AGENDA FOR

HEALTH SCRUTINY COMMITTEE

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To: All Members of Health Scrutiny Committee

Councillors : E FitzGerald (Chair), S Haroon, C Boles, L Ryder, M Rubinstein, D Duncalfe, K Simpson, D Green, G Martin, J Southworth and S Zaman

Dear Member/Colleague

Health Scrutiny Committee

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

Date:	Wednesday, 24 June 2026
Place:	Microsoft Teams **Microsoft Teams meeting** **Join:** https://teams.microsoft.com/meet/388068502495942?p=CceuThuANt6alQ9Mb9 Meeting ID: 388 068 502 495 942 Passcode: AH92Bj7i
Time:	7.00 pm
Briefing Facilities:	If Opposition Members and Co-opted Members require briefing on any particular item on the Agenda, the appropriate Director/Senior Officer originating the related report should be contacted.
Notes:	**Due to the extreme heat this meeting is now being held online on Microsoft teams**

AGENDA

a MICROSOFT TEAMS LINK TO ONLINE MEETING

Due to the Heat wave this meeting has been decided to be held online via Microsoft teams the link to the meeting is below

Microsoft Teams meeting
Join:

https://teams.microsoft.com/meet/388068502495942?p=CceuThuANt6alQ9Mb9

Meeting ID: 388 068 502 495 942
Passcode: AH92Bj7i

b APOLOGIES FOR ABSENCE

2 DECLARATIONS OF INTEREST

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

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

The minutes from the meeting held on 3rd March 2026 are attached for approval.

4 PUBLIC QUESTION TIME

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

5 MEMBER QUESTION TIME

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

6 APPOINTMENT OF CORPORATE PARENTING CHAMPION

Each committee meeting is required to have a nominated Corporate Parenting Champion; they will receive training from Childrens Services and will be responsible for advocating for Corporate Parenting matters in each committee. Champions will be appointed by each Committee at their first meeting of the municipal year.

7 OVERVIEW OF THE HEALTH SCRUTINY COMMITTEE *(Pages 13 - 18)*

For information, open to questions from members of the committee

8 HEALTH AND CARE UPDATE *(Pages 19 - 38)*

Presentation attached to be supported by Will Blandamer Executive Director for

Health and Adult Care

9 UPDATE ON NATIONAL POLICY FOR NEIGHBOURHOOD WORKING *(Pages 39 - 68)*

Presentation attached supported by Will Blandamer Executive Director for Health and Adult Care and Kath Wynn Jones NHS ICP

10 URGENT CARE UPDATE *(Pages 69 - 82)*

Presentation attached to be supported by David Latham Senior Programme Manager (Bury) NHS Greater Manchester

11 CHAIRS UPDATE STANDING ITEM

Verbal update from the chair, link to the meeting papers for the GMCA Joint Health Scrutiny Committee

Annual Meeting, Greater Manchester Joint Health Scrutiny Committee - Tuesday, 16th June, 2026 10.00 am

12 FORWARD PLANNER *(Pages 83 - 88)*

Report attached please advise in the committee if there are any items you would like to be brought to a future meeting

13 URGENT BUSINESS

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

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Agenda Item 3

Minutes of: **HEALTH SCRUTINY COMMITTEE**

Date of Meeting: 3 March 2026

Present: Councillor E FitzGerald (in the Chair)
Councillors S Haroon, C Boles, L Ryder, I Rizvi, D Duncalfe, K Simpson and G Staples-Jones

Also in attendance: Councillor T Tariq Cabinet Member for Health and Adult Care
Will Blandamer Executive Director Health and Adult Care
Jon Hobday Director of Public Health
Adrian Crook Director of Community Commissioning
Sian Grand Director of Housing
Andrew Griffiths Chief Operating Officer Healthwatch Bury

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

Apologies for Absence: Councillor N Frith, Councillor M Rubinstein and Councillor R Brown

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HSC.106 APOLOGIES FOR ABSENCE

Apologies for absence are listed above.

HSC.107 DECLARATIONS OF INTEREST

Councillor FitzGerald declared an interest due to being deputy cabinet member for Housing, during the home

HSC.108 MINUTES OF THE LAST MEETING

The minutes of the meeting held on 28th January 2026 were agreed as an accurate record.

Matters arising: Cllr Tariq raised actions relating to maternity services and requested that a response be taken back to the Locality Board. A report will then be submitted from the Locality Board to the Health Scrutiny Committee in due course.

Regarding the IT system supporting committee midwives, colleagues from the GM IT Council and interim services in Bolton had believed the issue was resolved. However, the matter has been referred back to colleagues for further clarification, and an updated report will be provided once available.

HSC.109 PUBLIC QUESTION TIME

There were no public questions.

HSC.110 MEMBER QUESTION TIME

There were no member questions.

HSC.111 WINTER PREPAREDNESS UPDATE POST WINTER

The Committee received a brief presentation from Will Blandamer, Executive Director for Health and Adult Care, providing an overview of the system's performance during the winter period. He highlighted that despite the significant pressures experienced, the system operated effectively and did not escalate to OPAL 4, the highest level of concern reached in many other localities. Strong partnership working was evident throughout the period.

Will Blandamer reported that flu vaccination rates were strong, supported by effective coordination with Public Health, care homes, and primary care partners. The Pharmacy First initiative and intermediate care services performed well, contributing to improved system flow. Although there were instances of patients being cared for in emergency department corridors, these situations were managed promptly each morning, and actions were taken to minimise the duration of corridor care. He offered to provide a more detailed report at a future meeting.

Councillor Tariq expressed his personal thanks to all teams involved, noting that winter is a particularly challenging period for people with long-term conditions. He emphasised that the system's coordinated approach and preparation had provided reassurance to residents at a time of significant pressure. He also highlighted the importance of recognising contributions from primary care and the Northwest Ambulance Service alongside the work undertaken within A&E departments.

Jon commended the work of the Vaccine Assurance Group, noting its well-coordinated efforts and the improvement in vaccination rates, as well as strong collaboration during the planning phase. Adrian added reassurance that both local hospitals were performing within the lowest four for key pressure indicators, reflecting positively on local system management.

Councillor Boles concluded by stating he felt reassured by the update and welcomed the positive performance reflected in the winter preparedness report.

It Was Agreed:

- The update be noted

HSC.112 HEALTH WATCH UPDATE

Andrew Griffiths, Chief Operating Officer of Healthwatch Bury, provided an update confirming that funding for Healthwatch has been extended for a further 12 months, enabling continued delivery of core services. He reported that Healthwatch remains fully engaged with local groups, continues to operate its drop-in office for walk-in support, and is progressing several ongoing projects. These include the prostate cancer pathway project, examining experiences from diagnosis through to aftercare, and the recently completed review of A&E at Fairfield Hospital. He emphasised that this work is being undertaken independent of current news coverage and reaffirmed Healthwatch's commitment to young people through Youth Watch, as well as ongoing engagement with the veterans community.

Members raised several observations. Cllr Duncalfe noted that the stoma prescribing service has moved to Salford. Cllr K. Simpson highlighted the expansion of engagement following the veterans conference and stressed the ambition for Healthwatch to be visible across all communities. Andrew reported he had been approached by a naval veteran and is exploring stronger links with HMS Eaglet, suggesting that work through the Valour Centre may need to expand into a larger regional offer. He confirmed discussions with Army HQ in Bury to maximise available spaces for veteran initiatives. Cllr S. Jones supported greater collaboration with both Army and Navy services, while Cllr K. Simpson expressed a preference for smaller, localised Valour Centres.

Cllr Tariq advised that initial engagement work had already begun through Cllr Walmsley, though full details were not yet available. The committee agreed to formally write to Cllr Walmsley and Chris Woodhouse to explore a joint Greater Manchester bid for a North Manchester Valour Centre. This will be pursued at the appropriate locality level. Cllr Tariq also thanked Healthwatch for its ongoing work, particularly in understanding patient experiences during a challenging period, and noted the positive impact of work around neurological needs. He encouraged elected members to amplify this work and continue raising issues through ICB channels, particularly given workforce pressures.

Cllr Boles asked how Healthwatch manages public expectations when passing on feedback, querying whether additional context is provided where certain issues fall outside Healthwatch's remit. Andrew advised he could not give a definitive answer at present but would take this away and provide a more detailed response. Cllr FitzGerald queried arrangements around survey and complaints handling. In response, Will Blandamer highlighted that Healthwatch recommendations are taken seriously, referencing examples (including the report at page 40) demonstrating how services respond, interview relevant teams, and evidence outcomes. He noted Healthwatch's strength in prioritisation and effective feedback.

A further question from Cllr Boles addressed inconsistent access to GP services and whether poor administration across practices in Bury contributed to this. Jon Hobday explained that triangulation of qualitative data with wider system information helps determine whether issues are isolated or reflect a broader trend. Will Blandamer added that Healthwatch had supported a focus group on GP administration, and the committee requested further detail on sample size and triangulation. This will be brought back as an action.

Cllr FitzGerald sought clarity on the goals of Youth Watch. Andrew explained that the intention is to use Healthwatch's statutory powers to strengthen engagement with young people, including links to neurodiversity hubs, upcoming consultations, GP service feedback, and targeted outreach through social media and gaming communities. He noted the model is based partly on work undertaken by another regional Healthwatch. An action was noted to outline the benefits and future development of Youth Watch.

Finally, Cllr FitzGerald asked whether Healthwatch had insight for the NCA Committee on cancellations of operations and appointments. Andrew acknowledged this would require further detail, and Adrian Crook noted that ongoing GP practice surveys would support better understanding. Issues raised included the practicality of new GP contract requirements, such as half-day sessions.

It Was Agreed:

- Write again to Cllr Walmsley and Chris Woodhouse
- Set out how triangulation will inform future reports
- Bring insight for NCA regarding operation cancellations

HSC.113 HOMELESSNESS STRATEGY

Sian Grant, Director of Housing, presented an update on the Government's new national 10-year plan to end homelessness, outlining the shift towards preventing homelessness before crisis point. She explained that the national strategy is built around five pillars, including universal prevention to tackle the root causes of homelessness, reforms through the Renters' Rights Act, and links to the national Child Poverty Strategy. The plan emphasises targeted prevention, stronger system-wide collaboration (including a potential new statutory duty to collaborate), and early intervention for individuals at higher risk. Sian highlighted a strong national emphasis on improving temporary accommodation, particularly reducing the use of B&B placements beyond six weeks.

She reported that the Government has allocated additional funding through the Homelessness Prevention Grant, creating an opportunity to redesign and reintegrate parts of the current service to improve coordination and efficiency. Locally, Bury has updated its own homelessness strategy following a comprehensive review, which shows a significant increase in demand over the past five years, alongside a sharp rise in the use and cost of temporary accommodation. Engagement with the voluntary and community sector has been completed to gather feedback, with organisations highlighting the need for respectful approaches and better recognition of lived experience. Next steps include deeper integration with public health, piloting an early-navigation model, and conducting an audit of temporary accommodation.

Cllr S. Jones reflected on feedback from charities, noting that although many have engaged, some organisations such as Red Door reported individuals feeling unable to speak to authority figures. He mentioned a case where someone with lived experience had attempted to help others, though this remained rare. He stressed that rough sleeping cases take time to resolve but are being treated seriously. Cllr Simpson shared an example of finding a veteran sleeping rough who felt intimidated by the system, noting this is a common experience among people living on the streets.

Cllr Boles asked who was responsible for producing the statutory action plan due in October. Sian confirmed that the Homelessness Partnership is leading this work and is collaborating with health, adult social care, and children’s services to define the strategic focus. She emphasised that co-production is central to the approach. Jon added that public health is involved due to the significant health risks associated with poor housing. Will Blandamer highlighted links between homelessness and hospital discharge pathways and mental health services, suggesting that new funding should help support earlier intervention for vulnerable individuals.

Cllr FitzGerald noted her involvement in the Homelessness Partnership and confirmed that policy development is ongoing. Cllr Boles asked who else should be included in the process who is not yet involved. Sian stated that people with lived experience need a stronger voice in both shaping and continuously influencing the service, and consideration is needed as to how this representation can be strengthened strategically.
Cllr Duncalfe raised concerns regarding landlords leaving the market following the end of Section 21 evictions, stating that many landlords are anxious about upcoming requirements. Sian advised she hoped the market would stabilise once the reforms were fully implemented. Cllr S. Jones asked about progress on Greater Manchester’s Housing First model, referencing Andy Burnham’s commitments. He noted that Bury has a small number of Housing First properties and asked whether more could be designated, as nine out of ten cases succeed once a stable home is provided. He also welcomed the idea of a “good landlord charter” to recognise responsible landlords, though acknowledged that upcoming changes in the Renters’ Rights Act may initially cause uncertainty.

Cllr Boles proposed that the committee take forward an action to ensure that lived-experience expectations are fully considered in the development of the homelessness strategy. Cllr Tariq concluded the discussion by emphasising that the relationship between health and housing is currently the strongest it has been in many years, with clear links demonstrated through the council’s new Extra Care Strategy. Bury aims to deliver five extra care schemes by 2035, including Redbank and Redvales, to support older adults. He suggested that, at an appropriate time, the strengthened partnership between housing and health should be brought back for further scrutiny.

It Was Agreed

- The update be noted

- To bring back an update in the next municipal year

HSC.114 PUBLIC HEALTH ANNUAL REPORT

Jon Hobday, Director of Public Health, presented the statutory annual report and highlighted a need to shine a light on commercial influences affecting public health. He emphasised that what is available, accessible, and affordable in the local environment directly shapes health outcomes. Around 70% of the commercial landscape relates to gambling, alcohol, and unhealthy food, all of which create pressures on the NHS and wider public services.

Jon outlined how central government policy, aggressive marketing, and lobbying particularly regarding tobacco and vaping contribute to shifting blame and worsening health outcomes. Locally, alcohol-related mortality is higher than the national average, with 1 in 5 children affected by alcohol-related harm. He demonstrated a licensing matrix that maps alcohol outlet density by postcode to support informed decision-making. He also highlighted gambling harms, with around 13,000 residents affected, often linked to poor mental health and suicide risk. Bury also has one of the highest densities of fast-food outlets, with 40% of Year 6 children obese, prompting the use of the SPD planning document to limit new takeaways. Smoking rates remain highest among routine and manual workers in the most deprived communities.

Jon outlined a system-wide approach focusing on regulating harmful practices, promoting healthier environments, and supporting businesses via the Good Health Charter. He referenced work in Transport for London, where unhealthy food advertising has been removed, and Scotland's progress in regulating harmful commercial practices. Jon issued a call to action, highlighting collective responsibility across partners.

Cllr Tariq thanked Jon and the team for producing a strong report and noted that challenges around hot food takeaways and night-time economy require ongoing focus. Cllr FitzGerald encouraged the committee to consider what more can be done outside formal meetings.

Cllr Duncalfe raised an issue regarding funding for Cocaine Anonymous groups, which cannot accept financial support due to anonymity requirements. Jon confirmed this but noted that other small funds, including social value allocations and GM Mental Health Trust resources, could sometimes support related work. Cllr FitzGerald added that citizen groups face barriers when financial thresholds require a treasurer after £1,000, discouraging participation.

Cllr Boles sought reassurance about the Fast Food SPD and shared concerns about gambling harms. A request was made for more data, particularly exploring links between gambling and homelessness and whether this should inform future commissioning. Jon confirmed that Bury does not currently commission a gambling-specific service due to limited funding, although GMCA plays a coordination role.

Adrian Crook added that while the Council cannot directly fund anonymous groups, it does support wider organisations addressing these issues.
Cllr Simpson asked about high inequality figures shown on page 93, seeking clarity on whether they were per 100,000. She noted that small areas like Redvales and Radcliffe significantly influence local averages and asked how Bury should present such data. Jon agreed these areas skew data and that more resource should be directed to them.

The committee then discussed vaping, with Cllr FitzGerald noting mixed messaging nationally. He referenced Chris Whitty's guidance: *"If you don't smoke, don't vape."* Jon agreed, noting that although campaigns exist to support smokers to switch, under no circumstances should children vape. He added that enforcement and testing frameworks are developing but take time, and trading standards remain key. Cllr Ryder asked how vaping harms could be

communicated to young people. Jon confirmed that Youthwatch and Early Break will be involved in youth engagement work.

Cllr Simpson asked whether vape shops could be regulated similarly to fast-food takeaways and whether cheaper products were more harmful. Jon noted ongoing issues with illegal vapes and the expectation that the national Vapes Bill will push them off high streets.

Cllr FitzGerald linked smoking, gambling, and mental health, noting that vulnerable people are disproportionately affected. Jon agreed that cause-and-effect relationships are complex, and lived experience must inform local responses.

The discussion concluded with recognition that children are being exposed to these harms early, and national legislation will be needed to support local interventions going forward.

It was agreed:

- Update be noted

HSC.115 PRINCIPAL SOCIAL WORKER ANNUAL REPORT - ADULT SOCIAL CARE

Adrian Crook, Director of Community Commissioning, provided a brief overview of the report, noting that while the service remains on an improvement journey, significant progress has been made. He emphasised the commitment to listening to lived experiences and using feedback to drive improvement. Workforce turnover is now below 12%, and the vacancy rate has fallen to 4%, reflecting increased stability and a strengthened approach to professional practice within adult social care.

Cllr Tariq praised the work of Emma Massey and the wider team, highlighting the strong foundations that have been built, including improvements in quality assurance, the performance dashboard, and workforce development. He noted low vacancy rates across adult social care, positive feedback from the LGA peer review, and ongoing preparation for CQC inspection. He expressed pride in the team and acknowledged recent positive judgements relating to extra care schemes and the work of Killalea.

Cllr Ryder welcomed the strong focus on professional development and staff retention, describing the progress as encouraging. Adrian agreed, stating that having an engaged workforce is a privilege and central to sustaining improvement.

Cllr FitzGerald asked about apprenticeship and development opportunities. Adrian explained that the apprenticeship route includes structured study, workplace support, and training, supported by a robust programme for newly qualified social workers. Most new starters remain with the service, reflecting the investment made in workforce development.
Cllr Tariq added that Bury's approach is becoming an exemplar for building and maintaining a strong adult social care workforce, and he hoped the positive culture could be promoted more widely.

Cllr Simpson raised concerns about high caseloads and workforce pressures. Adrian confirmed that caseloads average 22 cases, below the national average of 25, and efforts continue to keep them manageable. Every team has a wellbeing plan, along with one-to-one support, supervision, and a focus on psychological safety. He acknowledged the challenges of the role but emphasised the importance of resilience, reflective practice, and celebrating achievements.

In response to further questions about mental health support, Adrian confirmed that additional wellbeing initiatives are offered as needed. The meeting briefly noted that the Q4 Social Worker Report will feed into the upcoming CQC assessment due at the end of March.

It Was Agreed:

- Update be noted
- Further update from the Principal social worker at a future meeting

HSC.116 CHAIRS UPDATE STANDING ITEM

The Chair provided an update on the ICB report papers, drawing members' attention to the breadth and depth of recent work, particularly in relation to Adult Social Care. A comprehensive deep dive had been undertaken which highlighted the significant scale of Adult Social Care across the ICB footprint, including a budget supporting around 1,000 providers. The work focused on supporting people to live well for longer, including care and experiences during the final 12 weeks of life, where it was noted that 76% of individuals are supported appropriately when they reach services. Several recurring themes emerged from this work, and the Chair confirmed that the priority action areas identified would be filtered through and embedded within the Committee's ongoing workplan.

An update was also provided on service reconfiguration. Members were informed that proposals had been both disagreed and accepted within the ICB governance process. It was confirmed that the ICB Board had agreed that the minutes of the Board meeting would be circulated, and these would be shared with members once they had been formally approved and made available.
In relation to IVF provision, Will Blandamer advised that recent ICB discussions did not alter Bury's established position. Bury has historically operated in line with what is currently being proposed, and therefore there would be no local change arising from this matter.

Adrian highlighted wider concerns relating to people with disabilities and individuals with multiple and complex needs. He drew attention to the persistent and significant health inequalities faced across the Northwest and Greater Manchester, which continue to experience some of the longest periods of poor health nationally. It was emphasised that there is no clear correlation between levels of affluence and access to social care and health outcomes, noting that despite lower house prices in the Northwest, outcomes remain poorer than in the South. Members were reminded that Adult Social Care is under severe pressure, with demand outstripping capacity, and that poor health outcomes in the North are growing at a faster rate than elsewhere. The importance of prevention and addressing inequalities at an early stage was stressed, alongside the need for sustained action in this area.

Further to this, Adrian also raised the importance of shared data across Greater Manchester to support improved understanding of need, service planning, and more effective preventative approaches.

The Chair invited any additional comments on the ICB report from Jon, Will, Adrian and Cllr Tariq, and also opened the discussion to wider questions or comments from Committee members.

Members then discussed concerns regarding the handling of sexual assault-related complaints within the Northern Care Alliance. It was agreed that Bury should formally request that this issue is examined further and addressed appropriately going forward. Will Blandamer confirmed that the Council Leader, alongside Cllr Tariq, had already written to the NCA to raise concerns in a constructive manner, noting that the intention was not to belittle the issues but to ensure their seriousness and impact were properly acknowledged.

It Was Agreed:

- The update be noted

HSC.117 URGENT BUSINESS

The Chair confirmed that no urgent items of business had been requested prior to the meeting.

Councillor Tariq expressed thanks for the leadership shown throughout the meeting and for the wide range of issues covered, particularly in relation to Adult Social Care. He noted that several important matters had been brought forward for discussion and requested for inclusion on the agenda, and he wished to place on record his thanks to the Chair for facilitating the discussion and for their overall contribution.

The Chair thanked all members and officers for their input and engagement during the meeting and the years meetings. It was noted that the discussion had been well managed and constructive. The Chair thanked everyone for their attendance and contributions and confirmed that this concluded the meeting.

COUNCILLOR E FITZGERALD
Chair

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

Agenda Item 7

Classification	Item No.
Open	

Meeting:	Health Scrutiny Committee
Meeting date:	24th June 2026
Title of report:	Health Scrutiny Overview
Report by:	Josh Ashworth Senior Scrutiny Officer
Decision Type:	For Information
Ward(s) to which report relates	All

1.0 BACKGROUND

The Local Government Act 2000, introduced a requirement for local authorities with Executive arrangements to have one or more overview and scrutiny committees. It placed minimum requirements as to the power of those committees, their ability to appoint sub-committees, membership, access to information and provided them with the power of 'call-in.'

The current overview and scrutiny structures, stem from this legislative requirement and has been in place for 6 years, following an internal review. The review reflected on the learning of the previous five years and put forward suggested amendments to ensure an integrated, thematic overview and scrutiny function moving forward. The main change was the establishment of a third scrutiny committee with a focus on Children and Young People.

Moving to a model of themed scrutiny panels, with the work managed and co-ordinated by a the Scrutiny Chairs meeting regularly, has allowed individual panels to build up expertise and subject knowledge of particular areas of the Council's work. This new system does also allow (following consultation with the Monitoring Officer and the Statutory Scrutiny Officer) for cross cutting themes to be looked at jointly and also the establishment of task and finish groups.

- **Membership of Scrutiny Panels**

Overview and scrutiny is a good arena for new councillors to learn about the Council and develop skills. However there is a need for membership to be balanced with the involvement of experienced members who have the ability and skills to lead or contribute to overview and scrutiny work.

Scrutiny should be led by councillors who can put personal interests to one side and commit the time needed to the role. To be effective in holding the Cabinet to account, the Chair and Scrutiny Panel needs to have a constructive relationship with their respective Cabinet portfolio holders and Executive Directors. Unless this is underpinned by effective communication and planning, scrutiny will be unable to effectively exercise the power of influence over decisions to be made, as required by the Local Government legislation.

The membership of the Health Scrutiny Committee will consist of the Committee Chair, Councillor FitzGerald (Labour) and 11 other elected Members, in line with political balance calculations.

With regard to sub groups and taks and finish groups, political balance will be sought where possible, but balance requirements will not be mandatory as any findings/recommendations will be reported back to the balanced “parent” body for approval.

The Chair of the Health Scrutiny Committee shall not be members of the corresponding partnership bodies such as the Health and Wellbeing Board.

Deputy Cabinet Members are permitted to be members of individual scrutiny panels, for which the remit does not conflict with their portfolio responsibilities.

2.0 EFFECTIVE OVERVIEW AND SCRUTINY

The key components of overview and scrutiny work would fall broadly into the categories below:

Pre decision scrutiny - providing an opportunity for non-executive councillors to influence proposed decisions before they are made. If the Council increases the number of scrutiny panels, this will enable more councillors to have the opportunity to develop an understanding of the changing nature of the Council provision and contribute to and challenge the development of proposals in key areas.

Performance monitoring - Scrutiny has a role in asking searching questions, drilling down into information and data, ensuring targets are kept to and agreed actions implemented. Included in this will be monitoring the implementation of any agreed Scrutiny recommendations.

Service delivery - at the current time of change across the Council, Scrutiny Panels will largely focus on plans to review how services are delivered, the impacts on citizens, consultation and engagement, decision making processes, the implementation of change and evaluating outcomes and impacts. Scrutiny should encourage forward planning and communication that provides councillors with the opportunity to be better informed and clear on how proposed change affects their role.

Policy Review - If capacity is added to the current scrutiny arrangments through the addition of the proposed new panels, then there would be the opportunity for the scrutiny process to undertake some policy review work and contribute to policy development.

Partnerships and Regional Working - Where appropriate Scrutiny Panels will also look to scrutinise partners and regional working.

Holding decision makers to account – this cuts across all strands of overview and scrutiny work. In establishing a panel structure, Scrutiny Panels and the whole scrutiny process can build on practice over recent years with Cabinet portfolio holders and other decision makers, attending panel meetings and being held to account in a public arena for the decisions they are making, thereby enhancing transparency and accountability. It is also important that the scrutiny process considers the impact of significant decisions and whether the Cabinet achieves the anticipated outcomes.

3.0 HEALTH SCRUTINY COMMITTEE

The primary aim of health scrutiny is to strengthen the voice of local people, ensuring that their needs and experiences are considered as an integral part of the commissioning and delivery of health services and that those services are effective and safe. The new legislation extends the scope of health scrutiny and increases the flexibility of local authorities in deciding how to exercise their scrutiny function.

Health scrutiny also has a strategic role in taking an overview of how well integration of health, public health and social care is working. At the same time, health scrutiny has a legitimate role in proactively seeking information about the performance of local health services and institutions; in challenging the information provided to it by commissioners and providers of services for the health service

The following specific functions have been delegated to the Health Scrutiny Committee:

To review the policies and performance of the Council and external organisations in relation to the following areas:

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

The Committee discharges the statutory health scrutiny functions of the council (excluding referrals to the Secretary of State, but including receipt of referrals from the local Healthwatch) and scrutinises local health services. The Committee also considers the work and policies of the Health and Wellbeing Board, and also the services provided by the council's Adult Services and Children's Services Directorates.

The Committee also holds responsibility for the scrutiny of partners or key contractors relevant to the work of the Committee; and service performance monitoring. The Committee may also undertake its own studies and reviews.

- Power to review and review and scrutinise any matter relating to the planning provision and operational of health services

Where there are concerns about proposals for substantial developments or variation in health services (or reconfiguration as it is also known) local authorities and the local NHS should work together to attempt to resolve these locally if at all possible. If the decision is ultimately taken to formally refer the local NHS's reconfiguration proposals to the Secretary of State for Health, then this referral must be accompanied by an explanation of all steps taken locally to try to reach agreement in relation to those proposals. In considering substantial reconfiguration proposals health scrutiny needs to recognise the resource envelope within which the NHS operates and should therefore take into account the effect of the proposals on sustainability of services, as well as on their quality and safety.
The Health Scrutiny Committee may refer NHS substantial reconfiguration proposals to the Secretary of State if a local authority considers:

- The consultation has been inadequate in relation to the content or the amount of time allowed.
- The NHS body has given inadequate reasons where it has not consulted for reasons of urgency relating to the safety or welfare of patients or staff.
- A proposal would not be in the interests of the health service in its area.

4.0 HOW DOES THIS WORK IN PRACTICE

The Health Scrutiny Committee may identify topics for study and review to be undertaken. The committee may wish to review and scrutinise matters relating to the planning, provision and operation of the health service in the area. This may well include scrutinising the finances of local health services.

The Committee can

- Require information to be provided by certain NHS bodies about the planning, provision and operation of health services that is reasonably needed to carry out health scrutiny.
- Require employees including non-executive directors of certain NHS bodies to attend before them to answer questions.
- Make reports and recommendations to certain NHS bodies and expect a response within 28 days.
- Set up joint health scrutiny committees with other local authorities and delegate health scrutiny functions to an overview and scrutiny committee of another local authority.

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Local Healthwatch organisations and contractors have specific roles which complement those of health scrutiny bodies. For example, they can "enter and view" certain premises at which health and social care services are provided. This can enable local Healthwatch to act as the "eyes and ears" of patients and the public; to be a means for health scrutiny to supplement and triangulate information provided by service providers; and to gain an additional impression of quality of services, safety and issues of concern around specific services and provider institutions. Health scrutiny bodies and local Healthwatch are likely each to benefit from regular contact and exchange of information about their work programmes. It may also be helpful in planning work programmes, to try to ensure that certain aspects are aligned.
Representtives from Healthwatch are invited to all meetings of the Health Scrutiny Committee.

As well as the Local Health Scrutiny Committee the Council appoints to the Greater Manchester Scrutiny Committee. This body compliments the work of individual Council

Scrutiny Committees Reviews and scrutinises health services and acts as a consultative body to local health providers when they have a duty to consult.

If you would like more information on how Scrutiny Operates within Bury, contact the Councils Statutory Scrutiny Officer, Rachel Everitt or the Senior Scrutiny Officer, Josh Ashowrth – J.R.Ashworth@bury.gov.uk

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List of Background Papers:-
Health Scrutiny Committee - Terms of Reference

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Bury Locality Board
The Bury Health and Care System

6

Will Blandamer

Deputy Place Based Lead - NHS GM (Bury)

and Exec Director, Health and Adult Care - Bury Council

Part of Greater Manchester Integrated Care Partnership

1. Health Scrutiny

Role of Health Scrutiny

The role of Health Scrutiny is to:

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

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

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

Last year we reported to scrutiny on e.g:

BURY
INTEGRATED CARE
PARTNERSHIP

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

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

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

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

2. How the Health and Care System Works in Bury

Key Stakeholders

BURY
INTEGRATED CARE
PARTNERSHIP

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

The Bury Integrated Care Partnership

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

4 Clear Priorities (as per Locality Plan)

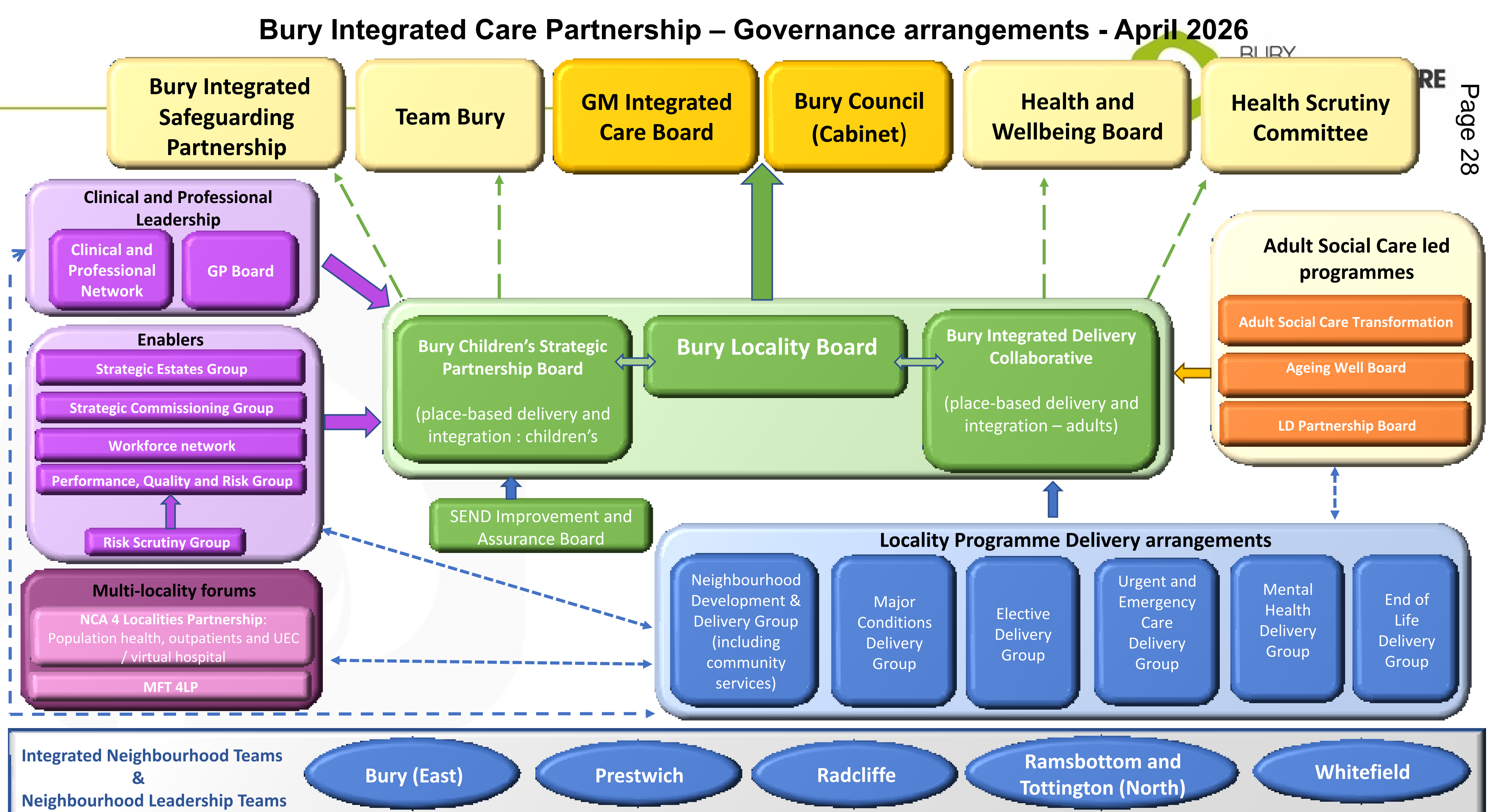
We work together across the Bury Integrated Care Partnership to :-	
1	Scale our work on Population Health Management - Improve population health and reduce health inequality of those in the most disadvantaged areas
2	Drive prevention, reducing prevalence and proactive care – supporting Demand Reduction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

Programmes of Work

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

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

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


Bury Integrated Care Partnership – Governance arrangements - April 2026
Bury Integrated Safeguarding Partnership
Team Bury
GM Integrated Care Board
Bury Council (Cabinet)
Health and Wellbeing Board
Health Scrutiny Committee
Clinical and Professional Leadership
Clinical and Professional Network
GP Board
Enablers
Strategic Estates Group
Strategic Commissioning Group
Workforce network
Performance, Quality and Risk Group
Risk Scrutiny Group
Multi-locality forums
NCA 4 Localities Partnership: Population health, outpatients and UEC / virtual hospital
MFT 4LP
Bury Children's Strategic Partnership Board
(place-based delivery and integration : children's
Bury Locality Board
Bury Integrated Delivery Collaborative
(place-based delivery and integration – adults)
Adult Social Care led programmes
Adult Social Care Transformation
Ageing Well Board
LD Partnership Board
SEND Improvement and Assurance Board
Locality Programme Delivery arrangements
Neighbourhood Development & Delivery Group (including community services)
Major Conditions Delivery Group
Elective Delivery Group
Urgent and Emergency Care Delivery Group
Mental Health Delivery Group
End of Life Delivery Group
Integrated Neighbourhood Teams & Neighbourhood Leadership Teams
Bury (East)
Prestwich
Radcliffe
Ramsbottom and Tottington (North)
Whitefield

Integrated working between our Place Partnerships and Strategic Commissioning teams is at the heart of our new model

System Convenor – to enable delivery of the ICP strategy

Improving Population Health Outcomes / Reducing Inequalities / Social & Economic Development / Statutory Accountabilities / Constitutional Standards / System Resilience

Strategic Commissioner

Needs Assessment & Outcomes Setting

- In-depth population analysis
- Analysis of resource utilisation (finance)
- Clinical-led evidence on opportunity
- Health economics (Public Health)

Strategy and Planning

- NHS GM / ICP / GMCA partnership priorities
- Assessment of national policy and local analysis (Planning)
- Setting system strategic ambition and place expectations.
- Setting clinical and professional commissioning policy for the system (Clinical)
- Setting financial policy rules (Finance)
- Strategic resource allocation (Finance)
- Operational planning (Planning)
- Agree transformation priorities based on constitutional standards
- Strategic digital leadership and development

Contracting & Evaluating Impact of System

- Manage market rules and core NHS contracts
- Assure delivery at place, provider, system groups
- Quality improvement

Ten Integrated Place Partnerships

Local Insight-led Planning

Develop priorities and plans to address:

- Agreed strategic goals and outcomes
- Utilising value based analytical capability
- JSNA, in-depth population analysis & community insight (BI / Planning / Insight)

Integrated Delivery at Place

- Engage partners, clinicians and communities in designing solutions to deliver priorities.
- Integrated Neighbourhood Health - work with partners to create neighbourhood health model
- Drive benefits realisation (Planning)
- Demand management
- Supporting the system wide Live Well model
- Population Health
- Co-design with communities
- Single view of allocation of place allocation

Aligning Partnership Incentives & Resource

- Coordinate the resources across pathways and partners to achieve shared outcomes.
- Support the development / strengthening of provider partnerships.

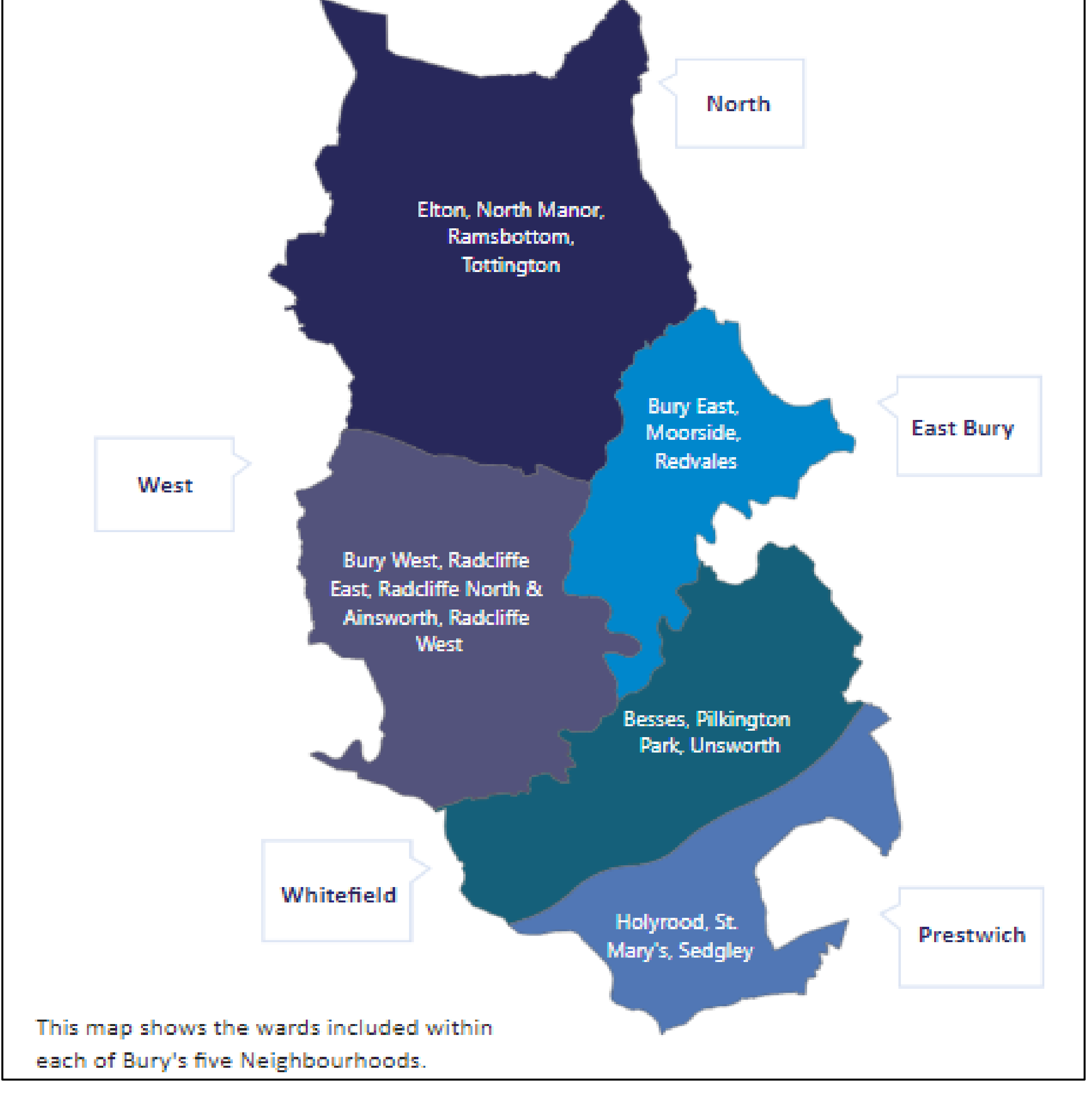
Enablers: portfolio/s to encompass all of these functions

Clinical & Professional Leadership	Communications & Engagement	Corporate & Clinical Governance	Digital & DII	EDI	Finance	People & Culture	Programme Management	Quality & Safety (Experience)

3. The Bury Whole System plan for Neighbourhood Working

Neighbourhood Working

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



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

4 Elements of Our Neighbourhood Model

1. Integrated Health and Care Adult Teams (INTS)

2. Neighbourhood Leadership Teams (formerly public service leadership teams) connecting a range of public and voluntary organisations in places

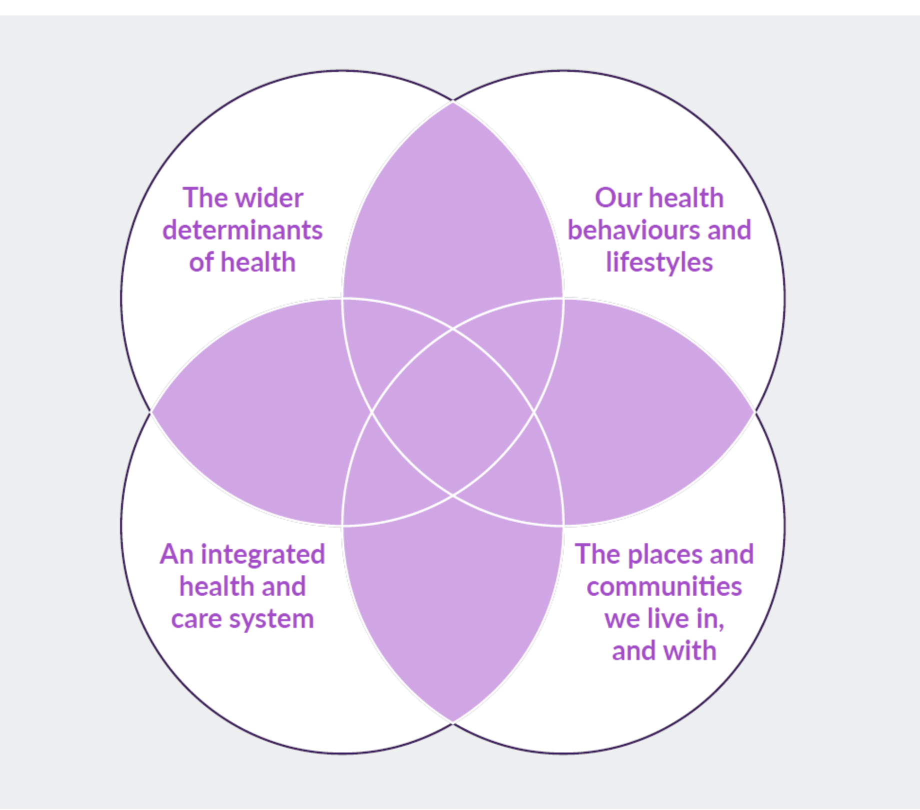
3. Implementation of the Live Well model

4. Neighbourhood approaches to supporting Childrens and Families.

Population Health and Health Inequalities

BURY INTEGRATED CARE PARTNERSHIP

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



Neighbourhood Working – our principles

- The neighbourhood level has a specific definition for us in Bury. It recognises populations of 30-50000 as 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.

- This is described in the **Strategy for the Borough. 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.

- 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

- 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 /Working Well/Bury Works
- A mechanism to allow us **to respond to Borough, GM, or national priorities** – e.g how to improve School Readiness,.

Neighborough Profiles

- https://www.theburydirectory.co.uk/jsna/neighbourhood-profiles

Bury Council

Bury Neighbourhoods
Population and Demographics
Population Health and Wellbeing
Education and Skills
Health Care
Employment and Income
Housing
Early Intervention and Prevention
Children Social Care
Adult Social Care
Crime & Safety
Environment
Data Sources

North
Elton, North Manor, Ramsbottom, Tottington
East Bury
Bury East, Moorside, Redvales
West
Bury West, Radcliffe East, Radcliffe North & Ainsworth, Radcliffe West
Whitefield
Besses, Pilkington Park, Unsworth
Prestwich
Holyrood, St. Mary's, Sedgley

Click on a label to see a neighbourhood's summary
This map shows the wards included within each of Bury's five Neighbourhoods.

Neighbourhood Profiles

KEY HEALTH AND WELLBEING INFORMATION FOR EACH OF THE 5 BURY NEIGHBOURHOODS

Bury has a population of **193,850** people across five different neighbourhoods as of the 2021 census (East Bury, West, North, Prestwich and Whitefield).

Bury is amongst the less deprived local authorities in Greater Manchester but internal inequalities vary significantly within and across neighbourhoods. These hidden inequalities are masked when we look at Bury as a whole, highlighting the importance of understanding and quantifying health needs and inequalities at neighbourhood and ward level.

In this report you can access some key information on health and wellbeing across the five neighbourhoods in Bury. Select a section from the menu on the left to begin.

please note: *any visuals that would display a value of less than 10 have been removed from this report.*

Total population by Neighbourhood from the Census 2021
(note this may not match the Bury total due to rounding)

West | North | East Bury | Prestwich | Whitefield

Version: 3 | Released: August 2023 | Contact: PLSDU@bury.gov.uk

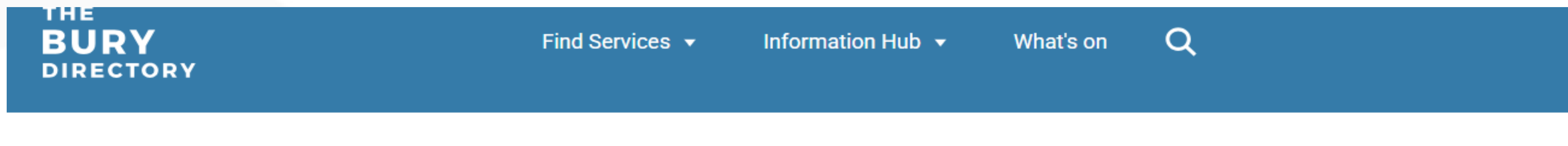
54%

Microsoft Power BI

1 of 13

Neighbourhood Placemats

- https://www.theburydirectory.co.uk/jsna/neighbourhood-placemats



Home ▸ Joint Strategic Needs Assessment ▸ Neighbourhood Placemats

Neighbourhood Placemats

An overview of place based assets.

Our placemats showcase community assets including buildings, groups, networks and other local anchor organisations. The Placemats provide an overview of community capacity in each Ward.

BURY INTEGRATED CARE PARTNERSHIP

4. Any questions

Neighbourhood Working
National Policy Context and Implementation in Bury

Will Blandamer

Kath Wynne Jones

Part of Greater Manchester Integrated Care Partnership

1. National goals and reform ambitions

10 Year Plan : 3 radical shifts

- Hospital to community
- Analogue to digital
- Sickness to prevention

In the NHS Ten Year Health Plan, this is a referred to as a **‘left shift’** towards prevention, community and digital care.

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Neighbourhood Health Framework

"In the 10 Year Health Plan for England, we promised to give power to people. If we are to do this, we need to end people being passed from pillar to post in a fragmented and, at times, chaotic system, and make local health services meaningfully accountable to local residents and service users.

We will address this by creating a neighbourhood health service - building on the plethora of inspiring pilot programmes that have tested this in different parts of the NHS, local government and wider health and care system over recent years.

Neighbourhood health will only work as a joint endeavour between the NHS and local authorities, alongside wider partners. We expect this to be a truly collaborative effort between all partners, combining the NHS's responsibility for our health services with local authorities' responsibility for adult and children's social care services and public health. This will foster a true partnership for the benefit of all citizens to ensure we achieve the left shift from hospital to community, and sickness to prevention."

Goals

1. Improve health outcomes and reduce inequalities, with focus on priority cohorts
2. Improve access to general practice, including faster and more equitable access
3. Improve experience of planned care, reducing fragmentation and variation
4. Strengthen urgent and emergency care (UEC) through better community alternatives
5. Improve patient and staff experience and satisfaction

Reform Agenda

1. Improve services for routine healthcare– Making neighbourhood health the “front door” for most care
2. Strengthen proactive care– Earlier identification, anticipatory care, MDT working and prevention
3. Provide better alternatives to hospital care– Including Urgent Community Response, Hospital at Home, virtual wards and coordinated crisis responses

Goal 1: Improve health outcomes

- Focus on high-priority cohorts:
  - People with frailty
  - Care home residents
  - Housebound patients
  - Those receiving end of life care
  - Those with CVD, diabetes, chronic obstructive pulmonary disease (COPD), dementia, mental health conditions
  - Children and young people
  - Any other cohort identified by local areas

Goal 1: Improve health outcomes

BURY INTEGRATED CARE PARTNERSHIP

- Help people with mid to severe frailty, in a care home or housebound, to stay healthier, manage escalating conditions and maintain greater independence for longer. **Reduce non-elective admissions and bed days of one day or over by 10% for this cohort by March 2029**
- Better identify people coming to the end of life and improve access to services so people can die in a place of their choosing. **By March 2029, increase the number of people identified as approaching end of life by 10% and reduce non-elective admissions and bed days of one day or over for people in the end of life cohort by 10%**
- Have better diagnosis and treatment for people with long-term conditions. ICBs should agree targets to reduce variation in access to elective care for each of these areas. Modern service frameworks will specify further metrics for CVD and mental health in due course.
  - **By March 2029, see an improvement of at least 10% in evidence-based clinical outcomes**, measured through quality and outcomes framework standards for CVD, diabetes, COPD, mental health conditions and dementia, where warranted.
  - **Increase the percentage of patients with diabetes who receive all 8 elements of the diabetes care process bundle in the preceding 12 months by 10%**
  - Improve quality and access to care for children and young people by enhancing paediatric expertise across the pathway, including primary care. By March 2029, **we will reduce acute outpatient appointments for children under the age of 16 by 10% and make substantial progress towards reduction of community waits for children,** as part of delivering Medium

Goal 2: Improve access to General Practice (Primary Care)

Comparing 2025 to 2026 baseline we will:

- Ensure that clinically urgent patients are seen on the same day by their GP practice team. We aim to **see 90% of clinically urgent patients on the same day by March 2027**
- Make sure there is **faster access for routine GP care**. During the 2026 to 2027 financial year, we will collect data to baseline and set future trajectories. In the interim, ICBs may set local goals in agreement with contractors
- **Improve patient satisfaction with GP access**. During the 2026 to 2027 financial year, we will collect data to baseline and set future trajectories. In the interim, ICBs may set local goals in agreement with contractors

Goal 3: Improve experiences of planned care and cancer care, and support delivery of the referral to treatment (RTT) standard

BURY INTEGRATED CARE PARTNERSHIP

Compared with 2025 to 2026 baseline we will:

- Reduce variation in referrals to outpatient services across the system through a **single point of access** (SpoA) and multidisciplinary team model.
- Aim to contribute to a **diversion rate of at least 25% by March 2027 for at least 10 high volume specialties**, supporting overall RTT trajectories of 70% by March 2027 and 92% by March 2029
- Make sure there is **better co-ordination of outpatient activity across multiple specialties for patients in high-priority cohorts**.
- **Deliver more follow-up outpatient care in neighbourhoods, and contribute to an overall reduction in secondary care follow-up appointments by at least 10% by March 2027.**
- **Cancer should be delivered in line with the metrics in the National Cancer Plan for England**

Goal 4: better urgent and emergency care (UEC) performance in line with agreed standards

BURY INTEGRATED CARE PARTNERSHIP

Compared with 2025 to 2026 baseline we will:

- Make sure there is better co-ordination of reactive care for high-priority cohorts (those with mid to severe frailty, in a care home or housebound and end of life), increasing use of urgent care provision in the community for example, by making use of a single point of access, urgent community response, hospital at home, and virtual wards.
- **By March 2029, we aim to:**
  - **Keep growth flat and work towards an overall reduction in non-elective admissions for high priority cohorts**
  - **Contribute to an increase in type 1 emergency department (ED or A&E) admitted and non-admitted performance, supporting overall 4-hour trajectories of 85%. Aim for an interim trajectory of 82% by March 2027**
  - **Contribute to an overall reduction in type 1 ED attendances for high priority cohorts**
  - **Have fewer ambulance call-outs for the least urgent cases, with appropriate diversion to relevant urgent care provision in the community.**
  - **Reduce category 3 and 4 ambulance conveyances in high-priority cohorts (those with mid to severe frailty, in a care home or housebound and end of life) by March 2029**
  - **Ensure there is better co-ordination of discharge process and capacity planning across health and care services, enabling patients to be discharged efficiently and effectively.**
  - **Contribute to an improvement in the average length of discharge delay for all acute adult patients, derived from the proportion of adult patients discharged from acute hospitals on their discharge ready date (DRD) and for adult patients not discharged on their DRD, the average (mean) number of days from the DRD to discharge**

Goal 5:improve patient and staff satisfaction with NHS services

Compared with 2025 to 2026 baseline we will:
Take a proactive approach, where the patient feels in control of their care. We will introduce a reformed set of patient-reported experience measures and patient-reported outcome measures in the 2026 to 2027 financial year, with trajectories for improvement each year. These will be collected consistently across places and details will be confirmed in due course.

In the interim,
• ICBs may set local goals. **In addition, by 2027, 95% of people with complex needs will have an agreed care plan**
•ensure that teams working within neighbourhoods feel more motivated in their work. We will introduce a set of neighbourhood staff experience measures in the 2026 to 2027 financial year, with trajectories for improvement each year. These will be collected consistently across places and details will be confirmed in due course.
In the interim, ICBs may set local goals

Reform agenda 1: improve services for people who need routine healthcare, so neighbourhood health benefits everyone

BURY INTEGRATED CARE PARTNERSHIP

- The NHS will deliver better GP access, with **increased digital tools**
- The NHS will empower GPs to deliver better care to better manage the health of their population by incentivising proactive population health management. This will take place through risk stratification, long-term condition management, secondary prevention and better continuity of care, backed up by improved access to specialist opinion.
- The NHS will improve GP access to diagnostics
- ICBs will implement the **Red Tape Challenge**, improving the connection between primary and secondary care through a range of common-sense interventions, including:
    - Full national implementation of the Getting It Right First Time (GIRFT) bridging the interface (or gap) checklist
    - New electronic patient records (EPRs) increasing access to shared care records
    - Direct prescribing to community pharmacy
    - Structured medication information
    - Prescriptions issued for 28 days in outpatients unless clinically inappropriate
    - NHS trusts will play a full role in maximising the interface for the benefit of patients and staff alike

Reform agenda 1: improve services for people who need routine healthcare, so neighbourhood health benefits everyone

BURY INTEGRATED CARE PARTNERSHIP

- The NHS will improve the productivity of GP practices by increasing the use of technology to free up clinical time and assist flow
- NHS England will work with ICBs to reform out-of-hours services, so the public can better access care when GP practices are closed
- ICBs will build on the progress we have made to strengthen pharmacists' role in delivering care, recognising that pharmacies are one of the most accessible parts of primary care for services such as contraception, blood pressure checking and support on smoking cessation, as well as the Pharmacy First service. Treating minor illness by our Pharmacists is our ambition

Reform agenda 2: improve proactive care for people

- INTs will bring together different professions and partners to work side by side to support people. These teams know their neighbourhoods and can tailor care to what matters most for local people. In line with the 10 Year Health Plan's commitment to support people to be active participants in their own care by ensuring 95% of people with complex needs will have an agreed care plan by 2027, these teams will deliver assessment, care planning, co-ordination and follow-on support.
- The NHS will not define nationally what should constitute an INT. This will vary based on different conditions and populations and will be decided locally. The NHS will amend national contracts and funding flows so ICBs can ensure the provision of INTs is commissioned effectively at an appropriate scale to serve patient cohorts.
- Nationally, NHS England will ask ICBs to ensure INTs are set up with an initial focus on
  - People with frailty, and those who need end of life care: this cohort is the priority because those over 75 living with frailty, those at end of life and care home residents account for 3 to 5% of the population yet represent over 25% of non-elective admissions and 50% of bed days
  - Multiple long-term conditions: better management of multiple long-term conditions can result in slow onset of frailty and reduced incidences of acute presentation. INT development should focus on the conditions which have the highest impact (CVD, diabetes, COPD, dementia). In some medical disciplines, such as diabetes, these will align with outpatient reform, and ICBs should consider how these areas will align
  - Children and young people (CYP): GPs will use children and young people INTs to provide timely access to paediatric expertise in the community, alongside wider health and care professionals, including mental health and community services. INTs will also help families to manage some conditions at home if clinically appropriate. The evidence base shows that many ED attendances and outpatient appointments are a result of children receiving care in the wrong place. The NHS will address this through the INTs, and we will build this service over time, with every child who needs one having access to an INT by the 2028 to 2029 financial year. In practice, we expect systems will see a shift in outcomes through the reduction of outpatient appointments, with wider benefits including a reduction in ED attendances and hospital appointments. As part of setting up INTs, ICBs and local authorities should work together to consider how these services join up with other children's services - for example, safeguarding, family help and multi-agency child protection teams, Best Start Family hubs, and the 'Experts at Hand' service for children with SEND

Reform agenda 2: improve proactive care for people

- Cancer: in line with the National Cancer Plan, over the course of the next 3 years, INTs will be set up to improve the quality of life for those living with cancer

- NHS England will produce a best practice guide for NHS frailty pathways. This will set out essential actions for ICBs and providers to improve the entire frailty provision, from identification and assessment to proactive and urgent care. This will be based on what systems have told us works across the health and care service, and ICBs will be able to use this as a baseline on which to improve pathways in line with the upcoming modern service frameworks.

- ICBs will maintain and develop access to women's health services as part of neighbourhood care, and women's health hubs will be aligned to new neighbourhood health pathways and structures Women face disproportionate challenges in access and quality of healthcare over the course of their lives. Women's health hubs are designed to improve care for women, including avoiding them having to have multiple appointments in different settings. ICBs will ensure that any changes to wider neighbourhood provision are aligned with women's health hubs

- ICBs will grow core community services and work with providers to reduce waiting times We recognise that community waits are having an impact on many high-priority population groups - those with frailty, those needing palliative and end of life care, children and young people, and those with multiple long-term conditions. We'll deliver better access to core community services by increasing capacity to meet demand growth (around 3% per year nationally), and actively managing long waits for community health services, with at least 78% of community health service activity occurring within 18 weeks by the 2026 to 2027 financial year and at least 80% by the 2028 to 2029 financial year, and backed up by new ICB plans to eliminate all 52-week waits.

Reform agenda 2: improve proactive care for people

- The NHS will introduce a new model for planned care that meets the 10 Year Health Plan commitment of "ending outpatient care as we know it", starting with closer working between GPs and specialists The NHS will put GPs in control when it's unclear whether a patient needs specialist care, so people do not make unnecessary trips to hospital and instead focus on providing care closer to home. GPs and secondary care consultants will work closer together, first by expanding advice through single points of access (starting with at least 10 specialties in all providers in the 2026 to 2027 financial year).
- We will move more follow ups, for those who need specialist input, into neighbourhood settings, delivered by professionals in the community, starting with conditions such as diabetes, all backed up by new digital pathways and single points of access. In line with the Medium-Term Planning Framework, systems should start planning for the introduction of a radical new neighbourhood approach to elective pathways, establishing a single point of access with better access to specialist opinion and diagnostics.
- This should focus on the core specialties identified in the elective reform plan: gastroenterology, ENT, cardiology, respiratory, diabetes, gynaecology and urology. We will work closely with GPs to ensure these arrangements work effectively within their competency and they are supported. Where systems are ready to go further and faster, devolution of budgets and reforms to funding flows will be available in exchange for credible plans.
- The NHS will standardise the expectations of data sharing between neighbourhood health services and hospitals
- Systems will make the NHS work around the needs of the individual, not the other way round, by improving data sharing between hospitals and neighbourhood health services, including social care. This will mean neighbourhoods can put in place more effective proactive care for those who might otherwise default to secondary care, rather than leaving patients to co-ordinate their own care.

Reform agenda 3: deliver better alternatives to hospital care

- Expand urgent community response services, so the NHS is there for people when they need it most. We will prevent avoidable attendances, particularly for frailty and falls, by expanding urgent community response capacity, delivered through the new community integrated neighbourhood teams.
- The NHS will increase the capacity of virtual wards, so people don’t have to attend hospital unnecessarily Rather than make patients come to hospital, the NHS will come to them by radically increasing the capacity and efficiency of virtual wards.
- The NHS will work with local authorities and other partners to increase intermediate care capacity. Increasing and optimising the capacity of step-up and step-down intermediate care will help avoid admissions and attendances, improve discharge and support better recovery. This includes making best use of community beds and expanding home-based care. We will reduce the length of stay in NHS-commissioned community beds, maintaining that improvement, and build intermediate care capacity (step-up and step-down).
- We will explore better alternatives to mental health hospitals. Some local areas have been piloting a neighbourhood approach for mental health through 24/7 neighbourhood mental health centres. These centres for people with severe mental illnesses are intended to improve care continuity, reduce crisis and provide an alternative to hospital for people experiencing a mental health crisis, and are distinct from INTs.

2. The Bury Whole System plan for Neighbourhood Working

Part of Greater Manchester
Integrated Care Partnership

Neighbourhood Working – our approach

- 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 /Working Well/Bury Works
- A mechanism to allow us **to respond to Borough, GM, or national priorities** – e.g how to improve School Readiness,.

Neighbourhood Working – our principles

- The neighbourhood level has a specific definition for us in Bury. It recognises populations of 30-50000 as 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.
- This is described in the **Strategy for the Borough. 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.
- 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**.

Neighborough Profiles

- https://www.theburydirectory.co.uk/jsna/neighbourhood-profiles

Bury Council

Bury Neighbourhoods
Population and Demographics
Population Health and Wellbeing
Education and Skills
Health Care
Employment and Income
Housing
Early Intervention and Prevention
Children Social Care
Adult Social Care
Crime & Safety
Environment
Data Sources

North
Elton, North Manor, Ramsbottom, Tottington
East Bury
Bury East, Moorside, Redvales
West
Bury West, Radcliffe East, Radcliffe North & Ainsworth, Radcliffe West
Besses, Pilkington Park, Unsworth
Whitefield
Holyrood, St. Mary's, Sedgley
Prestwich

Click on a label to see a neighbourhood's summary
This map shows the wards included within each of Bury's five Neighbourhoods.

Neighbourhood Profiles

KEY HEALTH AND WELLBEING INFORMATION FOR EACH OF THE 5 BURY NEIGHBOURHOODS

Bury has a population of **193,850** people across five different neighbourhoods as of the 2021 census (East Bury, West, North, Prestwich and Whitefield).

Bury is amongst the less deprived local authorities in Greater Manchester but internal inequalities vary significantly within and across neighbourhoods. These hidden inequalities are masked when we look at Bury as a whole, highlighting the importance of understanding and quantifying health needs and inequalities at neighbourhood and ward level.

In this report you can access some key information on health and wellbeing across the five neighbourhoods in Bury. Select a section from the menu on the left to begin.

please note: *any visuals that would display a value of less than 10 have been removed from this report.*

Total population by Neighbourhood from the Census 2021
(note this may not match the Bury total due to rounding)

West, North, East Bury, Prestwich, Whitefield

Version: 3 | Released: August 2023 | Contact: PLSDU@bury.gov.uk

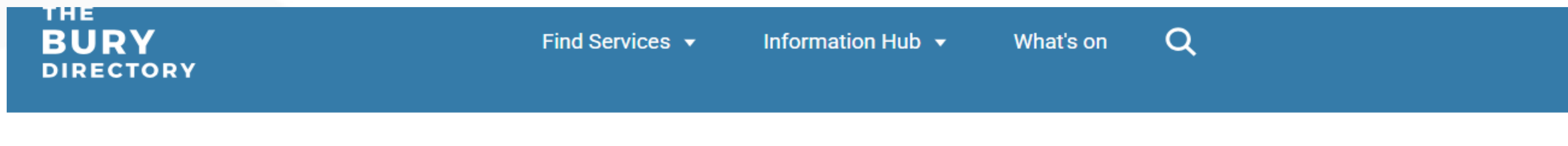
Microsoft Power BI

1 of 13

54%

Neighbourhood Placemats

- https://www.theburydirectory.co.uk/jsna/neighbourhood-placemats



Home ▸ Joint Strategic Needs Assessment ▸ Neighbourhood Placemats

Neighbourhood Placemats

An overview of place based assets.

Our placemats showcase community assets including buildings, groups, networks and other local anchor organisations. The Placemats provide an overview of community capacity in each Ward.

4 Elements of Our Neighbourhood Model

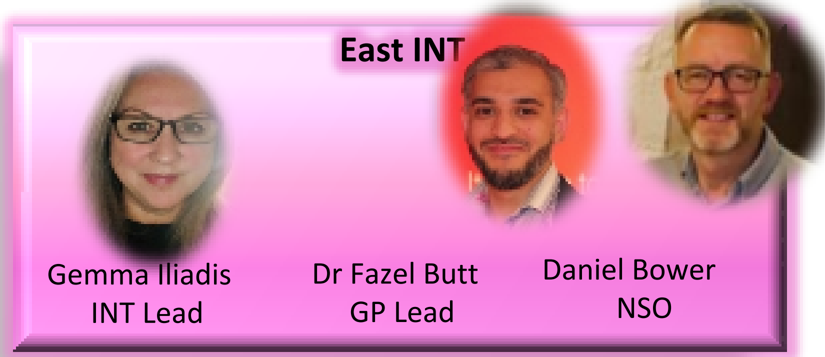
1. Integrated Health and Care Adult Teams (INTS)

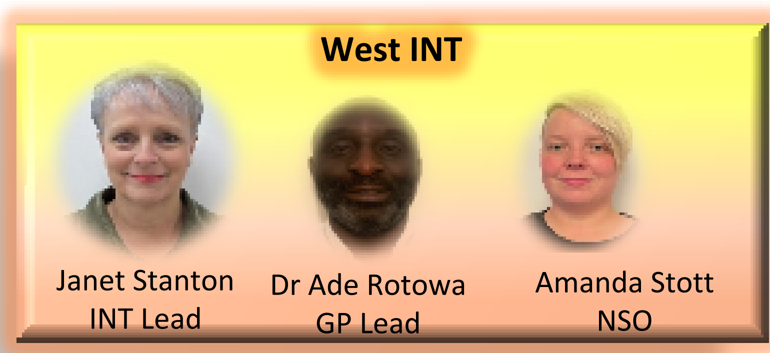
2. Neighbourhood Leadership Teams (formerly public service leadership teams) connecting a range of public and voluntary organisations in places

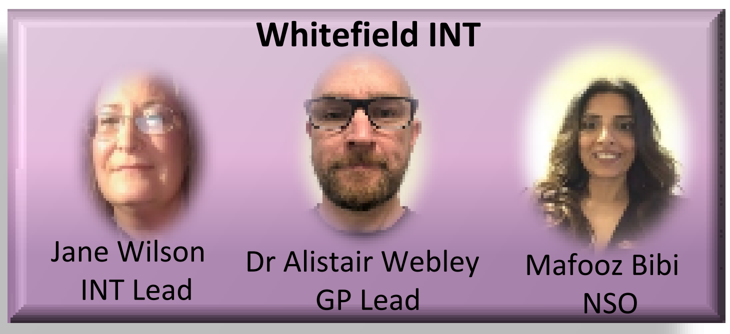
3. Implementation of the Live Well model

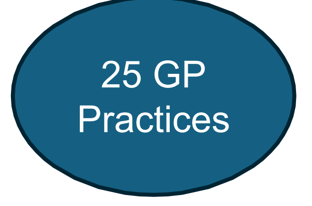
4. Neighbourhood approaches to supporting Childrens and Families.

1. Integrated Neighbourhood Team - Adult Care & Health









Implementing the national approach

NHS and social care working together to prevent people spending unnecessary time in hospital or care homes

Strengthening primary and community based care to enable more people to be supported closer to home or work

Connecting people accessing health and care to wider public services and third sector support, including social care, public health and other local government services

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

2. Neighbourhood Leadership Teams

(formerly public service leadership teams)

Example Risk Cohorts Identified with mult-service interventions

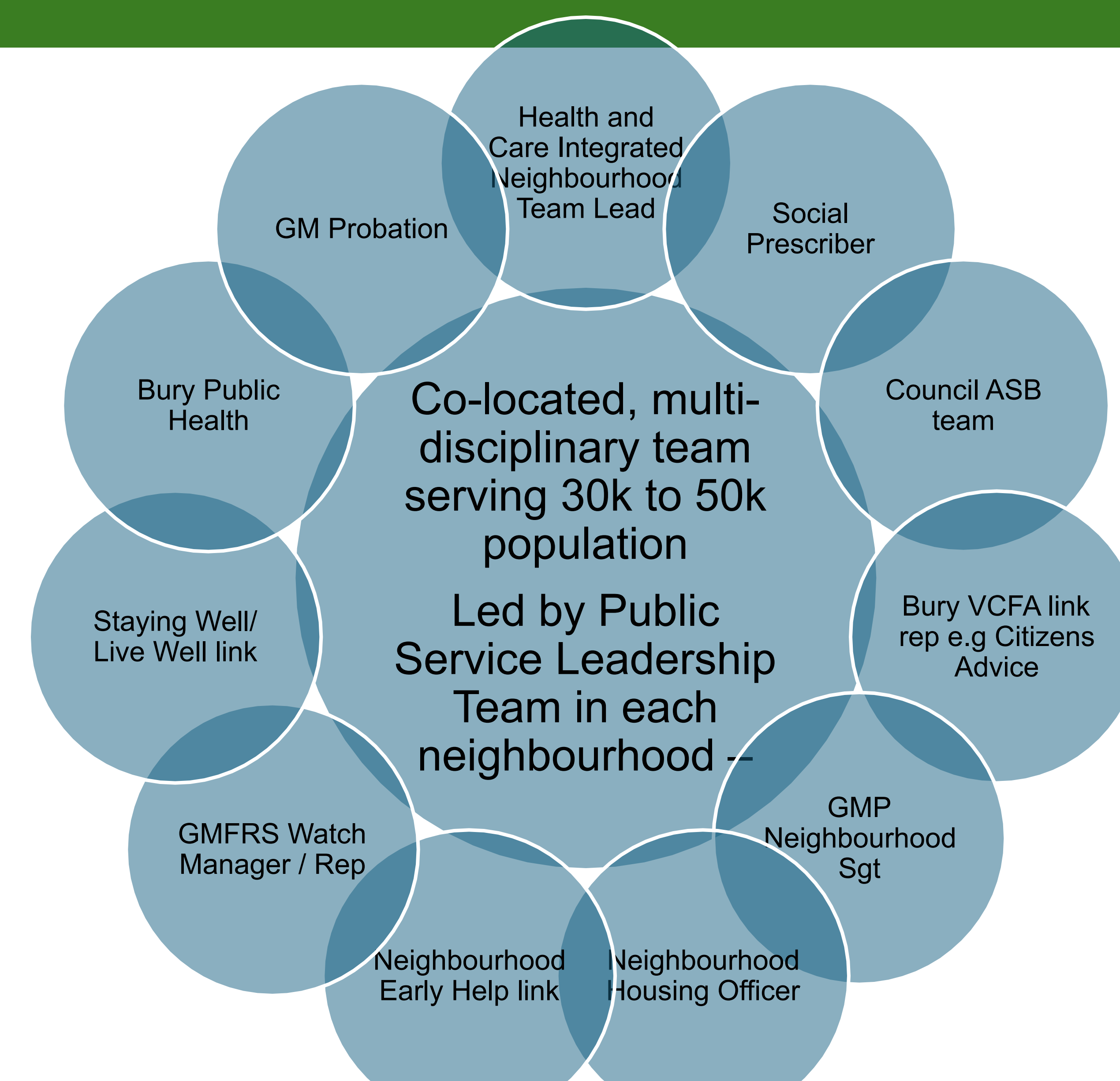
Bury East
Cuckooing
Hoarding
Repeat Domestic Abuse U21
GLD

Bury North
Social Isolation and Vulnerability
Digital Exclusion
Rent Arrears

Prestwich
Isolated older adults
Low income families with children

Bury West
Substance misuse
Cuckooing
OCG

Whitefield
Child neglect
Youth Crime



3. Implementation of Live Well by 2030

- ✓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 July, and other community assets are developing.
- ✓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 investment in the in Lift Centre to create front end live well offer. Also note alignment to pride in place funding
- ✓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. E.g Bury Neighbourhub in Millgate Shopping Centre focused on work and working age poverty but hallmark compliant

Live Well in Whitefield

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- Building on Community engagement and understanding of strengths
- Joint SRO Council/VCFA – VCFA appointed programme lead
- Connecting and strengthening existing community capacity to provide a rounded portfolio of support
- Conversion of the Ark to become Live Well Hub – ambitious!
- Focal point – addressing poverty, and family hub (with Ribble Drive CDC)
- Three phase implementation:
  - Community Rooms, Community Café (run by Persona based on their Ageing in place café in Clarence Park), Meeting Rooms – by April
  - Base for Family Hub Staff and Integrated Neighbourhood Team in health and care
  - Utilisation of Sports Hall
- On going community conversation and ownership – shadow management board to be formed

4. Childrens MDT Neighbourhood Working

- Communities of Practice – Our default setting for SEND Reform Implementation – Schools/Council inc Ed Psych/NHS partners connected on the neighbourhood footprint
- Good Level of Development – Risk cohort identification for each of 5 neighbourhoods by ward, split by gender, ethnicity etc supporting the contribution of all partners
- Family Hub roll out – new family hubs opening in each neighbourhood e.g in Bury (Chesham), Whitefield (Ark) etc.
- Family First Implementation – dedicated teams for neighbourhoods
- MD working in NHS -working in progress for us but keen to focus on the neighbourhood footprint.

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2025 – 26 UEC Update for the Bury IDC

Part of Greater Manchester Integrated Care Partnership

March 2026

UEC Update

BURY INTEGRATED CARE PARTNERSHIP

Content

1) FGH Improvement Plan 2025 -26 and 2026 - 27
2) Overall Performance at FGH 2025-26
    - 4 hour performance
    - 12 Hour waits
    - Ambulance turnaround
    - Corridor Care
    - DKAFH
3) NMGH Event
4) Pre-ED Streaming
5) IMC CQC Inspection

UEC Update

BURY INTEGRATED CARE PARTNERSHIP

1 FGH Improvement Plan 2025-26 and 2026-27

UEC Excellence programme collaborative focuson 4 Pillars,

1. Stroke LOS,
2. 7 day working,
3. Prehospital admission avoidance,
4. Understanding Length of Stay on our Wards

UEC Priorities and workstreams included:

- Ambulance conveyance
- Discharge Frontrunner (DKAFH and Dementia)
- My Next Patient
- Virtual Ward
- Front door Streaming & T3 flow
- SDEC Improvements
- DKAFH improvement

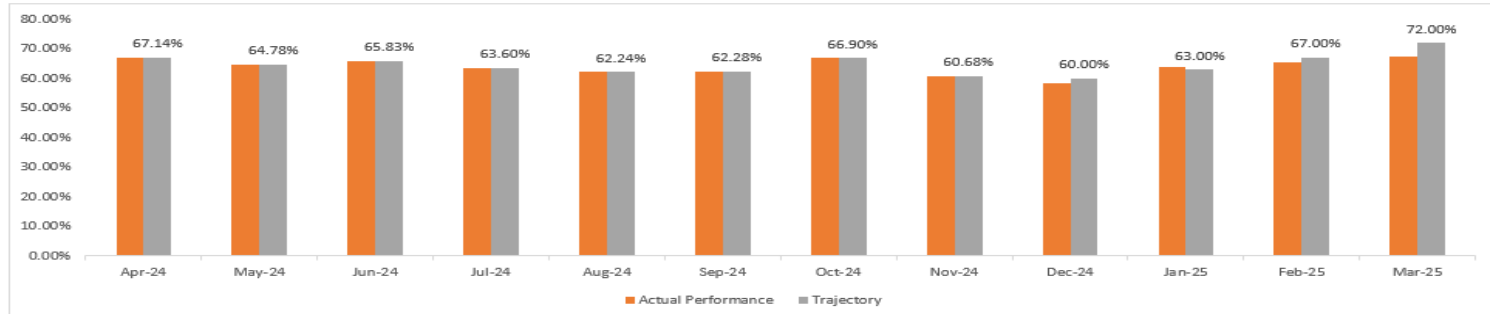
Plans for 2026-27 and currently under discussion as part of the NCA re-organiastion

2025 – 26 UEC Update

2 Overall Performance at FGH – 4 Hours

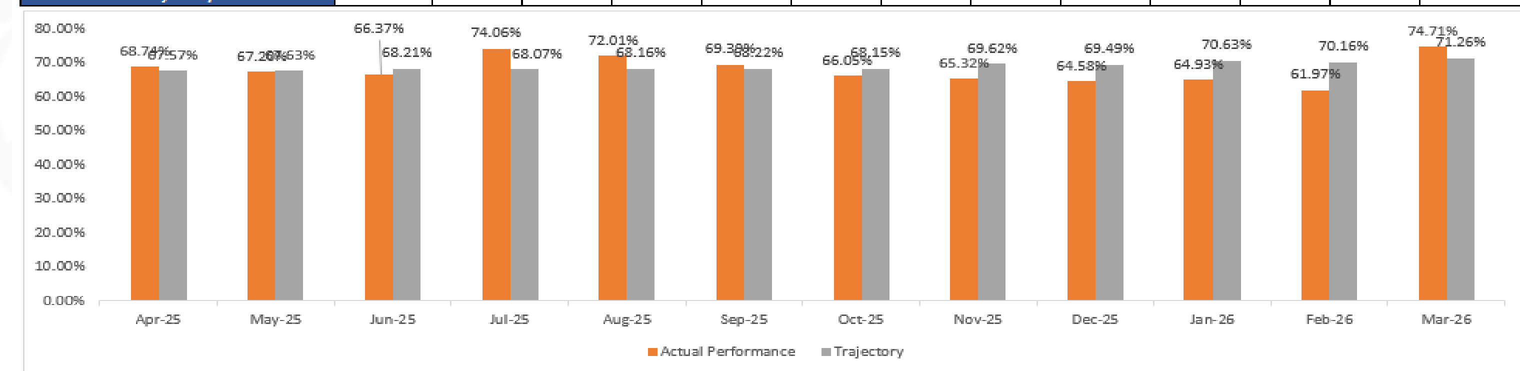
4 Hour Performance 2024/25

NCA - Fairfield General Hospital	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	YTD
Breaches Over 4 Hours	2222	2571	2372	2537	2452	2542	2382	2748	2972	2578	2208	2333	64.02%
Total Attendance	6978	7468	7275	7359	6870	6952	7381	7287	7318	7145	6348	7179	
Actual Performance	67.14%	64.78%	65.83%	63.60%	62.24%	62.28%	66.90%	60.68%	58.16%	63.92%	65.23%	67.50%	
Trajectory	67.14%	64.78%	65.83%	63.60%	62.24%	62.28%	66.90%	60.68%	60.00%	63.00%	67.00%	72.00%	



4 Hour Performance 2025/26

NCA - 4 Hour Fairfield General Hospital	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD
Breaches Over 4 Hours	2183	2416	2399	1917	1981	2226	2553	2495	2611	2578	2446	1922	68.01%
Total Attendance	6983	7365	7134	7391	7077	7271	7519	7194	7372	7351	6432	7601	
Actual Performance	68.74%	67.20%	66.37%	74.06%	72.01%	69.39%	66.05%	65.32%	64.58%	64.93%	61.97%	74.71%	
Trajectory	67.57%	67.63%	68.21%	68.07%	68.16%	68.22%	68.15%	69.62%	69.49%	70.63%	70.16%	71.26%	



4 Hour Performance

Performance

- 2.90% improvement for Feb 2025
- 2.27% improvement for March 2025
- 1.24% improvement for April 2025
- May 2025 slight down by 0.43% due to staffing gaps last 3 days of May took us below 60%
- June 2025 0.60% below May 2025 nighttime workforce staffing gaps (6 days of June below 60% mainly weekends)
- July 74.06% - Improved performance in month of 8%
- August 72.01% above trajectory
- Sept 69.39% above trajectory
- Oct 66.05% below trajectory 1.16%
- Nov 65.32% (4.64% better than Dec 24)
- Dec 64.58% (6.42% better than Dec 24)
- Jan 64.93%
- Feb 61.97%
- **March 2025: 67.50%**
- **March 2026: 74.71%**
- **7.21% Improvement**

(Bury Registered patient in any A&E Department, March 2025: 75.5%)

2025 – 26 UEC Update

BURY INTEGRATED CARE PARTNERSHIP

- **Overall FGH Performance – 4 Hours**

A 7.2% improvement is the second highest in the region and the regional office/other trusts have already reached out to FGH to discuss how FGH achieved this.

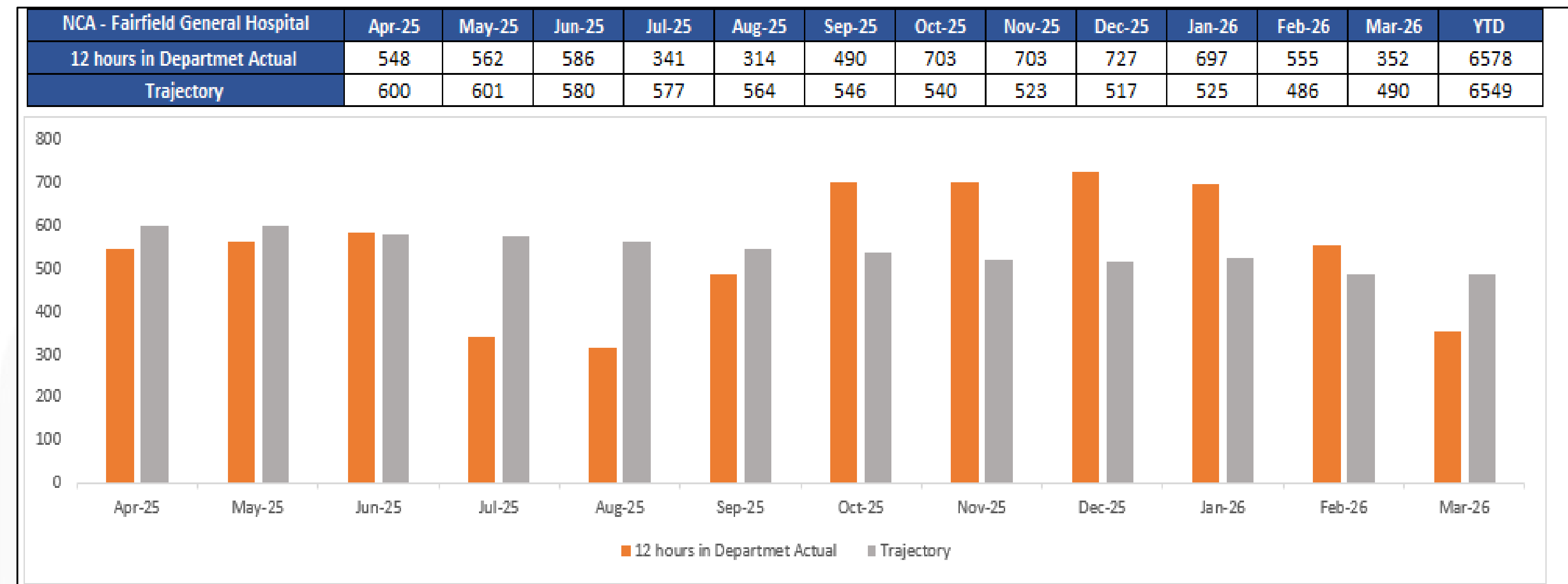
	4hr Performance - All Types (ECDS)		
Organisation	**Mar-26**	**Mar-25**	**Change +/-**
Northern Care Alliance NHS FT	**69.7%**	**64.9%**	**4.8%**
FAIRFIELD GENERAL HOSPITAL	73.4%	66.1%	7.2%
ROCHDALE INFIRMARY	92.3%	92.2%	0.1%
ROYAL OLDHAM HOSPITAL	60.9%	60.6%	0.3%
SALFORD ROYAL	62.5%	53.1%	9.4%

	4hr Performance - Type 1			4hr Performance - All types		
Organisation	**Mar-26**	**Mar-25**	**Change +/-**	**Mar-26**	**Mar-25**	**Change +/-**
North West	**61.5%**	**58.4%**	**3.1%**	**75.0%**	**73.1%**	**1.9%**
NHS Cheshire And Merseyside Integrated Care Board	**57.2%**	**55.1%**	**2.1%**	**74.1%**	**73.0%**	**1.2%**
Alder Hey Children's NHS Foundation Trust	83.5%	79.8%	3.7%	89.3%	87.7%	1.6%
Countess Of Chester Hospital NHS Foundation Trust	49.1%	47.4%	1.7%	61.0%	59.4%	1.6%
East Cheshire NHS Trust	50.1%	50.9%	-0.8%	50.8%	51.5%	-0.7%
Liverpool University Hospitals NHS Foundation Trust	54.3%	50.4%	3.9%	74.4%	72.6%	1.8%
Liverpool Women's NHS Foundation Trust	-	-	-	87.4%	89.2%	-1.9%
Mersey and West Lancashire Teaching Hospitals NHS Trust	64.8%	64.5%	0.3%	79.5%	79.1%	0.4%
Mid Cheshire Hospitals NHS Foundation Trust	47.4%	42.0%	5.5%	63.6%	59.8%	3.8%
Warrington And Halton Teaching Hospitals NHS Foundation Trust	52.2%	49.7%	2.5%	70.6%	68.4%	2.2%
Wirral University Teaching Hospital NHS Foundation Trust	48.3%	47.2%	1.0%	72.9%	73.3%	-0.4%
NHS Greater Manchester Integrated Care Board	**63.4%**	**59.5%**	**3.9%**	**74.3%**	**71.4%**	**2.8%**
Bolton NHS Foundation Trust	56.5%	60.3%	-3.8%	68.1%	71.8%	-3.7%
Manchester University NHS Foundation Trust	66.5%	61.6%	4.8%	77.2%	73.9%	3.2%
Northern Care Alliance NHS Foundation Trust	65.3%	59.6%	5.7%	74.3%	69.7%	4.6%
Stockport NHS Foundation Trust	62.0%	60.6%	1.4%	70.1%	69.0%	1.2%
Tameside And Glossop Integrated Care NHS Foundation Trust	60.1%	58.6%	1.5%	68.9%	68.9%	0.0%
Wrightington, Wigan And Leigh NHS Foundation Trust	57.5%	49.3%	8.2%	78.1%	71.7%	6.3%
NHS Lancashire And South Cumbria Integrated Care Board	**64.9%**	**61.6%**	**3.3%**	**77.7%**	**76.0%**	**1.7%**
Blackpool Teaching Hospitals NHS Foundation Trust	64.4%	55.6%	8.7%	82.7%	79.6%	3.1%
East Lancashire Hospitals NHS Trust	69.3%	66.6%	2.7%	81.3%	79.7%	1.6%
Lancashire Teaching Hospitals NHS Foundation Trust	66.2%	61.8%	4.5%	72.2%	69.1%	3.1%
University Hospitals Of Morecambe Bay NHS Foundation Trust	56.7%	60.4%	-3.6%	70.3%	72.2%	-1.9%

2025 – 26 UEC Update

BURY INTEGRATED CARE PARTNERSHIP

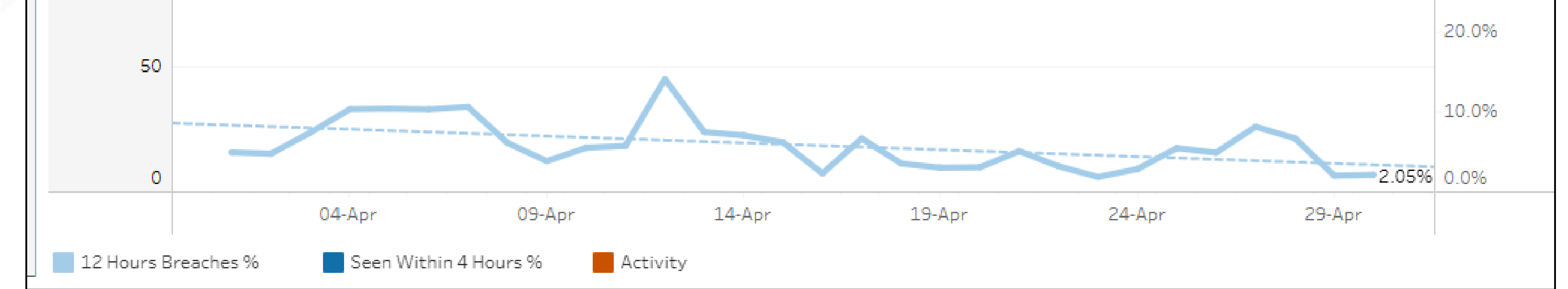
FGH 12 Hours in the Department



NCA - Fairfield General Hospital	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD
12 hours in Departmet Actual	548	562	586	341	314	490	703	703	727	697	555	352	6578
Trajectory	600	601	580	577	564	546	540	523	517	525	486	490	6549

FGH 12 Hours in the Department – Commentary

- Achieved Trajectory for April, May, June and July reduced by 245, reduced further in August, increased Sept, Oct & Nov 25 & Dec 25, Reduced in Jan, Feb 26 & Mar 26 .
- Full year performance represents circa 7.5% of all attendances waiting over 12 hours (national ambition is 10% or less).
- March 2026 was 4.6%.



April 2026 performance shows 2.05% of attendances waiting 12 hours or over

2025 – 26 UEC Update

Ambulance Handovers

Ambulance Arrival to Handover Monitoring: Select Provider Site

Metric Level: Provider Site

GM/Provider/Provider Site: Fairfield General Hospital

Total Hours Lost to Handover Delays Since 01/08/2025: 1,863:18

25/26 Ambition	Latest Day Average - 19/05/2026	Average MTD up to 19 May 2026	Average YTD 2025/2026	Average YTD 2026/2027
00:25:24	00:17:25	00:14:37	00:19:51	00:15:24

Average Daily Handover (Month of ...: (All))

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/2025	00:23:58	00:20:26	00:28:13	00:24:04	00:24:22	00:22:20	00:24:02	00:34:35	00:43:59	00:37:23	00:27:50	00:27:03
2025/2026	00:24:31	00:20:20	00:22:59	00:16:15	00:15:40	00:20:53	00:20:20	00:21:20	00:22:44	00:19:06	00:18:18	00:16:02

Average Daily Handover

Q1 2026/2027
00:15:24

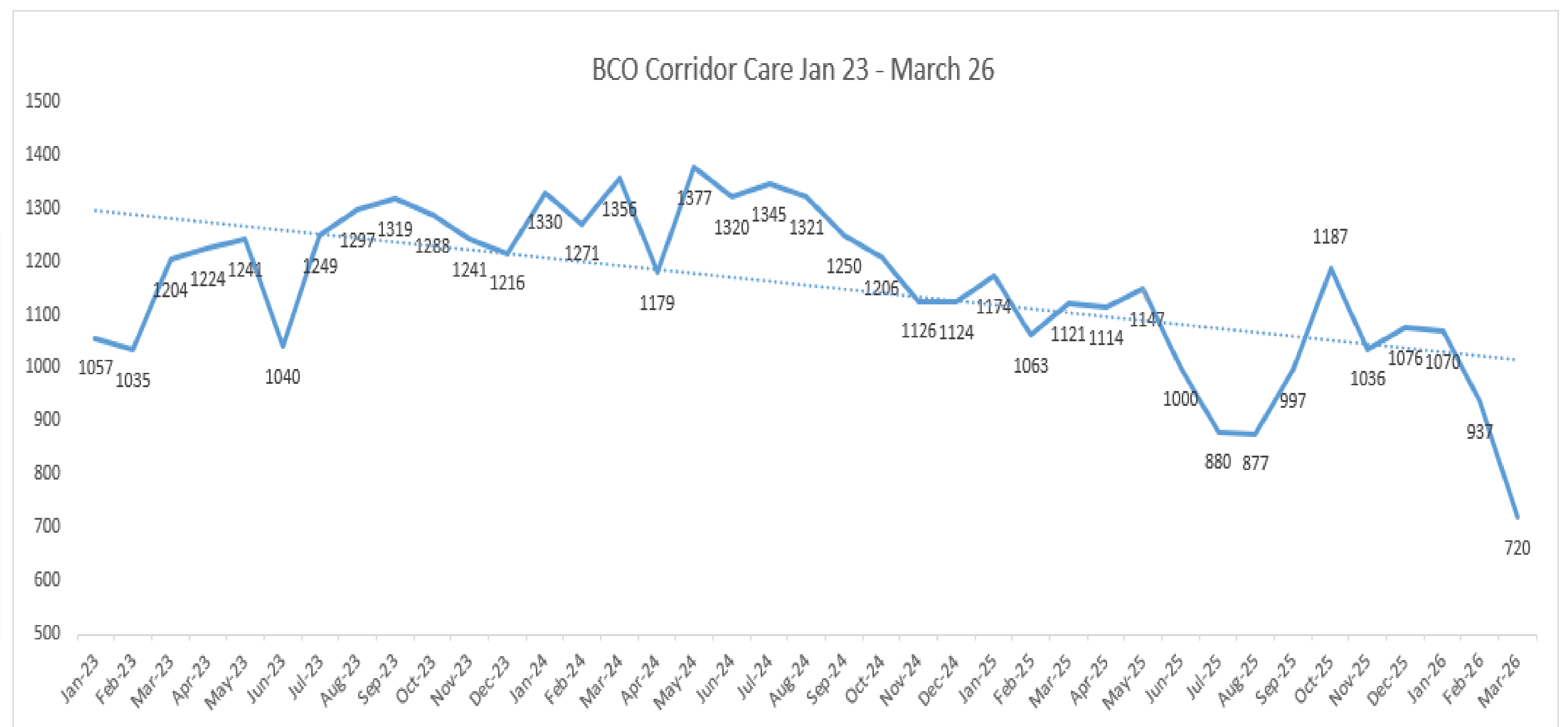
Average Daily Arrival to Handover (A2H) 25/26 Ambition (01/04/2025 – 31/03/2026)

[Handover Ambitions | GM ADSP]

Bury Performance Improvement Plan - Highlight Report

(The Bury PIP as requested reflects performance at the FGH not just Bury registered patients)

Corridor Care



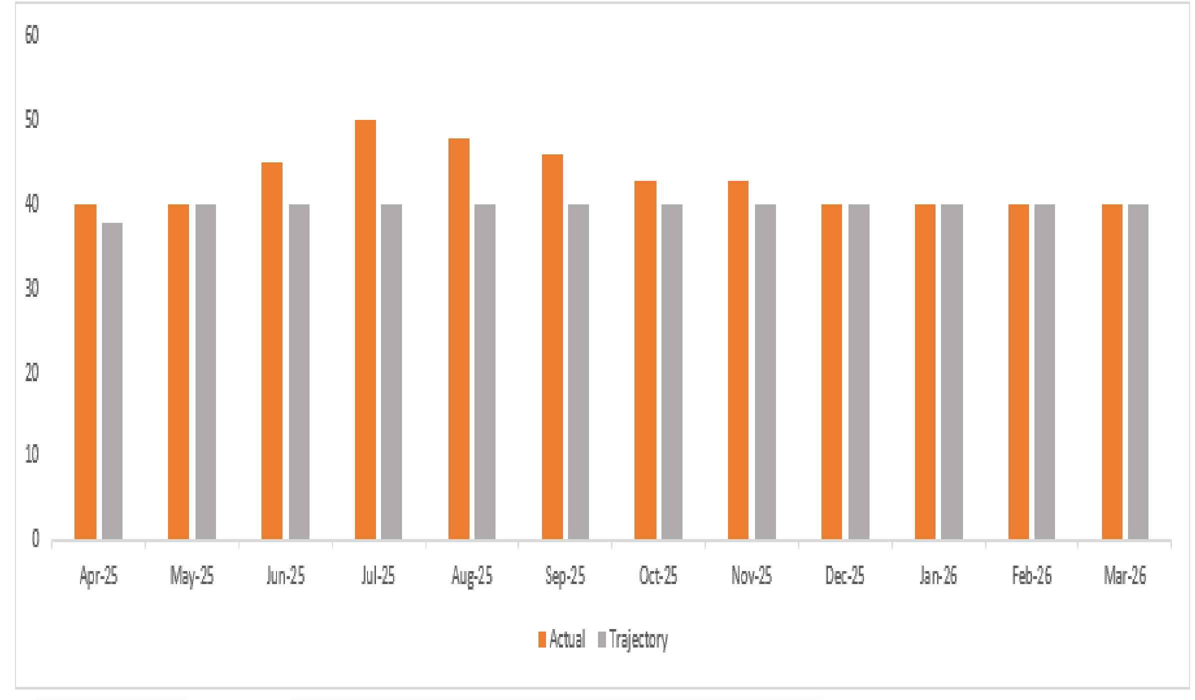
Corridor Care

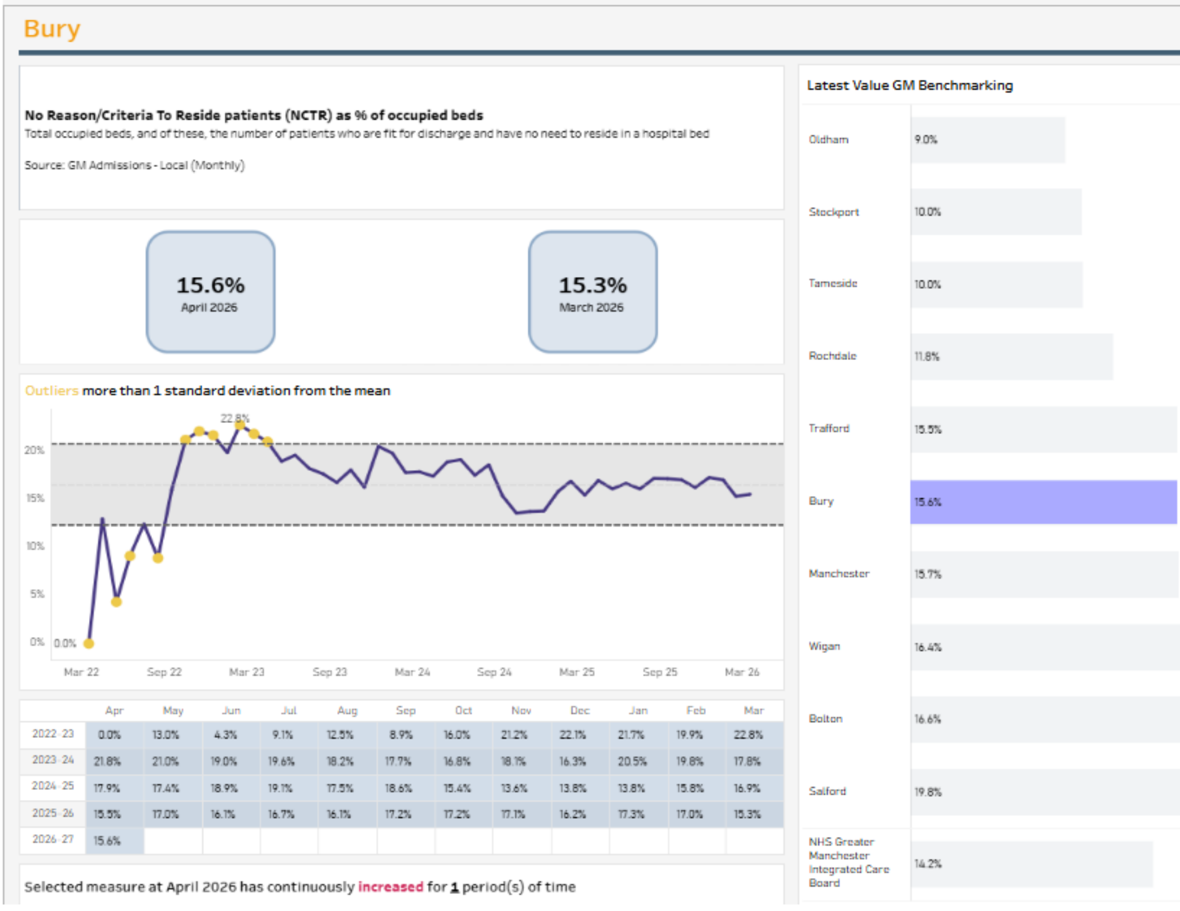
- Decrease in corridor care since April 25, increase Sept/Oct 25 Decrease Nov, Dec & Jan
- Phrase 2 of ED build to Increase cubicle space in resus and MH provision to reduced corridor care
- clinical team supporting streaming from the from door from 8am – 12pm
- Extended SDEC opening times to 2am
- Extended UTC opening times to 2am
- My Next patient in place creating 4 moves from the corridor Mon-Fri
- SDEC Frailty to start 6th Jan 25 Sat implemented
- EEMAC Implemented from Jan 26

UEC Update

DKAFH

NCA - Fairfield General Hospital - DKAFH	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Actual	40	40	45	50	48	46	43	43	40	40	40	40
Trajectory	38	40	40	40	40	40	40	40	40	40	40	40





	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	0.0%	13.0%	4.3%	9.1%	12.5%	8.9%	16.0%	21.2%	22.1%	21.7%	19.9%	22.8%
2023-24	21.8%	21.0%	19.0%	19.6%	18.2%	17.7%	16.8%	18.1%	16.3%	20.5%	19.8%	17.8%
2024-25	17.9%	17.4%	18.9%	19.1%	17.5%	18.6%	15.4%	13.6%	13.8%	13.8%	15.8%	16.9%
2025-26	15.5%	17.0%	16.1%	16.7%	16.1%	17.2%	17.2%	17.1%	16.2%	17.3%	17.0%	15.3%
2026-27	15.6%											

- DKAFH at FGH has seen improvements in the monthly average number of DKAFH patients since July 2025 reducing to trajectory level since November 2025.
- For Bury patients anywhere we have seen a reduction from 22.8% of occupied beds in March 2023 down to 15.3% in March 2026

UEC Update

BURY INTEGRATED CARE PARTNERSHIP

3 Bury and NMGH Discharge Event

- Host: NHS GM - Bury and Bury Locality System Partners
- Location: NMGH Post Graduate Education Centre
- Date & Time Thursday 26th March 202612:30pm - 4:00pm

Attendance

The event was extremely well attended by circa 60 – 70 attendees from across the Bury locality system partners and NMGH teams. From Bury the following organisations were represented:

Bury Local Authority, Bury Community Services, Bury VCFA, Bury Hospice, BARDOC, Bury Integrated Neighbourhood Teams, Bury Specialist Palliative Care Team, Bury Integrated Discharge Team, NHS GM – Bury , Stroke Association, Bury LCO, Bury GP Practices, Bury Intermediate Care, FGH Clinical Teams, Age UK – Bury

Six Table Top Sessions

Table 1:	Bury IMC Service Offer	Table 2:	Bury Hospice and EOL Support	Table 3:	Primary Care and Neighbourhoods
Table 4	Bury LA	Table 5	FGH Based Services	Table 6	Bury Community Services

Outcomes

There were circa 30 themes/outcomes/actions identified

Next Steps

- Initial write up of the event
- Review with NMGH the circa 30 themes/outcomes/actions identified
- Review with Bury the circa 30 themes/outcomes/actions identified
- Produce an agreed actions tracker
- Set up first quarterly review meeting in June 2026

UEC Update

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4 Pre-ED Streaming

Formal External Review of UEC Pathways at FGH

The review recommendations included:

- Redesign of the front door pathway
- FGH to be the ‘first eyes’ on walk-in patients allowing FGH to fully implement Acuity Tool Principles
- Primary Care input to the UEC Pathways, via the Pre-ED Streaming Service, to be redesigned to include GP Support as opposed to ANP level support
- Review the commissioning, procurement and funding requirements in relation to the proposals

Review of Commissioning, procurement and funding requirement

- GM contracting and procurement advise was sought and received
- Initial advise implied that changes could be made within current contractual arrangements
- As PSR procurement guidance evolved nationally the initial advise changed. The main stumbling block being that, in order to change the Pre-ED Streaming function to a GP function, at a later stage in the UEC pathway, a formal PSR pathway would have to be adopted. Changes needed to implement the review recommendations were no longer viable through service redesign with the current provider.
- It was agreed to in order to fulfil PSR requirement a Most Suitable Provider (MSP) process would need to followed. This much quicker than a full blown procurement

UEC Update

BURY INTEGRATED CARE PARTNERSHIP

4 Pre-ED Streaming cont…

Progress towards a Most Suitable Provider Process

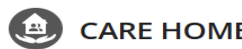
- Notify current provider of the implementation proposals.
- Notify GM, in advance, of the proposed implementation process, identify to GM that the changes proposed are within the amounts in the GP OOHs contract for Pre-Ed Streaming.
- Current GP OOHs to be roll forward for a further year using PSR Part C Extension. Forms completed and submitted to GM. Feedback received requiring content to be transferred onto a new form format.
- Work with the current provider to estimate the amount of GP time available within the cost of envelop.
- Work with FGH to design a new UEC pathway which incorporates primary care input, via GP support, and retains primary care input into the UTC as now.
- Discuss the FGH proposed pathway with GP clinical leads for Bury.
- Meeting for FGH and GP clinical leads to agree the scope, range and operational arrangements for the GP input.
- Develop a service specification for the new service.
- Commence a Most Suitable Provider process with GM contracts and procurement support. At the same time serve notice on the current Pre-ED Streaming Service and gain formal approval from GM for the proposed use of resources.
- New arrangement to operation no later 1st October 2026

UEC Update

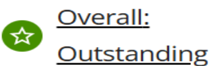
BURY INTEGRATED CARE PARTNERSHIP

5 IMC CQC Inspection

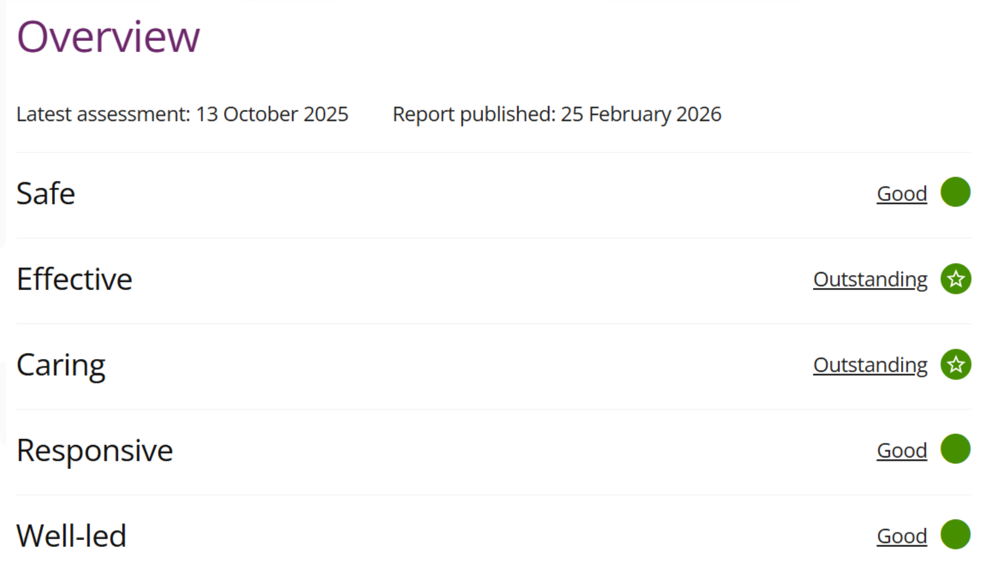
Choices for Living Well (Killelea) - Care Quality Commission



Choices for Living Well (Killelea)



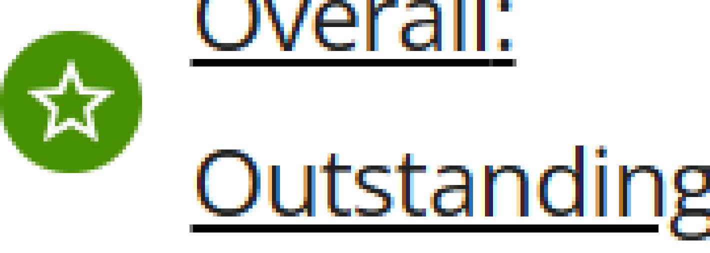
Brandlesholme Road, Bury, Lancashire, BL8 1JJ (0161) 253 5900
Provided and run by: Bury Metropolitan Borough Council



Overview

Latest assessment: 13 October 2025 Report published: 25 February 2026

Key question	Rating
Safe	Good
Effective	Outstanding
Caring	Outstanding
Responsive	Good
Well-led	Good



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Agenda Item 12

Classification	Item No.
Open	

Meeting:	Health Scrutiny
Meeting date:	24th June 2026
Title of report:	**Development of a work programme for 2025/2026**
Report by:	**Josh Ashworth** Senior Scrutiny Officer
Decision Type:	**For Information**
Ward(s) to which report relates	**All**

Health Scrutiny Committee – Forward Plan 2026/27

1. Purpose

This report sets out the proposed forward plan for the Health Scrutiny Committee for 2026/27. It ensures that statutory responsibilities continue to be fulfilled, core areas of focus are maintained, and previous commitments are progressed. It also draws on learning from the 2025/26 municipal year to help shape a focused and effective work programme.

2. Statutory Responsibilities

The Committee will continue to discharge its statutory functions, including:

- Scrutiny of NHS and Public Health services
- Consideration of any substantial variations or developments in health services
- Oversight of complaints, service user experience, and patient feedback

3. Ongoing Commitments and Partnership Working

The Committee will maintain its established partnerships and areas of focus, including:

- Engagement with Healthwatch to ensure the patient voice is represented
- Monitoring delivery against local Public Health priorities
- Collaborative working with Adult Social Care, Integrated Care System (ICS) partners, and wider stakeholders

4. Review of Activity in 2025/26

During 2025/26, the Committee considered a broad range of issues relating to health and care services, including:

- Health and Care system updates
- Elective Care performance
- Health Inequalities strategy and delivery
- Workforce challenges and development
- Urgent Care provision and Winter planning
- Adult Social Care provider workforce support
- Bury ICP locality performance
- Healthwatch updates and community insight
- Adult Social Care developments
- Women's Health priorities
- Local Government Association (LGA) engagement
- "Your Medicines Matter" campaign
- Locality Plan progress
- Pharmacy First implementation

In addition, the Committee strengthened its links with Greater Manchester governance arrangements. The Chair introduced a standing agenda item providing updates from the GMCA Overview and Scrutiny Committee and the GM Joint Health Scrutiny Committee. This has enhanced oversight of developments at a Greater Manchester level and will continue into 2026/27.

The breadth of these discussions provides a strong foundation for shaping priorities in the coming year.

5. Proposed Priority Areas for 2026/27

Building on the previous year's work, the Committee may wish to prioritise the following areas:

- **Access to Services**
  Access to primary and urgent care services, including GP provision, dentistry, NHS 111, and urgent care pathways
- **Health Inequalities**
  A more detailed exploration of local disparities, with a focus on measurable outcomes and delivery of the Health Inequalities Strategy

- **Workforce Pressures**
  Recruitment, retention, wellbeing, and capacity challenges across the health and social care system
- **ICS Governance and Locality Performance**
  Oversight of decision-making, transparency, integration, and delivery at a locality level
- **Public Health Priorities**
  Focus on prevention, including mental health, substance misuse, and wider determinants of health
- **Women's Health and Maternity Services**
  Follow-up work to assess progress and identify further areas for improvement

6. Terms of Reference

The Health Scrutiny Committee is established to hold partner organisations to account on matters affecting the health and wellbeing of borough residents. Its remit includes:

- Adult Social Care, including safeguarding
- The Health and Wellbeing Board
- Housing and its impact on health outcomes
- Public Health responsibilities
- The Adults and Communities budget and policy framework
- Statutory health scrutiny powers, including the review of planning, provision, and operation of health services for all age groups, including children, young people, and transitional services

The Committee may make reports and recommendations to influence service improvement and decision-making.

7. Work Programme 2026/27

7.1 Development of the Work Programme

The Committee is required to agree a work programme for 2026/27 that reflects its statutory duties, local priorities, and available resources.

7.2 Principles of an Effective Work Programme

A well-designed work programme will:

- Be outcome-focused, realistic, and measurable
- Ensure appropriate scheduling of key items
- Support effective use of Member and officer capacity

7.3 Flexibility and Responsiveness

The work programme must retain sufficient flexibility to:

- Respond to emerging issues and urgent matters
- Scrutinise key executive decisions as they arise
- Adapt to changes across the health and care system

7.4 Prioritisation Approach

To support the development of a balanced and deliverable programme, a prioritisation protocol will be used. This will:

- Assess the relevance and impact of proposed topics
- Consider the potential for added value through scrutiny
- Ensure alignment with Council priorities and resident needs

8. Conclusion

This report provides an updated framework for the Health Scrutiny Committee's role in 2026/27. It outlines statutory responsibilities, highlights key learning from 2025/26, and identifies priority areas for future focus.

Together with the prioritisation protocol, this will support the development of a structured, outcome-focused, and responsive work programme that reflects the priorities of Bury Council and delivers improved outcomes for residents.

Appendix 1

Prioritising Topics for Scrutiny

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

Section 1 - At the outset

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

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

Section 2 – Criteria to Reject

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

Reject if;

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

Section 3 – Prioritisation of Topics

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

Public interest

- Has the issue been identified by Members through surgeries and other contact with constituents? (on how many occasions – more occasions warrants a higher score).
- Has a user dissatisfaction with the service been identified? (complaints).
- Topic identified through Market Surveys/Citizens Panel.
- Has the issue been covered in the local media?

Internal Council priority

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

External Factors

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

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