HM Government

NHS England

BCF narrative plan template

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans. Although the template is optional, we ask that BCF planning leads ensure that narrative plans cover all headings and topics from this narrative template.

These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 25 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

Cover

Health and Wellbeing Board(s).

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

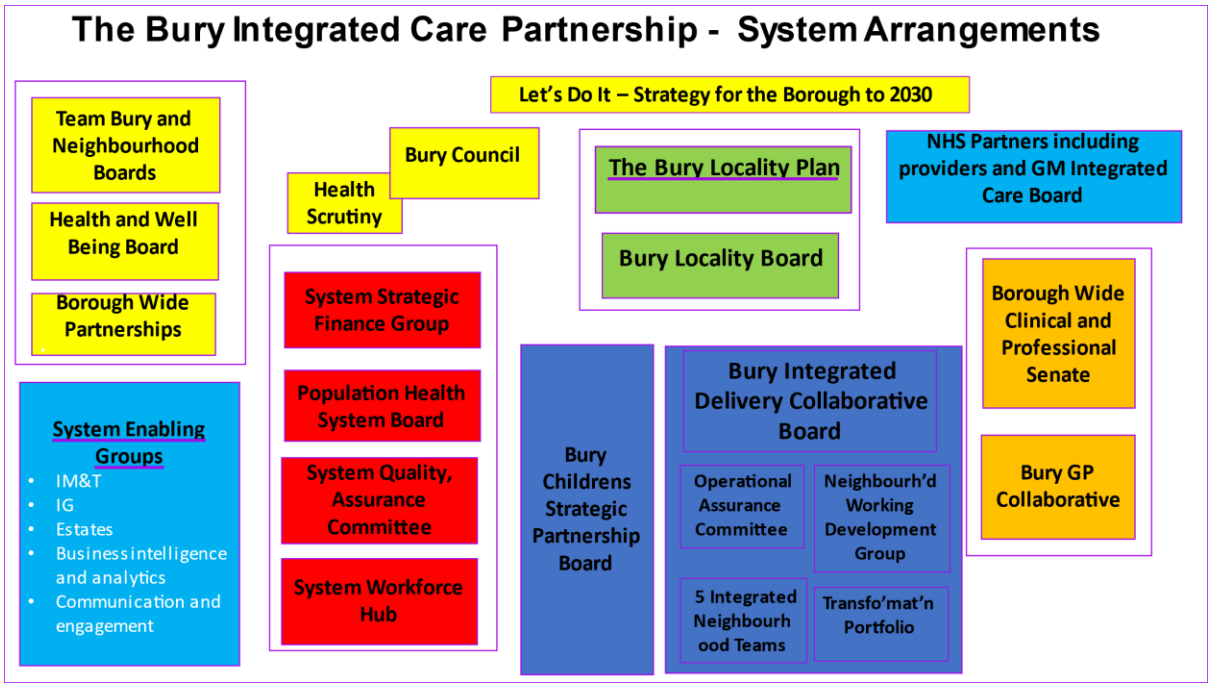
Membership of the Health and Wellbeing Board will be made up of leaders across the NHS, Social Care, Public Health, Wide Public Services, and other services directly related to Bury operating as a Population Health System

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, Health and Adult Care
- Director of Public Health
- Two nominated representatives from NHS GM Bury
- 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.

Bodies involved strategically and operationally in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils).



How have you gone about involving these stakeholders?

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 outcome 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.

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 explicitiy 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.

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

Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

The Health and Wellbeing Board has been established to act as a 'Standing Committee' within the Bury locality system architecture to focus on driving and coordinating action across all stakeholders to improve population health and reduce health inequalities.

The Board has adopted the Greater Manchester adapted Kings Fund Model of a Population Health System as a framework of delivery and the agenda is structured around the 4 quadrants within the model:

• Wider Determinants of Population Health

• Behavioural and Lifestyle determinants of health

• The effect of place and community on health and well being

• The operation of the health and care system, and wider public service reform, in pursuit of population health gain

A Population Health Delivery Partnership chaired by the Director of Public Health has been established to support the work of the Health & Wellbeing Board, facilitate the development of Bury as a 'Population Health System' and to support system assurance around delivery against the 'Better Health' element of 'Triple Aim'.

Bury Locality Board was formally constituted as a decision making board from 1st April 2023.

The Bury Locality Board would be a hybrid arrangement as outlined in the submitted documents and summarised as below:-

In respect of the Integrated Health and Care Fund (S75, Pooled Budget), the Locality Board will sit as a joint committee (of the ICB and Local Authority), established under Regulation 10(2) of the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 ("the 2000 Regulations"). In respect of the NHS GM Aligned Budget (non-pooled) element of the Integrated Health and Care Fund (Aligned Budgets), the Locality Board will sit as a Committee of the Integrated Care Board (ICB) of NHS GM on which there is Council and wider partner representation.

The Locality Board will fulfil the requirements as outlined in the NHS GM Scheme of Reservation and Delegation. The Locality Board would hold one meeting with all members present in which both elements would be discussed and received in a collaborative way and the agenda/report coversheet would clearly define which remit a decision was to be made under. All voting arrangements are outlined in the Terms of Reference accordingly.

Recognising that prior to 1st July 2022, the Locality was working in shadow form the approach to the formalisation of each document has been to use the shadow documentation as the base point with additional amendments included to reflect key changes post 1st July 2022. This approach ensures that the integrity of shadow locality working arrangements remains with amendments included as appropriate to further strengthen governance arrangements and the related detail.

In particular, finance schedules and the related documentation has needed to be amended to reflect the reduced level of budgets now delegated to localities. Whilst the Locality Board terms of reference are based on the shadow governance arrangements, a number of additional elements have been included to reflect key inclusions that all Greater Manchester localities are required to incorporate.

In Bury, the Locality Board is to work under a hybrid arrangement meaning that it is a Joint Committee of the Local Authority for the s75 and pooled budget decisions and then a committee of the ICB to enable it to receive and act on ICB delegations along with making decisions collectively on aligned and non-pooled budgets.

Operationally, the hybrid working arrangement will allow the Locality Board to operate as a single meeting which will have the section 75 Committee in Common embedded within it. This approach will ensure that all Locality Board members will be able to contribute to the discussions in an open and transparent manner.

The membership and voting rights have been amended to reflect current working arrangements. It is noted that these inclusions may need further consideration as ICB and locality working arrangements develop further.

The updated terms of reference clearly outlined which members have voting rights for section 75 decisions and which can vote for decisions linked to aligned (non-pooled) decisions. The agenda for Locality Board meetings will clearly detail under what section of the meeting a specific decision is to be made in to ensure voting rights for each item are explicit at the outset.

The revised terms of reference also include additional detail to fully reflect Local Government requirements for decision making– a number of elements of standardised text have been included to fully reflect processes and guidance to ensure compliance with the constitution.

The Locality Board terms of reference continues to be under pinned by the updated Locality Plan documentation along with the ongoing commitment to strong neighbourhood and partnership working within Bury.

The Bury Integrated Care Partnership Agreement remains an integral document that underpins our local commitment to strong neighbourhood and partnership working. In particular, this partnership agreement articulates in specific terms how the integral partnership working across the locality is governed by the Locality Board and related governance structures.

The formalisation of the Locality Board does not in any way change this partnership agreement rather, the two governing documents together help to strengthen and embed the strong working arrangements across the Borough.

A key component of the required GM ICB assurance is the rebasing of existing section 75 agreements recognising that revised budgetary delegations under ICB arrangements limit budgets that can be pooled under this agreement. It should be noted that this is an agreement between the Local Authority and NHS Greater Manchester.

Whilst not a formal requirement of GM ICB approvals, it is important to recognize that the Locality Plan remains the underlying commitment that partners work to around which all the formalised governance arrangements sit.

Executive summary

This should include:

- Priorities for 2023-25
- Key changes since previous BCF plan.

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, ICB 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 - The updated quality for life tool 'A Better You' is now live 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 and aligned to Primary Care Networks 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.

National Condition 1: Overall BCF plan and approach to integration

Please outline your approach to embedding integrated, person centred health, social care and housing services including:

- Joint priorities for 2023-25
- Approaches to joint/collaborative commissioning
- How BCF funded services are supporting your approach to continued integration of health and social care. Briefly describe any changes to the services you are commissioning through the BCF from 2023-25 and how they will support further improvement of outcomes for people with care and support needs.

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, ICB 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.

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National Condition 2

Use this section to describe how your area will meet BCF objective 1: **Enabling people to stay well, safe and independent at home for longer.**

Please describe the approach in your area to integrating care to support people to remain independent at home, including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to help people to remain at home. This could include:

- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management, and proactive care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at place or neighbourhood level, taking into account the vision set out in the Fuller Stocktake
- how work to support unpaid carers and deliver housing adaptations will support this objective.

Neighbourhood delivery is at the heart of the approach in Bury and will continue to be so in 2023.24. There are numerous components to this including:

Integrated Neighbourhood Health and Social Care Teams

There are 5 teams comprising ASC and adult nursing teams operating under single line management arrangements. These provde core social work and ditrict nursing functions for our population. Key priorities for 2023.24 include:

- Reduce waiting times for allocation of new referrals for a social work assessment.
- Improve and embed integrated assurance processes to support integration.
- Develop links and support closer working with wider public services through active representation in Public Service Leadership Teams in each Neighbourhood (see below).

Active Case Management (ACM)and Neighbourhood MDTs

Active Case Management is a key part of the Neighbourhood model providing targeted support to people with multiple long term conditions and wider health and social care needs via Multi Disciplinary Team Meetings (MDTs) 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. The approach is underpinned by the principles of proactive personalised care and strengths-based assessesment and working. About 1000 people a year are referred to ACM. In 2022 Ripple Effect Mapping evaluation was undertaken which showed the benefits to residents and professionals of this approach including the delivery of more preventative and holistic interventions and less siloed working together with improved professional relationships, trust and shared leaning. Priorities for 2023.24 include:

- Improved data collection, recording and reporting.
- The development of improved mechanisms for monitoring the outcome of ACM for individuals referred.
- Improving referral pathways and connectivity with childrens and family services.
- Improving referral pathways and connectivity with mental health services as the Mental Health Living Well model becomes embedded within our Neibourhoods (see below).

Neighbourhood Health and Care Plans

These are plans that have been informed by:

1. Local data and intelligence on need and health outcomes and inequalities
2. Identification of trends in relation to issues being picked up through ACM and local services
3. Engagement with local health and care partners including GPs and VCSE organisations

The overarching health improvement priority identified for 2023-25 is reducing the risk of coronary heart disease (CHD). In the first phase the emphasis will be on 'find and treat' through primary care with a focus on identify people at the highest risk of developing CHD and optimising treatment. There will also be an focus on improved data collection to support interventions aimed at reducing inequalities in access and outcome in relation to CHD. This programme of work is underpinned by a population health management approach.

In addition to this Borough-wide focus each neighbourhood has identified a priority and shared improvement plan setting out the contribution of primary care and other partners. These include:

- Increasing the uptake of bowel cancer screening in our Neighbourhood with the lowest current uptake.
- Increasing the completion of health checks with people with a serios mental illness [SMI] and improving support for people with a co-occuring mental health and drug / alcohol problems.
- Improving care planning and support for people with dementia (and their carers) especially at the end of life in our Neighbourhood with our oldest population profile.

Mental Health Living Well Model

A key priority for 2023.24 will be the establishment of new models of care for people with mental health problems. This will involve the establishment of Living Well Teams in our Neighbourhoods along with the redesign of our CMHTS to align with our Neighbourhood model. These Neighbourhood Living well Teams will:

- Comprise of mental health practitioners, wellbeing practitioners and support workers.
- Able to to draw on a locality-wide hub including a psychiatrist, psycologist, nursing, employment advice and substance misuse workers.
- Involve partnership devlivery between primary care, Pennine Care Foundation trust and VCSE providers.

- Be closely integrated with CMHTs and with mental health crisis services with simplified referral and care pathways.
- Work closely with our Integrated Neighbourhood Teams and ACM model.
- Embed an MDT approach to assessment, care planning and delivery drawing on the principles of asset and strengths based working.

An important part of the approach has been the involvement of people with lived experience in the design of the living well model through the commissioning of a lived experience partner organisation. This approach to actively involving people with lived experience will be sustained in 2023.24.

PCNs

In Bury we are working pragmatically with the fact that our 4 PCNs do not align with our 5 place-based Neighbourhoods.

Strategically our GP Leadership Committee provides an arena for joint leadership and planning across primary care and other parts of the health and care system and in some cases there are joint Neighbourhood and PCN planning meetings.

In some cases such as with the Mental Health Practitioners (funded by ARRS and through MH commissioning) these posts are aligned to the Neighbourhoods) and we have representation of PCN ARRS posts within our Neighbourhood MDTs e.g. the PCN pharmacists.

Over 2023.24 we will continue to work with PCNs and other health and care partners at a Neighbourhood level to develop integrated Neighbourhood 'teams of teams'. We will seek to align and integrate teams and approached were it make most sense to do so. For example we will build on work that has started to ensure effective joint working and pathways between our PCN care home teams and out two-hour crisis response team.

Virtual Wards – hospital at home

We have an established hospital at home programme with step up and step down pathways supported by joint working between acute clinicians and our community multidisciplinary Rapid Response Team. Over 2023.24 we will expand capacity and develop the pathways in and out of the service through strengthening the links with out Neighbourhood MDTs and primary care. We will also be working on how 'hospice at home' provision can be further delevelped again through better pathway integration with our Hospice, palliative care consultant and community nursing teams.

Public Service Leadership Teams

Over the past year we have established Public Service Leadership Teams in our 5 Neighbourhoods. Representation includes out Neighbourhood Health and Care Team Leads, the police, housing, fire service, public health and local authority. These provide an opportunity for building relationships, sharing intelligence and developing a shared understanding of need at a Neighbourhood level. We will continue to develop and embed these teams over 2023.24 and start to develop opportunities for more joined up planning and public service delivery at a Neighbourhood level. This will build on work which has started in

one of our Neighbourhoods with the development of a shared People and Communities Plan. This forms part of Bury's wider public service reform programme.

Enabler – integrated workforce development

An integrated workforce strategy is being developed which aligns with the GM ICB workforce strategy. Recruitment, retention, wellbeing and development are at the heart of this. There are specific plans about the development of system leadership skills among our clinical leadership.

To support the delivery of personalised care over the last couple of years we have had a focus on rolling our Strengths-Based Training across our health and care workforce with over 900 staff trained to date and 200 trained in ethnographic approaches. In 2023.24 the focus will be on:

- Further roll out of Strengths Based Training with a focus on the health workforce
- Identifying additional funding to train more frontline staff in ethnographic approaches
- The continued roll-out of dementia awareness training across our health and care workforce and specifically training on supporting people with dementia and their cares at the end of life.

Enabler – information and digital

While many health and care staff have access to the Greater Manchester Care Record (GMCR) we know that we could improve how it is used by practitioners to support the delivery of more joined up care. Our priorities in 2023.24 will be to:

- Promote the use of the GMCR across our workforce.
- Take part in a proof of value initiative led by Health Innovation Manchester to implement a shared electronic dementia care plan starting in one of our Neighbourhoods.
- Deliver an initiative to roll-out the Safe Steps application to care homes including the virtual sharing of information with PCN care home teams to support better triage proritisation and primary care response to patients in care homes.

National Condition 2 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support people in the community. This should include:

- learning from 2022-23 such as
    - where number of referrals did and did not meet expectations
    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. admissions avoidance and improved care in community settings, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
    - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?

  how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

The demand currently outweighs capacity due to the following pieces of work that the system has implemented in line with Home First Principles and Strengths based approaches to assessments. This is an ongoing piece of work and comprises of the following actions.

Bury FGH patients are supporting an increase in numbers of people via a Test of Change using Home First Principles reducing the amount of people going to bed based services.

Additionally work is in play with MRFT colleagues at NMGH to do the same with back to basics and a steady professional challenge to reduce the bed based pathway referrals to Home First.

This will see a continual increase in the demand for Home Based Services, whereby the funding for capacity for reablement would not afford the system to meet its Home First expectations.

This has been mitigated by the following workflows

- Strengths based assessments.
- Expenditire of cost of care onto ConTrocc system part of care management LAS which allows commissioning in more flexible ways reducing high cost care provision reducing 30 minute blocks to actuals care required.
- Use of commissioned care providers who are contracted to support the increase with oversight from reablement to reduce the length of stay for assessment of long term care needs and improved targets for discharge from community services.
- Reduce overprescribing increase by appropriate interventions.

However based on data from the last 3 years we know that we also have times of pressure in the system in September and again November to March as part of winter pressures. This data is based on the last 3 years aggregated average or referrals but we do expect with the work that is in place that this will reduce significantly.to home based services and these predictions will reduce significantly for the bed based referrals.

We do find that under the Trusted Assessment route though that Out of Area hospitals will increase referrals to bed base during these periods due to risk management and the onus remains on us to challenge professionally and appropriately and not react.

Our care at home providers have been commissioned on an 80/20 split in zoned areas of the borough to deal with the referrals each week allowing them to plan rota's and manage cacpcity and demand; and we always have the ability to use our peripheral providers who hold a contract ,and if there are serious blockages we will also utlise one of the peripheral providers on a block of hours if a specific area is struggling in the zones.

Inappropriate referrals are discussed with referrer for appropriate and consented pathway.

We are rewriting the pathway for reablement to reduce people who already have long term care being reviewed before re referring to reablement where there are no improvement/reablement goals allowing them to have full care act assessments in the community and reducing the number being referred incorrectly.

360 people were referred to Care at Home but they continued to be case managed by the Intermediate team to ensure goals were achieved and care providers supported in the last 6 months.

There will be no gaps as we will continue with this process, however we will aim to improve the flow in current services.

We are doing a back to basics with NMGH who assess for care and support in far greater demand than other GM hospitals.

Additionally FGH are continuing with Tests of Change as part of referral processes from therapy leads to therapy team which reduces time for unesscessarry referrals an strengths based assessment.

Admission avoidance has been supported by Bury's Rapid Response Service who support A&E within 2 hours.

Additionally we have commissioned Age UK to support Hospital to Home Scheme to prevent admissions and LOS, and HMR Cicrle for HMR patients.

We utlise the Home First slot daily for East Lancashire Patients and also work with HMR Stars(Reablement) as above.

Another good support is to have support for Unpaid Carers and Families for Bury Patients via The Bury Carers Hub for families who may need some support understanding strengths based services and dealing with queries as there is a significant change with their family member.

Bury's Integtarted Neighbourhood Team complete active case management and are supporting to 100 discharge and return customers to look at a plan for avoiding hospital.

Rapid Response are taking people from the NWAS stack to support admission avoidance

Rapid Response also support care homes pre 111/emergency calls to see if they can step in to support admission avoidance.

We have a virtual hospital in place and our equipment stores has put in a vast amount of money to ensure that equipment required for home is available on the day so as not to increase LOS.

In cases where complex needs are identified a full care act assessment can be completed at in the same time as trusted assessment by streamlining the assessment and sending to community review teams to act accordingly within 4 weeks, allowing these customers to not suffer multiple moves these are low in numbers but are usually complex pathway 3.

We are also aware from our local and GM systems that the number of residential and nursing placements are at a minimum and that is a further reason for looking to the Home First pathway.

Where criteria outweighs demand for bed based services on discharge or admissions for social reasons more work is happening in the community integrated teams and with GP's to prevent hospital being a place to be admitted to source placements by robust criteria for admission at the front door of A&E along with the INT Teams working on the top 100 people admitted and rapid response. We expect that the capacity outweighs demand due to funding and also whilst the system makes changes to the Home First Model.

Where an individual cannot be supported into short term services a full care act assessment will be completed to manage need and expectations reduce LOS where they are complex need and would be disadvantaged by multiple moves.

Where they are supported to bed based services we are also looking to reduce LOS in services to be able to support demand

National Condition 2 (cont)

Describe how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25, and how these services will impact on the following metrics:

- unplanned admissions to hospital for chronic ambulatory care sensitive conditions
- emergency hospital admissions following a fall for people over the age of 65
- the number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.

b) 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

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.

- 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 NWAS 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

The BCF plans to reduce unplanned admissions to hospital for chronic ambulatory care sensitive conditions by Bury patients. This would see 1,073.4 admissions per 100,000 population for Bury patients. In 2022-23 performance on this metric was 1,106 meaning that 3% improvement is being targeted.

The BCF plan targets a target 91,5% of all Bury patients to be discharged to there usual place of residence

The Bury Hospital at Home (H@H) Service commenced in October 2022 and 384 patients have been managed through this service fron October until end of May. Step up and Step Down models have been with the mainpathway has been the step up (admission avoidance frailty pathway) in the initial stages being on the frailty pathways with respiratory and end of life patients currently developing and Step down. There has been recruitment of a team and the team will be fully in place from June 2022 so that numbers can be increased to meet the agreed trajectory.

The Rapid Response / Hospital at Home service have begun a series of education and awareness raising sessions with GPs and Care homes about their services and what can be managed in this service and will be exteneding this programme. Also they are planning awareness raising and joint working events with staff on the hospital sites with the first being planned for July 2023 to increase awareness and identify patients suitable for the service in a step down model from ED, SDEC and the acute medical unit at fGH

Falls

One of the main pathways developed for the H@H service has been frailty with the H@H service linking ED, SDEC and community services.

There has been a successful pilot of a falls lifting service in the locality for patients with Carelink service that demonstrated that only 11% of the patients who used the service required ambulance conveyance to hosptial. There is also further work ongoing across GM with falls lifting service. Therefore, a priority for 23/24 for Bury is to review options and to establish a suitable locality service.

A significant proportion of the referrals to Rapid Response are for falls. Data from Apr 21-Mar 22 showed that 11% of referrals to Rapid Response were for falls. Of these referrals, only 6% were advised to attend an ED department.

One of the main prioroties for 23-25 is to review all the falls services within the locality and to ensure more streamlined pathways between them to link acute or crisis management to prevention with the Rapid Response service playing a key part in linking these services together.

Discharge to a Care Home

There is a programme of improvement underway for the IDT team . Part of this is a programme of work to increase the numbers sent on a Home Pathway.

From Sept 2022 to May 2023, 289 Bury residents who were inpatients at Fairifeld General Hosptital, were discharged to a nursing home as a new placement (temporary or permanent ie Pathway 2 or 3). This is equivalent to 4.5 % of the total Bury resident discharges from that hospital site.

There are also Bury residents at North Manchester General Hospital and the DKAFH list numbers for Bury patients is largely about the same on both sites. Therfore, it is likely that at least the same number of Bury patients from NMGH were discharged to a Care home (Pathway 2 or 3) but accurate data is not currently available for NMGH.

The current programme of improvement for IDT involves work across both FGH and NMGH. And will include data improvement and validation. One reason this performance meeting the Hospital Discharge and Community Support Policy, 2022 is the availability of the IMC at Home and reablement service in Bury, facilitating people to return to their own home with appropriate support and rehabilitation.

More joint working between the IMC and reablement service and collleages at FGH and NMGH is planned to further improve the dicharges to usual residence for Bury residents.

National Condition 3

Use this section to describe how your area will meet BCF objective 2: **Provide the right care in the right place at the right time.**

Please describe the approach in your area to integrating care to support people to receive the right care in the right place at the right time, how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to support safe and timely discharge, including:

- ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support, in line with the Government's hospital discharge and community support guidance.

- How additional discharge funding is being used to deliver investment in social care and community capacity to support discharge and free up beds.

- Implementing the ministerial priority to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow.

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.

- 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 NWAS 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

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	
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.

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.

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.

Discharge to Assess Beds - Bury's Discharge to Assess beds are 8 Nursing beds and 8 Dementia 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. Bury's discharge to assess beds are 8 nursing discharge to assess beds in Wolfson and 8 Dementia discharge to assess beds on Rowen Tree. All are single rooms and benefit from ensuite facilities. The care home has many communal lounges and facilities on its large site.

Hospital Discharges

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.

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.

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

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.

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. This service is currently under review.

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.

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.

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, utlising 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 centres 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.

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 being a new form of support not previously known in Bury.

Home from Hospital

Commissioned an enhanced home from hospital service, to replace the current 'Take Home and Tuck Up' scheme and various voluntary sector activities. . 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 speedily 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.

National Condition 3 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support discharge from hospital. This should include:

- learning from 2022-23 such as
    - where number of referrals did and did not meet expectations
    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. improved provision of support in a person's own home, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
- planned changes to your BCF plan as a result of this work.
    - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?
    - how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

There is an increased focus across the system on transfers of care and patients currently waiting in hosptial who do not have the criteria to reside, which we term in Bury locality as the Days Kept Away From Home (DKAFH). This DKAFH work forms part of the Bury wide Urgent Care Improvement Programme.

A review was carried out by the Emergency Care Improvement Support Team (ECIST) into our Integrated Discharge Team (IDT) in February 2023. The team covers all Bury residents in any acute hospital. The main team is based at Fairfield General Hospital in Bury and there is also a team on site at North Manchester General Hospital. ECIST made recommendations for improvement opportunities and potential options for further work in relation to the IDT and transfers of care. An action plan is being developed to address the recommendations to include themes focussing on; interdisciplinary working, more streamlined pathways, rebranding of team as a discharge hub, improved lines of accountabilty and governance. ECIST have offered their continued support and guidance as we carry out our improvement work in this area.

Monitoring and Responding to Demand and Capacity

A discharge app was developed and came into use in late 2022. This is used by the wards and IDT as a means of 2 way to ensure real time, accurate information on every patient. It

is also used as a source of data eg. numbers and days spent on the DKAFH list, discharge pathways. This has taken some time ensure the app is reliable source of data and information. Training has been carried out but there is further training planned that the IDT to carry out across ward teams and further work is planned to review and improve the app. All meetings related to the DKAFH patients including thye DKAFH meetings, long length of stay and out of area meetings will be reviewed to ensure that they are fit for purpose.

MDT working

One of the main recomendations made by ECIST for the discharge hub was increased therapy involvement. Two 'Home First Therapist' posts have just been advertised and when those people come into post, work will then begin to embed the therapy role into the IDT alongside with the current nursing and social work roles. A review of current, historic roles will the take place and a work plan will be developed to increase interdisciplinary working, in order to maximise efficiency and the skills of the team. A 'Home First Pathway Co-ordinator' is also currently being developed and it is planned that this role will be integrated into the discharge hub from early 2024.

The new Home from Hospital Team run by Age UK is now based in the discharge hub from October 2022. Further development and integration of this team into the hub is planned for 2023/24.

Home First / D2A

In addition to the work above, the Northern Care Alliance is involved with the Discharge Frontrunner programme which is made up of two parts – Complex Dementia Care and Strengths Based Approach.

For the dementia programme, system wide workshops have taken place to identify potential test of changes related to three priority areas; admission avoidance, care whilst in hospital and discharge options. Programmes of work are now being further developed in these three areas.

For the strengths based approach aspect of the Discharge Frontrunner work, the aim is that 95% of patients age 65 and over will be discharged to their usual place of residence by Janurary 2024. (The current figures is approximately 85%). There are tests of change being carried out on six of the medical wards at FGH and supported by the Quality Improvement team and intermediate tier teams such as IMC and Rapid Response. All are related to preventing deconditioning and encouraging a home first approach approach by using services to facilitate discharge home at the earliest opportunity eg. Hospital at home.

A frality service within the Same Day Emergency Care (SDEC) has been developed at FGH. This services manages frail patients and has shown good patient outcomes, admission avoidance and reduced length of stay. This service is a MDT approach and has strong links with intermediate tier teams including Rapid Response, Hospital at Home and reablement. Further work is planned between these services to ensure a seamless pathway between intermediate tier services and Frailty SDEC with a view to developing other SDEC pathways.

Flexible Working

With a recent increase staffing numbers within the IDT, the team began to work weekends again at the FGH site from May 2022. A further review of the weekend rota is planned to ensure appropriate cover. The intermediate tier services operate at weekends and accept patients for discharge or admission avoidance. The Rapid Response service also supports and bridges some delays in packages of care both during the week and at weekends. However the number of discharges from the DKAFH list remains low at weekends, therefore wider system work including a review of all services at weekends is planned.

Trusted Assessment

The IDT operate a trusted assessment model carrying out and accepting assessments from several professions and services across different organisations. Representatives from the team are also involved in the GM out of area discharges workstream which is expected to generate further ideas and work about how we best support the discharge Bury patients who are inpatients at an out of area sites.

Engagement and Communication

A review and update of information given to patients and relatives is planned. A programme of Strength Based Training took place across several teams across the Bury system last year. This training package is now being further developed and the IDT have been identified as a key team to take part in this training in the next cohort.

Improved discharge to care homes

The rapid response team have established closer links with care homes in the Bury locality and are engaged in education, advice and awareness raising work with the care homes. They receive information about admissions to the hospital site on a daily basis and will use this information to inform work with for specific homes and to focus on to take this work forwards.

The team are also commencing a programme for awareness raising for GPs across the locality about the Hospital at Home and Rapid Response services to support in order to keep people in their familiar place and avoid admission to an acute hospital site. From the point of view of discharge there will be a series of meetings planned with care home providers to look at how to return patients back to their care home residence (for both existing and new residents) including improved communication, discharge requirements, cut off times.

Housing and Related Services

The Home from Hospital run by Age UK service does supports minor adaptations eg fitting of key safes. However housing does remain a challenge including less minor adaptations, de-

cluttering, furniture removal to support downstairs living, mobility and funtion around the home. Improved links within the local housing team will be explored and established.

National Condition 3 (cont)

Set out how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25 and how these services will impact on the following metrics:

- Discharge to usual place of residence

Home First / D2A

In addition to the work above, the Northern Care Alliance is involved with the Discharge Frontrunner programme which is made up of two parts – Complex Dementia Care and Strengths Based Approach.

For the dementia programme, system wide workshops have taken place to identify potential test of changes related to three priority areas; admission avoidance, care whilst in hospital and discharge options. Programmes of work are now being further developed in these three areas.

For the strengths based approach aspect of the Discharge Frontrunner work, the aim is that 95% of patients age 65 and over will be discharged to their usual place of residence by Janurary 2024. (The current figures is approximately 85%). There are tests of change being carried out on six of the medical wards at FGH and supported by the Quality Improvement team and intermediate tier teams such as IMC and Rapid Response. All are related to preventing deconditioning and encouraging a home first approach approach by using services to facilitate discharge home at the earliest opportunity eg. Hospital at home.

Improved discharge to care homes

The rapid response team have established closer links with care homes in the Bury locality and are engaged in education, advice and awareness raising work with the care homes. They receive information about admissions to the hospital site on a daily basis and will use this information to inform work with for specific homes and to focus on to take this work forwards.

The team are also commencing a programme for awareness raising for GPs across the locality about the Hospital at Home and Rapid Response services to support in order to keep people in their familiar place and avoid admission to an acute hospital site. From the point of view of discharge there will be a series of meetings planned with care home providers to look at how to return patients back to their care home residence (for both existing and new residents) including improved communication, discharge requirements, cut off times.

National Condition 3 (cont)

Set out progress in implementing the High Impact Change Model for managing transfers of care, any areas for improvement identified and planned work to address these.

There is an increased focus across the system on transfers of care and patients currently waiting in hosptial who do not have the criteria to reside, which we term in Bury locality as the Days Kept Away From Home (DKAFH). This DKAFH work forms part of the Bury wide Urgent Care Improvement Programme.

A review was carried out by the Emergency Care Improvement Support Team (ECIST) into our Integrated Discharge Team (IDT) in February 2023. The team covers all Bury residents in any acute hospital. The main team is based at Fairfield General Hospital in Bury and there is also a team on site at North Manchester General Hospital. ECIST made recommendations for improvement opportunities and potential options for further work in relation to the IDT and transfers of care. An action plan is being developed to address the recommendations to include themes focussing on; interdisciplinary working, more streamlined pathways, rebranding of team as a discharge hub, improved lines of accountabilty and governance. ECIST have offered their continued support and guidance as we carry out our improvement work in this area.

Monitoring and Responding to Demand and Capacity

A discharge app was developed and came into use in late 2022. This is used by the wards and IDT as a means of 2 way to ensure real time, accurate information on every patient. It is also used as a source of data eg. numbers and days spent on the DKAFH list, discharge pathways. This has taken some time ensure the app is reliable source of data and information. Training has been carried out but there is further training planned that the IDT to carry out across ward teams and further work is planned to review and improve the app. All meetings related to the DKAFH patients including thye DKAFH meetings, long length of stay and out of area meetings will be reviewed to ensure that they are fit for purpose.

MDT working

One of the main recomendations made by ECIST for the discharge hub was increased therapy involvement. Two 'Home First Therapist' posts have just been advertised and when those people come into post, work will then begin to embed the therapy role into the IDT alongside with the current nursing and social work roles. A review of current, historic roles will the take place and a work plan will be developed to increase interdisciplinary working, in order to maximise efficiency and the skills of the team. A 'Home First Pathway Co-ordinator' is also currently being developed and it is planned that this role will be integrated into the discharge hub from early 2024.

The new Home from Hospital Team run by Age UK is now based in the discharge hub from October 2022. Further development and integration of this team into the hub is planned for 2023/24.

Home First / D2A

In addition to the work above, the Northern Care Alliance is involved with the Discharge Frontrunner programme which is made up of two parts – Complex Dementia Care and Strengths Based Approach.

For the dementia programme, system wide workshops have taken place to identify potential test of changes related to three priority areas; admission avoidance, care whilst in hospital and discharge options. Programmes of work are now being further developed in these three areas.

For the strengths based approach aspect of the Discharge Frontrunner work, the aim is that 95% of patients age 65 and over will be discharged to their usual place of residence by Janurary 2024. (The current figures is approximately 85%). There are tests of change being carried out on six of the medical wards at FGH and supported by the Quality Improvement team and intermediate tier teams such as IMC and Rapid Response. All are related to preventing deconditioning and encouraging a home first approach approach by using services to facilitate discharge home at the earliest opportunity eg. Hospital at home.

A frality service within the Same Day Emergency Care (SDEC) has been developed at FGH. This services manages frail patients and has shown good patient outcomes, admission avoidance and reduced length of stay. This service is a MDT approach and has strong links with intermediate tier teams including Rapid Response, Hospital at Home and reablement. Further work is planned between these services to ensure a seamless pathway between intermediate tier services and Frailty SDEC with a view to developing other SDEC pathways.

Flexible Working

With a recent increase staffing numbers within the IDT, the team began to work weekends again at the FGH site from May 2022. A further review of the weekend rota is planned to ensure appropriate cover. The intermediate tier services operate at weekends and accept patients for discharge or admission avoidance. The Rapid Response service also supports and bridges some delays in packages of care both during the week and at weekends.

However the number of discharges from the DKAFH list remains low at weekends, therefore wider system work including a review of all services at weekends is planned.

Trusted Assessment

The IDT operate a trusted assessment model carrying out and accepting assessments from several professions and services across different organisations. Representatives from the team are also involved in the GM out of area discharges workstream which is expected to generate further ideas and work about how we best support the discharge Bury patients who are inpatients at an out of area sites.

Engagement and Communication

A review and update of information given to patients and relatives is planned. A programme of Strength Based Training took place across several teams across the Bury system last year. This training package is now being further developed and the IDT have been identified as a key team to take part in this training in the next cohort.

Improved discharge to care homes

The rapid response team have established closer links with care homes in the Bury locality and are engaged in education, advice and awareness raising work with the care homes. They receive information about admissions to the hospital site on a daily basis and will use this information to inform work with for specific homes and to focus on to take this work forwards.

The team are also commencing a programme for awareness raising for GPs across the locality about the Hospital at Home and Rapid Response services to support in order to keep people in their familiar place and avoid admission to an acute hospital site. From the point of view of discharge there will be a series of meetings planned with care home providers to look at how to return patients back to their care home residence (for both existing and new residents) including improved communication, discharge requirements, cut off times.

Housing and Related Services

The Home from Hospital run by Age UK service does supports minor adaptations eg fitting of key safes. However housing does remain a challenge including less minor adaptations, de-cluttering, furniture removal to support downstairs living, mobility and funtion around the home. Improved links within the local housing team will be explored and established.

National Condition 3 (cont)

Please describe how you have used BCF funding, including the iBCF and ASC Discharge Fund to ensure that duties under the Care Act are being delivered?

Scheme Name	Scheme Description
Crisis Response/ Rapid Response/ Community Response	MDT of Health and Social Care Staff to prevent avoidable admissions to acute hospital or residential care. A rapid community response team providing short term, intensive, holistic support for people at risk of hospitalisation Multidisciplinary teams that are supporting independence, such as anticipatory care Vehicle to support transfer
Reablement Service	Short Term adult rehabilitation and reablement support Home-based intermediate care services Rehabilitation at home (accepting step up and step down users)
Intermediate Care	Short Term adult rehabilitation and reablement support Bed based intermediate Care Services (Reablement, rehabilitation, wider short-term services supporting recovery) Bed-based intermediate care with reablement accepting step up and step down users A single Bury wide integrated health and social care team focused on outcomes of individuals and their carer. Promotes independence, provides care, therapies and rehabilitation for prevention and early intervention Additional IMC beds (13) Bed-based intermediate care with rehabilitation (to support discharge)

Staying Well Programme	Systematic identification and support of older people aged 65+ at risk of needing social care Multidisciplinary teams that are supporting independence, and adopting prevention and early intervention approach
Meeting Care Act Requirements	Additional investment to enable local application of care act requirements Care Act Implementation Related Duties
Programme Management	Additional support to co-ordinate BCF and wider transformation programmes. The ask around the completion of the required templates has increased year on year. Reporting requirements have increased significantly.
Integrated Neighbourhood Teams/ IBCF Building Resilience and Enabling Systems	MDT case management supporting adults particularly at risk of admissions or readmission into hospital or permanent admission into nursing or residential care as well as high intensity users of various services Integrated Care Planning and Navigation and Assessment teams/joint assessment teams. Prevention and early intervention approach to case management
Protection of Social Care/ IBCF Building Resilience and Enabling Systems	Protection of Adult Social Care Services to enable continued whole system flow. The commissioning, quality assurance and contract monitoring of the following of the following: Home Care or Domiciliary Care Residential Placements - Care home Residential Placements – Nursing Home Residential Placements - Supported Living
Assistive Technologies and Equipment	Carelink 24 hr telephone link and technology to provide a home safety and personal safety security system that enables people to remain at home for longer

Disabled Facilities Grant	Meeting the costs of adapting homes to enable people to stay independent in their own homes Adaptations, including statutory DFG grants
Discharge to Assess Beds	8 Nursing D2A beds 8 step down beds to support those people in hospital with the most complex dementia needs, to have their long term needs assessed in a non-hospital setting Bed-based intermediate care with rehabilitation (to support discharge)
Primary Care Support	Primary Care Additional Support GP in reach to Intermediate Tier Additional Primary Care Appointments in the locality Additional GP support for the intermediate tier
Home From Hospital	Increasing voluntary sector capacity to support with discharges Support for discharge from the voluntary sector
Hospice / Palliative Care	Additional capacity in hospice services Additional support for the hospice to support discharge Palliative Care service expansion
Care of Vulnerable Adults - Fairfield Raid	Provide monitoring, treatment and support. Monitoring effects of medication, risk assessments and mental health risk assessments . Core 24 hour liaison support for physical health setting
Discharge Liaison Team	Plan discharge of patients with complex needs
Falls Prevention	Person based preventative support to adults at risk of falls Strength and Balance training

Supporting unpaid carers

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

Being a carer is one of Burys' protected characteristics to make sure that everyone is treated fairly and has equal access to our services and employment opportunities.

Links with the Corporate Priorities:

Bury Council and NHS GM Integrated Care currently commission n-compass to provide community carer services for adult carers caring for someone 18+ through the Bury Carers' Hub, as it is branded in Bury.

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 consultation and engagement with carers, the community, providers and partners.

The eight key emerging themes:

Carers are clear on what is important to them (4 Priority Statements)	**Information & Advice**	**Local community support; more activities & support**	**Respite**
Available support isn't right	**Befriending & peer support**	**Identification**	**Disjointed systems**

Four Key Priority Statements:
Balancing my own life with my caring role
Improving and maintaining my personal health and wellbeing
Being recognised, acknowleged and valued as a carer
To be socially active and not become isolated or lonely

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, mirroring and aligning to the Integrated Neighbourhood Teams, 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, offering and receiving a range of support and activities to enable carers to take a break and coming together to influence service delivery.

- 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. Link to spring/summer edition: https://www.n-compass.org.uk/flipbooks/28-04-2023-6th-bury-newsletter/index.html
- 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.
- Access to emotional wellbeing support through the Carers Help and Talk (CHAT) line available 24/7, 365 days, manned by volunteers.
- Outgoing calls to carers through the 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. The Bury Carers' Hub raise awareness and promote with GP Practices and carers.
- Digital groups and activities delivered on Zoom, including evening offer.
- Closed Facebook group for peer support.
- Pen Pal 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.
- Service briefings and overviews are offered to all organisations that could potentially work with, support, or identify carers. The briefings are now offered face to face or digitally. The sessions are bespoken to fit around busy teams and services. Carer Champion Training is also offered. The training is more in depth and looks at the impact of caring, legislation, a case study and includes the basic training.

- Delivery of training / courses for carers. Themes of the sessions are identified by carers.
- Support working carers to access / maintain employment or education.
- Informal advocacy for carers.

- The team know their clients well and have developed respectful and open professional relationships, this means they are able to intervene early to support carers needs from escalating.

- Bury Carers Hub and Northern Care Alliance (NCA) worked in partnership on a carers discharge pilot at Fairfield Hospital. The project originally focussed on three wards identified by the NCA which was extended to four, with the aim to identify carers at the point of discharge of a loved on and offered timely relevant support from the Bury Carers' Hub. For carers outside of the Bury locality, they would be directed to the relevant carer services. Delivery of carer awareness sessions were also delivered to staff at Fairfield Hospital.

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 carer and the social care professional who completes the assessment will create a support plan which will show how support will be arranged, and how the personal budget will be spent.
This may be a contribution towards:

- A UK break to recharge their batteries
- Towards a hobby
- Gardening or domestic help
- Practical equipment to help in the caring role, such as a washing machine, dryer
- Leisure to relieve stress

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 volunteer coordinators assess each carer and give ongoing support to them, their cared for, and the volunteers who visit them. This service is tailor made to meet individual needs of each carer and helps carers to have a life of their own alongside their caring role. This personalised service ensures that carers are valued, respected and listened to.

Depending on need, carers are offered regular support weekly, fortnightly or monthly.

Services offered include a regular visit from a volunteer befriender, phone support from volunteers, assessments and home visits from coordinators, phone support sessions from coordinators, invitations to wellbeing events, including monthly Coffee Stops, Jewish festival parties eg Chanukah party.

Coordinators carefully match volunteers to caring situations as this can be very sensitive. The cared for person may not wish to be left with anyone they are not familiar with, and the carer may feel uneasy about leaving the person they are caring for. Coordinators are very experienced at giving carers the confidence to accept the help and to ask for extra support when needed.

Volunteers often befriend the cared for person in their own home, sometimes take the cared for person out into the community, alleviating the carer from their caring role.

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.

Work is currently underway to review and refresh the Bury Directory.

Disabled Facilities Grant (DFG) and wider services

What is your strategic approach to using housing support, including DFG funding, that supports independence at home?

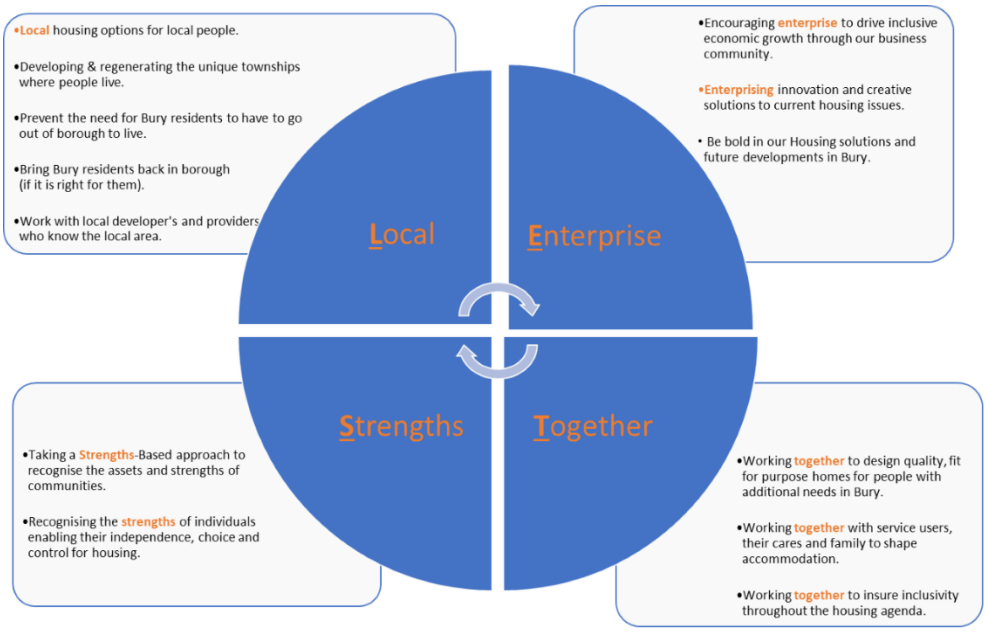
Bury has refreshed its strategic approach in using DFG funding. Revised national guidance, changes to resource in Bury Councils Community Commissioning department, corporate housing services, along with the development of the Housing for Adults with Additional Needs Vision, Strategy and Market Position Statement Adult Social Care Housing - Bury Council, and Bury 'Let's Do it' Strategy provide opportunities for an integrated approach to shape DFG usage in the best manner for residents.

As a system, these opportunities include:

- Technology Enabled Care (TEC).
- Expanding handy person scheme.
- Wider range of aids and adaptation solutions
- Utilise floating support to enable people to live independently at home for as long as possible.
- Working with providers in a different way, with a revised framework and considering how DFG can help people home from hospital in a timely manner.

Bury has an established Living Options Group (LOG) where partners collaborate to consider housing options and property allocation to individuals with care needs. There is now a Registered Provider Framework and strong relations with Housing Associations and developers in Bury to develop creative solutions to complex challenges. Along with the revised digital approach, with TEC at the forefront, all should be part of a revised pathway to support those with housing challenges in a different and innovative way. Therefore, end to end process mapping to understand the current process and design revised process is required.

The following diagram describes how the ASC housing programme for those with additional needs links with the corporate priorities:



Additional information (not assured)

Have you made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) to use a portion of DFG funding for discretionary services? (Y/N)

Yes

If so, what is the amount that is allocated for these discretionary uses and how many districts use this funding?

The Council will continue delivery of minor and major adaptations for households with additional need and agree to widen use of DFG for residents with additional needs. This includes by delivering:

- Innovation Grants/ Excess Cold Grants- preventing accidents and hospital admissions

- Repairs to adaptations- enabling people to stay in their home longer and prevent or delay the need for more costly formal care or residential placement.
- Minor Adaptations- Fund equipment store to provide larger minor adaptations costing less that £1,000 such as external metal handrails, grab rails and stair rails and other adaptations
- Technology Enabled Care (TEC)- allowing people to use technology to enable people to live independently at home, potentially preventing the need for adaption to properties.
- Housing support for older people- Handy Person to assist with minor adaptations and household DIY tasks.
- Incentivisation 'Moving Assistance'- help move tenants into a more suitable property or moving tenant out of an adapted property who no longer needs it to alternative home.

Full breakdown is below:

	Allocation of Disabled Facilities Grant	**Narrative/ Descriptor**	**Amount Allocated Per Annum**	**System benefit/ saving**
1	Main DFG Programme	Aids, adaptations extensions etc	£1,300,611	Income generated from means testing
2	DFG Top up Grants	Discretionary top up grant of up to £20,000 where costs of work exceed £30,000 max upper grant limit.	£80,000	Help provide parity across clients, helps supports those less well off financially.
3	Innovation Grants/ Excess Cold Grants	Fund range of innovation grants to prevent accidents and hospital admissions and to support people to live independently in their own home.	£15,000	Innovation grants enable flexibility to meet needs without adaptation or capital costs.
4	Repairs to adaptations	Capital related expenditure for repairs to existing adaptations in cases, where tenant remains in the property with the same needs	£20,000	Enables people to remain in the same property for longer – potential system savings as prevent or delay the need for more costly formal care or residential placement.
5	Minor Adaptations	Fund equipment store to provide larger minor	£225,000	Currently Equipment store budget funded via community care

		adaptations costing less that £1,000.		budget £40,000 adaptations stores budget & £185,000 personal Aids budget (Total £225,000)
6	Technology Enabled Care (TEC)	Fund the cost of TEC. Use monies to replace analogue units to digital. Help remove disparity/ inequitable process for funding/ charging for Carelink and other TEC. Enable people to live independently at home, potentially preventing the need for adaption to property.	£130,000	System saving for the Community Care Budget, but also for the wider system in preventing, reducing, or delaying the need for more formal care, or admission to hospital.
7	Housing support for older people	A Handy Person post linked to Home from Hospital service. The role would assist with minor adaptations and household DIY tasks. This role could prevent/ reduce people falls or injury to tenants.	£38,000	System savings as preventative and may be cheaper than going through procurement process for minor aids such as handrail fittings. The post could also help generate income if advertised and offered to support people who were willing and able to pay.
8	Incentivisation 'Moving Assistance'	Provide funding in cases where it is not possible/not appropriate course to adapt existing property. Monies would be utilised to help move tenants into	£100,000	Enables more speedily and efficient moves to achieve better outcomes for people. Would also be used when people are occupying an adapted property but no longer needing it.

		more suitable home or move someone out of an adapted property that no longer need it.		
9	Surveyor and technical suppor workforce	Providing resources to undertake surveying, technical and other workforce requirements for the adaptations t take place.	£168,000	The workforce cost has always been met by the DFG fund.
Total			**£2,076,611**	

Equality and health inequalities

How will the plan contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include

- Changes from previous BCF plan
- How equality impacts of the local BCF plan have been considered
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Changes to local priorities related to health inequality and equality and how activities in the document will address these
- Any actions moving forward that can contribute to reducing these differences in outcomes
- How priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.

Inclusion strategy and objectives 2021 to 2025

Bury Council and the ICB 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. This commitment is made as part of our leadership role in delivering the Bury 2030 vision through the Let's Do It! strategy, which has inclusion at its core.

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 ICB 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.

The inclusion vision for Bury 2030 is to enable every person in the Borough to fully participate in and shape the collective, by supporting people to be themselves; to speak out about ideas and concerns and to be heard. It describes commitments to develop relationships, create new and developed to hear every voice and co-design services with the people who use them, as well as ongoing community safety activity which drives cohesion through a culture of trust, tolerance and understanding.

The Council and ICBs strategic commitment to inclusion is further articulated in our joint inclusion strategy 2020 to 2024 that was agreed in early 2021 following a comprehensive external review.

This will help us to further improve our equality performance and also to ensure that we meet our obligations under the Equality Act 2010 and associated Public Sector Equality Duty.

In September 2021 Bury Council's Cabinet agreed to move towards the organisation's accreditation as a Real Living Wage employer by making arrangements to pay the Real Living Wage to all directly employed staff from April 2022 and move towards payment at this rate for staff employed by commissioned providers over a three-year period. The Council's

work here was recognised by the Living Wage Foundation with the Council awarded formal Real Living Wage accreditation in November 2021. Furthermore, this accreditation was fundamental in the Council's recognition as a Member of the Greater Manchester Good Employment Charter in February 2022. This commitment represented a significant financial investment for the Council, of a projected £5.5m over a five years period as of September 2021. The Council's October Medium Term Financial Strategy refresh added a further £3.2m to this cost owing to the unprecedented growth in the Real Living Wage this year. In making the case for payment of the Real Living Wage, Members noted that this would directly increase the pay of an estimated 4,000 of Bury's lowest paid workers, most significantly within the commissioned care setting. This approach was championed because of both its strategic importance in supporting the stability of this crucial sector, particularly in the context of Covid-19, but also in recognition of the evidenced link between 'good work' and 'good health'.

The Council's payment of the Real Living Wage is making a strong positive contribution to the Bury economy by directly increasing the income of nearly 5,000 Bury employees and influencing the decision of other local employers to follow suit. Furthermore, as the evidence above demonstrates this increase in employee income will be directly contributing to the health and wellbeing of the Bury workforce. It is, perhaps, too early to show any direct local impacts through, for example, reduced sickness absence rates or increased stability in the social care sector or lowest paid areas of the Council workforce. Demonstrating causation here would also be challenging given the current period of unprecedented change and economic uncertainty. The evidenced link here is, however, strong. Over the coming months the Council will continue to promote the Living Wage alongside the wider attributes of Good Employment through both its actions and own practices and will work to identify the positive impact of this work on the life chances of our communities.