lets Do It Strategy committed to a vision of integrated working and a strengths based approach in each of the 5 places in Bury.  This is neighbourhood working.

# Locality Plan Priorities for Health and Care

BURY INTEGRATED CARE PARTNERSHIP



The Model of Neighbourhood working is a cornstone of the Locality plan – the strategy for the health and care system in the Borough.


| 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 | Optimising Care in institutional settings and prioritising the key characteristics of reform |

# Neighbourhood Working – our principles

BURY INTEGRATED CARE PARTNERSHIP



- The neighbourhood level is the **building block** for organisations to work together and the **foundational unit for delivery** recognised across public service organisations and working with the voluntary sector
- There is a **look and feel of one public service workforce functioning together and with the voluntary and community sector**, unrestricted by role titles or organisational boundaries – working for the place and people.
- **Aligning services** within and around neighbourhood areas allows partners to have a **shared understanding of the strengths of communities and people** in that place – because our 5 places are different.
- The benefits to our populations are both **better integrated and joined up delivery, which is what the public expect of us and is a precondition for prevention and early intervention.**
- Neighbourhood working also allows the identification of particular risks and harms to people in places, and provides mutli-agency and **targeted approaches to enable early intervention** to prevent future problems.
- This approach will **help to reduce pressure on a range of public services characterised by unplanned , expensive intervention,** allowing them to focus their resources on those who need it most.
- It relies on a level of **integrated leadership, accountability, performance and governance structures**.

# Neighbourhood Working – our approach

BURY INTEGRATED CARE PARTNERSHIP



- Reflective of the **5 main towns in the borough – Whitefield, Prestwich, Radcliffe, Bury and Ramsbottom** – each of which has its town centre masterplan thus connecting reform to growth
- Creating opportunities for front line staff to know each other and problem solve and not just refer to each other
- Multi-agency teams having a shared appreciation of the strengths and assets of the community
- Co-location of teams and partner agencies where possible. Shared resources, skills and strengths
- Huddles and MDTs – bringing partners together to get to the root cause of issues and support those in the community most at risk
- Combining models of risk stratification to identify cohorts of avoidable risk, harm and cost, with the knowledge and experience of people in the place
- A more strategic approach to investment– for example scaled up investment in housing with care. Investing in prevention and community resilience – including through VCFSE partners (see VCSE MOU)
- Improving economic activity and participation – for example, DWP trailblazer opportunity
- Better organised public services but with a shared approach to engaging communities and residents differently.
- A mechanism to allow us to respond to Borough, GM, or national priorities – e.g how to improve School Readiness,.

# The Neighbourhoods




The demographics of the neighbourhoods vary significantly. North neighbourhood has the oldest age profile, with around 10% of residents over the age of 75. East and Prestwich neighbourhoods have a much younger age profile, with more than 20% of residents in these neighbourhoods under the age of 15.

North neighbourhood is the most affluent, with the highest average household income . Conversely, East and West neighbourhoods are far more deprived, with parts of these neighbourhoods (particularly Bury town centre, Radcliffe, and the M66 corridor) within the most deprived ten percent of areas in England. Average household income in East and West neighbourhoods is around £36,900 – almost £10,000 less than in North neighbourhood. Whitefield and Prestwich neighbourhoods sit roughly in the middle of these figures, although there are still pockets of relatively high deprivation, particularly in Whitefield.

Life expectancy in North neighbourhood is around 82 years, four years longer than the 78 years in East neighbourhood. In terms of healthy life expectancy, the average resident of North neighbourhood is expected to reach age 67 in good health, whereas in East neighbourhood this figure is only 59 years. West, Whitefield and Prestwich neighbourhoods are closer to the borough-wide average of 63 years of healthy life expectancy.

Within the Bury JSNA , we have profiles for each of the 5 neighbourhoods. We have placemats for each ward in each neighbourhood

# Our Neighbourhood Model Focus

BURY INTEGRATED CARE PARTNERSHIP



- Implementation of the Live Well model
- Neighbourhood Leadership Teams (formerly public service leadership teams) connecting a range of public and voluntary organisations in places
- Integrated Health and Care Adult Teams (INTS)
- Neighbourhood approaches to supporting Childrens and Families
- Estates Strategy and Alignment Supporting the model in each of 5 places

# Implementation of the GM Live Well model in Bury

BURY INTEGRATED CARE PARTNERSHIP



- The flagship initiative with the city-region is that of the Greater Manchester Live Well Model. Live Well is a cornerstone of the 10-year Growth & Prevention Delivery Plan and the Greater Manchester Strategy, aimed at reducing health, social, and economic inequalities across Greater Manchester
- The vision for Live Well is that by 2030 it will provide, “a comprehensive, connected, and equitable support system for all residents of Greater Manchester, fostering a supportive, inclusive, and thriving community environment. By integrating support, focusing on prevention, and promoting economic and social inclusion, 'Live Well' will ensure that every resident can live as well as possible”
- There are 4 key components of the model.
    - 1. The establishment of Live Well centres, spaces & offers
    - 2. Integration of support through an optimum Neighbourhood Model
    - 3. A resilient VCFSE eco-system
    - 4. A culture of prevention – with workforce and organisational development geared towards prevention
- To support the implementation of this approach NHS GM and GMCA have identified and created a £10m fund. This will sit alongside the £10m regional investment from DWP Economic Inactivity Trailblazer work.

# Implementation of Live Well by 2030

BURY INTEGRATED CARE PARTNERSHIP



- ✓2026 - Live Well in Whitefield builds on some excellent community capacity, on a number of years of community capacity building and development, and recognises gaps in provision of public services particularly in Besses.  A live well centre will be open in April, and other community assets are opening.
- ✓2027 - Live Well in Radcliffe will build out of not only exemplar  community capacity but also the substantial opportunity of the hub, the enterprise centre, the school, and an improved provision in the GP Centre
- ✓2028  - Live Well in Ramsbottom – again building out of strong VCSE capacity and likely to require an articulation of the virtual network of centres and capacity in the town
- ✓2029 – Live Well in Prestwich  - to build out of the opportunity of the Hub
- ✓2026-2030 – Live Well in Bury – a series of investments and projects increasingly described as joined up an integrated.

# Live Well Hub: Services

BURY INTEGRATED CARE PARTNERSHIP



**Services that could be increasingly available within the Live Well Hubs:**

- Integrated Neighbourhood Team
- Adult Safeguarding
- Adult Social Care
- Revenue and Benefits
- Public Health
- Children and Young People
- Live Well Leisure
- Cafes
- Libraries

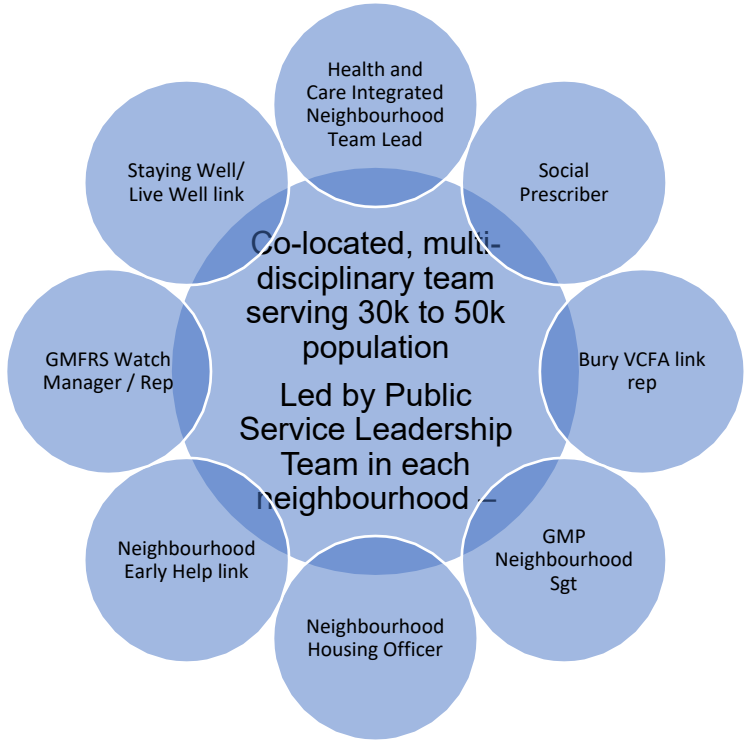

# Neighbourhood Leadership Teams

**( formerly public service leadership teams )**

BURY INTEGRATED CARE PARTNERSHIP




- ✓ We have stablished PSLT multi-agency teams working in each Neighbourhood. Include representatives from the Council, DWP, VCSE, GMP, GMFRS, Public . In addition it includes the operation (on the same footprint) of integrated health and care teams including primary care, community care, adult and children's care, mental health services, and aspects of secondary care delivered in neighbourhoods.
- ✓ Enables front line public service staff know each other, can work collaboratively with each other, and have a shared understanding of the community strengths in the place.
- ✓ Creates models of joined up and person-centered services, with a particular focus on the delivery of new joined up multi-agency working addressing segmented cohorts of the population in order to reduce, delay, or eliminate risk of escalated harm, poor outcomes, and unnecessary use of costly and reactive public service spend.



# Integrated Neighbourhood Teams in Health and Care for Adults

BURY INTEGRATED CARE PARTNERSHIP



**AIM:**
To achieve improved health and wellbeing and reducing inequality in access and outcome for people and communities through the development of an integrated model of health and care planning and delivery at a Neighbourhood level.


**FEATURES:**

- Application of a consistent operating model across the neighbourhoods but with flexibility to plan and deliver services in response to local need.
- Co-located teams working together addressing needs of the population ( including active case management)
- Embedding the principles of personalisation, and assets / strengths-based working with people and communities.
- Focus on prevention and avoiding, reducing and delaying the need for higher and costlier types of intervention.
- Focus on providing care at home / in the community wherever possible.
- Further integration of health and care services at a Neighbourhood level
- Clear service pathways and ‘offers’ for people according to need [Thrive model].
- Improved use of data and information technology to understand need, deliver services and connect people and the workforce specific to neighbourhood needs
- Connection to wider Public Service Leadership Teams in neighbourhoods.

# Neighbourhood Integrated Health and Care Model: Our priorities

BURY INTEGRATED CARE PARTNERSHIP



We will build on the existing Neighbourhood infrastructure of Integrated Neighbourhood Teams and Public Service Leadership Teams to work with our partners to deliver implement the NHSE Neighbourhood health guidelines and GM Neighbourhood model. The emphasis will be on:

- Providing better care close to or in people's own homes, helping them to maintain their independence for as long as possible.
- Promoting self-care, supporting early intervention and reducing health deterioration or avoidable exacerbations of ill health.
- Identifying opportunities for greater use of digital infrastructure and solutions to improve care.
- Supporting further service integration and joined up working between services including the VCSE.

**Priorities:**

1. Review the existing model of Active Case Management and MDTs and implement recommendations including the development of improved approach to impact evaluation.
2. Development and delivery of the Neighbourhood plans aligned to the local GP contract and agreed population health priorities with an emphasis on proactive personalised care and secondary prevention for CVD, respiratory and frailty, maintaining active input from health and care partners into the Public Service Leadership Teams and development and delivery of Neighbourhood People & Communities Plans.
3. Strengthen communication and integrated planning and delivery between key neighbourhood partners including GP Practices, PCNs leadership, community health services, adult social care, public health, care homes , community pharmacy and the voluntary sector.

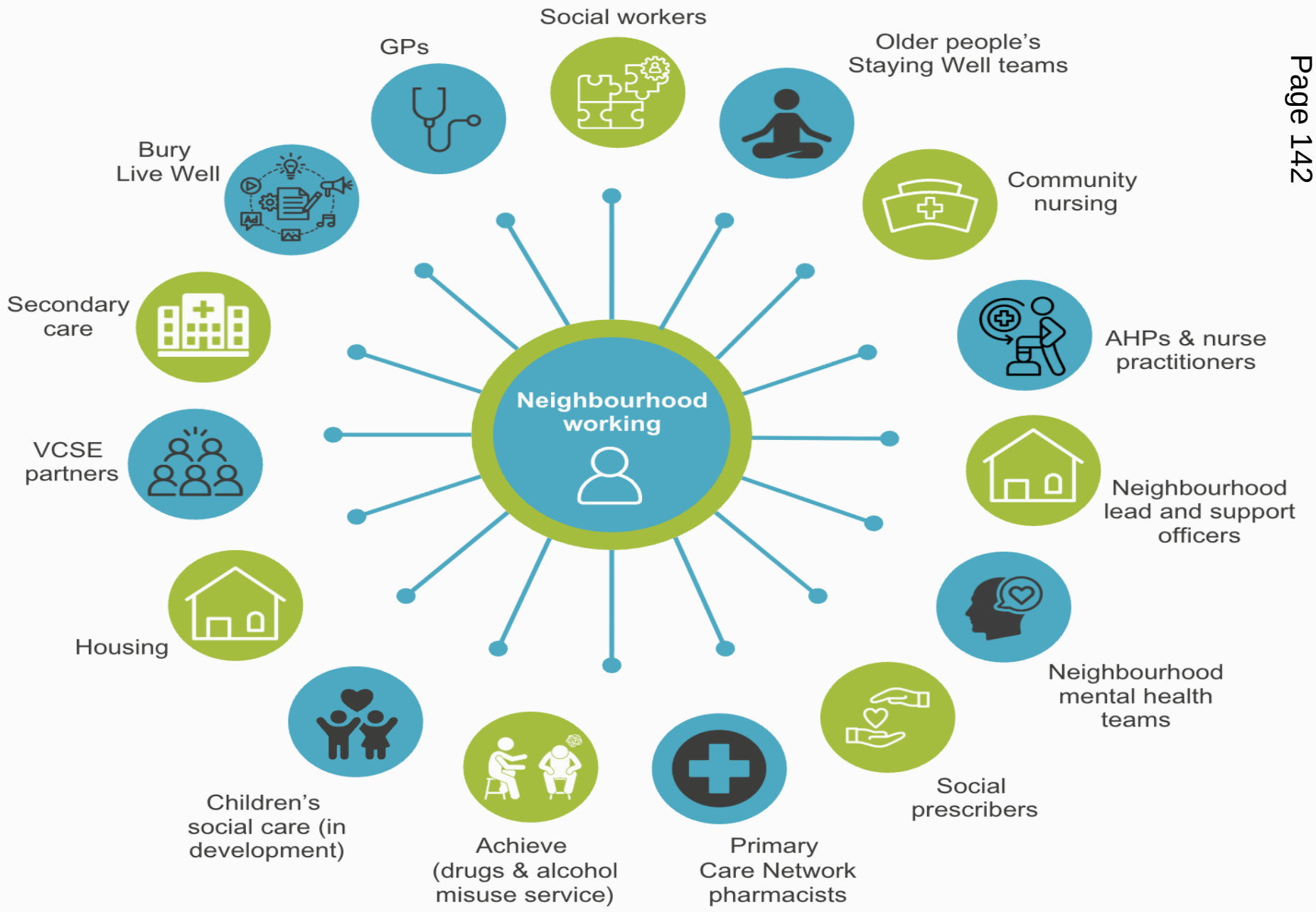
## Integrated care delivery

An improvement in the health and social care system in recent years has been the introduction of active case management, with multiple agencies coming together to support people and prevent their conditions getting worse.

People are put at the centre, with a plan created around them to help them achieve their goals, gain independence and improve their quality of life.

Good progress has been made, but there is a need to quicken improvements with a sharper focus on **reducing health inequalities**, **prevention**, **transforming care in community services** and **optimising care**.

The case studies on the following pages show how we aim to support people with different scenarios in future.



BURY INTEGRATED CARE PARTNERSHIP



## North INT


Linda Prescott
INT Lead


Dr Wiz El-Jouzi
GP Lead


Rachel Robinson
NSO


## East INT


Gemma Iliadis
INT Lead


Dr Fazel Butt
GP Lead


Daniel Bower
NSO

## West INT


Janet Stanton
INT Lead


Dr Ade Rotowa
GP Lead


Amanda Stott
NSO

## Whitefield INT


Jane Wilson
INT Lead


Dr Alistair Webley
GP Lead


Mafooz Bibi
NSO

25 GP Practices

## Prestwich INT

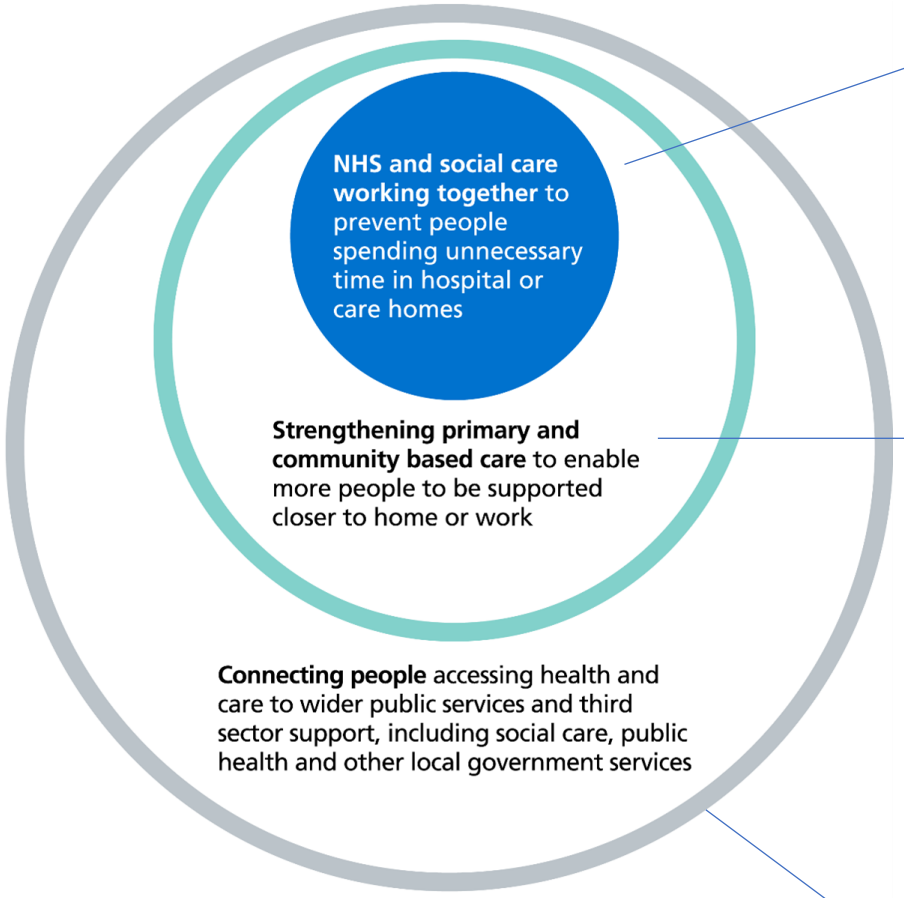

Clare Rayson
INT Lead


Dr Richard Deacon
GP Lead


Dawn Adderley
NSO

# Implementing the national approach






Active Case Management

Effective relationships between all partners in the neighbourhood

- Primary Care ( Core and LCS delivery )
- Community Services
- Social Care
- Living Well
- VCSE partners
- Care Homes
- Community Pharmacy
- Urgent Crisis response
- Intermediate Care
- Secondary Care

Public Service Leadership Teams

# Desired outcomes

BURY INTEGRATED CARE PARTNERSHIP



Increasing coordination, consistency and scale in delivering health and social care to specific sub-cohorts should result in the following benefits over time:

- avoiding or slowing health deterioration, preventing complications and the onset of additional conditions, and maximising recovery whenever possible to increase healthy years of life
- streamlining access to the right care at the right time, including continued focus on access to general practice and more responsive and accessible follow-up care enabled through remote monitoring and digital support for patient-initiated follow-up
- maximising the use of community services so that better care is provided close to or in people's own homes
- reducing emergency department attendances and hospital admissions, and where a hospital stay is needed, reducing the amount of time spent away from home and the likelihood of being readmitted to hospital
- reducing avoidable long-term admissions to residential or nursing care homes
- reducing health inequalities, supporting equity of access and consistency of service provision
- improving people's experience of care, including through increased agency to manage and improve their own health and wellbeing
- improving staff experience
- connecting communities and making optimal use of wider public services, including those provided by the VCFSE sector

# Next Steps for INTs

BURY INTEGRATED CARE PARTNERSHIP



The NHS 10 year plan is reflective of our local ambition. We have made progress made on integrated neighbourhood working through our active case management approach and single line management arrangements, connected to the reform of wider public services. We have had a relentless focus on addressing population health and health inequalities and will continue to so . We will also focus on increasing connectivity across the age spectrum.

We have strengthened primary care capacity and enabled a shift of services from hospital to the community . Where possible we have utilised technology – as evidenced in our adoption as a GM pilot of dementia care planning records using the GM Care Record, though we still have more to do.

Moving forwards, we will deepen our processes and relationships that enable integration, and have a stronger focus on the shift of diagnostic capacity and outpatient provision out of hospital, supported by digital and estates strategies.

# Neighbourhood Team Working for Children and Families

BURY INTEGRATED CARE PARTNERSHIP

NHS England



Greater benefits are realised when neighbourhood MDTs are also integrated with wider local services. MDTs for CYP, Family Hubs and Youth Hubs have fundamental differences in their function and purpose but collectively can offer a complementary suit of services to support CYP and their families/carers.

- **Best Start Family Hubs and MDTs** may have an overlap in workforce, including midwifery, health visiting and early years professionals, wellbeing and mental health practitioners.
- Family Hubs can link in with MDTs to refer onwards for further MH/PH support.
- MDTs to refer into Family Hubs if needs are identified.

**Neighbourhood MDTs for CYP**

Bringing together secondary and primary care to meet Mental Health and Physical Health needs (supported by wider MDT workforce)

**Family Hubs, Children's Centre (or similar Local Authority based MDT)**

Offering universal services to all children and families, including SEND

**Youth Hubs, mental health support teams (MHSTs) in schools & other local assets**

Physical and MH support and advice for young people inc on SEND, employment & housing.

**Shared colleagues will 'glue' the system together and help with shared learning.**

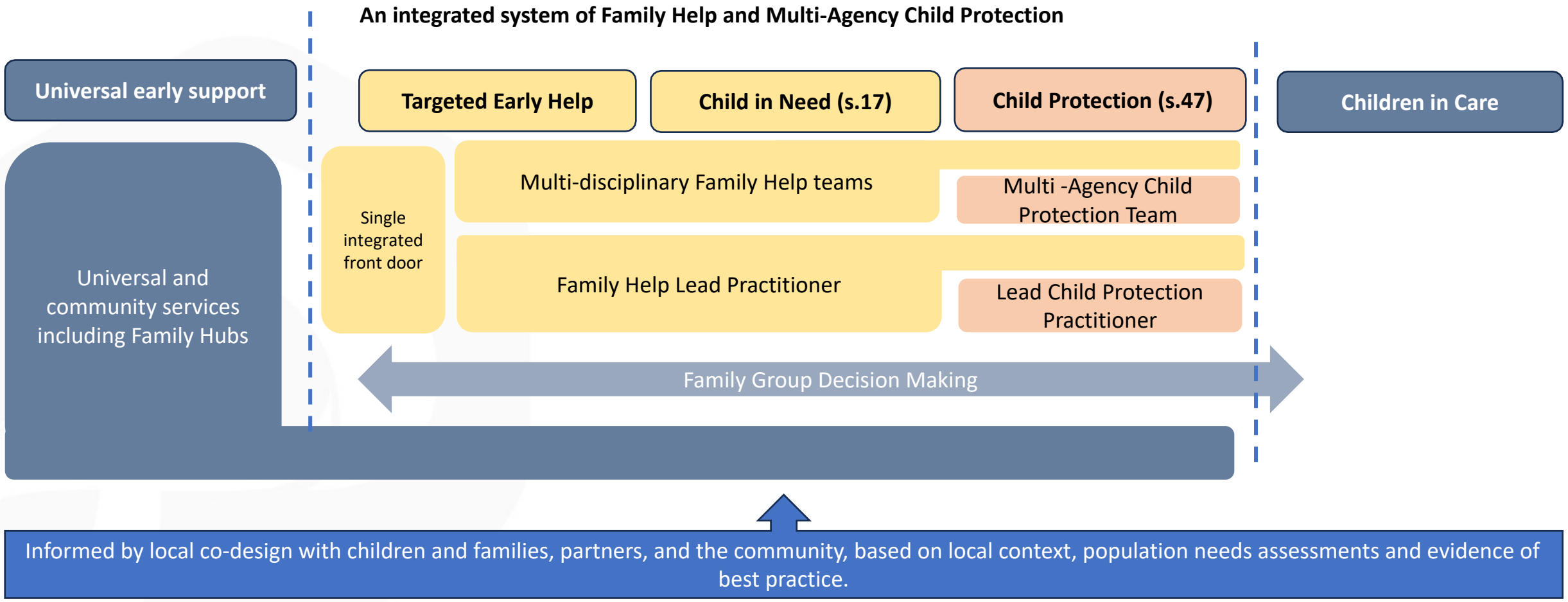
- Staff across all models need to work together.
- Some of the workforce may overlap.

- **Local community assets and MDTs** may have some staff roles such as mental health practitioners that are shared across both.
- Local community assets and MDTs may refer into each other to broaden the range of support provided.
- MHSTs may also reach out to MDTs or Youth Hubs.

# Local design of an end-to-end system of support and protection to rebalance the system towards prevention whilst keeping



Designing a system locally to meet the needs of the population with effective, integrated and joined up services with partners.



# Families First Partnership

BURY INTEGRATED CARE PARTNERSHIP



The Families First Partnership (FFP) programme comprises three key reform strands - implementing Family Help, Multi-agency Child Protection Teams and Family Group Decision Making.

**FFP Reforms**

## Family Help

- Family Help will take place at the heart of communities, bringing together local services under a combined, multi-disciplinary practice.
- It will wrap support around the whole-family at the earliest opportunity – using the expertise of multi-disciplinary practitioners.
- Family Help will ensure consistency of relationships between children, families and their lead practitioner;
- One plan will be adopted for children and families, but adapt as needs change.

## Multi Agency Child Protection Teams (MACPTs)

- Multi-agency child protection is a system where the right decisions are made at the right time for children, bringing experts together across agencies.
- MACPTs should seek to protect all children from actual or likely significant harm, inside and outside of the home, including online.
- MACP should also engage and empower parents, family networks and others in a transparent and compassionate way to care safely for their children, wherever this is possible.

## Family Group Decision Making

- Family group decision-making (FGDM) is a voluntary process that enables a family network to come together and make a family-led plan.
- The plan will include offering practical support to parents and carers, whilst prioritising the safety and wellbeing of the child.
- FGDM helps to ensure a family network is engaged and empowered to participate in decision-making while a child and their family is receiving help, support or protection.

# Location and timelines for Family Hub Implementation

BURY INTEGRATED CARE PARTNERSHIP



| Neighbourhood | Location | Date of implementation |
|---|---|---|
| Bury | Redvales | |
| | Chesham | |
| Whitefield | Live Well Centre and Ribble Drive | |
| | | |
| Prestwich | | |
| | | |
| North | | |
| | | |
| Radcliffe | | |
| | | |

A model of family hubs is in development, predicated on the 5-neighbourhood footprint but in practice delivered at a much more local community level (for example Chesham). This programme of work is currently being finalised

# Estates Framework to support neighbourhood working



We have Borough wide estates strategy, which is supportive of our ambition of neighbourhood working. A lead officer has been identified to complete the estates framework on behalf of the Borough. The programme of work and timelines are currently being determined.

BURY INTEGRATED CARE PARTNERSHIP

# Governance, Risks, Next Steps

Part of Greater Manchester Integrated Care Partnership

# Governance for delivery

BURY INTEGRATED CARE PARTNERSHIP



| Programme | Lead | Governance |
|---|---|---|
| Live Well | Will Blandamer | Public Service Reform Board/Locality Board |
| Neighbourhood Leadership Teams | Chris Woodhouse | Public Service Reform Board |
| Integrated Health and Care Adult Teams | Kath Wynne-Jones | Neighbourhood Design and Delivery Group and IDC Board/Locality Board |
| Neighbourhood approaches to supporting Children's and Families | Jeanette Richardson | Public service Reform Board/Childrens Strategic Partnership Board |
| Estates strategy | Claire Postlethwaite | Strategic Estates Group |

Quarterly Portfolio boards will be established to align the strategic ambition of the 5 neighbourhood programmes

* Quarterly neighbourhood delivery collaborative workshops are now in place to bring together teams working on the delivery of different the components at an operational level.

# Risks



- Lack of shared understanding of neighbourhood model by all partners including council functions
- A risk of replacing psilo agency working with the psilo working of multiagency teams
- Limitations of estates strategy
- Capacity to implement the model, especially in the midst of organisational change in a number of key partner organisations
- Digital capability to support neighbourhood development
- Communication and engagement capacity and capability

# Outcomes

BURY INTEGRATED CARE PARTNERSHIP



An outcomes framework is in development at GM relating to neighbourhood delivery, connected to the National Neighbourhood Health Implementation Programme.

Our local framework will be agreed once we have seen the outputs of this work.

# Summary





There is a lot to be proud of relating to neighbourhood working in Bury which we need to celebrate.

There are multiple opportunities through national guidance (in relation to family hubs or neighbourhood working in the NHS 10 year plan) to build on a solid platform of integrated delivery in the borough.

We have opportunities to strengthen the connection between our work on neighbourhood leadership teams, integrated neighbourhood teams in health and adult care, and in neighbourhood model for children and families.

We have an opportunity to bind that together through the implementation of live well in each of our 5 places.

BURY INTEGRATED CARE PARTNERSHIP

# Appendices

Part of Greater Manchester Integrated Care Partnership

# The Health of our Population

BURY INTEGRATED CARE PARTNERSHIP



## Demographic Profile Bury

**Population** 195,500
The total population of Bury (2023 ONS Mid-Year Estimates)

**Deprivation** 10%
The percentage of areas in Bury among the 10% most deprived areas in England (12 out of 120 LSOAs) IMD 2019

**Life Expectancy**
77.2 Years 80.9 Years
(2020-2022)

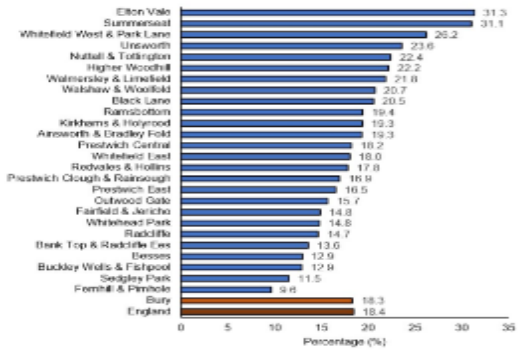
**Growth** 2.96%
The percentage that Bury population is expected to increase by 2033

The population of Bury is 195,500 (2023 ONS Mid-Year estimates). Bury has a relatively young population.
- 22.5% aged under 18 years
- 59% aged 18-64 years
- 18.5% aged 65+ years

Since 2003, the most notable demographic change has been a 33% increase in the 65+ years age group. In contrast, the growth in the under 18 and 18-64 years age groups has been more modest at 1.9% and 3.9% respectively.

**35,447 (18.3%)**

There are 35,447 (18.3%) older adults aged 65 years and over in Bury, similar to England average of 18.4%. Figure 1 below presents the proportion of population aged 65 years and over living in each Middle Super Output Area (MSOA) in Bury as a percentage of the total population in that MSOA (Census 2021).




Elton Vale (31.3%) and Summerseat (31.1%) have the highest proportion and Fernhill and Pimhole (9.6%) have the lowest proportion of older adults in Bury (Census, 2021).

**Life expectancy at 65 years**
17.4 Years 19.7 Years

Life expectancy at 65 years of age measures how long an individual who has reached the age of 65 years can expect to live on average.
- **Life Expectancy at 65 Years – Male in Bury**: 17.4 years (lower than the England average of 18.4 years)
- **Life Expectancy at 65 Years – Female in Bury**: 19.7 years (lower than the England average of 20.9 years)

(Source: ONS, 2022)

**Inequality in life expectancy at 65 years**
6 Years 5.9 Years

On average, those living in the most deprived areas of Bury can expect to live shorter lives than those in the least deprived.
- **Male in Bury**: The life expectancy gap between the most and least deprived decile is 6 years, compared with 5.2 years in England.
- **Female in Bury**: Thelife expectancy gap between the most and least deprived decile is 5.9 years, compared with 4.8 years in England. (Source: ONS, 2022)

- The population of Bury is growing and ageing. The proportion of the population aged 65 and over is projected to grow from 18% to 21% (a relative increase of 16%) by 2040, and the proportion of the population aged 80 and over is projected to from 5% to 7% (a relative increase of 40%) by 2040. Over the same time the proportion aged under 20 is projected to fall from 25% to 23%. This is almost certain to result in increasing numbers of deaths and more people needing healthcare and social care.

- The leading causes of death in Bury are cardiovascular diseases and cancers. The main causes of disability are musculoskeletal conditions and mental illnesses. Diabetes and liver disease are increasing rapidly as causes of disability and death, respectively.

- Health in Bury is somewhat less equal than across England as a whole. This likely reflects the diversity of population that Bury contains, ranging from urban to rural and affluent to deprived. The main causes of the gap in life expectancy between rich and poor are cardiovascular diseases, cancers, and liver diseases (the latter particularly for women).

- The main behavioural causes of these illnesses include poor diet, excess alcohol consumption, lack of physical activity, and smoking. These in turn are driven by low incomes, poor access to good food and housing and other building blocks of health.