

Bury Health and Well Being Board Better Care Fund Narrative Plan 2022/2023

Governance

Health and Well Being Board

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:

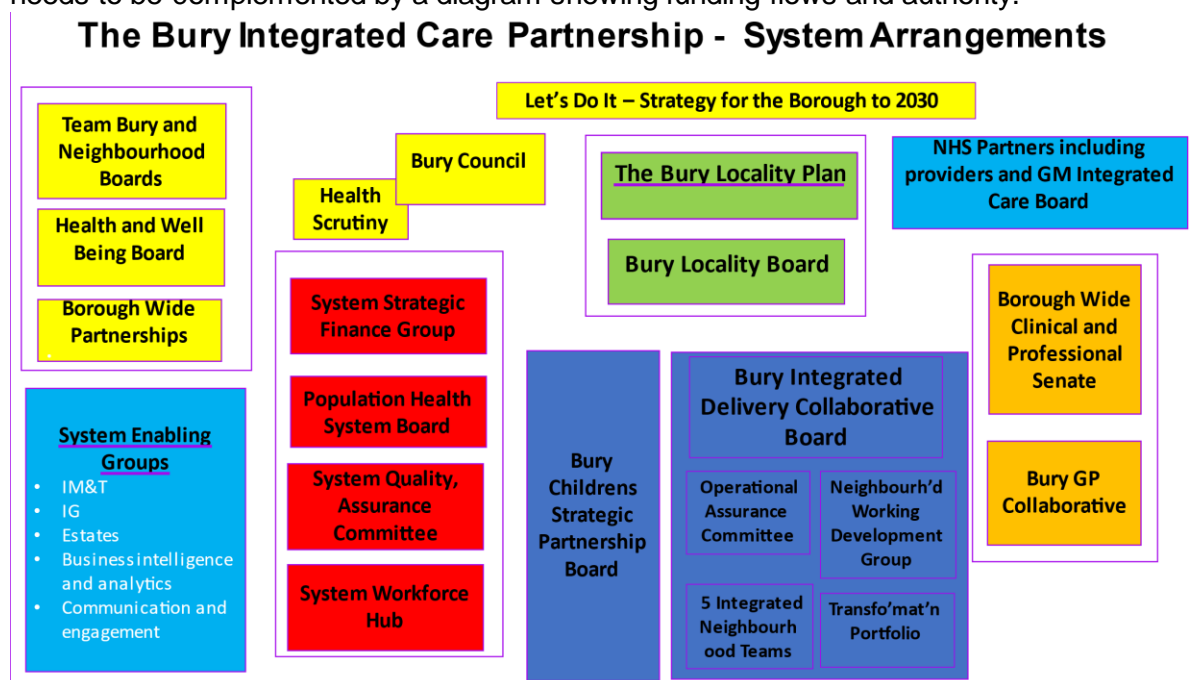
- Cabinet Member, Health and Wellbeing (Chair)
- A nominated representative from the voluntary sector
- Cabinet Member, Children and Young People
- Additional Labour Cabinet Member
- Shadow Cabinet Member, Health and Wellbeing
- Executive Director, Children, Young People and Culture
- Executive Director, 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

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

Bury Integrated Care Partnership – System Arrangements

Partners in Bury have from October 2021 established in transitional form the partnership arrangements we will have fully operational from 1/7/22. Work in the period December 2021 to date has been in maturing each component and understanding the connections between them. Further work is required to fully mature the arrangements, some of which is dependent on the GM operating model (e.g the delegated authority to the Locality Board). The diagram

below describes the partnership arrangements in the borough. It is recognised this diagram needs to be complemented by a diagram showing funding flows and authority.



Locality Board

The partnership leadership of the Bury Integrated Care Partnership is through the Locality Board, made up of senior representatives from all relevant statutory organisations and other key partners. It will bring together political, clinical, managerial and professional leaders to help shape the strategy, prioritise and focus on integrated health and care for the Place. The Locality Board will include the Council, Primary Care Leadership, Northern Care Alliance, Pennine Care NHS FT, Manchester Foundation Trust, GP Federation on behalf of PCNs, the Greater Manchester ICB, the Bury VCFA, and Healthwatch. The Locality Board sets the shared strategy for the partnership and ensures triple aim outcomes are improving, including overseeing the implementation of the planned budget for health and care in the borough (some of which may be formally pooled), ensuring services are high quality efficient and effective, and ensuring population health outcomes for our Borough are improving. The Board will set the direction for the way services are delivered as described in the Locality Plan.

Integrated Delivery Collaborative, and Board

The 'engine room' of the Bury Health, Care and Well Being system is the 'Bury Integrated Delivery Collaborative'. This is the vehicle through which we are building relationships, structures and solutions between all the partners to drive improvement in the way we are working to improve triple aim outcomes for our Borough, and to deliver services and interventions in innovative ways. The IDC includes all partners to the Locality Board and several other key providers – e.g Persona (the Council owned social care delivery organisation), the Voluntary and Community Faith Sector Alliance and Bardoc. The Integrated Delivery Collaborative supports collaborative working at borough, neighbourhood and individual community level.

We have undertaken significant organisational development work to determine the purpose, principles and values of the IDC. We have defined the purpose of Bury integrated delivery collaborative to be enabling health and care organisations and the voluntary sector in the borough to achieve more together than each individual organisation could do alone to provide

more effective integrated services, to achieve better outcomes and experience for people, to improve cost control in health and care services and to have a greater impact on improving population health, reducing health inequalities and increasing inclusivity. Our scope includes all health and social care services for people of all ages. We recognise that for some services their optimum footprint may be greater than the borough of Bury. However, it is still essential these services are considered part of, and integrate with, the Bury system for the benefit of our local population.

Key tasks for the Integrated Delivery Collaborative include:

- To create the conditions for the delivery of high-quality integrated health and care services in each of 5 neighbourhood teams,
- To co-ordinate the delivery of the system wide thematic programmes in the context of wider system working, including for example
 - The Bury urgent care board
 - The Bury mental Health programme board
 - The Bury Elective Care and Cancer Programme Board
 - All other key thematic programmes of work.
 - To create the frameworks and partnership arrangements to deliver the expectations of the Locality Board as described.
 - To assure the delivery of directly managed services

Neighbourhood Working

The default setting for integrated community health and care services in Bury is though joined up delivery across 5 integrated neighbourhood teams. These are:

- Ramsbottom and Tottington
- Bury
- Radcliffe
- Whitefield
- Prestwich

We have an operating model and development plan for integrated neighbourhood working in health and care which continues to develop and mature.

The model of integrated neighbourhood team working in health and care operates at the same spatial levels as our community hubs - a focal point for community leadership and co-ordination in each of 4 places. In 2021 the community hubs have created opportunities for public services and voluntary and community partners to come together with a shared understanding of each others role, the assets in those communities, and the residents and communities at risk of vulnerability.

Increasingly wider public services are also working on the same spatial level - this includes GMP, Housing Providers, GMFRS, wide Council Services - with the understanding that prevention and early intervention across a range of public service can sustainably improve outcomes. From a health and care perspective this work explicitly recognises that the organisation of service delivery of health and care is actually a minority contributor to the health and well being of residents. More important is, for example, the quality of housing, the availability of quality work, the extent to which residents are connected to their communities, and whether a life is led free from harm and fear. This work is co-ordinated by the Bury Public Service Reform Board

Primary care is at the heart of our model of integrated care. We have 4 Primary Care Networks working across the 5 neighbourhoods. The Primary Care Networks are supported in their development by the Bury GP Federation and work continues to explore how best to support the maturity and system leadership of the primary care networks, and the role of the GP Federation in doing so. The primary care team of the CCG/future ICB will work closely with the capacity of the GP Federation to support practices and PCNs.

Clinical and Professional Leadership

Bury has established a clinical and professional senate with the intention of ensuring clinical and wider professional (e.g social worker) leadership is significantly influencing, leading, guiding, and challenging the work of the wider partnership arrangements. It is also intended to create opportunities for strengthened clinical and professional leadership across different sectors and interfaces e.g primary care/secondary care, mental/physical health, health/care. A clinical senate board operates through mandated leadership and will coordinate the work of the wider clinical and professional senate.

In addition to the work of the GP Federation Bury has also established a GP Collaborative. This is a joint initiative between GP practices in Bury, the 4 Primary Care Networks, the GP Federation, and the Local Medical Committee. It is intended to support the voice of GP leadership particularly in the partnership arrangements, recognising the potential risk of the loss of the CCG as a GP membership organisation and as a key statutory authority in the borough.

Overall BCF plan and 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 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. Covid 19-continues to be a problem in relation to staffing in services in Adult Social Care and is still causing care home closure because of outbreaks which impacts upon system flow.

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.

Bury is using the King's Fund Population Health model to implement a whole system population health management approach to the main causes of death and illness. This incorporates an intervention decay framework to ensure focus across the whole clinical pathway, from awareness of symptoms, through diagnosis and care, to adherence and tackling barriers to care. Close working between public health and healthcare commissioners and providers has enabled payment incentives to be aligned with this model, to make sure providers are rewarded and incentivised for maximising diagnosis and uptake of preventive care. This is being implemented in Bury's five neighbourhoods – the structures that connect primary care to other community healthcare providers, social care, social prescribers, and public health living well services. Improving diagnosis, care (including social prescribing and social care), and removing barriers to treatment is intended to help people with long term conditions feel healthier, have better outcomes, and live better quality, independent lives.

Self-Care

Educational – The Bury Directory has many information and advice pages on self-care and self-management which can improve people's knowledge around their self-care.

Structured educational courses - For those who would like more information on self-care and for those people with long term conditions for example HY2W which the Live Well Service deliver.

Digital - currently working on a digital self-care hub on the directory which hopefully should be completed by December 2022. The updated quality for life tool 'A Better You' will be live this September 2022 and is a health and wellbeing focused self-assessment tool that will signpost to relevant services for further advice and information around self-care. There are also online courses delivered for HY2W and other self-management eLearning that the individual can work through at their pace.

Social prescribing – a team which is based in the voluntary sector which focuses on what matters to the person through making a personalised care and support plan and then

connecting the people to the community groups and agencies for practical and emotional support.

Implementing the BCF Policy Objectives (national condition four)

Supporting Discharge

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.

Across the Bury system there are a range of new and ongoing projects and plans targeted towards improvements in the number of avoidable admissions. These include the following.

- System Wide UEC Improvement Programme
- Exploring further enhancements to Pre-ED Triage
- Development of Urgent Treatment Centre at the FGH site including NWS direct Pathways
- Development of SDEC pathways including speciality services i.e. cardiology, ENT and Frailty etc
- Winter Planning including a Winter Planning Event
- A range of Community based Alternative To Admissions including;
 - GM CAS
 - Rapid Response
 - Virtual Ward
 - GP Extended hours
 - Referral to CPCS
 - Mental Health Community Support
 - ATT for NWS crews
 - Neighbourhood based MDT
 - Home first principles adopted across the system for hospital discharges
 - IDT to support discharges wherever appropriate to usual place of residence
 - Reablement and Package of Care support upon discharge

Anticipatory care

Through Active Case Management and the existing MDTs Bury has implemented a number of the components of Anticipatory Care. In addition, we have access to a shared care record via the Greater Manchester Care Record [GMCR] We are working with colleagues across the Greater Manchester ICS to use the emerging national guidance to develop a model for Anticipatory Care and will be working with our PCNs and wider system partners to agree and implement an approach locally.

Neighbourhood Integration

Bury has 5 Neighbourhoods with integrated health and social care teams in each Neighbourhood.

Active Case Management is a key part of the Neighbourhood model providing targeted support to people with multiple long term conditions and wider needs via an MDT in each Neighbourhood. The MDTs have representation from general practice, pharmacy, district nursing, social work, social prescribing, and mental health. Care plans are developed and regularly reviewed with a key worker or co-ordinator allocated for each case. Other services such as housing support are invited to join the MDT where relevant to the needs of a particular individual.

| 5b) Improving in-hospital flow and discharge | |
|--|--|
| <p>What practical processes are in place to monitor in-hospital length of stay?</p> <p>What work is underway to reduce long lengths of stay (patients with LOS of 14 and 21+ days)?</p> | <ul style="list-style-type: none"> • 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 Organisation Urgent Care Board • Current system wide reporting in place via Bury Bronze with escalation triggers set. |
| <p>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?</p> <p>What did the self-assessment against the national policy identify and what actions have followed?</p> | <ul style="list-style-type: none"> • 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.

The 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, offered in Bury. This is being addressed by the Greater Manchester Transformation Scheme funding and is currently in operation. 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 in one of these units. All are single

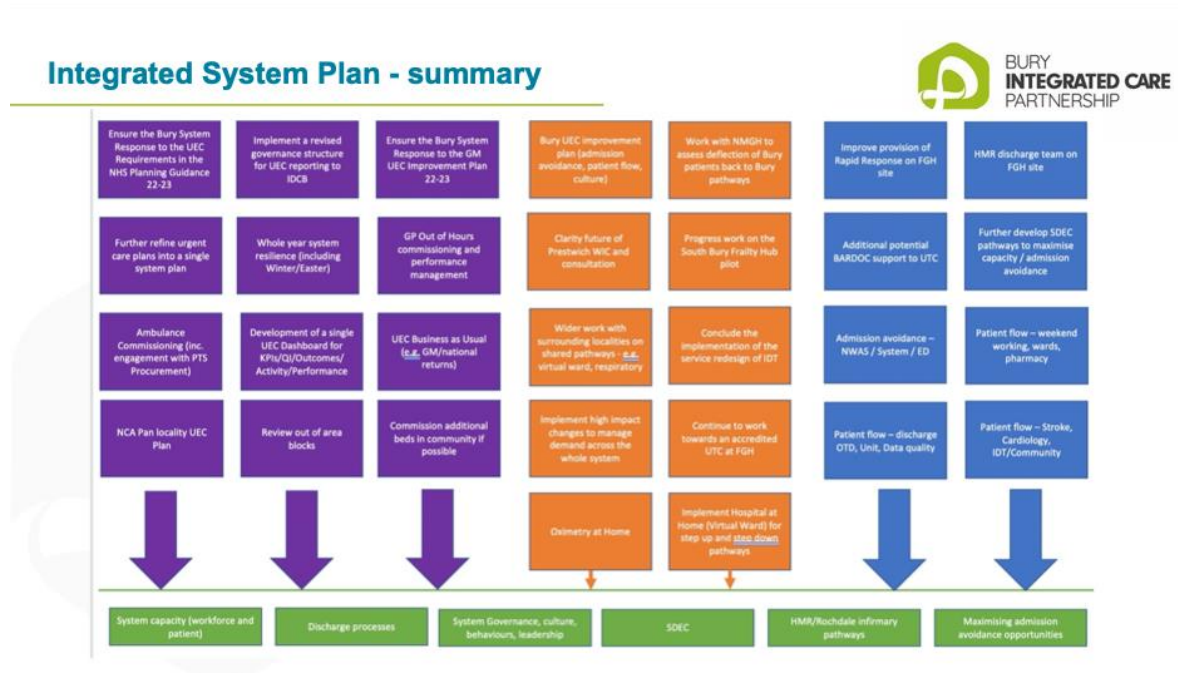
rooms and benefit from ensuite facilities. The care home has many communal lounges and facilities on its large site.

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%

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 at least 45% of people are assessed for discharge on this pathway from a hospital setting.

The HICM has been incorporated into a wider programme of work for Bury's Integrated Care Partnership, this includes the 100 day discharge challenge and a significant urgent care improvement programme. The planned work for this programme is described below:



Intermediate Tier (Home Based)

The Intermediate Tier (Home Based) service is a well-established 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.

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.

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.

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.

The service is currently under review and has been included in the recent development of a 'digital first' approach in Bury, where a dedicated Technology Enabled Care Team with explore a much wider plethora of Technology to support residents their family and carers in a person centred way.

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 re 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.

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**

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

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, the Brokerage team is firmly embedded in the service and capacity has been increased to reflect the increase in demand for hospital discharges and the brokerage of care at home and residential/nursing care because of a decreased level of acuity of patients on discharge. The Brokerage team works closely with the commissioning team to help prevent blockages to system flow throughout the wider system.

System Flow Group

A system flow group consisting of senior managers in Adult Social Care has been operational for a couple of years now and meets regularly to discuss concerns or issues in the flow from hospital into adult social care services. Task and Finish groups have been set up to review and test new pathways and the group now regularly reviews all pathways every quarter to ensure they are operating safely and efficiently. This group is supported by the Commissioning Team and the most recent piece of work is linked to hospital discharge pressures whereby commissioning team members are supporting senior managers to move people on through the system from D2A beds and IMC, thus freeing up further beds for hospital discharges. The demand for D2A beds is increasing and we currently have 19 in Heathlands, and a further 39 beds which have been purchased from the private sector to cope with increasing demand.

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. There are currently 15 providers offering back up provision. This system allows for more flexibility to handle increased service demand from the integrated hospital discharge teams, we have recently block booked 600 care at home hours from 2 Lot 2 providers for care at home provision to allow people to be discharged from hospital at a faster pace to free up hospital beds.

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 is embedded at the first interaction with our customers and at the review stage.
- Bury has embedded the '7 stage conversational tool' exploring how the person can be empowered to achieve outcomes that matter most to them, promoting independence and self-care, utilising technology enabled care, aids and adaptations, working with family, friends and carers, accessing community assets, universal services and when these elements are unable to support a person then considering person centred formal care.
- 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.
- Social Care and health staff along with a range of providers and partners have undertaken ethnographic training and will continue to access an online version.

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. Covid had a major impact upon our providers which meant the implementation of this project was delayed considerably, however the work has now been picked back up but the increased demand for care at home for hospital discharge is having an impact upon the pace of change.

Assistive Technology (Technology Enabled Care TEC)

TEC is central to the modernisation of health and social care. It offers a range of possibilities for individuals, through the application of technological advances in a social care setting. TEC enables people to live independently for longer by preventing hospital admissions and premature moves to residential care. Complimenting care by offering alternatives to formal care, maintaining quality outcomes often in a less intrusive manner and freeing up staff capacity to focus human interaction with those who most need it. TEC can also be used to better assess customers ensuing support is truly reflective of support required.

Personalisation is based on offering choice and control to our customers, working with them to co-develop individualised support plans. TEC offers numerous possibilities depending on the customer's needs and desired outcomes. TEC 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. A new transformation project has been set up via the Commissioning Team to move the TEC agenda forward, consultation has been carried out and recruitment for a new TEC team will be underway shortly. Our approach will be via a framework where people can have choice and control over which services or apps are used rather than to commission one size fits all products. Having a dedicated TEC team working alongside our health and social care professionals, linking into our VCSE sector, and supporting the customer directly via self-referral will bring a new form of support not previously known in Bury.

Home from Hospital

The Commissioning Team is currently leading on the development and commissioning of an enhanced home from hospital service, to replace the current 'Take Home and Tuck Up' scheme and various voluntary sector activities. The aim is to bring together all funding pots to commission an enhanced service which is more flexible in its approach and has levels of service dependent upon customer and patient need. The new service will bring together all providers including the voluntary sector to deliver one service instead of a host of very good, but disjointed services at the moment. The outcome of the service is to ensure people discharged from hospital on pathway 0 or 1 are supported to have a safe but speedy discharge, remain at home and to prevent hospital readmission. Ensuring people who live in the community are supported at times of life changes to prevent admissions to hospital and to reduce loneliness and isolation which should also help to prevent hospital admissions and reduce pressure on GP practices.

Supporting unpaid carers.

As a society we are increasingly dependent on the contribution of unpaid care. Carers are an essential part of enabling people to stay in their own homes for longer and allowing the move from hospital to community care.

The Bury Carers' Hub

The Bury Carers' Hub is the primary resource for adult carers in Bury to provide information, advice and a wide range of specialist support services designed to help adult carers caring for another adult 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 service is shaped on the main themes identified, following significant consultation and engagement with carers, the community, providers and partners.

Bury now has a model that delivers a service direct to carers as a 'One Stop Shop / Pop-Up' approach, in each of the 5-neighbourhoods of Bury, so that carers receive all the support they require via a single point of contact that is recognised and local to them, making it easier for carers to connect with others, to both offer and receive a range of support and to come together to influence service delivery.

We are gaining an understanding of the demographic of Bury, which reflects the diversity of the 5-neighbourhoods, enabling the service to build relationships with local community support in each of the neighbourhoods adopting a whole family approach, to maximise the impact of resources and identify opportunities to support carers.

- The Bury Carers' Hub offer volunteering opportunities for carers; fully supported by a Volunteer Co-ordinator.
- 1-2-1 support delivered by method and in location of carers choice
- Holistic assessment, outcome tools, and support planning employing a strengths-based approach.
- [Newsletter – designed by carers](#)
- Carers Community Network Platform with 1,600+ carer members from across the providers' carer services. Also, digital groups and activities delivered through the platform, including evening offer
- [Carers Help and Talk \(CHAT\) line available 24/7, 365 days, manned](#) by volunteers
- Outgoing calls to carers through CHAT Line. Carers are matched to volunteers who offer regular wellbeing calls
- Carers UK Digital Resource for Carers including Jointly App can be accessed by a code provided by the GP. Supporting GP Practices and carers to deliver this

- Digital groups and activities delivered on Zoom, including evening offer
- [Closed Facebook group for peer support](#)
- [PenPal scheme](#)
- [Carers clinics, coffee & chats and other activities delivered borough-wide](#)
- [Monthly community based walks in partnership with the Stepping Out Project and Manchester & Salford Ramblers](#)
- [Information, advice and signposting](#) to other more appropriate, specific and skilled services, organisations, groups and support networks
- Service briefings and Carers Awareness Training to professionals across all sectors.

Carers Personal Budgets

Carers Personal Budgets are part of the statutory Carers Assessment process delivered by Bury Council.

Carers Personal Budgets are a response to meet needs identified in the Carers Assessment which cannot be met otherwise and are about giving the carer choice and control over the way that their support is provided, to enable carers to achieve recognised quality of life outcomes which they are unable to achieve due to their caring role.

The FED Volunteer Service – Time for You Project

The Time For You project, based within The Fed's Volunteer services, supports carers in the Jewish Community. This project has been providing this culturally appropriate service to carers for over 20 years.

The service aims to provide carers with a much-needed break from their caring role. They recruit, train and support volunteers who sit with or take out the person being cared for, enabling the carer to have some time away from their caring responsibilities.

The Bury Directory

The Bury Directory is Bury's one-stop information point for advice, support, activities, services and more. Following several workshops with carers of all ages, a dedicated carers section has been developed which brings together information, advice and services for carers all in one place.

Disabled Facilities Grant (DFG) and wider services

Housing

The Adult Social Care White Paper 'People at the Heart of Care: adult social care reform' focusses on making every decision about care a decision about housing. Writing 'ensuring people receive the right care and support all begins with where they live and the people they live with'. The ambition is to give more people the choice to live independently and healthy in their own homes for longer. 'This means adults of all ages being able to access or remain in the home of their choice, whether that be their own home of today or one they move into - which forms part of a community they have chosen to call home'.

The white paper outlines four 'I' statements in relation to housing, these are 'I' statements that Bury will consider throughout our housing agenda:

- I can live as part of a community, where I am connected to the people who are important to me, including friends and family and I have the opportunity to meet people who share my interests.

- I lead a fulfilling life with access to support, aids and adaptations to maintain and enhance my wellbeing.
- I can live in my own home, with the necessary adaptations, technology, and personal support as designed by me, to enable me to be as independent as possible.
- I have a good choice of alternative housing and support options, so I am able to choose where I live and who I live with, with the opportunities to plan ahead, and take up those options in a timely fashion.

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 readmissions.
- Enabling rapid recovery from periods of ill health or planned admissions

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 health, key 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.

Bury has spent the past 18 months researching, listening, and collaboratively understanding the current and future need for housing for adults with additional needs. This has been a joint health and social care effort linked into wider housing colleagues and partners, both care and housing providers along with our customers to understand what is important regarding housing. This work led to the development of a housing for those with additional needs vision, strategy and market position statement, the 'blueprint' for Bury.

Through our housing solutions we will:

- Promote wellbeing and social inclusion.
- Support improved quality of life in terms of financial wellbeing, reduced social isolation, continuation of community life, and potential for continued role for carers and families.
- Enable people to maintain their independence in their own self-contained accommodation.
- Provide care and support which is flexible and accessible (either onsite or nearby).
- Offer alternatives to residential care and sheltered housing (for those who need it).

- Supply affordable solutions so that the chosen options can be “a home for life”.
- Deliver high-quality, fit for purpose dwellings with low-running costs in local communities.
- Provide a choice of housing options.

Overall, across the priority areas (learning disabilities including autism, mental health and our older people) there is a requirement by 2025 to increase supported accommodation by C.245 bedspaces. To deliver the defined blueprint a cross council (health and social care) Housing Growth Programme Board and Subgroup has been established. Supported by a dedicated resource within the Community Commissioning team focused on reviewing and improving existing housing stock, ensuring it meets expectations set out in the OCO ‘Checklist of accommodation standards and tenancy-related housing services in supported housing’. Decommissioning inappropriate stock, focussing on reducing voids in the system and aligning agreements to our voids policy. Standing up a plethora of new housing schemes which are at various stages from embryonic, planning through to build stage. Collaboration with our housing and care providers is important, several care provider networks are used as a vehicle along with the GM housing provider network and the newly formed Bury Registered Provider Framework.

The full housing market position statement is embedded below and link to the webpage with accompanying housing related documents: <https://www.bury.gov.uk/aschousing>



Final- Bury ASC
Housing for Adults wi

Disabled Facilities Grants

We are embarking on an exciting time in Bury where we start to look at our DFG and the way it is used to adapt properties to enable independent living, privacy, confidence and dignity for individuals and their families as a system. Collaboration across health and social care, our housing colleagues and where we can our providers and residents will help shape the way we work and align the objectives of our DFG usage and adaptations policy with existing local social care, health and older people related strategies. Bury now has its Housing for Additional Needs Vision, Strategy and Market Position Statement, The Bury Let’s Do it Strategy and several other strategies and market position statements sitting across learning disabilities, mental health and our ageing population will all enable a revised DFG and adaptations policy, process and pathways that aligns to them all.

As a system we will look at opportunities around Technology Enabled Care, expanding our handy person scheme, a wide range of aids and adaptation solutions, looking at floating support to offer information, advice and guidance helping enable people to live independently at home for as long as possible, working with providers in a different way with a potential revised framework and considering how DFG can help get people home from hospital in a timely manner and prevent the need for admission in the first place. A cross system Adaptations Steering Group has been established, a term of reference produced, and an action plan has been developed with all stakeholders support to drive this work forward collaboratively.

Equality and health inequalities

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

- Changes from previous BCF plan
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Where data is available, how differential outcomes dependent on protected characteristics or for members of vulnerable groups in relation to BCF metrics have been considered
- Any actions moving forward that can contribute to reducing these differences in outcomes

Continuing the commitment of Bury Council and the CCG (Now ICS) to make significant improvements in equalities both as an employer and service provider, there has been a lot of progression since the last report. We are working together to deliver the Equality, Diversity, and Inclusion Strategy. Two new roles have been established this year; Equality, Diversity and inclusion Manager role which is a joint role between Bury Council and NHS GM (Bury) and a Project Manager role focused on Inclusive Recruitment and Reciprocal Mentoring which will work across Bury and Rochdale Public Services, Bury Council are hosting the role after leading on and succeeding in a bid to the Gm Health and Social Care Partnership.

Our aim has been not only to protect those who are the most vulnerable and engage with those whose voices are seldomly heard but also to create a provision which is not only reflective of our communities but also understands the cultural and religious needs of our communities.

There has been significant community funding through the Neighbourhood pitch events to address neighbourhood inequalities as well as a development of the Radcliffe People and Communities plan, one of the priorities of which is Health and Wellbeing

In line with our strategy of focusing on one protected characteristic each year we created a Bury Race Plan and over the past year we have had conversations across our neighbourhoods with different communities to discuss Race and Racism. There has been lots of engagement with our communities and an action plan has been developed that will be delivered over the next few years, in line with the Let's Do It Strategy. We are committed to focus on; more education around different races and cultures for staff as well as creating more methods for inclusive recruitment e.g., easier, more accessible applications, going into community venues with job opportunities and creating safe spaces for feedback about the process of recruitment. In conjunction with partners, we will ensure we give voice to lived experience, be vocal and positive advocates and celebrate diversity.

This year we have started to create and action our Disability Plan which will comprise of Bury Council, ICS and other partners including Bury VCFA developing structures which are more inclusive to create safer spaces for the staff and residents of Bury who have disabilities. This plan includes strengthening our approach to reasonable adjustments for staff and engaging with residents, building the confidence of our workforce around

disabilities, to support the progression of people who are disabled within our workforce and more.

We have continued to engage Team Bury partners, businesses and investors into the Inclusion Strategy; the Inclusion Working group which now engages with a wider range of members from other public services as well as the VCSE. Positive outcomes from this group have included inclusion forming part of the inaugural Team Bury Away Day, which was held in July, the Council's Director of People & Inclusion presenting on the Inclusion Strategy to the Bury Business Leaders Group and signposting to various sources of support for businesses to strengthen their focus on inclusion.

To develop our commitment further towards equality we have also set up a community cohesion sub-group from the Community Safety Partnership in which community leaders are involved to continue the partnership working.

Currently there is work underway to formally review all HR policies and develop a new managers handbook as a single source for all relevant policy and guidance information. All new and revised policies are subject to formal Equality Impact Assessment

- Goals for the following year:
- Celebrate the voices of those with lived experience
- Deliver the next steps of the race equality plan
- Deliver the Disability plan
- Continue working with the Inclusion Working Group to ensure EDI is embedded through our work

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.