BCF narrative plan template

Section 1 - Governance

Bury Health and Wellbeing Board

The Health and Well Being Board is committee of the Council required by statute. Its precise responsibilities can be quite broad but are focused on co-ordinating the Joint Strategic Needs assessment, and the local pharmaceutical needs assessment, and providing a focal point for senior leadership in partnership organisations on health and care.

The system board therefore provides a leadership focal point for the strategy and transformation of the operation of the health and care system. However, the Bury locality plan 2019-2024 recognises that the likelihood of the Bury Health and Care system being clinically and financially sustainable is significantly dependent on a step change in population health gain and a reduction in health inequalities. This is because we need to harness the fully effect of a range of interventions outside of the health and care system that have in their grasp the opportunity to reduce demand and cost in the health and care system.

A Health and Well Being Board providing the visible leadership on supporting the population health system development, in the context of (and challenging as required) the vision for Bury 2030 is an important component of our partnership arrangements.

The Health and Well Being board focuses upon the population health system and the implementation of the Kings Fund 4 quadrant model as below;

- The Wider Determinants of Health
- Health Related Behaviours
- An Integrated Health and Care System
- The Places and Communities we live in and with

Membership of the Health and Wellbeing Board will be made up of leaders across the NHS, Social Care, Public Health, Wide Public Services, and other services directly related to Bury operating as a Population Health System

Core voting members:

- Cabinet Member, Health and Wellbeing (Chair)
- A nominated representative from the voluntary sector
- Cabinet Member, Children and Young People
- Additional Labour Cabinet Member
- Shadow Cabinet Member, Health and Wellbeing
- Executive Director, Children, Young People and Culture
- Executive Director, Communities and Wellbeing
- Director of Public Health
- Two nominated representatives from the Clinical Commissioning Group
- A nominated representative from Bury Health watch
- A nominated representative from the Community Safety Partnership.
- A nominated representative from Greater Manchester Fire and Rescue.
- A nominated representative from Northern Care Alliance
- A nominated representative from Pennine Care NHS Foundation Trust.
- A nominated representative from SixTown Housing
- Deputy Cabinet Member, Health and Wellbeing and Public Health Lead

The Board may also decide to co-opt/invite by invitation additional members to advise in respect of issues.

Bury Strategic Commissioning Board

As part of the Bury 2030 Strategy and progressing the wider public service reform agenda, there is a commitment to full alignment and integration between the Council and the Clinical Commissioning Group, Public Health and the Bury One Commissioning Organisation has now been formed. Within the Council there are 5 joint commissioning pillars, Older People and Ageing Well, Learning Disabilities, Mental Health, Contract Management and Provider Development and Carers, Prevention and Physical Disability. All of these pillars report through to the Director of Adult Social Care and then onto the Executive Director of Strategic Commissioning who is responsible for both Adult Social Care and Clinical Commissioning Group commissioning activity.

As part of this commitment a single Strategic Commissioning Board has been formed to bring together the integrated governance for joint commissioning in its widest sense.

The Strategic Commissioning Board has a wide-ranging responsibility for all matters relating to Health and Social Care and the Council's 'health related' functions, which can be delegated to it (subject to reserved matters) under the main legal mechanism set out at Section 75 of the National Health Services Act 2006.

The Strategic Commissioning Board has been established as a Joint Committee, under the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 (as amended) to support the delivery of health and social care commissioning.

The Strategic Commissioning Board is made up of the following members:

- Councillors – Cabinet Members of the Council to include no more than 9 voting Cabinet Members
- CCG Governing Body Members – 9 members to include 9 voting members, of which the majority will be clinicians
- The joint Chief Executive and Accountable Officer;
- The joint Chief Finance Officer (including S151 responsibilities); and
- The joint Executive Director of Strategic Commissioning.

In addition, other Officers and representatives will be invited to the SCB, and will be recognised as in attendance, enabled to participate fully in discussions to inform the decisions of the SCB, but will not hold voting rights. This will include, but is not limited to:

- 2 opposition party representatives;
- Additional members of the CCG Governing Body (who are not members of the SCB)
- Additional members of the CCG/Council Joint Executive Team or any such equivalent successor team (who are not members of the SCB)

We are currently in the transition period to the new health and care partnership arrangements in the borough as part of the wider GM ICS development. This will see continuation of the Bury Health and Well Being Board as a focal point for our work on population health system working and tackling health inequalities. It will see the cessation of the work of the Strategic Commissioning Board, to be replaced by the more substantial and whole system wide Locality Board. The Locality Board, comprised of Council, all NHS partners including the IDCB, and others (e.g., the voluntary and community faith alliance),

and with an oversight of the integrated budget for the place is ideally placed to ensure the full compliance of the BCF delivery. The Locality Board has already met twice in transitional form, supported by the work of the System Wide Strategic Finance Group for the borough, and will be fully operational from 1st April 2022.

Section 2 - Overall approach to Integration

A focus upon links to the Health and Well Being Strategy and the Let's Do It! 2030 Strategy. Alongside ensuring alignment with the Bury Health and Care locality Plan, CCG Operating Plan, the NHS long Term Plan and future ICS development plans. One of the main aims is for people to be healthier and have a higher quality of life for longer. People will not be defined by their needs or disabilities, but by their abilities, their potential and what they can do for themselves with or without support.

The intention is to ensure that individuals and families are at the centre of their care and support, and we are meeting their needs in a holistic way by providing the right care and support, at the right time.

Our approach is to make the optimum use of health and social resources in the community, to intervene earlier, and build resilience in order to secure better outcomes by providing more coordinated and reactive services and to focus upon prevention and early intervention to support people to retain and regain their independence.

Four priorities of the Health and Well Being Strategy are;
- Start Well
- Live Well
- Age Well
- Die Well

The Covid -19 pandemic presented the greatest challenge that our communities, business and public services have ever faced, and we will be dealing with the consequences for some time. The pandemic also highlighted and exacerbated pre-existing health inequalities.

The Let's Do It! Strategy is a 10-year transformation programme to 2030 but the first 2 years is where we attempt to repair the damage caused by the pandemic. Where we will respond to issues such as poverty and the health impacts of covid on our communities and our health and care system.

We aim to maintain the good relationships between public services and public services and communities that were forged during the pandemic.

We aim to deliver health and care services that are increasingly integrated with staff from different organisations working more effectively together. Increasingly, our services are jointly delivered through 5 integrated neighbourhood teams across the Borough and focused upon the prevention of poor health and early intervention to avoid unplanned care in hospital and other settings.

Health and Care teams in Neighbourhoods are working alongside community hubs-connecting and supporting vulnerable residents to be more independent and connected. Health and care teams are also working closely across the neighbourhood footprint with staff from other services e.g., GMP and schools. Delivering against the following key principles;

Local Neighbourhoods
- Integrated public service teams
- Housing for Homes

- Community Safety
- Carbon Neutral

Delivering Together
- Community Voice
- Cultural Legacy
- Joined up Health and Social Care

Strengths Based Approach
- Community Wealth Building
- Community Capacity
- Population Health

The main priorities of the 2030 strategy are:

- A Housing Strategy for every township, more affordable homes, developing a more dynamic housing market, with additional support that enables people to live healthily and well in their community for long into later life. Eliminating rough sleeping by 2025, by helping homeless people achieve financial independence.

- Further development of integrated teams. Creating a 600 strong team of nurses, social workers, health workers, clinicians and volunteers working with primary care services supporting people to live healthy lives as part of Living Well at Home Strategy.

- Transforming services to maximise quality and sustainability including a focus on;

- Mental Health
- Urgent Care
- Planned Care
- Community based services
- Intermediate Care
- Learning Disabilities.

- Delivering this transformation through a strengths-based approach. Listening to what is important to people, supporting neighbourhoods to determine their own priorities, recognising and valuing the Voluntary, Community and Faith Alliance and their role in enabling people to improve their health and Wellbeing.

- Empowering public services to support people in ways that work for them. Staff will not be constrained by organisational boundaries.

All partners have signed up to a common inclusion strategy which reflects all nine of the protected characteristics in law. The Inclusion strategy also recognizes additional groups defined as vulnerable who will be supported with the same level of priority as follows;

- Carers
- LAC and Care Leavers
- Military Veterans
- Socio-economically vulnerable.

Section 3 Housing Priorities

The first priority is to address the shortfall in housing provision for older people in the borough and the second priority is to increase housing options for specialist groups.

We are committed to working collaboratively with our housing partners and Bury residents so we can design and deliver options for homes which meet people's needs. Using an evidenced based understanding of where the existing generation of older people live and where the next generation of older people are currently living in the Borough, also those who need supported housing. Understanding their health needs, and aspirations for housing over the next 25 years.

Working in collaboration with partners, housing developers and providers to identify sites and buildings in the right locations for development and conversion/improvement to meet the needs of older people, specialist groups and people with a learning disability. The focus is to increase housing choices for our older people, specialist groups and people with a learning disability.

Our approach is focused on providing local homes for those with additional needs in Bury both now and in the future. Increasing housing choices for our older generation and adults with specialist needs, enabling an increased number of people living independently at home.

We want to encourage enterprise to drive inclusive economic growth through our business community, enterprising innovation, and creative solutions to the current housing issues.

Working together to design quality, fit for purpose homes for people with additional needs in Bury. Reviewing, designing and shaping homes in coproduction with service users, their carers and family. Working together to ensure inclusivity throughout the housing agenda.

Taking a strengths-based approach to recognise the assets and strengths of communities and the people within, empowering their independence, choice, and control for positive housing solutions.

Bury Council has published guidelines for what good housing looks like in Bury. This document is called 'Checklist of accommodation standards and tenancy-related housing services in supported housing' (May 2021). This checklist sets out the expected standards for accommodation-related housing services that should be applied in all One Commissioned Organisation (OCO) supported housing. It covers legal requirements, minimum standards and what constitutes best practice.

Section 4 - Wider services that align with and support BCF activity

The Bury Carers' Hub

The Bury Carers' Hub is commissioned by Bury Council & CCG to provide information, advice and a wide range of specialist support services designed to help adult carers 18+ caring for another adult 18+ to continue in their caring role for as long as they choose and reduce the impact the caring role can have on their own health and wellbeing.

The team work directly with individual carers to discuss their concerns and needs and design a tailored personalised support package.

Support available includes:

- Access to a specialist staff member with 1-2-1 or group-based support
- All carers are offered a holistic assessment and support planning
- Weekly Coffee & Chats – one held digitally, and one held in the community
- Drop ins' / Pop-ups' in the community
- Access to online support including the Carers' Community Network and on-line forum / chat room

- Wraparound digital offer, i.e., evening coffee and chats, carers choir, Facebook, (public and closed page), Meditation and Relaxation
- Access to the Carers UK Digital Resource for free
- Access to a 24-hour CHAT Line delivered by other Carers
- Wellbeing 'check-in' telephone calls to carers who are identified as requiring ongoing support due to the impact of Covid
- Post Covid, the team are now delivering more face-to-face visits with carers. These have primarily been undertaken outdoors in parks and in coffee shops
- Access to peer support
- A Pen Pal scheme
- Providing information, advice and guidance on a variety of topics
- Support to access community, health and wellbeing services
- Support to access grants from other organisations on an individual basis, i.e., white goods from LEAP
- Access to activities, training and much more
- Opportunities to volunteer, as a 'Friend of Bury Carers' make friends and provide support for others
- Access to the Bury Carers' Hub magazine
- Transition support for young carers from Bury Young Carers to the Bury Carers' Hub

The team also offer to deliver a Carer Awareness briefing to all services, health, social care and voluntary sector to raise awareness, support in identifying and referring carers into the service.

Section 5 - Supporting Discharge (national condition four)

Bury has invested a lot of time and effort in creating a single system approach to urgent care. A range of work across the urgent care footprint has taken place, including to improve system flow and support effective discharges. This was reflected in the recent Winter Planning submission:

5b) Improving in-hospital flow and discharge	
What practical processes are in place to monitor in-hospital length of stay? What work is underway to reduce long lengths of stay (patients with LOS of 14 and 21+ days)?	• Review of Long Length of stay process pending in conjunction with deep dive outcomes and EDD • Review of bed meeting in line with system reset • The NRTR patients are reviewed daily by our integrated discharge team • Weekly long length of stay reviews on site • Daily bed meetings are held 3 times a day • Point prevalence audits are undertaken to ensure patients still require in hospital care • Bury system trajectories in place to reduce LLOS patients • 7, 14 and 21 day LLOS reviewed weekly at Care Organsation Urgent Care Board • Current system wide reporting in place via Bury Bronze with escalation triggers set.
What Discharge to Assess model is in place to ensure that people are efficiently discharged on the correct pathway when they no longer meet the Clinical Criteria to Reside? What did the self-assessment against the national policy identify and what actions have followed?	• Daily assessment of patients pathways 1-3 for discharge target of those with NRTR to be discharged within 48 hours unless Complex where there is a provision shortage such as nursing/nursing dementia. • 7 day service in place for discharge and action plan for wider system 7 day working • Acute site competing reset which will include pathway 0 and reduce LOS of those in acute setting • Annex A&B leaflets to be distributed as per process • Discharge to Assess is in place and supported via the IDT team. Capacity regularly reviewed and increased as and when needed

Intermediate Tier Services

We want all our services to treat each person according to their individual care, support needs and preferences. It is important that providers adapt their service to deliver flexible options and

Intermediate care services support people in the community, helping to promote independence and providing care, therapies and rehabilitation. Intermediate Tier: • provides short-term rehabilitation to enable service users to regain their optimal levels of independence; • prevents people from being admitted to hospital, supports people to return home after a recent hospital admission, and enables people to live at home rather than in a care home, if they choose; and • provides multi-disciplinary teams that support people and their carers when they are in transition between hospital and home or have entered some kind of health and/or social care crisis at home.

There are four primary categories of intermediate care:

- Rapid Community Response (crisis response);
- Home-based intermediate care;
- Bed-based intermediate care; and Reablement

Bury has an existing Rapid Community Response service which primarily offers rapid social care support to individuals, with the aim of preventing non-elective admissions to hospital or unnecessary or premature admission to residential or care homes. The rapid community response team currently has a staffing model of:

- Nursing;
- Social work;
- Occupational therapy;
- Physiotherapy;
- Night-sitting

Home Based Intermediate Care Despite being a core component of intermediate care, empowering individuals to maintain their independence and helping to prevent unnecessary admissions to hospital and care homes, there is currently no home-based intermediate care offered in Bury. This is being addressed by the Greater Manchester Transformation Scheme funding and has just begun operating. Intermediate Care at Home comprises of Occupational Therapy and Physiotherapy delivered in a person's own home for a short period to aid recovery.

Reablement is the assessment and interventions provided to people in their home aiming to help them to recover skills and confidence and maximise their independence. Bury's current reablement service, supports individuals after a recent hospital admission or crisis at home with up to six weeks of intensive support in their own home. A wide range of services are now offered as part of Bury's Choices for Living Well service. Unlike intermediate care at home Reablement meets people's daily personal care needs such as washing, dressing and making meals in addition to any therapy needs. The recent combination of the Killelea unit with the reablement team has provided a more streamlined and integrated service to support flow of users through rehabilitation and reablement, from bed-based to home-based. However, feedback from local stakeholders is that there is further requirement to supplement these services with more robust and consistent support from pharmacy, therapy, nursing and medical cover

Killelea Intermediate Care Facility Killelea is an intermediate care facility delivering 36 single rooms all with ensuite facilities. It is located on Brandlesholme Road and is north of the

centre of Bury. Built in the 1960s it recently benefitted from a complete refurbishment and now boasts a fully equipped therapy hub to help people regain confidence and skills to manage everyday tasks, as well as a bistro and hairdressers. Whilst residents are encouraged to prepare their own meals wherever possible hot food is prepared and available on site. Four of the larger single rooms are set up as flats equipped with assistive technology enabling residents to test out equipment before they go home.

Discharge to Assess Beds Bury's Discharge to Assess beds are 19 beds delivered within the Heathlands Village Care Home in Prestwich. Located in the south of the Borough very close to Manchester. The Heathlands Village provides a wide range of care services for up to 214 older people from both the Jewish and Non–Jewish community. The Heathlands Village is divided into six units. Beach House, residential dementia, Wolfson, residential, Unit 2 residential, First floor residential, the Simon Jenkins nursing unit and Oakwood nursing dementia unit. Bury's discharge to assess beds are located in one of these units. All are single rooms and benefit from ensuite facilities. The care home has many communal lounges and facilities on its large site.

The year of the pandemic saw these services at the front line of the response to the pandemic as they supported people at home and in their services to avoid them being admitted to hospital and supported those being discharged from hospital sooner than normal.

Prior to the pandemic the intermediate care at home service did not exist and was set up in the middle of the pandemic and most recently accepted **70** people into its services

The reablement service provides support in people's homes and supports on average **64** people per month. Throughout June to January activity increased as Bury dealt with the second and third waves of Coronavirus infections and increased demands on the hospital.

Killelea Intermediate Care home saw its activity drop this year. This was due to suppressed occupancy as one corridor was designated COVID +ve and not always fully occupied. In addition, the previously residential care home became a nursing home and supported patients who would have previously been cared for in Bealey's, this meant the length of stay increased due to higher dependency which in turn reduced admissions. This drop in activity was more than made up by increases in intermediate care at home.

In addition to delivering the ordinary services in response to the demands for hospital discharge and increased hospital admission avoidance the service also opened and supported

- **33** COVID +ve beds at Spurr House, Bridge House and Gorsey Clough
- Changed **7** of the beds at Killelea to COVID +ve beds
- Opened an additional **30** discharge to assess beds at Heathlands
- Supported a further **40** people a month discharged from hospital to short term services purchased from the independent sector
- In its multiple service offers it now supports **200** people per day.

Rapid Response

Benefiting from expansion plans delivered as part of Bury's transformation plans but also the need to expand and respond to the need to reduce hospital admissions during the pandemic Bury's Rapid Response Service has gone from strength to strength and now sees **4** times more people per month than before the pandemic and its transformation where average monthly admissions were only **40** per month

The average time from referral to service start is less than ½ a day with people spending an average of **2** days on the service. Over the last year only **6%** of the people supported required an admission to hospital the rest were able to remain at home.

Equipment Services

Bury Local Authority equipment services provides equipment and aids to people in their own home to aid and maintain their independence

In response to the pandemic the service expanded to run over 7 days and extended its hours.

Demand for these services has continued to grow with the number of deliveries made in March 2021 being **313** more than the same month the previous year and the number of pieces of equipment being **444** more than the same month the previous year, this represents an increase of **47%** on last year.

Care Link

Carelink provides a remote alarm monitoring system in people's own home which provides a button for people to press if they experience any difficulty along with other sensors and telecare equipment.

It currently supports **2216** people, this is a drop of 3% from 2285 in April 2020. The service operates 24 hours a day and received **86,495** alarm calls last year or an average of **7207** per month, or **237** per day

Support at Home Service

The support at home service provides outreach support to **18** sheltered housing developments across Bury which house **423** people aged 55 and over in rented flats and apartments. Of these tenants **155** receive tenancy and wellbeing support from the Support at Home service.

During the pandemic this service went through a structure and now offers a 24 hour a day emergency response service to the 2200 Care Link customers. When the person cannot be contacted over the CareLink system and a relative is not available to call on the person, rather than calling the emergency services the support at home service now responds. In its first year of operation, it responded **400** times avoiding **400** ambulances being called.

Half of the calls involved helping people get up following a fall and only **10%** of the people required an ambulance to be called and visit to A and E, saving a net **360** ambulance call outs.

Falcon and Griffin Extra Care Housing

Falcon and Griffin Extra Care Service provides care and support to a development of **69** flats for older adults.

The service provides **150** hours of care and support per week to **21** residents and wellbeing and tenancy support to a further **71**

Bury's Employment Support Service (BEST)

BEST provides support to adults with disability in gaining skills that improve their opportunities for occupation and employment.

The service had to suspend activities during the height of the pandemic and did not reopen until September. This opening was gradual and social distancing requirements mean it is still operating below capacity. It current support **70** adults in its service.

COVID-19 has had a significant impact on both Residential Care and Care at Home and the demand for both services has increased significantly for 2021. In addition to the demand increase there has also been an increase in the acuity of customers, which has resulted in more care being delivered to each customer in Care at Home, 48% increase in hours and an increase of around 2.5 hours per package.

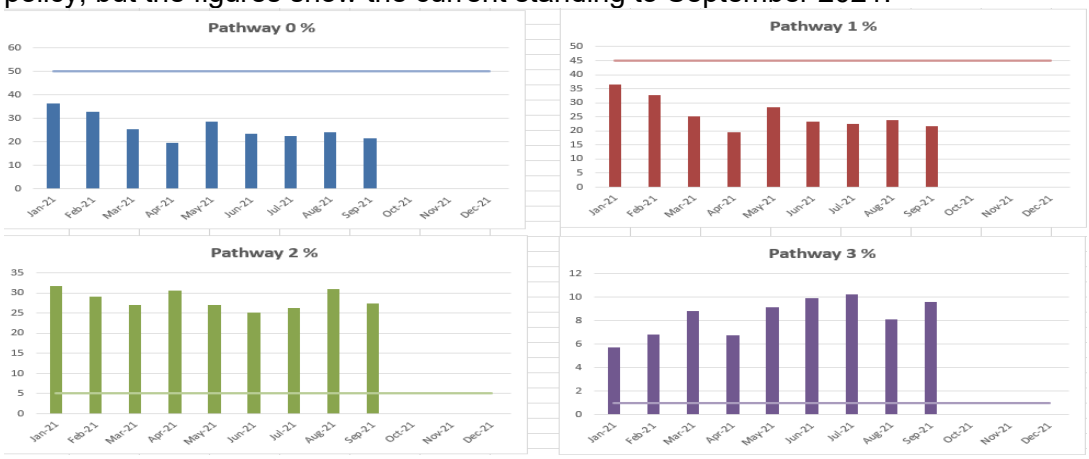
Hospital Integrated Discharge Team

The Hospital team is based over 2 hospitals, and the role of the team is to assess people who require support for discharge. The team are multi agency workers from social care and health

Staff based at Fairfield assess every customer regardless of the local authority they reside in. to support discharge, the staff at North Manchester assess some Bury customers at North Manchester and manage assessments that come in from North Manchester and other Out of Area Hospitals. The team use the Trusted Assessment model for all assessments and referrals to external partners.

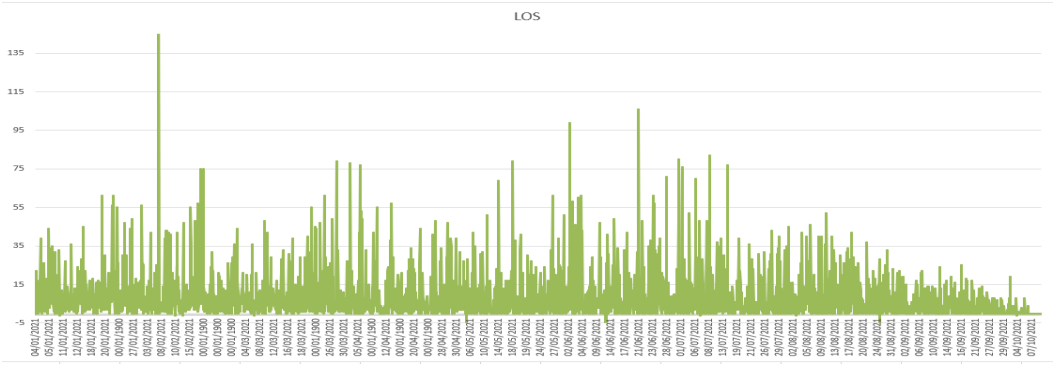
From January 1st, 2021, the team have supported **3292** customers to be discharged from hospitals across Greater Manchester

The Team are aware there is more work to be done to align the discharge destination with the policy, but the figures show the current standing to September 2021.



The team follow the Hospital Discharge and Community Support: Policy and Operating Model https://www.gov.uk/government/publications/hospital-discharge-service-policy-and-operating-model

The team are also responsible for prevention of delayed discharges and reducing the Length of Stay in Hospital and the chart below has shown a significant decrease in the LOS. Part of the improvement is evidentially aligned to the Brokerage Service joining the team.



The Team are currently in restructure, and it is envisaged that this will further support pathway alignment and reduction in Length of Stay

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Hospital Discharges

One of the reasons for the increase in Care at Home hours could be that the increased acuity in customers has reduced the capacity in the intermediate Tier. Consequently, more packages are being brokered directly from the hospital into the community, an increase of 46% from 2021 to 2021.

Additionally, under the Hospital Discharge and Community Policy there is a requirement for people to be supported at home on pathway 1 to reduce the number of bed-based services accessed as Bury is also an outlier for overuse of bed-based services in England. The Hospital Discharge and Community Policy pathway denotes that 45% of people are assessed for discharge on this pathway from a hospital setting.

Intermediate Tier (Home Based)

The Intermediate Tier (Home Based) service is a well establish service which provide time limited, up to 6 weeks reablement services to customers to assess their needs.

The outcomes for this service are extremely positive with just over 50% of customers who have been through the Reablement services being discharged without any further care from Adult Care Services, a further 16% of customers who were referred on to Care at Home with a reduced package of care

Intermediate Tier (Bed Based)

The Intermediate Tier (Home Based) service provide an assessment of customers' needs either in Killelea or through the Discharge to Assess (D2A) service.

The outcomes for both these services are again extremely positive with just over 42.8% of customers who have completed an assessment returning home with either no care or support from family/private care provider.

Care at Home

In line with best practice, it was agreed to review the Care at Home service in advance of its initial 3-year contract end to ensure that the contract is both effective and high performing for its final year and beyond.

As part of the new contract Providers will work with customers to agree a more flexible, person-centred approach based on the individuals needs and agreed hours over a four week period. This flexible plan is then assessed by CWB with the care plan / service order updated internally to reflect the agreed service delivery.

Lot 1: Primary Framework Providers - to deliver the Care at Home service in the most cost-effective way, it has been agreed that the borough of Bury will be separated into five neighbourhoods; these are based on the Integrated Neighbourhood Teams, West Bury, Bury East, North Bury, Whitefield and Prestwich. Two providers will be allocated to each neighbourhood as main provider on alternate weeks for the purposes of accepting new referrals and managing provision.

Lot 2: Providers who wish to remain at low volume (from 0 to 600 hours/week) will be accommodated on this framework. Lot 2 will be open to new market entrants two time per year (April and September) based upon identified need for provision. There are currently 15 providers offering back up provision.

The new service will:

- Align to the Locality Plan, having providers work across the 5 neighbourhoods, mirroring and aligning to the Integrated Neighbourhood Teams.
- Provide a greater focus on partnership working alongside the Integrated Neighbourhood Teams with our care providers having an equal role in best meeting the needs of the people of Bury.
- Encourage innovation and flexibility in service delivery including taking an asset based approaches to care and support.

The new Care at Home contract allows for changes to be made to the service specification that will allow greater flexibility and choice for customers in how their needs are met. The strengths of this are:

- A well-functioning and sustainable Care at Home service will have a positive impact for other areas of health and social care, for example, reduced social isolation, reduced admissions to hospitals, reduced carer breakdown, more people being able to live at home for longer.
- Enabling providers to have a stronger role in assessment and care management will allow more capacity for social workers.
- A truly person-centred service for customers will be developed.
- Implementation of innovative ideas that the current contract does not allow.
- Alignment to the Integrated Neighbourhood Teams and Locality Plan.

Strength Based Approach

- Care management conduct a strength-based assessment to identify broad outcomes and available budget.

- Provider and customer to continue strength-based approach to support planning by working up support plan details and timings.
- Providers to use the ability to subcontract to consider working with voluntary and community sector organisations in the neighbourhood which may be able to support certain specialist needs or sections of the community.
- Strengths-based approach with customers
- Providers able to deliver a level of reablement when there is insufficient capacity, or it is inappropriate for them to be referred to the Bury Council Reablement Team.

Living Well at Home

Bury's 'Blended Roles' project aims to identify and explore opportunities to support Care at Home staff to undertake healthcare tasks historically undertaken by District Nurses. With full training and support, these tasks could include basic tasks such as basic wound care and eye drops etc. This will create an opportunity to optimise and improve the Care at Home role in Bury which will develop career opportunities by supporting potential transfer to roles in the NHS. It will also ensure that experience of care is improved as fewer professionals will be involved in the facilitation of a person's care.

Blended Roles sits within 'Living Well at Home' - a Greater Manchester programme of work which promotes a model of independent living and support delivered through transformed adult social care and health. The aim of this programme is to support people to stay well and independent in their own homes and communities of choice, as well as ensuring high quality support where needed. This will be achieved by developing a strong, attractive, and aspirational workforce offer with careers in health and care that offers progression through education, training, apprenticeships and a good career pathway. It will also ensure interventions and prevention models are in place so that people can avoid going into long term support services and it will also change the way the money drives the outcomes, with payment reform incentivising retention of independence and improved outcomes

Assistive Technology

Assistive Technology has a key role to play in the modernisation of social care. It offers a range of possibilities for individuals, through the application of technological advances in a social care setting. Assistive Technology can enable people to live independently for longer by preventing hospital admissions and premature moves to residential care.

Personalisation is based on offering choice and control to our customers, working with them to co-develop individualised support plans. Assistive Technology offers numerous possibilities depending on the customer's needs and desired outcomes. Assistive technology ranges from simple devices to prevent sinks flooding, to GPS tracking and smart-phone applications. By ensuring technology is considered during the development of every support plan we can support customers to find the best possible solutions to meet their needs and is often the cheaper solution.

Technology can't replace human care, but it can hugely assist in reducing the need for care, particularly where the care is predominantly about monitoring and managing risks. This increases independence for the customer and frees up capacity in the home care sector.

Section 6 - Disabled Facilities Grant (DFG) and wider services

Disability Services

Disability Services provides assessments for adaptations, processing minor adaptations and applying for Disabled Facilities Grants for major adaptions.

In 2020/2021 the service received **658** referrals for adults and **76** for children. The pandemic has had a significant impact on the performance of this service and the delivery of adaptations, this was due to being unable to visit people in their own homes or to progress work in people's own homes at the start of the pandemic.

Housing

The Void Management policy will apply to all properties where there is a joint or part responsibility between Bury Council and Registered Providers. It is underpinned by the following principles:

- Enabling inclusion in communities and decision making
- Equality of housing choice
- Enabling independent living in communities of choice for all Adult Social Care customers
- Openness and transparency in decision making
- Supporting priority needs of those people with adult social care needs
- Ensuring high standards and good quality accommodation
- Enables 'own front door' accommodation where possible

The Void Management policy sets out an approach when dealing with void properties to ensure an efficient and customer focused service which:

- Complies with regulatory and legislative requirements
- Ensures value for money in repairing void properties and achieving re-let standard
- Balances the need to minimise rent loss whilst letting empty properties to the right applicant and ensuring best use of the property
- Maximises customer satisfaction in relation to the standard of their new home
- Is consistent with the demand across the One Commissioning Organisation (OCO) of Bury Council.
- Repurposes void properties to meet current demand and increase viability of letting a property.
- Stand down void properties that neither meet the priority needs of residents nor meet the 'Checklist of accommodation standards and tenancy-related housing services in supported housing' policy.

The Void Management policy is designed to meet the following strategic objectives to:

- Continue to improve the quality and accessibility of our services, meeting people's needs at different stages of their lives
- Target investment effectively to maintain attractive, well-designed homes and places where people want to live
- Extend housing and tenure choice for all people who require specialised housing in Adult Social Care setting
- Demonstrate value for money and social impact
- Minimise the loss of rental income because of properties being empty
- Ensure that housing providers make the most effective use of their housing stock to let to the best matched applicant(s)
- Ensure that properties are brought up to a consistent and acceptable standard when let.

The Void Management policy will be the reference point for all future contractual and lease arrangements for future specialised housing developments commissioned and developed by the department. Also, there will be a review of historical arrangements with Registered

Providers to ensure alignment with the new position outlined in the voids management policy.

"Let's Do It!" 2020-30, provides the vision to enable people of all ages to live well within their neighbourhoods, supported by the integration of public services with our neighbourhood hubs. From an Adult Social Care perspective, we must create conditions for older people, and those who need extra support to live well in their communities, retaining their independence, choice, and control for as long as they want to. "Living well at home"

The Bury Housing Strategy states that: The right home environment enables people to:

- Manage their own health and care needs, including long term conditions
- Live independently, safely, and well in their own home for as long as they choose
- Complete treatment and recover from substance misuse, tuberculosis, or other ill-health
- Move on successfully from homelessness or other traumatic life event
- Access and sustain education, training, and employment
- Participate and contribute to society.

This means that the right home can be beneficial for the wider health and care system, and can be a key factor in contributing to:

- Delaying and reducing the need for primary care and social care
- Preventing hospital admissions
- Enabling timely discharge from hospital, and prevent re-admissions
- Enabling rapid recovery from periods of ill health or planned admissions.

Commissioning intentions for priority group one, older people are that we will:

- Understand the type of accommodation with support people want and need in Bury (Informed by feedback from the Council's housing strategy and local coproduction networks).
- Work with providers to deliver Bury resident's aspirations and commission accordingly.
- Discourage developments where there is a saturation of supply.
- Work with Providers to understand how they can best meet demand based on their knowledge and expertise.
- Encourage innovative forms of accommodation with support for older people, to diversify the market e.g., retirement villages etc.
- Develop a plan in partnership with existing suppliers to adapt nomination processes, and re-purpose sheltered properties, to meet demand from working-age adults.
- Referring to our principles, we will co-design and deliver housing solutions with Bury people, as well as our housing partners, using our well-developed networks, knowledge and expertise.
- Ensure the ethos of the 'Let's do it strategy' and the Inclusion agenda is central to housing for those with additional needs.

Commissioning intentions for priority group two, people with long term conditions:

- The shortage of accommodation for these three groups (learning disabilities, autism and mental health) needs to be addressed with innovative solutions which support an "own front door" model.
- We will work with existing providers to meet immediate and future needs identified
- Explore with landlords and key partners the potential to re-purpose sheltered schemes into accommodation for adults with Long Term Conditions.
- Utilise 'Assistive Technology' in existing and new housing stock to better meet the needs of people.

- Work with key providers to identify and de-commission, or re-purpose supported living properties no longer needed, based on customer preference and viability.
- We will work with children's service colleagues to identify people who may need accommodation-based support from the age of 14 years.
- Develop a 'roadmap' for accommodation, as for older people, so that both commissioners and providers understand medium- and long-term plans for accommodation with support.
- Referring to our principles, we will co-design and deliver housing solutions with Bury people, as well as our housing partners, using our well-developed networks, knowledge and expertise.
- Ensure the ethos of the 'Let's do it strategy' and the Inclusion agenda is central to housing for those with additional needs.

Section 7 - Equality and health inequalities.

The Bury Council and CCG partnership has, through the leadership of the Strategic Commissioning Board, made a commitment to significant improvements in our equalities and inclusion practice as both an employer and service provider/commissioner. In doing so, both organisations have recognised the centrality of inclusion to the delivery of the overarching Let's Do It Strategy. This commitment is made as part of our leadership role in delivering the Bury 2030 vision and wider organization transformation.

An independent review into internal practice and our broader equality related activity was undertaken in Summer 2020 and, as a result, a Joint Inclusion Strategy has been co-produced with staff groups; community leaders and senior champions. It sets out the context for this work including the current disparity in outcomes across different communities and how the Bury 2030 vision intends to address this.
Organisation-specific equality objectives and an action plan for delivery to 2025. The term inclusion has been intentionally used for this strategy as it incorporates equality, diversity and human rights, and our legal requirements under the Equality Act. Previously Bury Council and Bury CCG have used a combination of these terms, so inclusion provides a common term to corral around given this is a joint strategy and encompasses the intent to promote equal access and take up of opportunities; to respect and celebrate diversity; to protect and raise human rights, of all people across the Borough.

More widely the overall philosophy of the strategy is to protect the most vulnerable; drive economic growth and ensure all residents have the skills, opportunity and confidence to access the opportunity growth brings. Other actions which support inclusion and tackle inequality within the vision include:

- Safeguarding the welfare of vulnerable children and adults
- Provision of all-age Learning Disabilities services
- The development of a neighbourhood model of public services to develop greater understanding of local community issues and joined-up public services to respond
- Ensuring that our streets and neighbourhoods are safe, cohesive and accessible
- Raising the profile of volunteering and community action
- Pursuing digital infrastructure as a lever for inclusion
- The use of apprenticeships to create opportunities for young people in particular and the wider Supported Employment offer including the current Kickstart initiative with DWP to give those not in education or employment placement opportunities and support to become work ready
- Ensuring that wider issues around vulnerability, disadvantage and poverty are at the heart of our decisions.

The development of the Council's antipoverty strategy is a key part of the Covid recovery work and includes work to support food banks; provide financial and benefits support to residents who are out of work or experiencing in-work poverty and to facilitate an "opportunity guarantee" to give every person looking for support, coaching or work opportunity the resources to progress

As public services the Council and CCG operate within the context of the following legislation:

The Equality Act 2010 (The Act) brings together all the legal requirements on equality that the public, private and voluntary sectors need to follow. It protects people from discrimination, harassment and victimisation on the basis of their 'protected characteristics',

The Council and CCG's joint Inclusion Strategy goes beyond the statutory requirements and gives equal weighting to 13 protected characteristics (more than the nine covered by the Equality Act). This includes Carers, Looked After Children and Care Leavers, Military Veterans and the Socioeconomically Disadvantaged.

The Strategic Commissioning Board ensures compliance with the Council and CCGs shared equality's objectives by:

Ensuring every decision is equality assessed, to ensure it reflects the duties of preventing discrimination; fostering good relations and advancing equality of opportunity. The strength of the Equality Assessment process is one of the areas of work that we have carried out this year.

Objectives in our capacity as both service provider/commissioner and employer at the heart of our Corporate Plan. The objectives for the next 12 months are set out below;

- Engaging Team Bury partners, businesses and investors in our Inclusion strategy to role model and seek to embed wider good practice, as community leaders
- Reporting progress and outcomes of the Inclusion Objectives to the Strategic Commissioning Board as part of quarterly reviews against the Corporate Plan set annually
- Overseeing the maintenance of Human Resources (HR) policies which are clear about eliminating discrimination in the workplace and ensuring fair and equal opportunity to staff from all groups
- A particular focus on Race Inclusion as a characteristic of focus for the Strategy's initial 12 months of operation.

Governance of the Inclusion Strategy

This is a joint strategy between Bury Council and Bury CCG and such ownership in terms of driving implementation and evaluation sits with the Strategic Commissioning Board (SCB) under the accountable leads of:

- The CCG Chair as Clinical Lead for Inclusion
- The Council's Cabinet Member for Corporate Affairs

Reporting against the Implementation Plan will take monthly to the Cabinet Member for Corporate Affairs and the Clinical Lead for inclusion; who together shall present joint updates to SCB every six months and to the respective scrutiny committees (Bury Council – Overview and Scrutiny Committee). As outlined above reporting on progress and outcomes

of the Inclusion Objectives will also take place through the quarterly reviews of the Corporate Plan by the SCB.

The Health and Wellbeing Board has also been refreshed with an explicit role to act as a ‘standing committee’ on population health and health inequalities. All programmes of work are challenged to demonstrate their understanding of health inequalities (geographic, demographic, and social) and how the programmes will monitor and address inequalities through design and delivery. This includes ensuring co-production with those with lived experiences.