Agenda

Locality Board – Meeting in Public (face to face)

Date: 7th April 2025

Time: 4.00 pm – 6.00 pm

Venue: Committee Rooms A & B, Bury Town Hall , Knowsley Street, Bury

Chair: Dr Cathy Fines

Item No.	Time	Duration	Subject	Paper Verbal	For Approval Discussion Information	By Whom
1.0	4.00 – 4.10	10 mins	Welcome, apologies and quoracy	Verbal	Information	Chair
2.0			Declarations of Interest	Paper	Information	Chair
3.0			Minutes of previous meeting held on 3rd March 2025 and action log	Paper	Approval	Chair
4.0			Public questions	Verbal	Discussion	Chair
Place Based Lead Update						
5.0	4.10 – 4.20	10 mins	Key Issues in Bury	Paper	Discussion	Lynne Ridsdale
Locality Board Priorities						
6.0	4.20-4.30	10 mins	Outcome of LGA Assessment and next steps	Paper	Information	Adrian Crook
7.1	4.30-4.40	10 mins	Lets do it Strategy	Paper	Discussion	Lynne Ridsdale
7.2	4.40-4.50	10 mins	Locality Plan -25/26	Paper	Approval	Will Blandamer
8.0	4.50-5.00	10 mins	Pennine Care Service Mapping	Paper	Discussion	Sarah Preedy
Integrated Delivery Collaborative Update						
9.0	5.00-5.10	10 mins	Integrated Delivery Board Update	Paper	Discussion	Kath Wynne-Jones
10.0	5.10-5.20	10 mins	Performance Report	Paper	Discussion	Kath Wynne-Jones
Updates						

11.1 11.2	5.20-35	15mins	Strategic Finance Group Update Better Care Fund 25/26 paper	Paper Paper	Approval Discussion	Simon O'Hare Simon O'Hare
12.0	5.35.5.40	5 mins	Population Health and Wellbeing update	Paper	Information	Jon Hobday
Committee/Meeting updates						
13.0	5.40-5.45	5 mins	Clinical and Professional Senate update	Paper	Information	Kiran Patel
14.0	5.45-5.50	5 mins	Primary Care Commisisoning Committee(PCCC) Update	Paper	Information	Adrian Crook
15.0	5.55	5 mins	SEND Improvement and Assurance Board Minutes and outcome of Deep Dive	Paper	Information	Will Blandamer
Closing Items						
16.0	5.55 – 6.00	5 mins	Any Other Business		Verbal	
17.0	_____	_____	**Date and time of next meeting in public - Monday, 2 June 2025, 4.00 - 6.00pm On Microsoft Teams**		_____	

Meeting: Locality Board			
Meeting Date	07 April 2025	**Action**	Consider
Item No.	2	**Confidential**	No
Title	Declarations of Interest		
Presented By	Chair of the Locality Board		
Author	Emma Kennett, Head of Locality Admin and Governance (Bury)		
Clinical Lead	N/A		

Executive Summary

NHS GM has responsibilities in relation to declarations of interest as part of their governance arrangements (details of which can be found outlined in the NHS Greater Manchester Integrated Care Conflict of Interest Policy version 1.2).

NHS GM (Bury Locality) therefore, has a requirement to keep, maintain and make available a register of declarations of interest for all employees and for a number of boards and committees.

The Local Authority has statutory responsibilities detailed as part of Sections 29 to 31 of the Localism Act 2011 and the Relevant Authorities (Disclosable Pecuniary Interests) Regulations 2012. For other partners and providers, we understand that conflicts of interest are recorded locally and processed within their respective (employing) NHS and other organisations as part of their own governance and statutory arrangements too.

Taking into consideration the above, a register of Interests has been included detailing Declaration of Interests for the Locality Board.

In terms of agreed protocol, the Locality Board members should ensure that they declare any relevant interests as part of the Declaration of Interest Standing item on the meeting agenda or as soon as a potential conflict becomes apparent as part of meeting discussions.

The specific management action required as a result of a conflict of interest being declared will be determined by the Chair of the Locality Board with an accurate record of the action being taken captured as part of the meeting minutes.

There is a need for the Locality Board members to ensure that any changes to their existing conflicts of interest are notified to NHS GM (Bury Locality) Corporate Office within 28 days of a change occurring to ensure that the Declarations of Interest register can be updated.

Recommendations

It is recommended that the Locality Board:-

- Receive the latest Declarations of interest Register;
- Consider whether there are any interests that may impact on the business to be transacted at the meeting on 7th April 2025 and
- Provide any further updates to existing Declarations of Interest within the Register.

OUTCOME REQUIRED *(Please Indicate)*	**Approval** ☐	**Assurance** ☐	**Discussion** ☐	**Information** ☒
APPROVAL ONLY; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	**Pooled Budget** ☐	**Non-Pooled Budget** ☐		

Links to Locality Plan outcomes	
To support a local population that is living healthier for longer and where healthy expectancy matches or exceeds the national average by 2025.	☒
To achieve a reduction in inequalities (including health inequality) in Bury, that is greater than the national rate of reduction.	☒
To deliver a local health and social care system that provides high quality services which are financially sustainable and clinically safe.	☒
To ensure that a greater proportion of local people are playing an active role in managing their own health and supporting those around them.	☒

Implications						
Are the risks already included on the Locality Risk Register?	Yes	☐	No	☒	N/A	☐
Are there any risks of 15 and above that need to be considered for escalation via an NHS GM Statutory Committee or Board in line with the Risk Escalation process ?	Yes	☐	No	☒	N/A	☐
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☒	N/A	☐
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☒	N/A	☐
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☒	N/A	☐
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☒	N/A	☐
Are there any financial Implications?	Yes	☐	No	☒	N/A	☐
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☒	N/A	☐
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
If yes, please give details below:						

Implications						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☒	No	☐	N/A	☐

Governance and Reporting		
Meeting	**Date**	**Outcome**
N/A		

Committees and Sub-Committees

Locality Board

Declaration of interest as per policy:
- Declare in meetings where relevant
- Not to be sent papers where conflicted
- Not to be involved in any decision making where conflicted (which may then also involve the following action to be taken at a meeting)
- Remaining present at the meeting but withdrawing from the discussion and voting capacity
- Remaining present at the meeting and participating in the discussion but not involved in any voting capacity
- Being asked to leave the meeting

Name			Current Position	Declared Interest- (Name of organisation and nature of business)	Type of Interest			Is the Interest direct or indirect?	Nature of Interest	Date of Interest		Comments
					Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests			From	To	
Voting Members (Pooled Budget & Aligned & Non-Pooled Budget)												
Cllr	Eamonn	O'Brien	Leader of Bury Council & Joint Chair of the Locality Board	Bury Council - Councillor	X			Direct	Councillor		Present	As per policy - see details above
				Young Christian Workers - Training & Development	X			Direct	Development Team		Present	
				Labour Party		X		Direct	Member		Present	
				Prestwich Arts College		X		Direct	Governor		Present	
				Bury Corporate Parenting Board		X		Direct	Member		Present	
				No Barriers Foundation		X		Direct	Trustee		Present	
				CAFOD Salford		X		Direct	Member		Present	
				Prestwich Methodist Youth		X		Direct	Trustee		Present	
				Unite the Union		X		Direct	Member		Present	
Cllr	Tariq	Tamoor	Executive Member of the Council Adult Care and Health	Bury Council - Councillor	X			Direct	Councillor	May-10	Present	As per policy - see details above
				Health Watch Oldham	X			Direct	Manager	Aug-20	Present	
				Pretty Little Thing				Indirect			Present	
				Action Together CIC	X			Direct	Employed		Present	
				The Derby High School			X	Direct	Governor	Apr-18	Present	
				St Lukes Primary School		X		Direct	Member		Present	
				Unite the Union		X		Direct	Community Member	May-12	Present	
				Labour Party		X		Direct	Member	Jun-07	Present	
Cllr	Smith	Lucy	Executive Member of the Council for Children and Young People	Bury Council	X			Direct	Councillor		Present	As per policy - see details above
				Business in the Community	X			Direct		July 2023	Sep-23	
				The Christie NHS Foundation Trust				Indirect	Related to Spouse	Jul-23	Present	
				Labour Party				Direct	Member		Present	
				Community in the Union				Direct	Member		Present	
				Socialist Health Association				Direct	Member		Present	
				Catholics for Labour				Direct	Member		Present	
				GMB Union				Direct	Member		Present	
Dr	Fines	Cathy	Associate Medical Director and Named GP	GP Federation	X			Direct	Practice is a member	2013	Present	Declaration of interest as per policy as detailed above (Y,Y,Y,Y,Y)
				Tower Family Health Care	X			Direct	Partner in a member practice in Bury Locality	2017	Present	
				Horizon Clinical Network	X			Direct	Practice is a member	2019	Present	
				Greater Manchester Foundation Trust				Indirect	Husband is employed		Present	
	Jackson	Catherine	Associate Director of Nursing, Quality & Safeguarding	Northern Care Alliance				Indirect	Partner is a Director at the Northern Care Alliance	2019	Present	As per policy - see details above
	Ridsdale	Lynne	Chief Executive for Bury Council	Bury Council		X		Direct	Chief Executive	Mar-23	Present	As per policy - see details above (Y,Y,Y,Y,Y)
	O'Hare	Simon	Locality Finance Lead	Simkat Shore Holdings LTD	X			Direct	Director	Apr-19	Present	As per policy - see details above. (Y,Y,Y,Y,Y)
	Kissock	Neil	Director of Finance/Section 151 Officer	None Declared					Nil Interest	Aug-24	Present	
	Heppolette	Warren	Chief Officer for Strategy & Innovation	Greater Sport			X	Direct	Trustee	2018	Present	As per policy - see details above (Y,Y,Y,Y,Y)
				FC United			X	Direct	Director	2021	Present	
Voting Members (Aligned & Non-Pooled Budget)												
Dr	Howarth	Vicki	Medical Director – Bury Care Organisation, NCA	Unilabs Ltd - Private Histopathology Service	X			Direct	Providing services as Consultant Histopathologist to the	2011	Present	As per policy - see details above (Y,Y,Y,Y,Y)
				Tameside and Glossop Integrated Care NHS Foundation Trust	X			Direct	Bank Consultant Histopathologist performing Coronial Post-	2015	Present	
	Fawcus	Joanna	Director of Operations, NCA	None Declared					Nil Interest	Nov 23	Present	
	Allan	Lorna	Chief Digital and Information Officer Digital Services. NCA	Trustee at St Leonard's Hospice in York			X	Direct	Trustee	Dec-23	Present	
Dr	Patel	Kiran	Member of the Locality Board	Tower Family Health Care - Primary Care General Practice	X			Direct	GP Partner	Jul-18	Present	As per policy - see details above (Y,Y,Y,Y,Y)
				Bury GP Federation - Enhanced Primary Care Services	X			Direct	Medical Director	Apr-18	Present	
				Laserase Bolton - Provider of a range of cosmetic laser and injectable	X			Direct	Medical Director	1994	Present	
				Laserase Bolton - Provider of a range of cosmetic laser and injectable				Indirect	Spouse is a Shareholder	2012	Present	
				Tower Family Health Care - Primary Care General Practice				Indirect	Spouse is a Director	Jul-18	Present	
	Preedy	Sarah	Chief Operating Officer, Pennine Care NHS Foundation Trust	None Declared					Nil Interest	Nov 23	Present	
	Hargreaves	Sophie	Chief Officer, Manchester Foundation Trust	Manchester & Trafford LCO				Indirect	Spouse works as Transformation Manager	Sep-18	Present	As per policy - see details above (Y,N,N,N,N)
	Tomlinson	Helen	Chief Officer, Bury VCFA	Bury VCFA (Voluntary, Community, Faith & Social Enterprise)	X			Direct	Chief Officer in organisation which may seek to do business with health or social care organisations	Nov-21	Present	As per policy - see details above (Y,Y,Y,Y,Y)
	Blandamer	Will	Deputy Place Based Lead & Executive Director Health and Adult Care	Ashton on Mersey Football Club Trafford			X	Direct	Chairman	2024	Present	As per policy - see details above (Y,Y,Y,Y,Y)
				Manchester Football Association			X	Direct	Non Exec Director (Board Champion for Safeguarding)	2018	Present	
				Francis House Hospice (Manchester)				Indirect	Spouse is a Registered Nurse	2024	Present	
				University Hospital of Wales				Indirect	Daughter is a Foundation Year 1 Doctor	2024	Present	
				Leeds University				Indirect	Daughter is a medical student	2019	Present	
	Richards	Jeanette	Executive Director of Children and Young People, Bury	None Declared					Nil Interest	Nov 23	Present	
	Hobday	Jon	Director of Public Health	None Declared					Nil Interest		Present	As per policy - see details above
	Bulman	Richard	Director of Nursing, Bury Care Organisation	None Declared					Nil Interest	2025	Present	
	Crook	Adrian	Director of Adult Social Care and Community Services	Bolton Hospice			X	Direct	Trustee	Jul-05	Present	As per policy - see details above (Y,Y,Y,Y,Y)
Non-Voting Members												
	Wynne-Jones	Kath	Chief Officer, Bury Integrated Delivery Collabrative	KWJ Coaching and Consulting	X			Direct	Owner	July 21	Present	As per policy - see details above (Y,Y,Y,Y,Y)
				Roots and Branches CIC	X			Direct	Director	Nov 23	Present	
				The University of Manchester - Elizabeth Garrelt Anderson programme	X			Direct	Tutor	Oct-22	Present	
	Richardson	Stuart	Chief Executive, Bury Hospice	None Declared					Nil Interest	Mar-25	Present	
Invited Members												
Cllr	Bernstein	Russell	Cllr Bury Council, Conservative Leader	Bury Council	X			Direct	Councillor	May-21	Present	As per policy - see details above (Y,Y,Y,Y,Y)
				Philips High School			X	Direct		Sep-19	Present	
				Bury and Whitefield Jewish Primary			X	Direct		Sep-19	Present	
				Conservative Party		X		Direct	Councillor	Jul-19	Present	
Cllr	Smith	Mike	Attendee of the Locality Board as Leader of Radcliffe First	Angles and Arches	X			Direct	Director	16/1/2009	Present	As per policy - see details above (Y,Y,Y,Y,Y)
				Anodising Colour		X		Indirect	Spouse is a lab technician	2017	Present	
				Radcliffe First		X		Direct	Leader	2019	Present	
				Radcliffe Litter Pickers		X		Direct	Member	2019	Present	
				Growing Older Together		X		Direct	Member	2019	Present	

Meeting: Locality Board			
Meeting Date	07 April 2025	**Action**	Approve
Item No.	3	**Confidential**	No
Title	Minutes of the Previous Meeting held on 3rd March 2025 and action log		
Presented By	Chair of the Locality Board		
Author	Emma Kennett, Head of Locality Admin and Governance (Bury)		
Clinical Lead			

Executive Summary

The minutes of the Locality Board meeting held on 3rd March 2025 are presented as an accurate reflection of the previous meeting, reflecting the discussion, decision and actions agreed.

Recommendations

It is recommended that the Locality Board:-

- Approve the minutes of the previous meeting held as an accurate record;
- Ratify the decisions made at the Locality Board meeting on the 3rd March 2025.
- Provide an update on the action listed in the log.

OUTCOME REQUIRED *(Please Indicate)*	**Approval** ☐	**Assurance** ☐	**Discussion** ☐	**Information** ☒
APPROVAL ONLY; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	**Pooled Budget** ☐	**Non-Pooled Budget** ☐		

Links to Locality Plan outcomes	
To support a local population that is living healthier for longer and where healthy expectancy matches or exceeds the national average by 2025.	☒
To achieve a reduction in inequalities (including health inequality) in Bury, that is greater than the national rate of reduction.	☒
To deliver a local health and social care system that provides high quality services which are financially sustainable and clinically safe.	☒

Links to Locality Plan outcomes	
To ensure that a greater proportion of local people are playing an active role in managing their own health and supporting those around them.	☒

Implications						
Are the risks already included on the Locality Risk Register?	Yes	☐	No	☒	N/A	☐
Are there any risks of 15 and above that need to be considered for escalation via an NHS GM Statutory Committee or Board in line with the Risk Escalation process ?	Yes	☐	No	☒	N/A	☐
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☒	N/A	☐
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☒	N/A	☐
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☒	N/A	☐
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☒	N/A	☐
Are there any financial Implications?	Yes	☐	No	☒	N/A	☐
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☒	N/A	☐
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☒	No	☐	N/A	☐

Governance and Reporting		
Meeting	**Date**	**Outcome**
N/A		

Draft Minutes

Date: Locality Board, 3rd March 2025

Time: 4.00 pm

Venue: Microsoft Teams

Title	**Draft Minutes of the Locality Board**
Author	Emma Kennett
Version	0.1
Target Audience	Locality Board
Date Created	March 2025
Date of Issue	March 2025
To be Agreed	Monday, 7th April 2025.
Document Status (Draft/Final)	Draft
Description	Locality Board Minutes

Document History:

Date	Version	Author	Notes
March 2025	0.1	Emma Kennett	Draft Minutes produced
Approved:			
Signature:			..... **Add name of Committee/Chair**

Locality Board

MINUTES OF MEETING
Locality Board Meeting in Public (on Teams) 3rd March 2025 4.00 pm until 6.00 pm **Chair – Cllr Eamonn O'Brien**

ATTENDANCE

Voting Members
Cllr Eamonn O'Brien, Leader of Bury Council (Chair) Cllr Lucy Smith, Executive Member of the Council for Children and Young People Cllr Tamoor Tariq, Executive Member of the Council for Adult Care and Health Mr Warren Heppolette, Chief Officer for Strategy and Innovation (GMIC) Ms Lynne Ridsdale, Place Based Lead Mr Simon O'Hare, Associate Director of Finance Ms Catherine Jackson, Associate Director for Nursing, Quality and Safeguarding (Bury) Ms Lorna Allan, Chief Digital and Information Officer, NCA Ms Joanna Fawcus, Director of Operations, NCA Ms Sarah Preedy, Chief Operating Officer, Pennine Care Foundation Trust Ms Helen Tomlinson, Chief Officer, Bury VCFA (Voluntary, Community, Faith & Social Enterprise) Ms Jeanette Richards, Executive Director of Children and Young People, Bury Council Dr Kiran Patel, Medical Director, IDCB Mr Jon Hobday, Director of Public Health Mr Will Blandamer, Deputy Place Based Lead, Executive Director of Health and Care Mr Adrian Crook, Director of Adult Social Services and Community Commissioning
Non-Voting Members
Ms Kath Wynne-Jones, Chief Officer, Bury IDC Cllr Mike Smith, Leader, Radcliffe First Ms Ruth Passman, Chair, Bury Healthwatch Mr Stuart Richardson, Chief Executive, Bury Hospice
Invited Members and Observers
Cllr Bernstein, Conservative Opposition Party Ceri Kay, Legal Services, Bury Council Dr Sanjay Kotegaonkar, Clinical Lead Elective & Community Bury ICB Mr Damian Aston, Transformation and Delivery Manager, NHS Greater Manchester (Bury) Ms Karen Richardson, Assistant Director of Transformation, NHS Greater Manchester (Bury) Ms Postlethwaite. Associate Programme Director, NHS Greater Manchester (Bury) Ms Chloe Ashworth, Democratic Services, Bury Council Mrs Emma Kennett, Head of Locality Admin & Governance, NHS Greater Manchester (Bury)

BURY INTEGRATED CARE PARTNERSHIP

MEETING NARRATIVE & OUTCOMES

1	Welcome, Apologies and Quoracy
1.1	The Chair welcomed all to the meeting.
1.2	Apologies were received from Dr Cathy Fines, Mr Neil Kissock, Dr Vicky Howarth and Mr Richard Bulman.
1.3	The meeting was declared quorate.

2	Declarations Of Interest
2.1	NHS GM has responsibilities in relation to declarations of interest as part of their governance arrangements (details of which can be found outlined in the NHS Greater Manchester Integrated Care Conflict of Interest Policy version 1.2).
2.2	NHS GM (Bury Locality) therefore, has a requirement to keep, maintain and make available a register of declarations of interest for all employees and for a number of boards and committees.
2.3	The Local Authority has statutory responsibilities detailed as part of Sections 29 to 31 of the Localism Act 2011 and the Relevant Authorities (Disclosable Pecuniary Interests) Regulations 2012. For other partners and providers, we understand that conflicts of interest are recorded locally and processed within their respective (employing) NHS and other organisations as part of their own governance and statutory arrangements too.
2.4	Taking into consideration the above, a register of Interests has been included detailing Declaration of Interests for the Locality Board.
2.5	In terms of agreed protocol, the Locality Board members should ensure that they declare any relevant interests as part of the Declaration of Interest Standing item on the meeting agenda or as soon as a potential conflict becomes apparent as part of meeting discussions.
2.6	The specific management action required as a result of a conflict of interest being declared will be determined by the Chair of the Locality Board with an accurate record of the action being taken captured as part of the meeting minutes.
2.7	There is a need for the Locality Board members to ensure that any changes to their existing conflicts of interest are notified to NHS GM (Bury Locality) Corporate Office within 28 days of a change occurring to ensure that the Declarations of Interest register can be updated.
2.8	**Declarations of interest from today's meeting 3rd March 2025 and previous meeting 3rd February 2025.**

ID	Type	The Locality Board	Owner
D/03/01	Decision	Received the declaration of interest register.	

3	Minutes Of the Last Meeting and Action Log
3.1	The minutes from the Locality Board meeting held on 3rd February 2025 were considered as a true and accurate reflection of the meeting.
3.2	The status in relation to existing actions was documented as part of the Action Log and a revised paper was submitted in respect of the Family Hub Governance item to reflect neighbourhood working.

3.3	Ms Richards commented that this paper had been updated to reflect some of the wider neighbourhood work however there were still further changes within this area needed in light of the further guidance issued around population size which would also need to include the wider aspirations of the Family Hub and partnership working. It was noted that these changes had been difficult to document in full at this time due to the pace of change/ timing however the paper would be further updated as this work progresses.

ID	Type	The Locality Board	Owner
D/03/02	Decision	Accepted the minutes from the previous meeting as a true and accurate reflection of the meeting and noted the updates including the revised neighbourhood working paper in respect of the actions from the last meeting.	

4	Public Questions
4.1	There were no public questions received.

ID	Type	The Locality Board	Owner
D/03/03	Decision	Received the update.	

5	Place Based Lead Update
5.1	Mrs Ridsdale presented the latest Place Based Lead update to the Locality Board. It was reported that: • At the last Locality Board meeting, there was particular recognition of the NHS planning guidance pertaining to integrated neighbourhood delivery. The meeting considered that the model of INT working in Bury, aligned to the work of the GP Strategy and future opportunity of strengthening community diagnostic capability. Since the last Locality Board meeting, further guidance proposing that model of neighbourhood working on populations of 30-50,000 should also be the default setting for integrated multi-disciplinary team working on children's services. The guidance indicates that: - Neighbourhood MDTs for children and young people will provide integrated care that provides timely access to specialist advice, including paediatric and mental health expertise, through primary care-led team working. This will deliver care closer to home and improve the outcomes and experience for children and young people, as well as their families and carers. - Greater benefits are realised when neighbourhood MDTs are integrated with wider local services, especially education, social care, voluntary sector, and community and social enterprise (VCSE) partners to provide holistic, targeted needs-led planning and support. - This approach will enhance the current primary care offer for children and young people who might otherwise require referrals to secondary care, community services or other health and social care support. It also increases the opportunities for early intervention and prevention support, especially for children in their early years. • It was suggested that the Locality Board invites the Integrated Delivery Board to convene a workshop to discuss this next stage of our neighbourhood model of working and invites all key partners to positively contribute and input into the meeting describing how they would align services accordingly. • In relation to the GP Collective Action in Bury, all partners including GPs, NHS GM, NCA, Pennine Care and others have worked effectively to understand and address issues of unnecessary duplication, miscommunication, and bureaucracy related to the primary /secondary care interface. The Locality Board recognised this work as responding to a commitment in the GP strategy. It was noted that whilst the collective action may conclude, it was proposed that the locality continue to work in partnership to strengthen the primary/secondary care interface work and build on some of the insights and solutions that have been made during this period,

	and for a further update on the GP strategy progress including this issue be brought to a future Locality board.
5.2	The following comments/observations were made by Locality Board members: - • Further information requested in relation to the proposal for Rock Healthcare in Radcliffe to relocate to the Moorgate Primary Care Centre site. It was reported that the locality was aware of this proposal and a consultation exercise was currently underway with registered patients and discussions were also ongoing with neighbouring practices. In terms of decision making, any proposals would need to be discussed further via the Primary Care Commissioning Committee and advise was currently being sought from the ICB in relation to the criteria and scope for decision making within this area. It was noted that a regular update report from the Primary Care Commissioning Committee was provided to the Locality Board therefore an update on these plans would be brought back to this meeting at the appropriate time. • Locality Leaders, staff and councillors were commended for all their hard work in respect of the LGA Assessment and the informal feedback received had been of an extremely positive nature and the formal feedback would be shared with the Locality Board.

ID	Type	The Locality Board	Owner
D/03/04	Decision	Received the update.	

6	Elective Care/Waiting time position (Broad) including Pathway Redesign and Paediatric ENT Update
6.1	Dr Sanjay Kotegaonkar was in attendance to provide a presentation in relation to Pathway Redesign with a particular focus on the paediatric ENT pathway. It was reported that:- • There was a vast amount of BI data within this area which hadn't historically provided any specific answers to solve the issues being presented and improve the patient journey. This piece of work has aimed to get to the bottom of some of these issues from a qualitative perspective using a set methodology and principles. • The issues with Paediatric ENT were discussed which included long waiting times which had adversely impacted on patients and their families and many patients end up coming back into primary care. • There has been a real focus on the referral part of the pathway as part of this work in terms of the referral questions currently being asked and the proposed new questions required. The principles were to make the referral template easier to use, provide faster resolution and most importantly not to be a barrier to referral. Work with paediatric ENT colleagues to try and find a collaborative solution, looking at the pathway from not only a primary care perspective but also from a secondary care perspective and on a Greater Manchester wide level.
6.2	Ms Damian Aston and Ms Karen Richardson were in attendance to support the discussion in relation to elective care. Ms Fawcus discussed the slides that had been circulated to members in relation to NCA Diagnostic (DM01) & Cancer diagnosis (FDS) waiting times for Bury locality patients, Referral to treatment (RTT) waiting times for Bury locality patients and the Bury RTT Patients at MFT as at Dec 2024. It was reported that work had commenced and progress was being made but there was still a lot of work to do. It was noted that work was underway to clear the backlog and additional capacity would likely be needed which will be difficult to in the current financial situation
6.3	The following comments/observations were made by Locality Board members: - • This was the most insightful clinically led system analysis presentation to come out of the Locality Board. Nothing less than I would expect from Dr Sanjay Kotegaonkar! Really helpful!

	• Huge thanks to Dr Sanjay Kotegaonkar, Jo Fawcus and the team. Values-led , insightful system and data analysis at its best Healthwatch happy to help in any way needed with any co creation/ consultation. • There was a need to adopt more of a co-design approach going forward within the locality given how successful it can be. • The NCA welcomed undertaking further pathway work of this nature going forward by means of open ended dialogue and co-creation and design. • Some of the ongoing NCA pathway work in Ophthalmology was discussed.

ID	Type	The Locality Board	Owner
D/03/05	Decision	Noted the update.	

7	Whitefield Scheme Paper
7.1	Ms Postlethwaite presented a report in relation to the Whitefield scheme. It was reported that: - • Whitefield Health Centre was a facility that was becoming increasingly difficult to maintain to a sufficient standard for clinical service delivery and for a number of years, attempts have been made to find a solution for the Uplands Medical Practice who deliver services from that site. • Significant partnership working between all local partners had enabled the development of a proposal involving the redevelopment of the former library site. • This report provided an overview of the current position on this important project and also outlined the work now required to secure this scheme. • With the support of all system partners, significant progress on this priority scheme had been made over recent months however, there remains significant work to do to secure this scheme and allow construction to start on site. • In order to drawdown the national funds allocated to the scheme, there is a requirement to first ensure that the GP practice have agreed and signed the related agreement to lease document. Whilst the practice is supportive of the scheme and work is progressing to reach this agreement, this remains a risk until a final agreed and signed document is achieved. • The current funds allocated to the scheme were based on budgeted estimates for the construction works proposed and this remains the target for the scheme however, until the scheme is presented to the market for tender there remains a risk that scheme costs will be in excess of budget set. This is a usual risk of schemes of this type at project initiation stage and the Greater Manchester ICB estates team continues to work with locality team colleagues to assess the likely actual budget requirements. • Whilst initial views from planners have been sought, the scheme will need to follow the usual planning process and hence, this should be noted as a risk until a full planning permission is secured.
7.2	The following comments/observations were made by Locality Board members: - • A request made that Mrs Postlethwaite keeps the ward councillors in the area up to speed on the latest developments with the scheme. Mrs Postlethwaite agreed to ensure that the ward councillors were kept up to date over the coming weeks/months. • Mrs Postlethwaite was commended for all of her hard work in this area for getting the scheme to this near final stage. • There was a need to explore further any opportunities for health in the Prestwich area given the planned regeneration of the area to ensure there are no opportunities missed.

ID	Type	The Locality Board	Owner
D/03/06	Decision	Noted the progress to date on this project and supported progression to project completion, noting the associated risks.	

8	Overview of Children's National Policy changes including Children's Priorities
8.1	Ms Richards provided an overview of the Children's national Policy changes including Children's priorities.
8.2	The presentation covered in detail the: - • Children's Wellbeing and Schools Bill - Children's social care measures. • Children's Wellbeing and Schools Bill - Education measures. • Relevant reforms 2025 and beyond.
8.3	The following comments/observations were made by Locality Board members: - • A query as to what the impact of the requirements for Academies would have across the borough given the blended system that exists and teachers being required to have QTS, all schools having to teach the national curriculum, SoS powers of direction, plans to end academy order in response to failings and parity on teacher pay and conditions. It was reported that the powers were helpful in driving up quality. • There was a need to clearly articulate the actions required within this area following the policy changes.

		The Locality Board	
D/03/07	Decision	Noted the update	

9	Pennine Care Service Mapping
9.1	Ms Preedy informed members that the Pennine Care Service Mapping work had not yet been concluded and needed to be considered by the internal governance structure in the first instance. It was anticipated that the paper would be available for the Locality Board meeting in April 2025.

ID	Type	The Locality Board	Owner
D/03/08	Decision	Noted the update	
A/03/01	Action	Pennine Care Service Mapping work to be brought back to the Locality Board meeting in April 2025.	Ms Preedy

10	Lets Do it strategy for borough Locality Plan
10.1	Ms Ridsdale reported that further work was being undertaken in respect of the Lets Do it Strategy with some further detail being added in relation to Community empowerment and the VCFE were thanked in this regard.
10.2	Mr Blandamer reported that work continued in order to refresh the Locality Plan following the workshop in January 2025 and the presentation to the February Locality Board. It was noted that the key learning was to ensure a sharper articulation of locality plan priorities within which our individual programmes of work (e.g urgent care, mental health, Adult Care transformation etc) sit. The locality was working to re-present the priorities according to 4 key themes, themselves reflective of the GM strategy namely: - • Population health management • Prevention, reducing prevalence, and proactive active care • Transforming Community Care in Neighbourhoods

10.3	• Optimising Care It was highlighted that the next iteration would be brought to the April 2025 Locality Board meeting. The following comments/observations were made by Locality Board members: - • There was a new levelling up process being implemented within Greater Manchester in respect of the LES contract and Bury would be one of the first areas to benefit from this positive change.

ID	Type	The Locality Board	Owner
D/03/09	Decision	Noted the updates	
A/03/02	Action	Lets do It Strategy and Locality Plan items to be brought back to the Locality Board meeting in April 2025.	

11	Integrated Delivery Board Update
12.1	Ms Wynne-Jones presented the latest Integrated Delivery report to the Locality Board which provided an update to the Board of progress with the work of the IDC, and progress with the delivery of programmes across the Borough. It was reported that: - • Planning guidance had been published since the last IDC Board and the publications were included within the papers. The neighbourhood delivery model was a welcome publication to support the direction of travel with neighbourhood working and to inform the review of neighbourhood working due to commence in April 2025. • Work continued to focus on the operational issues raised by GP Collective Action collectively across Bury and HMR with the LMC and our local providers. • Governance arrangements were being established with the NCA from April 2025 to progress implementation of the primary / secondary care interface principles, which was very closely linked to the actions that GPs were taking under collective action. • A Major conditions board workshop was held which identified next steps to scope programmes for CVD and diabetes, respiratory, MSK, dementia and cancer. Further prioritisation will take place in March, including determination of how we use out £50k allocated spend from GM for CVD and diabetes. • A draft MOU to support joint working between the PCN's and neighbourhoods had been developed which would be considered at the first meeting of the neighbourhood/PCN Board in April 2025. • The first meeting of the 4LP Programme Board was held to ensure delivery of this programme was rooted in localities. • Work had continued to support place partners to design the place element of the NCA CLM. This was due to be presented to the Programme Board in March/April 2025. • A workshop took place on the 27th February 2025. in relation to the Understanding of prevention services across the locality and opportunities for closer integration. Mr Blandamer commended Ms Wynne-Jones for this workshop.

ID	Type	The Locality Board	Owner
D/03/10	Decision	Noted the update	

12	Performance Report
13.1 13.2	Ms Wynne-Jones presented the latest Performance report to the Locality Board. It was reported that: - • In terms of Learning disability Health checks 14+, the percentage of patients aged 14+ having received an Learning disability health check in December 24 was 52.1%, which was an increase on December 23 which was 41.3%. Bury was lower than the GM percentage of 58.8% and has

	the lowest percentage of the Greater Manchester localities. For the last two years Bury had delivered the majority of annual checks in months January to March. • In relation to A&E 4-Hour Performance, in January 25 this was 64.1%, an increase on the previous month's performance of 61.3%, which is higher than January 24 which was 58.7%. • In relation to 28-day wait from referral to faster diagnosis (all patients), the percentage of patients told of a cancer diagnosis outcome within 28 days of the 2WW referral in December 24 for the Bury population was 80.1% - an increase on November 24 which was 78.6%. Bury locality currently had the 5th lowest performance out of all the Greater Manchester localities. Greater Manchester performance was currently 79.5%. Bury was above the target of 75% or greater.

ID	Type	The Locality Board	Owner
D/03/11	Decision	Noted the Performance report.	

13	Risk Report
13.1	Ms Jackson presented the latest Risk report to the Locality Board.
13.2	It was highlighted that the report detailed the locality strategic and programme risks set by the Risk and Scrutiny Group as scored above 15 using the strategic risk descriptors detailed in section 3 of the report. The risks were described in summary and high-level mitigating actions are included. Further detailed information on the risk mitigations is discussed and actioned through the transformation/programme boards and workstreams.
13.3	It was reported that a further quality risk register is available and scrutinised at the System Assurance Committee.
13.4	In terms of risk closure, the risk around safeguarding had been closed in its current guise however a new risk may be required within this area. There was a need to review the Whitefield/Uplands scheme risk scoring in light of the recent progress within this area which would be undertaken ahead of the next Locality Board update.
13.5	The following comments/observations were made by Locality Board members: - • This was a helpful report for the Locality Board to have sight of. • It was important to remember the dual role of the Locality Board when dealing with risk as there was a requirement as part of the formal reporting to NHS Greater Manchester to have these arrangements in place.

ID	Type	The Locality Board	Owner
D/03/12	Decision	The Locality Board discussed and considered the risks.	

14	Strategic Finance Group Update
14.1	Mr O'Hare submitted the latest Finance Report to the meeting
14.2	It was reported that : - • The purpose of this report was to update the Locality Board on the financial position of all partners, with specific focus upon the budgets delegated to the Locality Board by NHS Greater Manchester (GM). The position of all partners continued to be very challenged in 2024/25. The month 9 NHS GM position was showing a deficit of £79.5m versus an expected deficit of £7.8m, giving an unplanned variance of £71.7m adverse to plan, and remained forecasting recovery of this position by 31st March 2025 to break even, to allow delivery of the agreed £175m deficit. Within this position the Bury locality budgets, for which this board is responsible for are forecasting a deficit of £6.16m versus an expected break even annual position.

	• The Northern Care Alliance (NCA) were £3.4m overspent at month 8 versus a plan of £1.9m and had forecast to achieve their agreed deficit of £4.4m. Pennine Care NHS Foundation Trust (PCFT) were reporting a £1.3m deficit at month 8 versus a break even plan, but continued to forecast a very slight surplus at year end. • The council was progressing sign off, of the 2025/26 financial plan through it's own governance route and an update would be brought on this to the next Locality Board. • As at Month 9, £339m of CIP had been delivered by NHS Greater Manchester against a plan of £331m, a slight over delivery of £8m. The forecast CIP position is delivery of £495.2m against a target of £490.3m, again a slight overachievement of £1.3m but this delivery does have a level of risk attached. In terms of CIP delivery on the budgets delegated to the locality, at month 9 £3.08m has been delivered against a month 9 plan of £3.86m, with shortfalls against plan in Medicines Optimisation and Complex Care, this therefore puts a risk of £1.47m on the full delivery of 2024/25 CIP. • 2025/26 NHS planning guidance and financial allocations were received in late January and the impacts of this upon NHS GM were being understood, with conversations with NHS England ongoing and a final agreed plan to be submitted in March. The impacts of the guidance upon the budgets that this board is responsible are not yet known but this was anticipated in March and an update will be brought to the April meeting. The overall inflationary uplift for NHS services is 2.15%, after the application of a 2% saving, but the uplift is differential across budget lines. • The Better Care Fund was receiving a 1.7% inflationary uplift, all of which is mandated to be passed to the Local Authority, with a headline uplift of 3.9% nationally but the local impact of this will be different depending upon the make up of the services within the BCF. • Alongside these very significant pressures there are also smaller pressures with regard ADHD / ASD assessments (£0.6m), with this being particularly volatile as more providers are being approved nationally to delivered services therefore this area needed to be closely monitored going forward to mitigate risk accordingly.
14.3	The following comments/observations were made by Locality Board members: - • It was helpful that the current financial position and risks had been documented as part of the Risk Register presented to the Locality Board. • Commended the locality team for all of the hard work in the attempts to improve the CHC administration processes and associated spend.

ID	Type	The Locality Board	Owner
D/03/13	Decision	Noted the contents of this report and the financial challenges across the Bury system and NHS GM	
D/03/14	Decision	Noted the reduction in the deficit on the budgets that the locality board is responsible for and the distance still to delivery a break even position recurrently.	
D/03/15	Decision	Noted the high level impact of the 2025/26 planning guidance and anticipate further locality specific information in the April meeting	

15	Population Health and Wellbeing update
15.1	Mr Hobday submitted the latest update in relation to Population health and wellbeing.
15.2	It was reported that: - • A Greater Manchester Population Health Committee meeting was held on 18th February 2025. Key items discussed included shaping healthy places which included an overview of the

	sustainability agenda and the NHS green plan, population heath and prevention ambitions linked to the NHS annual planning and investment, and the health innovation Manchester work programme. • The next Health and Wellbeing Board was scheduled to take place on the 18th March 2025 with a number of key items scheduled including the Community Safety Plan, Physical Activity Framework, VCFE and BCF.

ID	Type	The Locality Board	Owner
D/03/16	Decision	Noted the update.	

16	Clinical and Professional Senate update
16.1	Dr Patel presented the latest update report in relation to the Clinical and Professional Senate.

ID	Type	The Locality Board	Owner
D/03/17	Decision	Noted the information	

17	Any Other Business
17.1	There were no items raised.

ID	Type	The Locality Board	Owner
D/03/18	Decision	Noted the information	

18	Date and time of next meeting
18.1	It was noted that the next Locality Board meeting would take place on **Monday, 7th April 4.00 - 6.00pm Committee Rooms A&B, Bury Town Hall**

Locality Board Action Log – March 2025

Status Rating: - **In Progress** **Completed** - **Not Yet Due** **Overdue**

Date	Reference	Action	Lead	Status	Due Date	Update
4th November 2024	A/11/07	Chair of the Send Improvement and Assurance Board could be invited to a future Locality Board meeting.	Dr Fines		TBC	It was noted that Mr Blandamer had mentioned to the Chair of the Send Improvement and Assurance Board and this would be picked up in due course.
2nd December 2024/3rd February 2025/3rd March 2025	A/12/01/ A/02/05/ A03/01	A further detailed paper in relation to Service Mapping would take place on the Locality Board meeting in January 2025.	Ms Preedy		April 2025	Update schedules for April Locality Board meeting.
2nd December 2024/3rd March 2025	A/12/02/03/02	A further version of the Locality plan and Lets Do It Strategy would be brought back to the Locality Board meeting in February 2025.	Ms Wynne-Jones /Ms Ridsdale		April 2025	Final plan scheduled to be submitted to the Locality Board in March 2025
3rd February 2025	A/02/01	An update on End of Life Care/Hospices be submitted to a future Locality Board meeting.	Mr Richardson	---	Summer 2025	
3rd February 2025	A/02/03	Mr McCaul agreed to provide some further detailed Bury specific Pharmacy First data to the Locality Board in due course.	Mr McCaul		TBC	

Meeting: **Locality Board**			
Meeting Date	07 April 2025	**Action**	Receive
Item No.	5	**Confidential**	No
Title	Place Based Lead Update - Key Issues in Bury		
Presented By	Lynne Ridsdale, Place Based Lead		
Clinical Lead	Dr Cathy Fines		

Executive Summary
To provide an update on key issues of the Bury Integrated Care Partnership
Recommendations
The Locality Board is asked to note the update.

Links to Strategic Objectives	
SO1 - To support the Borough through a robust emergency response to the Covid-19 pandemic.	☒
SO2 - To deliver our role in the Bury 2030 local industrial strategy priorities and recovery.	☒
SO3 - To deliver improved outcomes through a programme of transformation to establish the capabilities required to deliver the 2030 vision.	☒
SO4 - To secure financial sustainability through the delivery of the agreed budget strategy.	☒
Does this report seek to address any of the risks included on the NHS GM Assurance Framework?	☒

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☐	N/A	☒
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☐	N/A	☒
Have any departments/organisations who will be affected been consulted?	Yes	☐	No	☐	N/A	☒
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☐	N/A	☒
Are there any financial Implications?	Yes	☐	No	☐	N/A	☒
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☒
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
If yes, please give details below:						

Implications						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☒
Are the risks on the NHS GM risk register?	Yes	☐	No	☐	N/A	☒

Governance and Reporting		
Meeting	**Date**	**Outcome**
N/A		

1. NHS Structural Changes

All colleagues will be aware of the recent announcements regarding the abolition of NHSE and the challenge to significantly reduce ICB costs by 50%. Focus across NHS GM has been to engage with NHS GM staff as fully as possible in a spirit of openness and transparent, including a GM wide all staff briefing event on 2nd April. Locally we are holding weekly briefing and listening events with NHS GM staff, amplifying the weekly live leadership briefings from Mark Fisher. We recognise this is a very challenging time for NHS GM staff in Bury and I am sure colleagues will offer support as required.

NHS GM Bury leadership and staff intend to fully contribute to the development of the new operating model required of the ICB. While recognised the very challenging position, we believe the transformation of the operation of the health and care system underway in Bury, described in our locality plan, and so strongly supported by NHS GM Bury colleagues, is very much with the grain of intent – place focused, integrated delivery in neighbourhoods, prevention rather than treatment orientated, high quality partnership working regardless of organisation, and aligning and benefitting from GM wide strategic intent.

Locality Board will also recognise the challenge to NHS Trusts to reduce their corporate cost growth by 50% during Quarter 3 2025/26, and the very challenging financial position all organisations face in this year. I would call on members of the Locality Board to redouble our commitment to partnership working that is our strength. At times of complexity and financial pressure the quality of partnership and engagement can face strain and yet it is the partnership that will allow us to continue to improve outcomes for the people we serve. In this context i hope colleagues embrace the 'North Star' of the Locality Plan, nested in the Lets Do It strategy for the borough.

2. North Manchester Hospital Redevelopment

I warmly welcome the Government's confirmation of the full rebuild of North Manchester General Hospital. This is a vital step forward for both patients and NHS staff, ensuring access to a modern, high-quality healthcare. As an area facing some of the most significant health challenges in the country, the patients of North Manchester General will greatly benefit from this investment, helping to reduce health inequalities and improve outcomes for local people.

The Locality Board will be aware that North Manchester General is the hospital of choice for many residents in the South of our borough for elective and also urgent care and we are delighted to see this investment.

We will work with colleagues from MFT in continuing to refine the proposed operating model for the redevelopment particularly ensuring a strong connection to community and primary colleagues as the outline business case develops. Colleagues from MFT will attend a future locality board to provide more detail and clarifying mechanisms for further engagement of key stakeholders.

3. **GP Incentive Scheme (Beyond Core Contract)**

Locality Board colleagues will recall previous the commitment to improve relative funding for GP services in Bury. Colleagues from Bury have advocated strongly into the NHS GM BeCCoR Programme - an accelerated GM GP Incentive Scheme is to deliver consistent solutions to some of the system challenges we are facing and preventative, proactive care closer to home. The broader ambition is to expand this approach to wider primary care. This is part of the strategic delivery of the GM Primary Care Blueprint previously considered at this Locality Board.

I am pleased to advise that I am pleased to inform you that an additional investment of £7.28 million has been included in the NHS GM budget setting for 2025/26. This is a phased, additional investment that would start the levelling up process from 2025/26 and as such Bury stands to benefit from the programme in order to close the gap in LCS funding between Bury and most other parts of GM. This is a positive development for Bury and the Primary Care Commissioning meeting last week reviewed the prioritisation of the additional funding. Further details will follow.

I would like to thank colleagues from across Bury for making this case, based on the presentation of December 2023 from Dr Patel to this board.

4. Whitefield GP Premises Scheme

I am pleased to advise the Locality Board that all relevant permissions are in place to support the progression of the prevision of the GP services currently delivered from the Uplands building in Whitefield to the former library site. Thanks to the Council for the leadership around unlocking the site, to NHS Property Services for their commitment to the scheme, to NHSE and NHS GM for approval for the scheme, and to the practice and local Patient Participation Group for their on going support. We look forward to confirming a construction timeline as soon as possible.

Lynne Ridsdale
Place Lead NHS GM (Bury)
Chief Executive Bury Council
6/4/25

Meeting:			
Meeting Date	07 April 2025	**Action**	Receive
Item No.	6	**Confidential**	No
Title	Local Government Association Peer Review of Adult Social Care		
Presented By	Adrian Crook		
Author	Marcus Coulson of the LGA		
Clinical Lead			

Executive Summary

Adult Social Care is now subject to inspection following a change in the health and care act under the last government.

As part of our ongoing preparation to be ready for this forthcoming inspection the council commissioned a peer review from the local government association (LGA)

Whilst not the CQC, the LGA structed the review to mirror as closely as possible the real CQC inspection process.

The attached slide deck provides a comprehensive overview of the Local Government Association's peer challenge for Bury Metropolitan Borough Council (MBC). The peer challenge team, consisting of experts from various councils and roles, conducted an extensive review involving documentation, case files, and numerous meetings with stakeholders.

The presentation outlines key assurance themes such as working with people, providing support, ensuring safety, and leadership. It highlights the strengths of Bury MBC, including passionate staff, visible leadership, financial stability, and progress in managing waiting lists. Additionally, it emphasizes the exemplary integration with health services, strong relationships with commissioners, and robust quality assurance frameworks.

Key considerations for improvement include better engagement with Carers, addressing website accessibility issues, and expanding the commissioning function. The presentation also discusses strengths and considerations in areas such as assessing needs, supporting people to live healthier lives, equity in experiences and outcomes, care provision, and commissioning
.
The peer challenge team commends Bury MBC for its strong governance, management, and sustainability practices, highlighting the competence of Cabinet Members, supportive senior leadership, and exceptional health and care partnerships.

The presentation concludes with a focus on learning, improvement, and innovation, recognizing the value of collaborative relationships, formal development opportunities for staff, and innovative integrated teams.

Overall, the peer challenge team appreciates the dedication and achievements of Bury MBC staff and encourages continued progress in areas identified for improvement. Three quotes made by the peer team of note: “the staff are spectular” “the sense of collaboration in every service and at every level is pallable” “we have travelled the length and breadth of the country looking for integrated neighourhoods that work, we found them for the first time here in Bury” The review has provided considerable assurance we are on the right track to achieving Good and have given us areas where we can deliver further improvement to ensure this result
Recommendations
Localty Board is asked to note the presentation and findings within

OUTCOME REQUIRED *(Please Indicate)*	**Approval** ☐	**Assurance** ☒	**Discussion** ☐	**Information** ☐
APPROVAL ONLY; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	**Pooled Budget** ☐	**Non-Pooled Budget** ☐		

Links to Locality Plan outcomes	
To support a local population that is living healthier for longer and where healthy expectancy matches or exceeds the national average by 2025.	☐
To achieve a reduction in inequalities (including health inequality) in Bury, that is greater than the national rate of reduction.	☐
To deliver a local health and social care system that provides high quality services which are financially sustainable and clinically safe.	☒
To ensure that a greater proportion of local people are playing an active role in managing their own health and supporting those around them.	☐

Implications						
Are the risks already included on the Locality Risk Register?	Yes	☐	No	☐	N/A	☒
Are there any risks of 15 and above that need to be considered for escalation via an NHS GM Statutory Committee or Board in line with the Risk Escalation process ?	Yes	☐	No	☐	N/A	☒
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☐	N/A	☒
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☐	N/A	☒
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☐	N/A	☒
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☐	N/A	☒
Are there any financial Implications?	Yes	☐	No	☐	N/A	☒
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☒
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☐

Governance and Reporting		
Meeting	**Date**	**Outcome**
N/A		

BURY
INTEGRATED CARE
PARTNERSHIP

Local Government Association

Bury MBC Preparation for Assurance Peer Challenge

Feedback from the peer challenge team

13th February 2025

Peer Challenge Team

- **Jill Britton**, (DASS), Director of Adult Social Care, Luton Borough Council
- **Councillor Joanne Harding**, Executive Member for Finance, Change & Governance – Trafford Council
- **Alun Davis**, Expert by Experience Peer
- **Ruth Harrington**, Director of Adult Social Care, Adults with Disabilities and SE Essex, Essex County Council
- **Christine Conway**, Head of Adult Safeguarding & Principal Social Worker, Dudley Council
- **Sue Whetton**, Commissioning, Contracting and Market Management, Derbyshire County Council
- **Sarah Morris**, Principal Social Worker for Adults, North Northamptonshire Council
- **Marcus Coulson**, Peer Challenge Manager, Local Government Association

Local Government Association

Care Quality Commission

Assurance Themes

1: Working with People

- assessing needs
- direct payments
- charging arrangements
- supporting people to live healthier lives
- prevention
- wellbeing
- information and advice
- addressing barriers and reducing inequalities

2: Providing Support

- care provision, integration and continuity
- market shaping
- commissioning
- workforce capacity and capability
- integration and partnership working

3: Ensuring safety

- safeguarding enquiries and reviews
- Safeguarding Adult Board
- safe systems - continuity of care
- safe systems - pathways and transitions

4: Leadership

- culture
- strategic planning
- learning
- improvement
- innovation
- governance
- management
- Sustainability

Our feedback is based on:

- The peer team read relevant documentation including a self-assessment.
- Members of the peer team considered six case files from across the areas of adult social care.
- Throughout the peer challenge the team had more than 38 meetings with over 154 different people from adult social care and partners.
- The peer challenge team bring 174 years of experience in adult social care and have spent over 250 hours with Bury MBC and its documentation, the equivalent of 35 working days.

Key Messages – Strengths 1

- Staff are passionate and positive about their work. They are proud to work for Bury
- Staff clearly articulated the improvement journey they have been on and how strengths based practice makes a difference for residents
- Staff feel they have the resources to do their jobs, in addition to providing support to one another across and within teams
- ASC Leadership is self-aware and providing staff opportunities to thrive.
- Leadership is very visible and approachable, staff consistently commented upon this
- Financial stability in a very difficult climate. You are achieving significant corporate savings and committing additional staff resources into ASC
- Really good progress on waiting lists for new assessments, reviews and occupational therapy. The staff can clearly articulate how they prioritise and manage those lists, keeping in contact with residents to ensure safety

Key Messages – Strengths 2

- Integration with health at operational and strategic levels is enviable and exemplary
- Staff can give clear examples of the difference integration has made to residents and the positive impact on the adult social care service
- Providers have strong relationships with commissioners and there is a robust quality assurance framework to work with those providers, with ambitions to have the resident voice at the heart of those conversations
- Good partnership with the SAB
- There are some real strengths to your co-production work and you recognise there is further to go
- Strong oversight of data, quality and a financial grip

Key Messages – Considerations 1

- Safeguarding practice, and the pathway, needs to be understood by everybody
- There is more work to do with Carers to ensure they understand the offer, how to access it and are fully engaged in the strategic direction
- The Neighbourhood Teams approach to ethnicity and religion is well developed but other teams and other areas of EDI have not received the same attention
- You recognise the need to address the website and accessibility issues, including ensuring people's communication needs are clearly identified
- We felt the commissioning function was predominately focused on accommodation based support and there is more to do in a prevention arena, e.g. in partnership with the VCSFE

QS.1: Assessing needs

- **Strengths**
- Staff feel well supported by managers, leaders and colleagues
- Staff talk about strengths-based working and working with people to identify their outcomes
- There is a use of population data to understand individual neighbourhood's needs
- There is a continuous development of the practice framework which is viewed positively
- All carers reported receiving a carers assessment but reviews were overdue
- **Considerations**
- Ease of access to OTs needs to be consistent
- Improve accessibility of the Directory of Services and website is recognised
- Consider how to give advocacy a greater profile

QS.2 - Supporting people to live healthier lives

- **Strengths**
- Responsive equipment service
- Tech seems embedded, new tech is being piloted – good examples and user perspectives.
- There is a preventative pathway – Staying Well, Social Prescribing and community assets
- INTs – integration works really well and is producing good outcomes for people, and supporting partners (including the Council)
- Very good, well integrated Intermediate Tier
- Reablement can be accessed by the community teams
- Impressive work by the Bury Employment and Support Team (café, workshop, garden on site, run by people attending the service)

QS.2 - Supporting people to live healthier lives

- **Considerations**
- The service should consider alternative ways of addressing needs for people with Autism
- Improve information available at referral to the reablement service
- Consider an All Age Prevention Pathway
- Issues were raised about access to mental health support for those who don't meet the threshold for secondary services
- Clearer pathway required for referrals into Adult Social Care
- Consideration should be made for referrals to Persona being outcomes based

QS.3 - Equity in Experiences and Outcomes

- **Strengths**
- The Learning Disability Team described that they're considering how to overcome digital exclusion
- Staff reported good access to interpreters / translation services
- Staff described having access to cultural and religious competence training
- Integrated Neighbourhood Teams are considering their diverse communities
- Good links made to the Jewish and Asian communities
- **Considerations**
- There was an awareness of seldom heard communities but need to be able to clearly articulate outcomes achieved
- Improve the recording of demographic information to be able to describe the outcomes for people
- Grow the offer of staff networks

QS.4 & QS.5 Care Provision & Commissioning

- **Strengths**
- Carers Service – improvement in identifying carers and increase in referrals from a range of agencies
- Positive and respectful Providers relationships – '*best its been in Bury*'
- Bury Flex initiative excellent – supporting training and recruitment for permanent and relief staff
- Really strong evidence of quality assurance – teams really proud
- Goods work around accommodation
- **Considerations**
- Consider fee differentials for complexity of need
- Consider a revised approach to evidencing commissioning for outcomes
- Further work maybe needed to develop some of the lived experience partnerships

QS.4 & QS.5 Care Provision & Commissioning

- **Strengths**
- Performance data was available and regularly referenced by staff in meetings across a number of areas.
- Being able to compare performance with other GM Councils is clearly helpful and could support the development of clear targets alongside the focus on Obsessions.
- **Considerations**
- The current presentation of your data does not clearly evidence a Home First approach, you may want to consider splitting out Nursing Care and/or highlighting self-funders and number of people in Supported Living who live in individual homes.

QS.6 - Safe systems, Pathways & Transitions 1

PFA *strengths*

- Involvement with young people and families is happening earlier forming stronger relationships between children's and adults
- There is now an established PFA team with improved communication and relationships
- Re-designed financial services including welfare benefits advice for families

PFA *considerations*

- PFA data could be improved
- Consideration to improve access to CS and ASC recording systems

QS.6 - Safe systems, Pathways & Transitions

- There is a clear pathway in place for hospital discharge and innovative use of technology
- Neighbourhood teams proactively working with waiting lists
- Good examples of person-centred rehabilitation
- Good relationships with partners including Community safety and Safeguarding Adults Board

QS.7 – Safeguarding

- **Strengths**
- Feeling that safeguarding is everybody's business was getting through
- Safeguarding Board strategic partners appear to work well together and have seen improved outcomes
- Multi Agency Risk Management process appears robust and there was evidence of how it was working
- DoLS message was very positive, and staff are proud of their achievements
- Safeguarding transformation and plan for a Hub and Spoke safeguarding model was mentioned
- **Considerations**
- You recognise there are too many routes into safeguarding
- Consider how feedback to those who raise safeguarding concerns could be strengthened
- Raise staff awareness of quality assurance process and risk management framework links to safeguarding

QS.8 Governance, Management & Sustainability

- **Strengths**
- Competent, skilled Cabinet Member who is across the detail, without veering into operational level detail.
- Opposition Cllrs are all behind the leadership vision for ASC – they too have regular briefings. Scrutiny appears to work well and Chair is well regarded
- Strong and trusted relationships with DASS, response to all casework related to ASC is dealt with swiftly.
- The leadership of the DASS is exemplary, visible and proactive.
- Collective responsibility and oversight of performance, quality and finance, throughout all management layers demonstrating positive governance and accountability.
- Senior leadership is accessible and supportive, staff are proud of the improvement journey they have been on and keen to develop further where needed
- .

QS.8 Governance, Management & Sustainability

- **Strengths**
- The quality of the health and care partnership is exceptional and is a joint force that is really visible.
- The Council is wedded to integration with health and the VCFE sector and this is evident from strategic perspectives through to operational delivery, all officers and health staff are rightly proud of what has been achieved.
- There appeared to be good council cohesion across departments such as housing, finance and transformation
- Integrated Neighbourhood Teams were developing in maturity as they start to identify priorities for specific areas, using data and knowledge of the local community.

QS.8 Governance, Management & Sustainability

- **Considerations**
- The management structure of adult social care is complex and the same individual is often expected to manage people at different levels of seniority. There are two groups of Senior Leadership Meetings described. There may be a rational for bringing in an additional Assistant Director and to simplify the structure and give greater support to the DASS to focus on strategy and partnership.
- Providers need to be supported to engage with the ambitions of the Market Position Statements
- Increase visibility of the joint health and care KPIs
- The health economy situation is a real risk to adult social care and the integration achievements delivered thus far. The integration of health and care for the children's sector will need to accelerated for it not to impact the wider system.

QS.9 - Learning, Improvement and Innovation

- **Strengths**
- Recognition of the value of the Greater Manchester relationship and support, including the value of the 10 DASS's working collaboratively.
- There are real and tangible examples of staff having formal development opportunities and access to resources to achieve this.
- Fantastic examples of whole workforce training across health and care frontline staff, such as Strength Based Training.
- As part of the GM social work teaching partnership social workers have access to training and development opportunities
- Innovative integrated teams with health and care leadership, leading to tangible improvements in hospital attendance and rehabilitation

QS.9 - Learning, Improvement and Innovation

- **Considerations**
- Work to be done on consistency of social work practice. Strengthening the Quality Assurance Framework implementation would support this.
- Website and Directory of Services could be working harder for you.
- There are opportunities to have your arm's length trading body to support more innovation, that could support the strategic direction of the rest of the provider market and strategic vision of wider council services.
- Greater opportunities to bring user voice and co-design into development of services including those integrated with health.

Summary

- Your staff are your greatest asset.
- Its been a pleasure to meet them and hear their stories.
- Health and care integration is outstanding. It’s the best any of us have seen and something to promote beyond Greater Manchester
- Alun thought your journey of co-production is more advanced than many areas
- Thank you and good luck.

Meeting:			
Meeting Date	07 April 2025	**Action**	Receive
Item No.	7.1	**Confidential**	No
Title	Let's Do It strategy refresh		
Presented By	Lynne Ridsdale/Will Blandamer		
Author	David Segal (PPL)		
Clinical Lead	n/a		

Executive Summary

The LET'S Do It Strategy was created in 2020 and is a partnership strategy that sets out a vision for Bury in 2030.

The Strategy outlines how partners across Team Bury will work with residents and communities to deliver better and more equal outcomes for people.

While the core missions of the strategy remain the same, the strategy was written in the wake of COVID and since then significant changes to the context have happened. The strategy refresh is an opportunity to reconsider what the missions and outcomes of the strategy mean in 2024, and how we want to work together to delvier on these in the remaining 6 years of the strategy's life.

The strategy has been co-produced through Team Bury and through engagement with residents and communities.

A finalised version of the strategy has been provided alongside this cover sheet.

Recommendations

The strategy is being provided for information and for discussion on the role of the Integrated Care Partnership in delivering on the outcomes and priorities outlined in the strategy.

OUTCOME REQUIRED *(Please Indicate)*	**Approval** ☐	**Assurance** ☐	**Discussion** ☒	**Information** ☒
APPROVAL ONLY; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	**Pooled Budget** ☐	**Non-Pooled Budget** ☐		

To support a local population that is living healthier for longer and where healthy expectancy matches or exceeds the national average by 2025.	☒
To achieve a reduction in inequalities (including health inequality) in Bury, that is greater than the national rate of reduction.	☒
To deliver a local health and social care system that provides high quality services which are financially sustainable and clinically safe.	☒
To ensure that a greater proportion of local people are playing an active role in managing their own health and supporting those around them.	☒

Implications						
Are the risks already included on the Locality Risk Register?	Yes	☐	No	☐	N/A	☒
Are there any risks of 15 and above that need to be considered for escalation via an NHS GM Statutory Committee or Board in line with the Risk Escalation process ?	Yes	☐	No	☐	N/A	☒
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☐	N/A	☒
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☐	N/A	☒
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☐	N/A	☒
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☐	N/A	☒
Are there any financial Implications?	Yes	☐	No	☐	N/A	☒
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☒
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
EPQIA would be completed only any subsequent policy changes, business cases, or action plans.						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☒

Governance and Reporting		
Meeting	**Date**	**Outcome**
Team Bury Meeting	25/03/2025	Soft launch of the refresh document

Paper:

LETS Refresh_26th March 2025.pdf

Next steps on our journey to success

LET'S do it!

Shared success across Bury

Contents

Team Bury

The LET'S do it! Strategy was created by Team Bury. Team Bury is a partnership of all Bury public services, our schools and colleges, the voluntary and community sector and businesses.

...and all our broader partners across Bury.

Introduction

LET'S do it! is a call to action. For civic, business and community leaders to work together to achieve, by 2030, faster economic growth in Bury than the national average and with lower levels of deprivation.

Our ambition was developed with residents; over 1500 colleagues and partners. We are making progress but, halfway to our journey to 2030, the context is tough. It is time to re-group and consider our next steps.

We are doing it, but we are not done.

Since 2020 we have made great strides in delivering on our priorities. Bury is leading its peers in many places, remaining the third most prosperous borough in Greater Manchester based on average income (which has increased by 30% since the strategy began), investing nearly £3m in grants to Bury's vital voluntary community and social enterprise sector, supporting the Bury Business Improvement District to realise its potential of over £2m investment over 5 years, and with regeneration projects worth over £100m on track for delivery.

While we have made progress, we also recognise that not everyone has felt the benefit of those successes. The cost-of-living crisis is widening inequalities; demand in the health and care system is escalating; we must improve services to our children and young people and establish a partnership of equals between the community sector and public services.

This document is **a plan to the end of the decade** to tackle these issues and realise our vision for shared success.

The opportunity capital of Greater Manchester.

Bury is a Borough of six proud towns and an overarching sense of community, through the energy of over 26, 000 volunteers and 1,200 voluntary groups.

We have a proud industrial heritage and a beating retail heart. Bury is one of the principal retail destinations in Greater Manchester; hosts an internationally recognised market; is home to 15 Green Flag parks and has a £100m regeneration programme to create new jobs and homes for the decades to come.

Bury provides a rich cultural home to world-class artists, writers, musicians, sportsman and performers. The English National Opera is working here to develop its performers of tomorrow; our heritage railway has secured a repairs grant of over £1m to sustain its future and football has returned to Gigg Lane.

Public services work together in our neighbourhoods, in integrated teams which in 2023 the Local Government Association described as “innovative and brave.” Whilst the Council's statutory services are under pressure, significant investment has been made in children’s and adult’s services to support a prevention-first approach; reduce waiting lists and help more people to stay independent.

As part of the Greater Manchester City region, Bury has one of the fastest growing economies in the UK. We are grasping the opportunities of local devolution to bring power back to place; to benefit from local control over our skills and transport systems and the deep integration of our health and care services. Greater Manchester is a pioneering example of devolution and, within that context, Bury is its opportunity capital.

Our Vision

Our strategy sets out a clear vision for Bury in 2030 :

To stand out as a place that is achieving faster economic growth than the national average, with lower than national average levels of deprivation.

LET'S do it!
Shared success across Bury

We will achieve this by communities, businesses and public services working together:

- **Locally**, by empowering and enabling community led approaches and support, working with increasingly integrated public services
- With **Enterprise** through ambitious programmes of regeneration; opening up employment land and creating new jobs. We will connect local people to opportunities through skills development and by encouraging innovation and new ideas
- **Together**, by working as one system across communities, public services and businesses, recognising and valuing our increasingly diverse communities of race, faith and identity
- Through **Strengths**, by taking an asset-based approach to our work; helping people to focus on what is strong, not what is wrong and encouraging resilience and independence

Achieving our vision will mean that :

1. People in Bury have better lives
2. All our children have the best start in life
3. Our young children thrive in education and by developing skills
4. Our adults reach their potential for skills and work
5. All people can access sustained employment in a thriving local business
6. We progress our fight against climate change
7. Our people have full opportunity to take part in life in Bury by being digitally included

Local

In Bury we "do it" in our five neighbourhoods of North Bury, East Bury, West Bury and Radcliffe, Whitefield, and Prestwich. Here communities, public services and broader partners work as one team operating with permission, agency and trust.

Our improvements in the local health service was recognised as best practice by the Kings Fund in 2024 and won several external awards for the impact it is having on local residents. This includes 5000 more GP appointments in 2024 than in 2023, 4 local Respiratory Hubs opened, 57% reduction in ambulance call outs to care homes through utilising an innovative digital app, SafeSteps, and a 34% increase in Cardio-Vascular Disease health checks. A focus on prevention and early intervention meant that Bury had the second lowest levels of people attending hospital across Greater Manchester in 2024.

In 2024 over 50 community groups provided collected over 10 000 bags of litter and helped maintain our 15 Green Flag parks. As well as creating the equivalent of over £100 000 of social value these groups also helped tackle loneliness, isolation and suicide prevention. In Radcliffe, the "Community Legends" awards night showcased volunteers who fundraise for local charities; run local food banks; clean up streets, alleys and canals and create warm community spaces where everyone belongs.

Homelessness, migration and rough sleeping are increasing issues but the partnership is taking an increasingly strategic view of housing needs, including integration with the Council's housing function ; the community sector such as Red Door and by taking a prevention-first approach. The Council is increasingly engaged with the tenants in its 7000 homes , with monthly days of multi-agency community action and £20m of investment planned in the stock.

Bury is one of the safest boroughs to live in Greater Manchester but we are not complacent. The Community Safety Partnership has a plan to 2028 which leads innovative solutions such as the Forcer Protocol, to support service veterans who have gone missing when they return home and the Safer Streets cross-organisation partnership to spot risks of violence to women and girls.

"I'm proud to make a difference to people and communities in the neighbourhoods where they live"

Case Study

The Discharge Integration Frontrunner Programme is an innovative approach to working with people with Dementia to support them leave hospital as soon as they are ready to do so. The work was showcased for its high impact by the Local Government Association in supporting people to return home as quickly as possible following a hospital stay.

The approach focused on people not process, ensured leadership at all levels, utilised data and information to identify needs quickly and embedded effective communication and engagement at all points to support people with Dementia out of hospital effectively.

"I strive to develop and improve; to play my part in delivering great solutions with the people of Bury"

Case Study

Working Well Work & Health Programme (Community Impact Funds), the Bury Neighbourhub is a single 'coffee shop style' location in the Millgate Shopping Centre which brings together multiple agencies and partners in one place to reach those furthest from employment through health issues or social isolation. This approach is re-thinking what public services should look and feel like, fitting them around people's day to day lives in an environment that is more inclusive and welcoming. Partners include Citizens Advice Bury and Bolton, National Careers Service, Digital Inclusion providers, Bury Adult Learning, Health related services, Connexions and Welfare to Work.

Enterprising

A strong local economy is a critical driver of jobs and opportunities for our residents. The Council is driving this through a £100m regeneration programme which will create vibrant community spaces and hundreds of new jobs by 2030. The supporting transport strategy, including a new transport interchange in Bury town centre, sees investment in local highways and more active travel.

Construction began in Radcliffe in 2024 for a new Civic Hub, Enterprise Centre and £20m secondary school ; Planning permission has been secured for the multi-phase development of Prestwich Village and land assembly completed for the new flexible food and events space in Bury, the Flexi Hall. A masterplan for Bury town centre has been approved and the Council has entered into a Joint Venture partnership to redevelop the Millgate shopping centre, including up to 800 new homes and redeveloped retail and leisure space.

Housing supply has long been an issue in Bury, so the Council has also been releasing its brownfield land for housing development. A pipeline of over 1000 new homes is now in delivery including at the former East Lancs Papermill site; Seedfield school and various sites in Radcliffe and Bury town centre.

Business leadership is strengthening to ensure these new opportunities work for our small and medium sized enterprises (SMEs). The Bury Business Leader's Group, which is independently chaired by a business owner, has doubled in size over the last four years; a Business Improvement District has been established in Bury town centre and is activating the place through improvements in public realm, business engagement and events ; the council has established two joint venture partnerships with the private sector to develop some of its principal sites.

Social value is being created for our communities through these developments. Our principal construction partner in Radcliffe, Vinci, won a Gold award for the social value they have delivered including a Construction Skills Academy for local people and repairs and donations for local community groups; each of the Council's Joint Venture partners is now employing a care leaver and the Council has adopted a formal social value policy to ensure that every pound it spends delivers value for local people.

Together

The apostrophe in the Let's do it! call is its communities' *us* do it. Increasingly, the strength of Bury centres on its active volunteers, community groups and vibrant voluntary, community and faith sector -including Local Infrastructure Organisation, Bury VCFA, which amplifies and connects the work of over 180 separate groups which advocate, support and enable local people to live better lives.

Our vision to tackle deprivation relies on the goodwill, insight and sheer people - power of our army of volunteers. Through them, we have so far hosted four anti poverty summits to support communities with the cost of living. We have successfully piloted the "connected communities" model for the Greater Manchester and Sports England Get Moving strategy and built on the Aging in Place Pathfinder through the Bury Older People's Network to promote Aging Well, financial resilience and increasing representation in decision making.

Our social prescribing service provides link workers for hospital discharge and now supports over 3500 people. Many more hours of volunteering take place informally, providing social connections, groups and activities for people with low-level mental health issues and who may otherwise be left behind.

Change is also now increasingly co-produced. For example, the annual Circles of Influence listening event with children, led by the Youth Cabinet, informs the council's priorities for its young people and those who special educational needs and disabilities; Self-advocacy groups such as Bury People First which is run by residents with learning disabilities and our parents-carer forum for children with SEND, Bury 2Gether, are important partners for public services.

With guidance from our communities, public services are becoming more consciously inclusive. The Faith Forum is moving towards an interfaith leadership model; the Council's social care company, Persona, is pioneering inclusive recruitment practices nationally and the VCFA have led a series of cohesion roundtables looking at issues faced by diverse local communities of identity.

We are proud that since 2020 two community leaders have been awarded an MBE for outstanding contributions to local life and in the last two years Besses Boys' Band; Bury Active Women's Centre; Bury LGBT Forum; Bury People First; Caritas Red Door; and Supporting Sisters have been awarded the King's Award for Voluntary Service.

Case Study

"Team Bury, where all the partners come together, is a very lively and real and vibrant thing…Whilst there's a bit of a spectrum, fundamentally, people get it in their heart and have a shared view and you don't get that in many places"

Quote in the King's Fund case study of Bury population health approach 2024)

“I'm proud to build on the strengths of Bury people, my colleagues and myself to deliver”

Case Study

MyHappyMind is an early intervention programme available in almost all Primary and Secondary schools, supporting mental wellbeing education developed in response to rising needs in children and young people’s mental health following the pandemic. Digitally delivered to classrooms, lessons are guided by primary school teachers to promote positive mental health and emotional wellbeing and reduce the number of children needing clinical mental health provision.

89 per cent of teachers said that children have learned to self-regulate through the programme; and 80 per cent of teachers reported seeing their children's self-esteem improve from using the programme. For every £1 invested in the programme, the NHS saves £2.

Strengths

We believe everyone is born with individual strengths, but the world they are born to does not always enable them to use them. Our health, care and early years transformation work is establishing new models to help people stay as independent as possible by accessing resources in their community and proactive health management.

And it is working; Bury residents have some of the lowest numbers of days kept away from home due to hospital discharge delays and the integrated teams have won awards for innovative schemes to improve hospital flow including frailty clinics; same day emergency care; improving discharge arrangements for those with dementia and a falls prevention app. These improvements have tangible results – attendances to the local A&E went down last year in Bury, but were up as much as 19% in other neighbouring boroughs.

We recognise that Children and Young People are some of the most affected by the challenges our society is facing, and we have begun the work to create more opportunities and ensure they have the support they need. We are working to deliver a model of care and support that empowers parents, families and communities as the best people to support the needs of children, working in partnership with public services and wider community.

We have delivered exciting and innovative changes in-line with this model, including the Family Safeguarding model of practice; the Mockingbird model of foster care, nationally-respected initiatives such as the MyHappyMind app, an autism project to improve mental health and emotional resilience in school age children, and the launch of a partnership improvement programme to tackle challenges in SEND. Changes we have made have led to real impact:

- an increase of 7 more foster families this year, and greater stability for children with 73% of children in the same home two years later (up from 53%)
- a multi-disciplinary Safeguarding team recruited and supporting families
- a new housing policy that prioritises care leavers for housing
- 8 care experienced young people taking up apprenticeships this year

Looking to the Future

Making change takes time, which is why our strategy runs to 2030 but **with the scale of our ambition, every day counts**

Through our strong civil, business and community leadership investing in shared priorities , we can drive forward the next stage of delivery.

Let's do more *Locally*

Good growth is dependent on the development of preventative, integrated and more effective community services.

We will continue to develop our neighbourhood model and be a key part of the GM partnership which is piloting a "Prevention Demonstrator" for the whole of the UK.

In practice this means increasing activity through our neighbourhood teams and the representation of all public services in these teams.

We will use neighbourhood teams to identify and proactively support four priority cohorts where prevention and early intervention can make a difference, as part of a business case to UK government

- Individuals who are economically inactive and unemployed
- Demand in the health system presenting to emergency departments and GP surgeries
- Local Authority demand (Children's and Adults social care & Temporary Accommodation)
- Multiple Complex Cohorts with a range of crosscutting issues

lEt's be more *Enterprising*

We have a spatial plan and development pipeline that will deliver thousands of new houses and jobs. Our task now is to connect the most vulnerable to these opportunities

We will continue to move at pace with our existing ambitious regeneration programmes and the Northern Gateway, one of Greater Manchester's regionally significantly growth projects. But this is not economic growth at any cost. we need to ensure our business and investors have the talented workforce they need to invest and grow; we need to tackle head on the challenge of worklessness, economic inactivity and ill health; we need to provide the right spaces for industry growth, and we need to increase levels of R&D spend and technology adoption to continue finding new sources of growth through innovation.

We will work to provide job and career opportunities for all through the delivery of our Work and Skills strategy: delivering skills training to people who aren't in employment, promoting in-work training to further the skills of employees, removing the barriers to participation and supporting businesses to provide high quality jobs and drive infrastructure

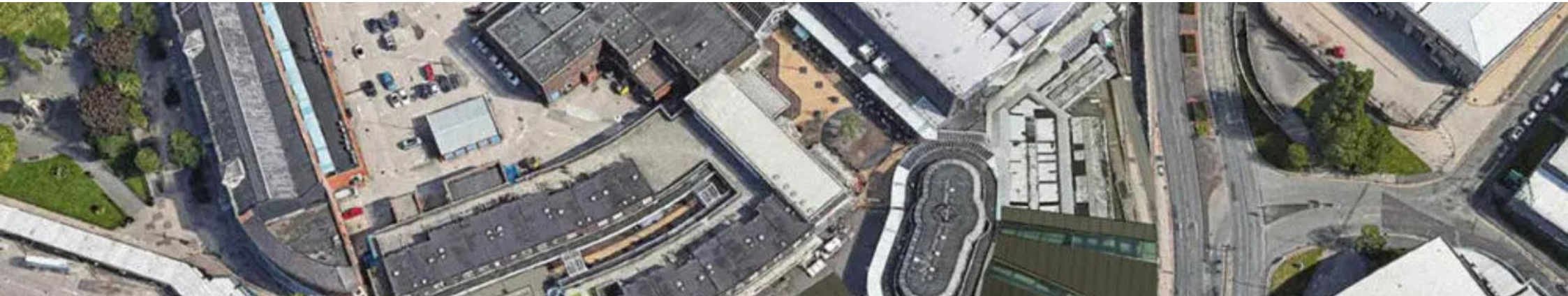
leT's do it *Together*

For too long our public services and local systems have prevented some people and communities from reaching their potential. We need a deep collaboration with our voluntary and community partners to enact change

We want a movement for change which reflects a parity of esteem between the Voluntary, Community and Faith Sector (VCFS) and public services in Team Bury. This will require more investment in community infrastructure, of which the 'Memorandum of Understanding' between the Voluntary, Community and Faith Alliance and the council is a start. In 2025 we will also be launching a Single Strategic Grant Investment – the Bury Fund – to harness and grow grants and investment in the community sector, including a recurring investment of £100,000 from Bury Council.

This will create a foundation to build on, with an ambition to push further on how we give the VCFS and communities more control of assets and resources in Bury; alongside a commitment to co-production. We will be launching a co-production Kite Mark , awarded to services who have evidenced a commitment to co-production.

This approach to working together across organisations and industries will flow through everything we do; from the delivery of our Economic and Transport Strategies to deliver green sustainable growth, to the delivery of our Culture Strategy, creating a vibrant, connected and inclusive borough for all.



let'S do it through *Strengths*

We have the assets and solutions to accelerate growth and tackle deprivation; now we need to maximise the collective strengths of residents and communities to live independent lives, by helping them to Live Well.

Support for our communities to grow even stronger will be through local implementation of the GM Live Well strategy, including agreeing a specific Live Well support theme/offer that others in GM can learn from.

Live Well is about ensuring that 'everyday support' is available in every neighbourhood to help people to better manage the pressures of life, live as well as they can and find purpose through good work. To achieve this we will, by 2030, establish

- a culture of prevention
- A network of "Live Well Centres"
- the resilience of the VCSFE sector
- An optimised neighbourhood model

Our approach will be further strengthened through the Council's commitment to delivering change in the six Marmot areas: providing the best start in life, maximising children and young people's opportunities, fair employment, healthy living standards, healthy places and communities and ill health prevention.

Support for our Children and Young People will have the greatest impact. We will do more to give them the opportunities they deserve through skill development, job opportunities and access to cultural assets in the borough. We will deliver these opportunities for all our Children and Young People including those most disadvantaged (e.g. expanding apprenticeships for care leavers) alongside the ongoing improvement of our Children Social Care and Special Educational Needs services.

Realising our ambitions means that by 2030 we will ...

Locally in 2030

We will have established multi agency neighbourhood teams in each of our towns to address a range of interconnected issues at the same time (including health, social care, employment and housing)**.** Alongside developed neighborhood teams we will have rolled out our Family Hubs (2025-30), improved the local environment through our Clean Air Plan (2025), refreshed our Homeless Prevention Strategy (2025) and created safe spaces through the delivery of our Community Safety Plan (2028).

Enterprising in 2030

We will have built new facilities including completed the Radcliffe Hub and Flexi Hall (2026), the first phase of the Prestwich town centre and Phase 1 of the Mill Gate (2028). Phase 1 on the Northern Gateway will be in delivery, creating new jobs for skilled local people and to the standard of the GM Good Employment Charter. T**he** new Transport interchange be completed in 2030 and there will be over 2,200 new homes, many of which will be affordable and built on brownfield land.

Together in 2030

We will have made community power a reality, working together to support better outcomes for people. We will have had 5 years investment in the VCSFE through our Bury Fund; our Memorandum of Understanding with the Voluntary and Community Sector will be in place and volunteers and public service staff will be working together as equals in integrated teams.

Strengths in 2030

We will have rolled out our integrated support offer (Live Well) and be meeting the standards of a Marmot town. We will be starting to see fewer people reaching crisis point and a reduction in demand increases for children's and adult's social care, temporary accommodation and avoidable hospital admissions

For info on thousands of activities, services and events in Bury scan the QR code

LET'S do it!

Shared success across Bury

Meeting:			
Meeting Date	07 April 2025	**Action**	Approve
Item No.	7.2	**Confidential**	No
Title	Locality Plan - 2025/26		
Presented By	Will Blandamer		
Author	Kath Wynne-Jones		
Clinical Lead			

Executive Summary

The Bury Integrated Care Partnership Locality Plan has been refreshed for 2025/2026 in the context of the revised Lets Do It Strategy for the Borough (2025) and the NHS Greater Manchester 3-year Sustainability plan (2025-2027).

This Locality Plan builds on a period of transformation and improvement in the operation of the health and care system in Bury since 2021. Progress has been built on high quality partnership working and a shared ambition for better outcomes for our residents. However, there is still more to do.

This plan outlines the next stage of our Health and Care reform journey, connected to the reform of wider public services and the economic ambition in the borough. The detail of the plan focuses on the first 12 months of delivery which includes the asks of the NHS operating plan for 25/26. Because of the heavy focus in our Locality Plan on population health, prevention and well-being, this document also serves as the Borough Health and Well Being Strategy, as required by the Bury Health and Well Being Board.

Recommendations

The Locality Board is asked to approve the refreshed Locality Plan for 2025/26.

OUTCOME REQUIRED *(Please Indicate)*	**Approval** ☒	**Assurance** ☐	**Discussion** ☐	**Information** ☐
APPROVAL ONLY; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	**Pooled Budget** ☐	**Non-Pooled Budget** ☐		

Links to Locality Plan outcomes	
To support a local population that is living healthier for longer and where healthy expectancy matches or exceeds the national average by 2025.	☒
To achieve a reduction in inequalities (including health inequality) in Bury, that is greater than the national rate of reduction.	☒
To deliver a local health and social care system that provides high quality services which are financially sustainable and clinically safe.	☒
To ensure that a greater proportion of local people are playing an active role in managing their own health and supporting those around them.	☒

Implications						
Are the risks already included on the Locality Risk Register?	Yes	☐	No	☐	N/A	☒
Are there any risks of 15 and above that need to be considered for escalation via an NHS GM Statutory Committee or Board in line with the Risk Escalation process ?	Yes	☐	No	☐	N/A	☒
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☐	N/A	☒
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☐	N/A	☒
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☐	N/A	☒
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☐	N/A	☒
Are there any financial Implications?	Yes	☐	No	☐	N/A	☒
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☒
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☐

Implications
N/A

Governance and Reporting		
Meeting	**Date**	**Outcome**
N/A		

Bury Integrated Care Partnership Locality Plan Refreshed for 2025/2026

FINAL V15 – 26/3/25

Part of Greater Manchester Integrated Care Partnership

Presentation by:

Kath Wynne-Jones – Chief Officer – Bury Integrated Delivery Board

Will Blandamer - Executive Director Bury Council, and Deputy Place Lead NHS GM (Bury)

Introduction

The Bury Health and Care system – referred to as the Bury Integrated Care Partnership - developed a Locality Plan in 2021 and updated it in January 2023.

The Locality Plan describes a strategic ambition for the operation and improvement of the health and care system in Bury, and for improved population health and reducing health inequalities.

This document is the refreshed Locality Plan for 2025, in the context of the revised Lets Do It Strategy for the Borough (2025), and in the context of the NHS Greater Manchester 3-year Sustainability plan (2025-2027).

This Locality Plan builds on a period of transformation and improvement in the operation of the health and care system in Bury since 2021. Progress has been built on high quality partnership working and a shared ambition for better outcomes for our residents. However, there is still more to do.

This plan outlines the next stage of our Health and Care reform journey, connected to the reform of wider public services and the economic ambition in the borough. The detail of the plan focuses on the first 12 months of delivery which includes the asks of the NHS operating plan for 25/26.

Because of the heavy focus in our Locality Plan on population health, prevention and well-being, this document also serves as the Borough **Health and Well Being Strategy**, as required by the Bury Health and Well Being Board.

Executive Summary

This Locality Plan outlines the current and forecast state of the health of our population, the policy context of this Locality Plan, and describes an ambition for the further reform of our health and care system and for the improved health of all people of Bury.

The Locality Plan highlights that improved outcomes for Bury residents and a clinically and financially sustainable health and care system is dependent on improved population health, improved prevention, transformed community care and the optimal delivery of health and care services.

Consequently, the Locality Plan identified 4 key priorities:

- improving population health and reducing health inequalities
- preventing ill health and intervening earlier to reduce demand on secondary care services
- transforming community-based care through improved neighbourhood team working with primary care at its heart
- optimising delivery of health and care services, particularly in secondary care and care homes

These priorities should be reflected in across the breadth of our programmes of work.

Despite challenging risks (which are identified) the Bury Integrated Care Partnership is committed to delivering on these key priorities and has confidence in our partnership arrangements to do so. We will routinely review progress.

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Contents

1. Locality Context

BURY INTEGRATED CARE PARTNERSHIP

Summary:

Bury is a fantastic borough with a clear strategy to reduce deprivation and to capitalise on economic potential. Partners in Bury work effectively together and there is evidence the system is transforming. However, the health and care system faces national and local challenges that we need to address, including entrenched inequality of access and outcome, and the financial sustainability of the system.

Part of Greater Manchester Integrated Care Partnership

About Bury

Bury is a proud borough in Greater Manchester made up of 6 distinct towns, and home to 190,000 residents.

It is the principal retail destination after the city centre and Trafford Centre; hosts an internationally recognised market; is home to 15 Green Flag parks and is a heritage visitor destination.

As six proud towns there is a strength in our individual identities and an overarching sense of community that exists from the energy of over 26,229 volunteers and 1,249 voluntary groups, working with integrated public services in neighbourhood teams which were described in 2023 by the Local Government Association as “innovative and brave”.

Bury has a proud industrial heritage and a landscape which still boasts the legacy of a mill town. It is now a place where digital economies thrive; with a beating retail heart and a success in small business start-ups.

Bury has a history of high-quality partnership working – between public services, with business, with the voluntary, community and faith sectors, and with residents. We call this ‘Team Bury’.

The Bury Integrated Care Partnership – describing the work of all key partners in the health and care system such as hospitals, community services, primary care, social care, voluntary sector, mental health services Bury Hospice and NHS Greater Manchester in Bury – typifies excellent joint working.

The Strategy for Borough – Lets Do It

Our locality plan for health and care sits in the context of the wider ambition for the borough – the Lets Do It strategy (refreshed 2025) – with its ambition for faster economic growth and significant reduction in health inequalities.

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

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

The Health of our Population

BURY INTEGRATED CARE PARTNERSHIP

Demographic Profile Bury

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

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

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

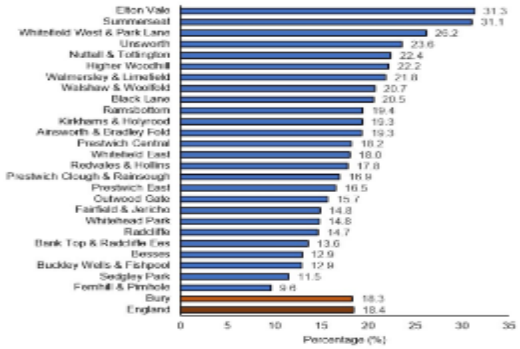
Growth
2.96%
The percentage that Bury population is expected to increase by 2033

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

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

35,447 (18.3%)

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



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

Life expectancy at 65 years
17.4 Years | 19.7 Years

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

(Source: ONS, 2022)

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

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

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

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

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

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

The Current Health Status of our Population

BURY INTEGRATED CARE PARTNERSHIP

- The population of Bury is both growing and ageing. There are 35,447 older adults aged 65 years and over in Bury with the highest proportion living in Eton Vale (31.3%) and Summerseat (31.1%) and lowest proportion in Fernhill and Pimhole (9.5%) and Sedgley Park (11.5%)

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

- Life expectancy at 65 years of age for Males in Bury is 17.4 years and for Females is 19.7 years. However, there are inequalities in life expectancy at age 65 years with a gap in life expectancy of 6 years in Males and 5.9 years in females between the most and least deprived deciles.

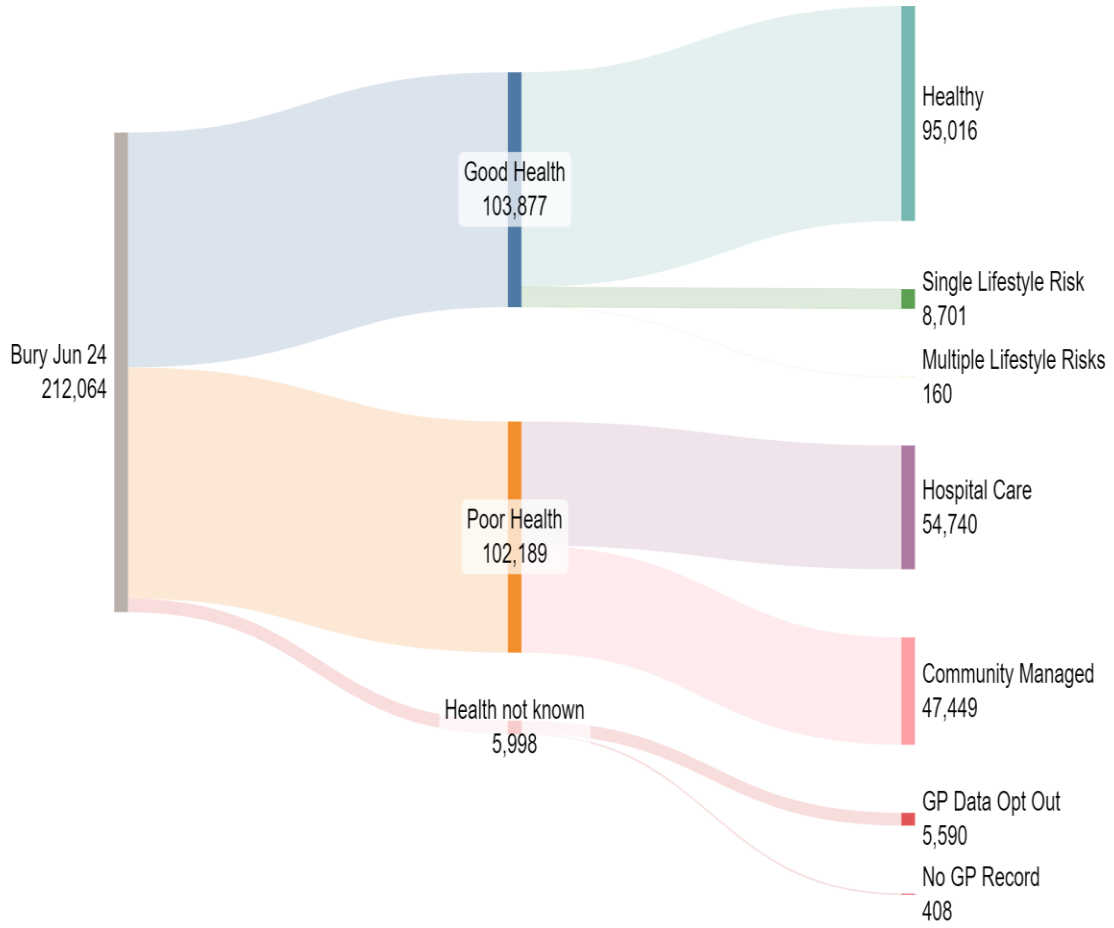
- The leading causes of death in Bury are cardiovascular diseases and cancers. The main causes of disability are musculoskeletal conditions and mental illnesses. Diabetes and liver disease are increasing rapidly as causes of disability and death respectively.

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

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

- Full details around Bury's population and health needs including breakdowns by neighbourhoods can be found on the Bury JSNA (https://theburydirectory.co.uk/jsna)

Bury Health Projections

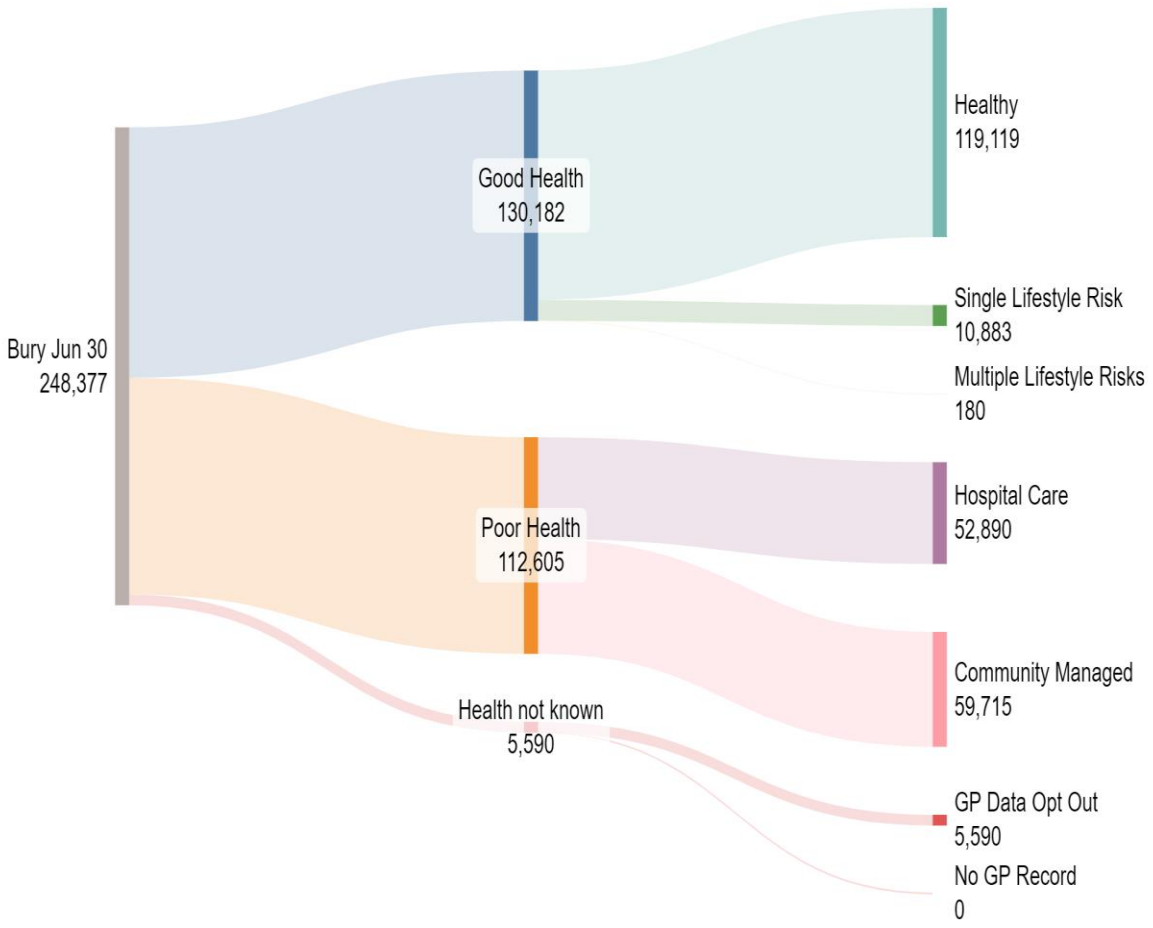


Note: These health projections are based on GM population segments using the Carnall Farrar segmentation model. Additionally, they use Bury's registered population rather than the resident population and may not necessarily reflect the health of all Bury residents.

According to Carnall Farrar segmentation of Bury's population according to healthcare use (2024)

- The ageing population is likely to increase the proportion of people in the frailty segment (the costliest).
- **Good Health (n=103,877 , 48.9%):** Nearly half of Bury's population is classified as being in "Good Health." This includes 95,016 individuals (91.4%) with no recorded lifestyle risks, 8,701 individuals (8.4%) with one lifestyle-related risk and 160 individuals (0.2%) facing multiple risks, which are likely underreported due to gaps in GP record documentation. However, this classification may not account for undiagnosed conditions or limited healthcare interactions.
- **Poor Health (n=102,189 , 48.2%):** A significant portion of Bury's population lives with diagnosed health conditions requiring medical intervention. Over half of this group (54,740 individuals or 53.6%) rely on hospital services, reflecting high secondary care usage. The remaining 47,449 individuals (46.4%) are managed outside hospital settings. This indicates a high demand for both hospital and community healthcare services.
- **Health Not Known (n=5,998 , 2.8%):** This segment lacks sufficient data for accurate categorisation. The majority of this group (5,590 individuals) have opted out of sharing their health data. Additionally, 408 individuals lack a recorded GP presence, potentially due to disengagement with healthcare services or administrative gaps. The lack of data makes it challenging to accurately assess and address the health needs of this segment.
- **Invest in prevention:** Prioritise addressing lifestyle risks and strengthening early intervention efforts to prevent the transition from good health to poor health.
- **Improve data quality:** Implement strategies to better capture and analyse health data, including engaging individuals who have opted out of sharing their records.

Projected Non-Demographic Growth (NDG) for Bury



Note: These forecasts are not based on recognised ONS population projects, known age-specific rates of illness or healthcare use, or established epidemiological methods. They should be treated with caution.

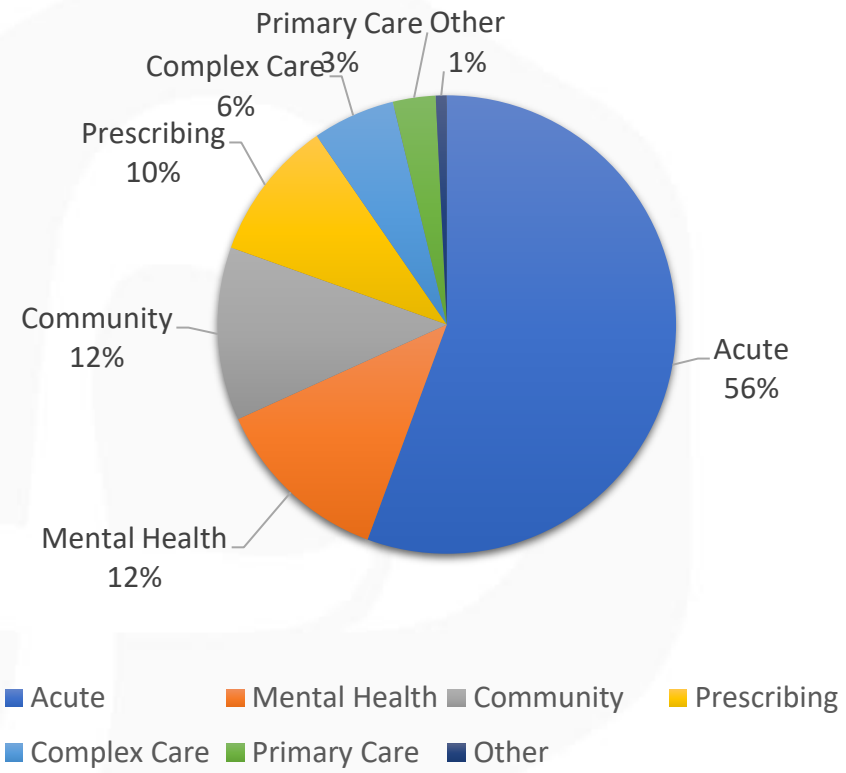
According to the Carnall Farrar locality projections:

- Bury's registered population is expected to grow to 248,377
- **Good Health (n=130,182 , 52.4%):** Over half of Bury's population is classified as being in "Good Health." This includes 119,119 individuals (91.5%) with no recorded lifestyle risks, 10,883 individuals (8.4%) with one lifestyle-related risk and 180 individuals (0.1%) facing multiple risks, which are likely underreported due to gaps in GP record documentation. However, this classification may not account for undiagnosed conditions or limited healthcare interactions.
- **Poor Health (n=112,605 , 45.3%):** A significant portion of Bury's population is projected to have diagnosed health conditions requiring medical intervention. Nearly half of this group (52,890 individuals or 46.9%) will rely on hospital services, reflecting high secondary care usage. The remaining 59,715 individuals (53.1%) will be managed outside hospital settings. This indicates a high demand for both hospital and community healthcare services.
- **Health Not Known (n=5,590 , 2.3%):** This segment lacks sufficient data for accurate categorisation. Majority of this group (5,590 individuals) are projected to opt out of sharing their health data.
- The projected growth of the "Good Health" group in 2030 to 52.4% indicates progress in preventative measures and overall health maintenance.
- Over half of those in "Poor Health" are expected to rely on community-based care. Strengthening community services will be essential to meet this demand and reduce the pressure on hospital services.
- The persistent GP data opt-out group limits visibility into their health status, creating potential gaps in care and resource allocation.
- Although a small proportion, addressing single and multiple lifestyle risks early remains critical to preventing progression to chronic conditions.

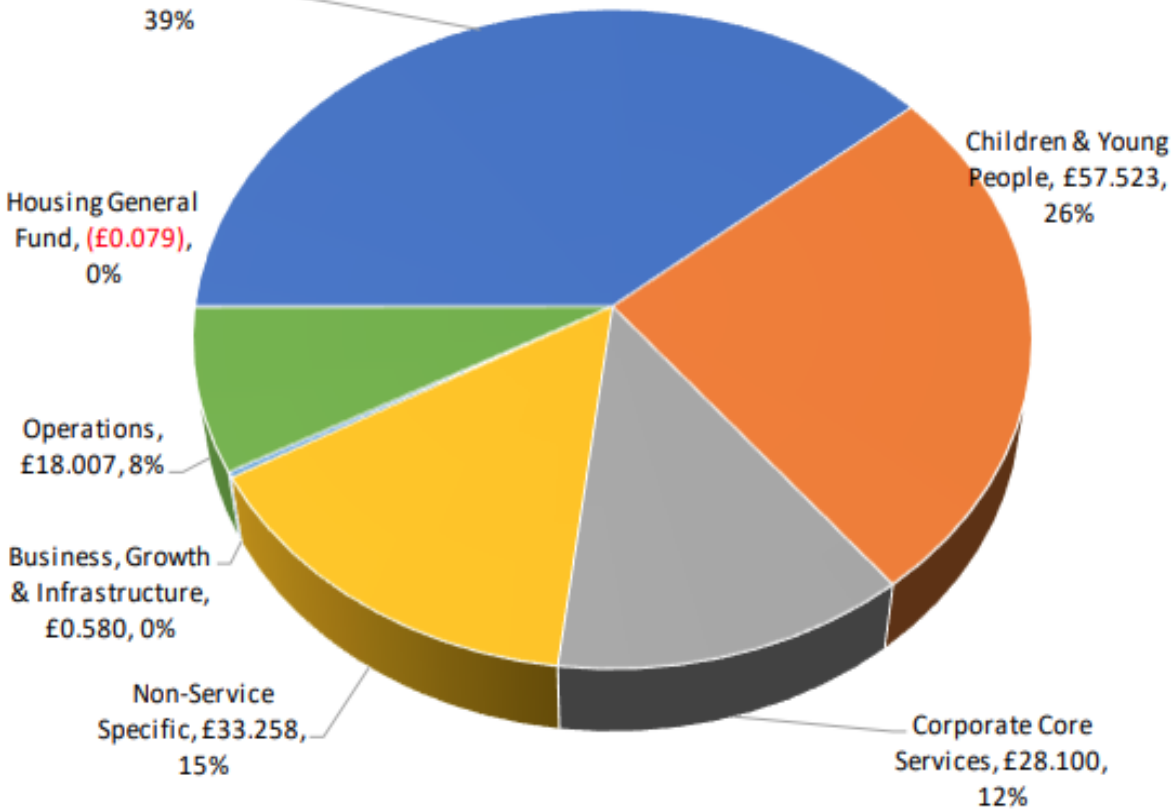
Our Current NHS and Council Spend

BURY INTEGRATED CARE PARTNERSHIP

Forecast 2024/25 Bury Health Expenditure



2024-25 Revised Net Revenue Budget £224.480m



2. NHS GM Sustainability Plan

BURY INTEGRATED CARE PARTNERSHIP

Summary:
Our plan for Health and Care transformation in Bury is framed by the NHS Greater Manchester Sustainability plan 2025-2027. This plan signals a clear intent around a step change in prevention and early intervention, reflects a national priority around shifting to a neighbourhood based system, and requires a focus on optimising care through new models of delivery.

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The GM Sustainability Plan 2025-2027

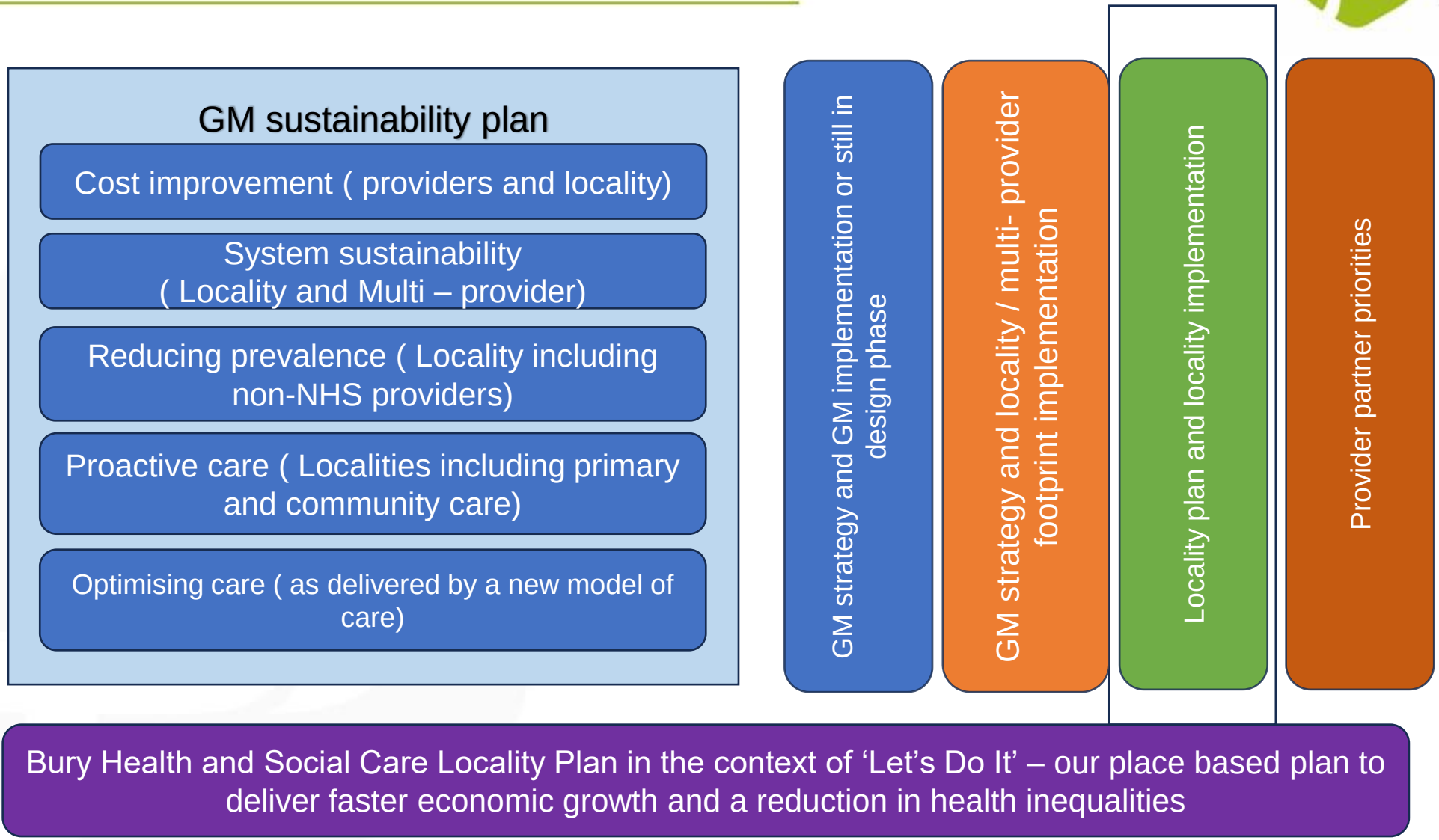
BURY INTEGRATED CARE PARTNERSHIP

The 5 pillars of Sustainability

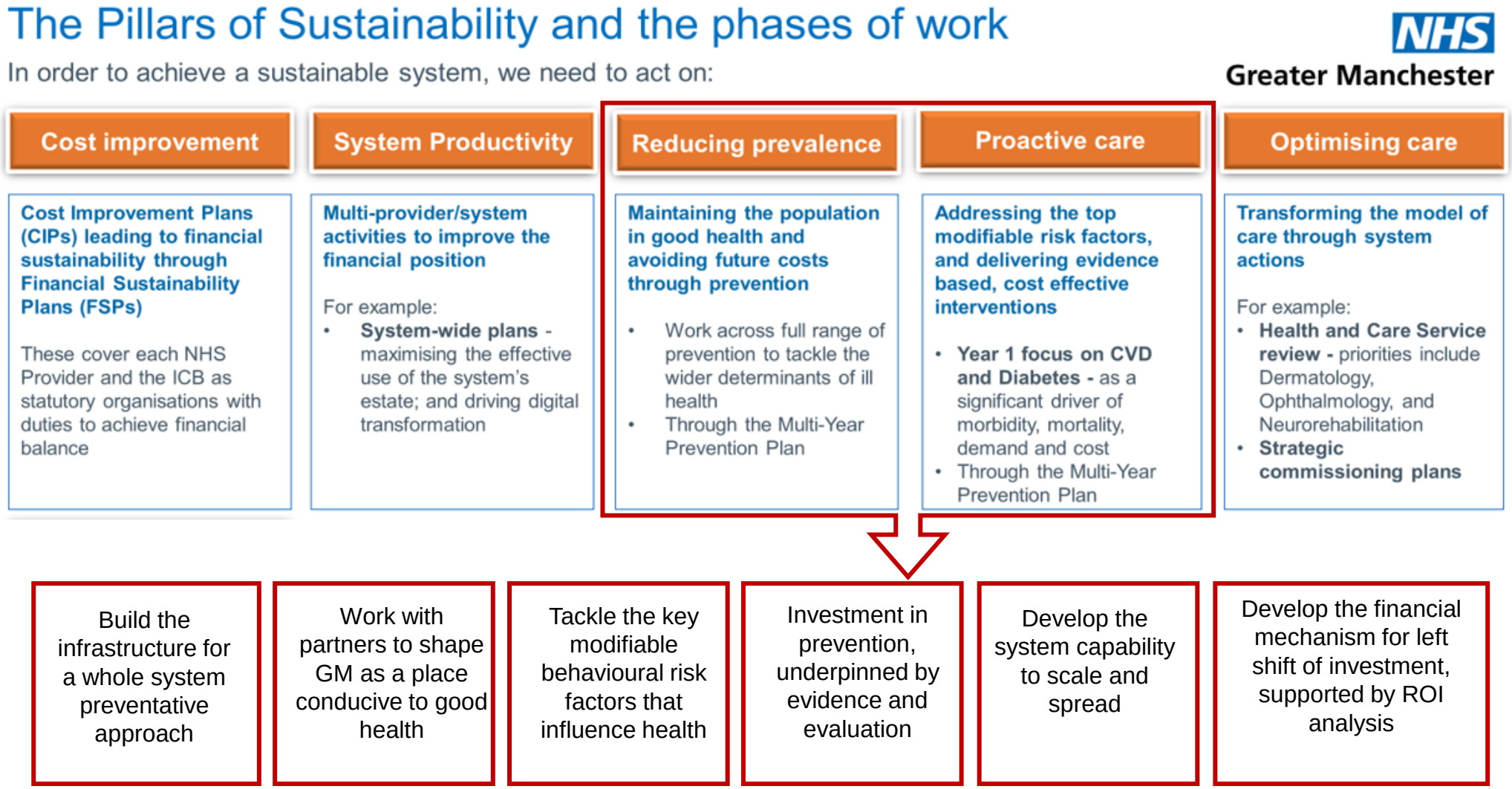
Cost improvement	System Productivity and Performance	Reducing prevalence	Proactive care	Optimising care
Cost Improvement Plans (CIPs) leading to financial sustainability through Financial Sustainability Plans (FSPs)	Multi-provider/system activities to improve the use of our resources and our performance	Maintaining the population in good health and avoiding future costs through prevention	Catching ill health early, managing risk factors, and delivering evidence based, cost effective interventions to reduce the level of harm	Transforming the model of care through system actions

Our locality plan in the context of the GM wide planning

BURY INTEGRATED CARE PARTNERSHIP

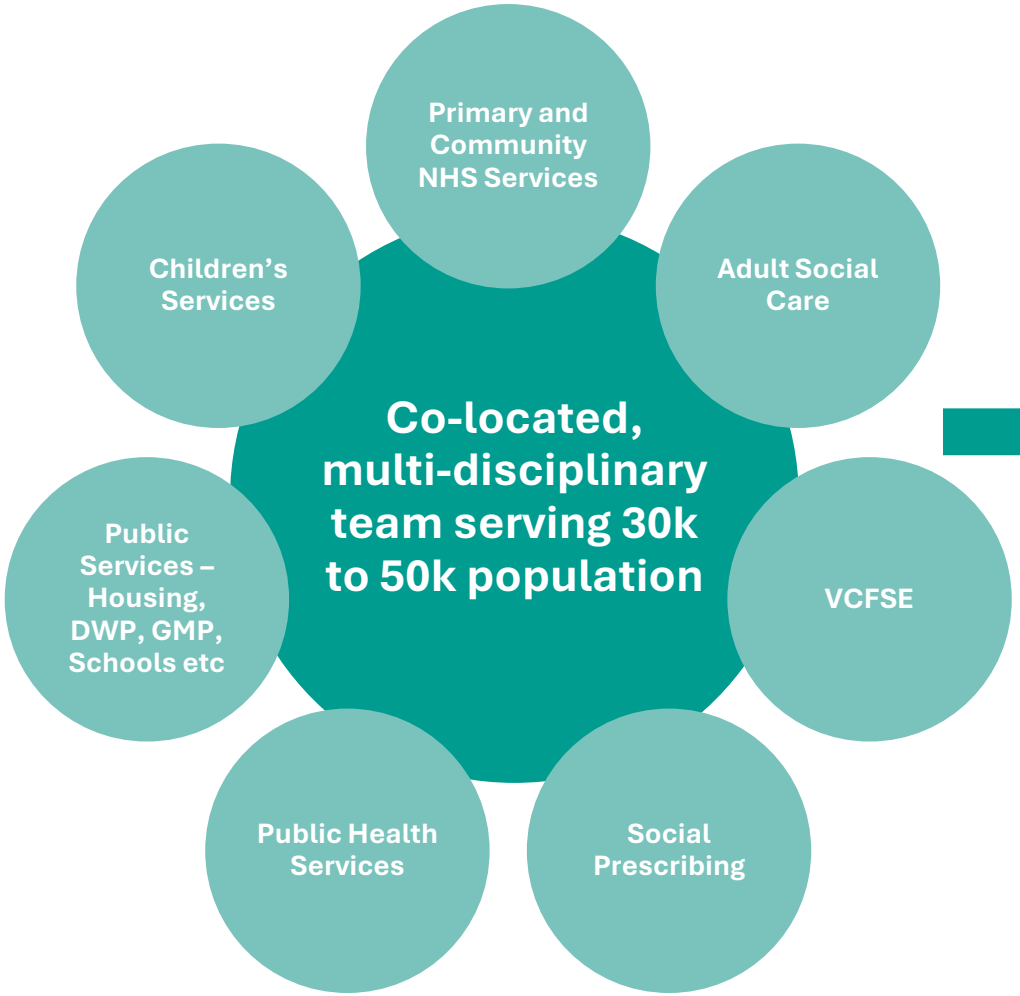


Prevention: a core component of the GM Sustainability Plan



Prevention and the Neighbourhood Model

- Full Live Well Prevention Offer – Primary, Secondary and Tertiary
- Using full range of PHM tools
- Asset Based
- Integrated Leadership Arrangements
- Pooled Budgets



Local Leadership – Locality Board and Place-Based Lead

Neighbourhood Offer

- Use Risk Stratification and Proactive Case Finding
- Identify those at risk or approaching crisis
- Integrated response to issue/s and current need
- Proactive plan to prevent future need

Agreed Outcomes

Improved Health and Independence
- Reduced Demand on Acute and Crisis-Based Services

NHS Greater Manchester

GMCA GREATER MANCHESTER COMBINED AUTHORITY

3. Building on Progress

BURY INTEGRATED CARE PARTNERSHIP

Summary:
There is evidence that the Bury health and care system overall works as well or better than other systems, and we can demonstrate a track record of improvement and a transition to a new and transformed system. This is a solid foundation of achievement from which to further improve.

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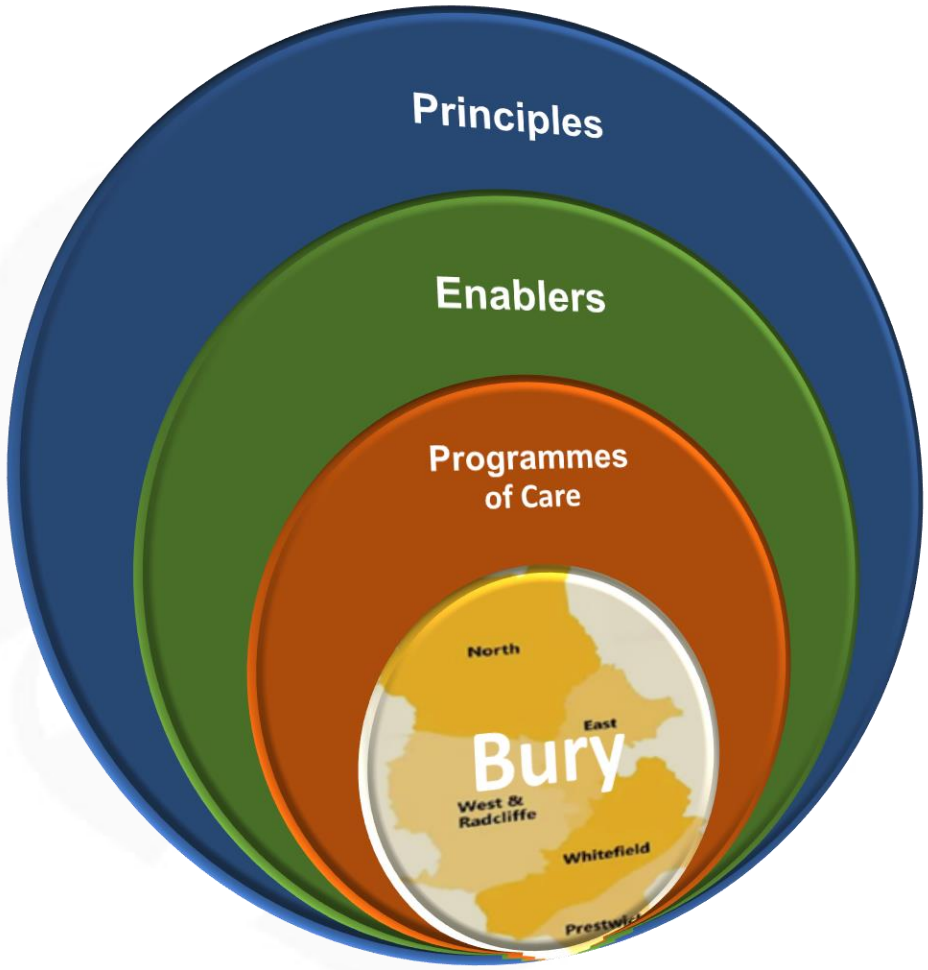
We are transforming across multiple programmes, supporting by enablers and guiding principles



Programmes of Care

- Urgent and emergency Care
- Mental health
- Primary care
- Elective and community care,
- Major conditions,
- End of life,
- Adult social care,
- Learning disabilities,
- Children and young people

Enablers

- Workforce
- Estates
- Digital
- Clinical and professional leadership
- Communications and engagement
- Financial flows
- Partnership working and collaboration
- VCSE provision

Principles

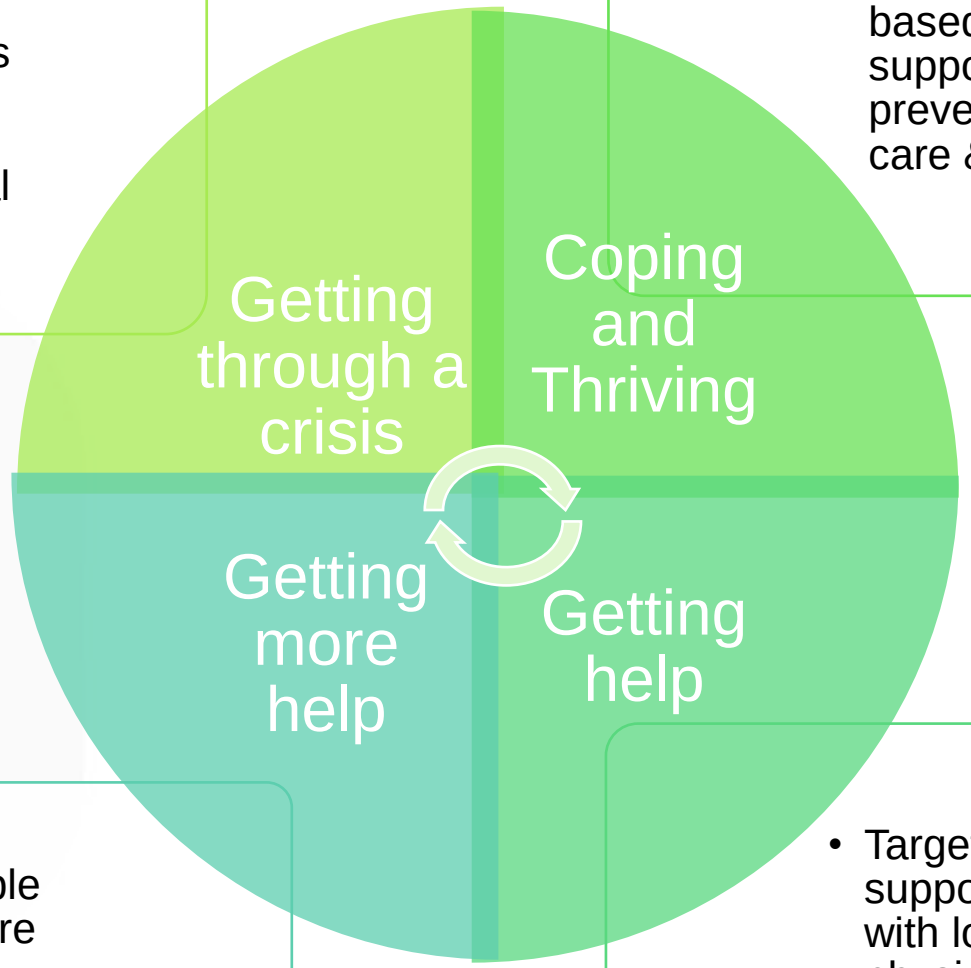
- Focus on prevention and population health through neighbourhood working
- Residents to be well, independent, in control of their own health and connected to their communities
- Residents in control of how services are organised around them and delivered closer to home where necessary
- Supporting children to start well
- Timely and effective access to services where required
- Adoption of strengths-based approaches
- Co-production
- Controlling the overall costs and the health and care system
- Clinical, professional , managerial and political leads working together

And we target interventions according to need

BURY INTEGRATED CARE PARTNERSHIP

- Supporting people through short term crisis / escalation of needs e.g. to prevent hospital or residential care admission

- Whole population-based approach to supported, preventative self-care & wellbeing



- Supporting people with complex care needs/at risk of deterioration

- Targeted, proactive support for people with long term physical and mental health conditions

Our Strengths

- Good quality partnership working at operational and strategic levels across all partners as described in the work of the Bury Integrated Care Partnership
- A model of integrated neighbourhood team working in adults at neighbourhood level reflective of the circumstances of each of the 5 main towns in the borough (Prestwich Whitefield, Bury, Radcliffe and Ramsbottom), nested in the context aligned capacity from key partners including housing, GMP and others as part of a model of public service reform
- High quality population health analysis and population health improvement delivery mechanisms
- Good quality primary care delivery albeit relatively under funded
- The successful and ongoing delivery of the Adult Care transformational programme
- Steps taken to address relatively poor benchmarked funding of council children's care services.
- Increasingly mature partnership working across the NCA footprint, referred to as the 4 localities partnership.
- Expertise in connected to and managing the relationship of NHS GM in a way that secures benefit to Bury
- A rapidly maturing and strengthening collaboration of voluntary, community and faith partners and the work of the VCFA
- Improvement in a significant number of outcomes for the Borough, which are outlined in detail in the appendix.

Our Key Challenges

- The need to strengthen our model of neighbourhood working
- The need for more confidence in our work on the first 1000 days, and a strengthened NHS response to the operation of the Bury SEND partnership
- The need to address some of the legacy service gaps in Bury caused by historic underfunding of Bury PCT/CCG e.g in mental health
- The need to invest in capacity and capability of primary and community services to affect the ‘left shift’ away from unnecessary secondary care
- Bury being relatively ‘under GP’d’ compared to most other parts of GM
- The need to ensure the prioritisation of prevention and early intervention.
- The need to ensure greater engagement of people in co-design and co-production
- The opportunity of the voluntary and community sector
- Balancing accessibility of secondary care with clinical sustainability/critical mass
- Addressing challenging waiting times for NHS services (urgent, mental health, community and elective care) for adults and children
- Financial stability within locality budgets

4. Our 4 Key Priorities

BURY INTEGRATED CARE PARTNERSHIP

Summary:
On the basis of the strategic context described, and the need to continue and quicken our transformation in the light of potential future demand, we have identified 4 key priorities. Our key priorities should be clear to all of us and allow us the necessary focus to deliver further and faster.

Part of Greater Manchester Integrated Care Partnership

4 Clear Priorities

BURY INTEGRATED CARE PARTNERSHIP

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

Example Components of Each Priority

1. **Population Health Improvement including reducing health inequalities.**
   - addressing the wider determinants of health
   - supporting people and families to take control of their own health and well being,
   - recognising and supporting families and carers
   - recognising the role of the voluntary, community and faith sectors in supporting people to be independent and well and connected.

2. **Prevention, reducing prevalence and proactive care**
   - primary care led risk identification and management
   - supporting people to live well and independently at home as much as possible
   - I thrive model for children and adults
   - Integrated Care delivered for Major Conditions across Primary, Community and Acute Care , including CVD and diabetes, respiratory, dementia, MSK and cancer

3. **Transforming the Model of Care in the Community through neighbourhood working and strong integration**
   - creating services and support around local joined up health and care services in each of the largest 5 towns in the borough ('neighbourhood working'), connected to wider public service delivery in each. The core of these teams will include community service nurses and social workers working closely with Primary Care
   - shifting the balance of service delivery and utilization of new funding to community and primary care and away from hospital
   - reducing unnecessary or premature institutional care or crisis services through responsive intermediate tier and community crisis response services
   - availability of community diagnostic capacity
   - Investment in primary and community estate

4. **Optimising Care**
   - Optimising the way services that of necessity need to be institutionally based - secondary care, or care homes residential
   - Reducing Indicators of poor system productivity – e.g delayed discharges, out of area placements,
   - ensuring timely access to good quality services – reducing waiting times

What it means for our service users and workforce

BURY INTEGRATED CARE PARTNERSHIP

1. Population Health Improvement including reducing health inequalities.

Brenda, a 48-year-old lady is struggling to cope with life as she approaches the menopause. She is encouraged through social media to take more control of her own health and well being through menopause. She sees a local walking group advertised in her GP Surgery, and starts to attend which means she is getting outside, moving and meeting new people. She visits her GP Surgery less about her menopause challenges; however, she receives a text alert to inform her of drop-in sessions happening at the women's health hub which she finds very educational and supportive.

Sophie is 11. and is frequently experiencing anxiety and depression and is increasingly anxious at the thought of attending school .Sophie is able put in place the tools she has learned from my happy minds to support her own wellbeing and resilience . She has support the community mental health team in school if she needs it. She happier at school , her grades improve and she feels more confident and optimistic about her life .

2. Prevention, reducing prevalence and proactive care

Mohammed is diagnosed with diabetes by his GP aged 68. His GP practice provide medication and lifestyle advice and refer him to the diabetes education programme which is culturally sensitive to his needs. They give him information on what diabetes is , how to manage is diet and other aspects of healthy living. His practice enrol him in the chronic disease monitoring programme and ensure that he receives that 8 processes of care the practice (including being enrolled onto the diabetes eye screening programme. They advise him that if any complexities arise, he will be referred to the community diabetes service

3. Transforming the Model of Care in the Community through neighbourhood working and strong integration

Jack is 85 and is experiencing regular falls due his increasing frailty. Sometimes this necessitates him calling for an ambulance, and results in him staying in hospital for unnecessarily long periods of time due to the waits in A&E. Jack is referred to the Integrated Neighbourhood Teams who devise him a care plan in conjunction with his GP and the falls prevention team, and ensure he has a pendant alarm in place. If Jack falls, the falls lifting service respond to him instead of ambulance. If he has any medical needs, they seek the support of the rapid response and hospital at home service to keep him in his own home.

4. Optimising Care

Claire is 32 and has been waiting for a diagnostic procedure at the hospital for her joint pain, which leaves her unable to play with her child or exercise and is causing her to gain weight and feel depressed. In the future, she will receive a specialist assessment the community who determine the diagnostics she needs and will undertake them promptly in the community. If she needs further assessment, she will attend an outpatient clinic in the community and will undergo treatment in a timely manner if she needs it. She will receive advice on how to keep herself well whilst she is waiting.

5. Design principles for health and care

BURY INTEGRATED CARE PARTNERSHIP

Summary:
On the basis of the strategic context described and the 4 key priorities, we have agreed a number of key design principles for health and care that will flow though all of our work.

Part of Greater Manchester Integrated Care Partnership

Design principles for our Delivery Model for Health and Social Care

Principle 1: Neighbourhoods & General Practice should be the 'locus of integration',with a focus on population health

- A scaled and Marmot compliant programme addressing wider determinants of population health, support to behaviour change, creating communities, and targeting the operation of the health and care system and wider public services in health inequality.
- A model of integrated team neighbourhood working that is all age and comprehensive, that has a wider range of services connected as part of the integrated team, is a focal point for strengthened intermediate care, and uses more refined and targeted models of proactive primary and secondary prevention.
- A strengthened primary care offer properly and sustainably funded – with single points of access, better care navigation, more responsive services and primary care element of proactive care being more pronounced
- The practice-based registered list is the only place within system where there is the most complete record of health which also includes the most holistic record of the totality of healthcare interventions This potentially provides an invaluable resource for tackling health inequalities, personalising care and transforming commissioning decisions
- Providing appropriate levels of support in the community for mental health conditions

Principle 2: Primary and community diagnostic provision including the extended role of nursing and allied health professionals

- Improved access to primary and community facing community diagnosis provision (revisit the business case for the Bury diagnostic hub) .Ideally, a Community Diagnostic Centre based in the town centre offering non obstetric ultrasound, Spirometry Phlebotomy ECG, Feno, Echo, ECG DEXA-Scanning 24-hour tape & 3day holter and Quality Assured Spirometry
- Delivery of most long-term conditions management and the deployment of new technology approaches all depend on the extended role of nursing and AHPs
- This requires a new relationship between nurses and AHPs working in General Practice with those working in community health (including mental health) teams and secondary care, and requires a focus on clinical education and training

Design Principles for our Delivery Model for Health and Social Care

BURY INTEGRATED CARE PARTNERSHIP

Principle 3: Consultant / Specialist opinion is an essential component of effective integrated services

- To introduce a new model of care, consultant/specialist opinion is crucial to effectively manage the full range of morbidity. Consultants will shift some clinic time to focus on strategic care model development, providing individual support to primary care management and supervision of new community-based teams
- Full expansion of the virtual ward with Acute Physicians doing virtual ward rounds but also doing physical ward rounds/clinics based with the neighbourhood teams, with graduated closure of acute wards over time.
- Only those that are acutely sick that requires actual hospital input should stay. This requires the capacity and a wraparound model for those including complex dementia patients
- Strengthened SDEC frailty and SDEC function at FGH, with community capacity to enable patients to get straight back to their home.
- A new model of Stroke Care. Moving to a community-based model, care at home and support must be the direction of travel.
- The avoidance of mental health patients unnecessarily in ED, which will be dependent on addressing the legacy of underinvestment in Bury in both crisis and early intervention services in mental health and the currently unfunded and not operational section 136 suite
- A new mode of outpatient's services which includes significant expansion of consultant advice and guidance to GPs, and digital utilisation, and a change in service location to a central hub in the town centre to support the economy & bring income to the town centre. Support the transport strategy and ease the parking burden at FGH.

Principle 4: Integrated services will be enhanced by the involvement of social care

- Formal integration of social care needs to extend not only to the work of professional teams but also to use of information systems and sharing of patient and client information – subject to the appropriate controls – to ensure that packages of care can be supplied that best meet the needs of individuals.
- We should not be conveying patients to ED that have social issues, from care homes and so on unless they have an acute medical problem. We need to make the community teams bigger with the resource from acute providers moving out into the community. We then have an ED that can function and cope with the demand footprint

Design Principles for our Delivery Model for Health and Social Care

BURY INTEGRATED CARE PARTNERSHIP

Principle 6: Future integrated services would bring together the full range of primary care

- The incorporation of new technology diagnostics, the further development of patient choice and the concept of a network of interlinked services opens the prospect for a greater role for pharmacy and optometry in the delivery of the future

Principle 7: Unscheduled care should be simple to access and fully integrated.

- The distinctions between primary care out of hours support, UTC and A&E attendances do not make the best use of the available clinical expertise and are confusing for the individual using services. We will ensure that a single clinical governance regime and infrastructure provides the appropriate level of support in a variety of settings which are convenient to patients

Principle 5: The voluntary sector, carers and our population need a strong voice in the design and sustainability of services

- There are areas of care where the voluntary sector is better placed than statutory bodies to deliver effective care and support
- One of the key benefits of integration will be an improved 'signposting' of services and greater support for people navigating the system for both carers and patients
- We wish to engage with our population to design services and encourage shared responsibilities for health – this is not just the job of statutory services

Principle 8: We will secure benefits through cooperation between integrated care services and acute hospital services, maximising the use of digital and our collective workforce

- We wish to ensure that conventional hospital acute services are provided safely and in geographically convenient locations. It may be that a sharing of infrastructure produces greater economic efficiency and/or makes possible the provision of services within the area
- A reimagined secondary care offer which balances access to services, including proximity to key transport nodes, with hospital provision that serves only those who uniquely need the hospital
- We wish to have a stronger focus on the use of digital tools to allow people to take control of their lives and their care information and reduce duplication of information eg example utilisation of the NHS app
- We wish to engage all of our workforce in adopting strength based approaches and consider greater workforce integration across all of our sectors

4.1 Priority 1 – Population Health Management.

BURY INTEGRATED CARE PARTNERSHIP

Summary:
We have a good programme of work on Population Health Management, overseen by the Bury Health and Well Being Board. It reflects the 4 determinants of population heath – wider determinants such as housing and work, behaviour change such as alcohol and screening uptake, the positive role of community connectedness, and the operation of wider public services. The Health and Well Being Board will oversee delivery and progress.

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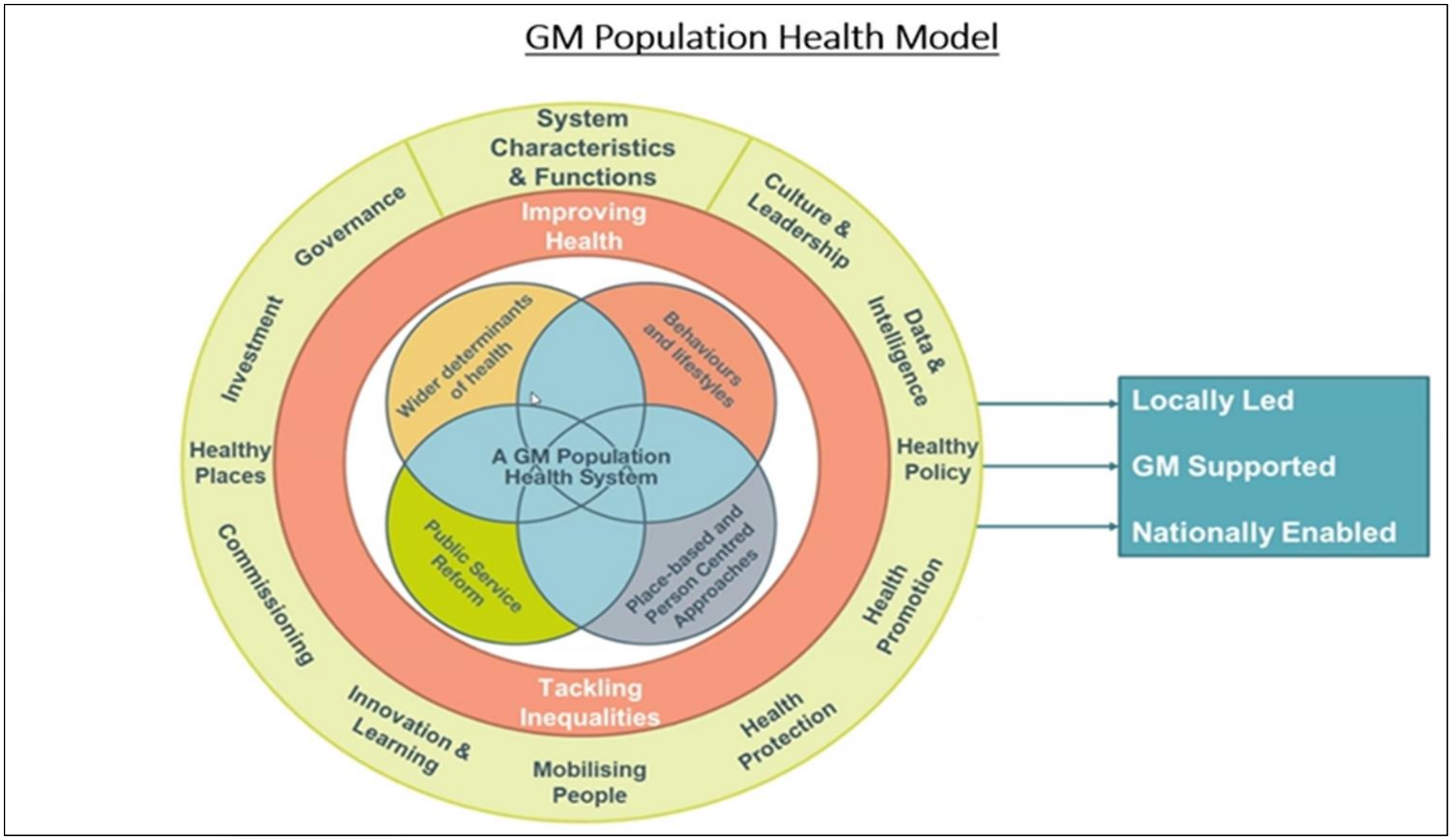
We have transformed our approach to improving Population Health

BURY INTEGRATED CARE PARTNERSHIP



The Health Inequalities Implementation plan, agreed by Team Bury , is the foundation stone for our work on prioritising health inequalities.

This is managed and overseen by the Health and Well Being Board

Population Health and our approach to prevention

- Our vision is ***'to create thriving communities where every individual has the opportunity to live a healthy and fulfilling life, from childhood to old age'***

- Prevention is a broad concept, but for the purposes of this plan we are defining prevention as 'Behaviors/actions/ways of working/services which prevent or reduce the risk of long-term illness and the use of health and social care'

- To achieve this, we will need a combination of primary, secondary and tertiary prevention across all of our health and social care services

- To ensure prevention is central to what we do we will have a system prevention framework which will outline our principles of practice which all our provision will align to. We will also have detailed plans of everything we do to support this.

Working with the VCSE

To support our locality ambitions, we have developed a multi-agency collaboration agreement between:

- The Bury Health & Public Sector* represented by the members of the Bury Integrated Care Partnership (ICP) / Bury Integrated Care Board (ICB)
- The Bury Voluntary, Community and Social Enterprise (VCSE) Sector represented by the Bury VCSE Leaders Group

It is based on a shared principle of mutual trust, working together, and sharing responsibility. This memorandum of understanding aims to develop further how we work together to improve outcomes for Bury's communities and citizens. There are 4 key principles:

Embedding Social Value: Ensuring social value is recognised alongside and as part of a mutually beneficial partnership beyond the current legislative framework and procurement instruments that currently dominate the conversations between commissioners and the VCSE sector. This will help facilitate the above activity while enabling VCSE organisations to express their intrinsic social value.

Ensuring that the voice of the VCSE sector and local communities is heard and valued in strategic governance: Appropriate voice and representation of the sector and local communities enables many aspects of this MoU. Ultimately, ensuring this voice will support our partnership approach to tackling inequalities and inequity within the borough, and addressing health and wellbeing's social, environmental, and economic determinants.

Ensuring a financially resilient VCSE Sector: Ensuring a financially resilient VCSE Sector with appropriate resources is a key enabler for the ambitions of this MoU and our broader challenges around addressing poverty, improving health and wellbeing, and tackling inequalities in Bury.

Our People: This element of the MoU supports a shared ambition for "One Workforce," which meets the needs of Bury residents by ensuring high-quality services and support.

4.2 Priority 2 - Prevention, Reducing Prevalence, and Proactive Care

BURY INTEGRATED CARE PARTNERSHIP

Summary:
We have a solid platform of good and innovative working in proactive and preventative interventions – in CVD, in diabetes, in childrens emotional health, in health checks for those with learning disabilities. But we need to do more and be more effective. This will be the work of our Major Conditions Board.

Part of Greater Manchester Integrated Care Partnership

Major Conditions Approach

Bury has established a Major Conditions Board to bring strategic oversight of all the work the work going on in the local system to address major conditions.

This looks across primary, secondary, and tertiary prevention as well as primary care, elective care, and urgent and emergency care.

The board exists to identify key issues, gaps, and risks as well as duplication and mange overlaps and dependencies between pathways.

The board will ensure we understand as a system where the governance and leadership sits around the work plans of work for each major condition.

Its scope includes:

- Cardiovascular disease
- Respiratory disease (COPD and Asthma)
- Cancers
- Musculoskeletal conditions

Identifying patients proactively to reduce harm.

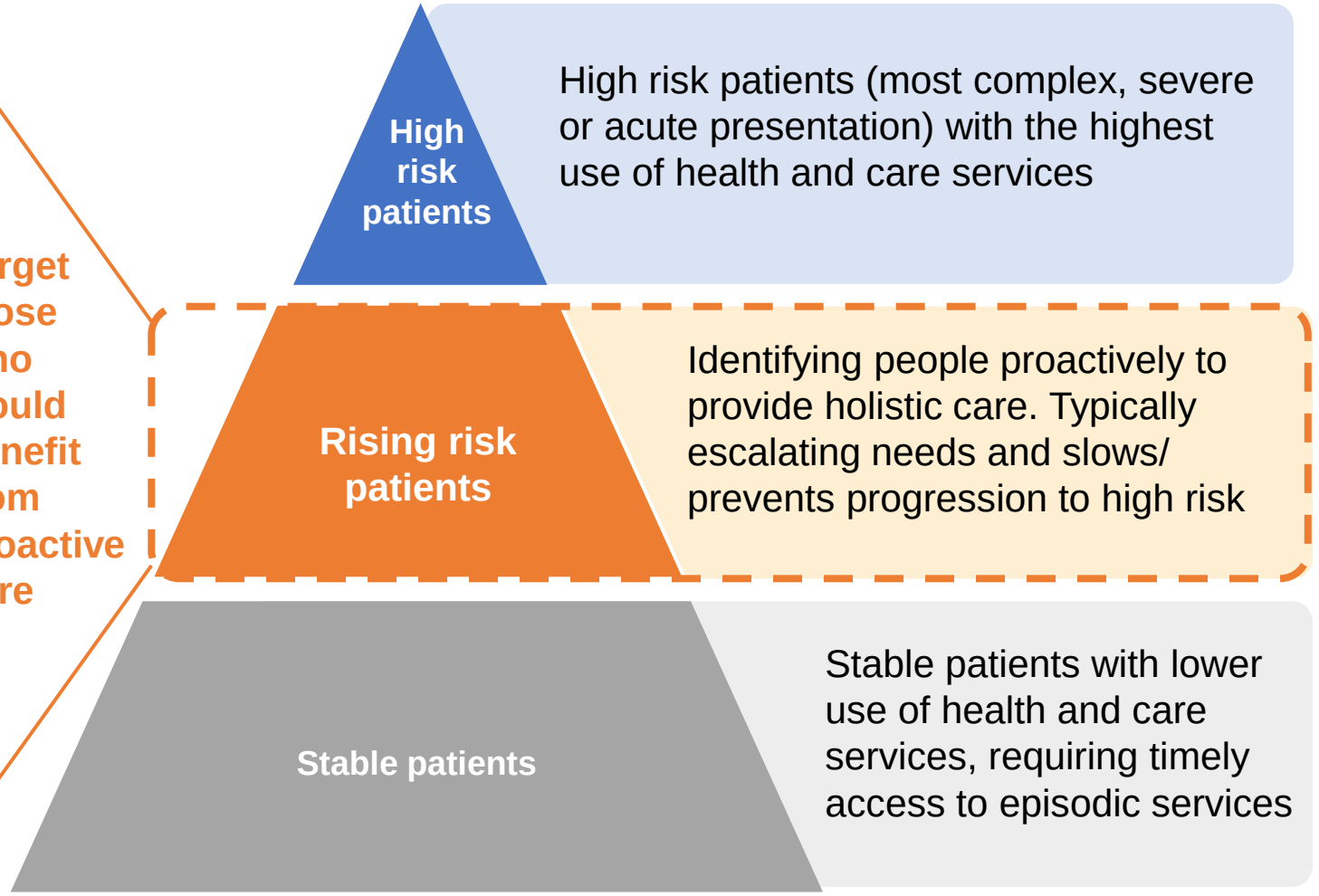
Secondary prevention uses a data-driven approach to identify groups that would benefit from more proactive and holistic care.

It is data driven – to support proactive identification

Aims to understand and meet the holistic needs of an individual

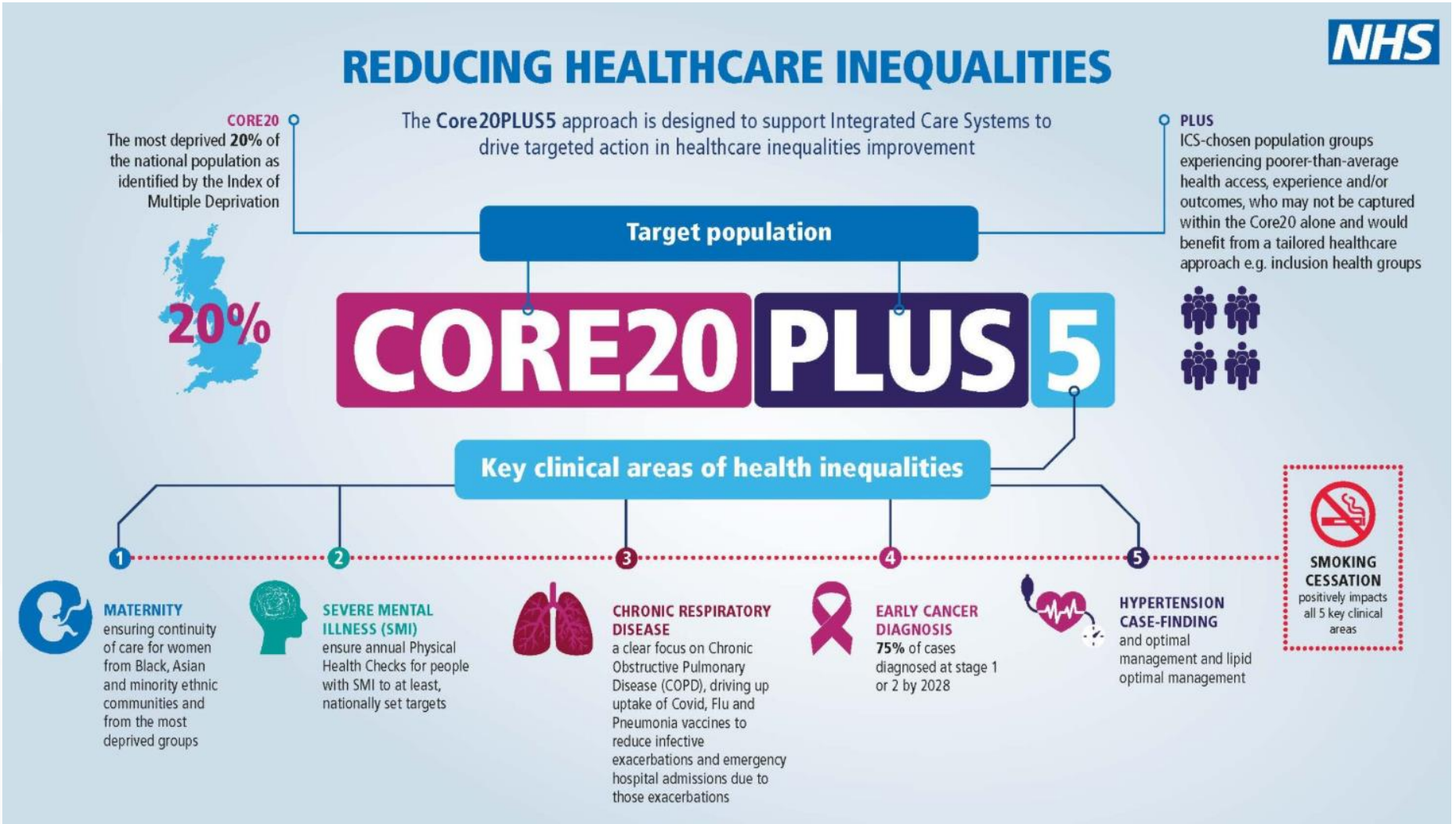
Links across NHS providers, the wider public sector and voluntary sector in integrated neighbourhood teams

Target those who would benefit from proactive care



Keeping in mind core 20 plus 5

BURY INTEGRATED CARE PARTNERSHIP



Mental Health – Coping & Thriving & Early Help

We will work with our partners to deliver the missions set out in the five-year Greater Manchester Mental Health and Wellbeing strategy to:

- Enable people to be part of mentally healthy, safe and supportive families, workplaces and communities.
- Enable people to be comfortable talking about their mental health and wellbeing and be actively involved in any support and care that they receive.

Priorities:

- Continue to develop targeted communications and resources to promote mental wellbeing through the Bury Directory CYP MH padlets and other channels.
- Continued development and implementation of the suicide prevention plan including programme of suicide prevention training with our VCSE and other partners.
- The ongoing provision of Mental Health Support Teams in Schools and looking for opportunities to expand coverage.
- Implementing the I-Thrive model of MH support provision for CYP with PCFT and Early Break with an emphasis on ensuring early help.
- Piloting a Neurodevelopment Hub for children and families.
- Implementing the Sensory Processing Toolkit with partners to enable early identification and support to children with sensory processing difficulties.
- Work with practices and the PCFT physical health team to support improved uptake of the SMI physical health check and LD health checks.

Palliative and End of Life Care

The vision of the Bury Palliative & EoLC strategy is that Bury patients, their families and carers receive high quality, timely, effective services that meets needs and preferences as far as possible, ensuring that respect and dignity is preserved both during and after the patient's life.

The main programmes of work for 2025.26 are aimed at increasing the capacity and capability of community-based provision and improving care co-ordination.

Priorities include:

- The phased roll-out of an Electronic Palliative Care Co-ordination System [EPaCCS].
- The delivery of a programme of workforce development and training.
- A programme of work to improve integrated working and community pathways and for the provision of specialist palliative care.

The work will be led through the Bury Palliative & EoLC Board supported by the Palliative & EoLC Clinical and Professional Delivery Group with key partners including Bury Hospice, the NCA Community and Hospital Palliative Care Teams as well as wider community health teams.

4.3. Priority 3 – Transforming Community Care in Neighbourhoods.

Summary:
Bury has a model of integrated neighbourhood team working in health and care – connecting GPs, adult care and community nursing – in each of 5 teams. And we have a model of wider public service leadership team working on the same footprint creating opportunities of better joined up working and in a shared understanding of the assets of communities and the strengths of people. But there is more to do, to sustain and strengthen GP and other primary care services as the cornerstone of the model, and to challenge more partners to align.

Part of Greater Manchester Integrated Care Partnership

Neighbourhood Working

- The neighbourhood level is the **building block** for organisations to work together and the **foundational unit for delivery** recognised across public service organisations.

- There is a **look and feel of one public service workforce functioning together**, unrestricted by role titles or organisational boundaries – working for the place and people.

- **Aligning services** within and around neighbourhood areas allows us to **start with the person and begin in the home**.

- The benefits to our populations are both **better integrated delivery** and **targeted approaches to enable early intervention to prevent future problems**.

- This approach will **help to reduce pressure on acute and specialist services**, allowing them to focus their resources on those who need it most.

- It relies on a level of **integrated leadership, accountability, performance and governance structures**.

Our Neighbourhood Model Principles

BURY INTEGRATED CARE PARTNERSHIP

- Reflective of the 5 main towns in the borough – Whitefield, Prestwich, Radcliffe, Bury and Ramsbottom – each of which has its town centre masterplan thus connecting reform to growth
- Creating opportunities for front line staff to know each other and problem solve and not just refer to each
- Integrated public service teams – covering the range of preventative support across health and care, community safety, employment support, housing and the VCFSE
- Shared appreciation of the strengths and assets of the community
- Co-location of teams and partner agencies. Shared resources, skills and strengths
- Daily huddles and MDTs – bringing partners together to get to the root cause of issues and support those in the community most at risk
- Combining models of risk stratification to identify cohorts of avoidable risk, harm and cost, with the knowledge and experience of people in the place
- A more strategic approach to investment– for example scaled up investment in housing with care. Investing in prevention and community resilience – including through VCFSE partners
- Improving economic activity and participation – for example, DWP trailblazer opportunity
- Better organised public services but with a shared approach to engaging communities and residents differently.

Neighbourhood Integrated Health and Care Model

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

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

Priorities:

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

We deliver community health and care services in 5 neighbourhood teams

BURY INTEGRATED CARE PARTNERSHIP

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

FEATURES:

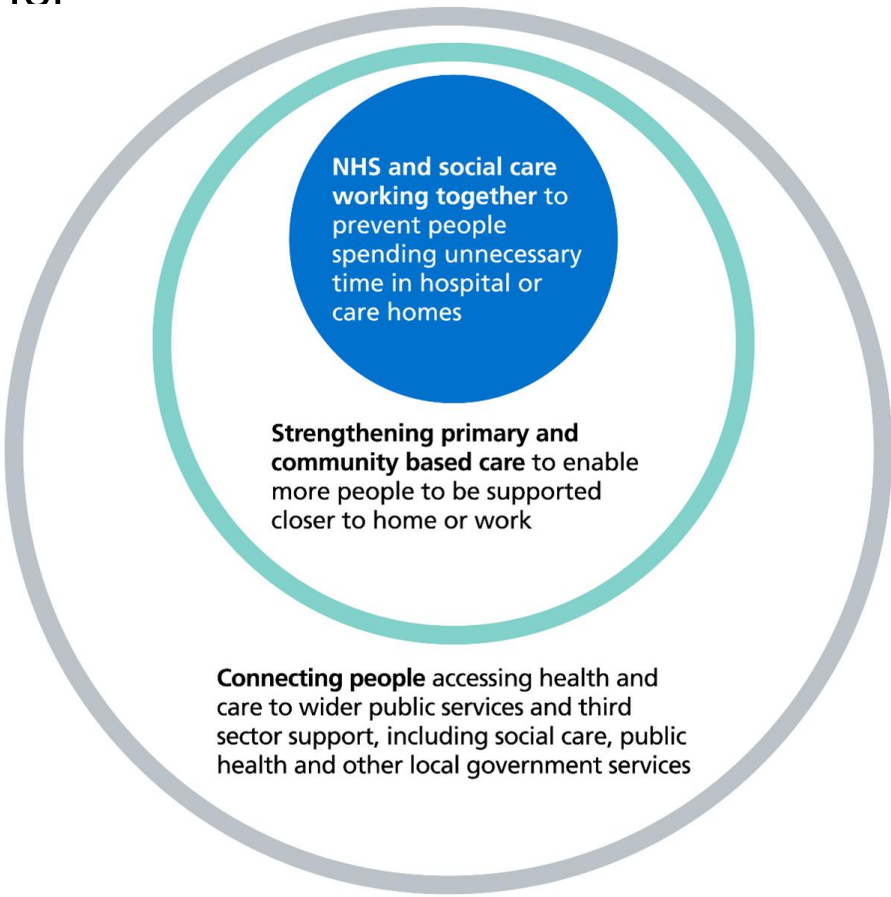
- Application of a consistent operating model across the neighbourhoods but with flexibility to plan and deliver services in response to local need.
- Co-located teams working together addressing needs of the population (including active case management)
- Embedding the principles of personalisation,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

Neighbourhood Health Guidelines 25/26

BURY INTEGRATED CARE PARTNERSHIP

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

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



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

We have all the building blocks in place but need to do more systematise, scale and spread our work

National children's MDT NHS guidance

- Neighbourhood MDTs for children and young people will provide integrated care that provides timely access to specialist advice, including paediatric and mental health expertise, through primary care-led team working. This will deliver care closer to home and improve the outcomes and experience for children and young people, as well as their families and carers.

- Greater benefits are realised when neighbourhood MDTs are integrated with wider local services, especially education, social care, voluntary sector, and community and social enterprise (VCSE) partners to provide holistic, targeted needs-led planning and support.

- This approach will enhance the current primary care offer for children and young people who might otherwise require referrals to secondary care, community services or other health and social care support. It also increases the opportunities for early intervention and prevention support, especially for children in their early years.

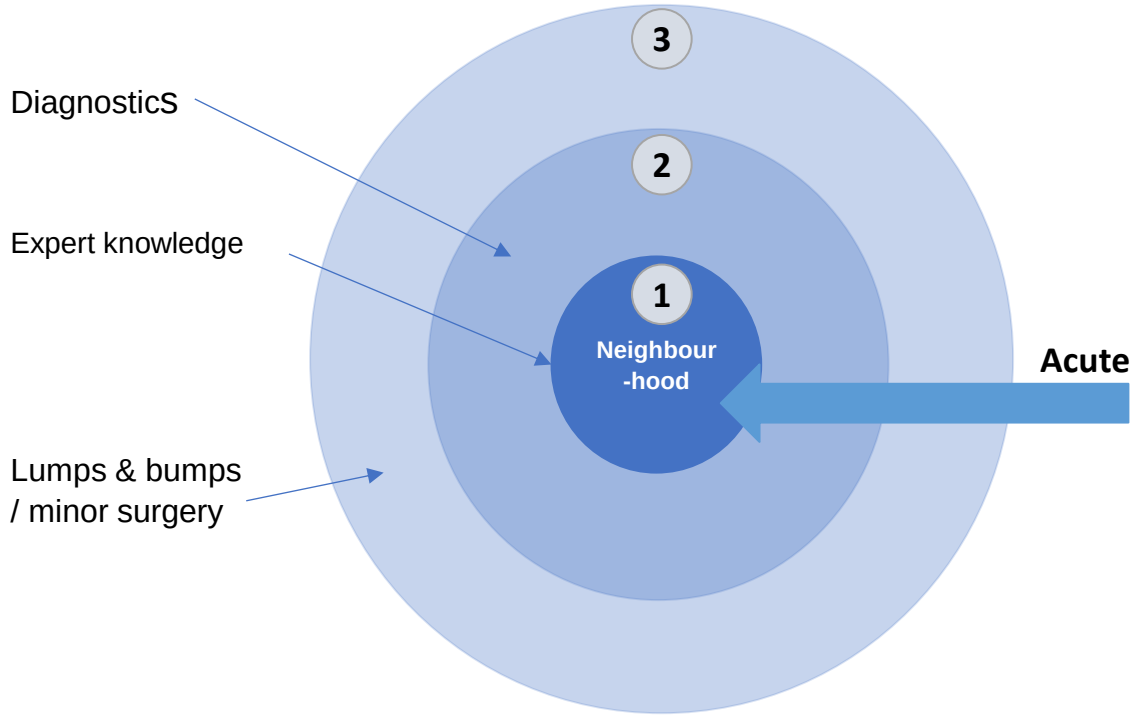
General Practice as the Cornerstone of the Health and Care Economy

BURY INTEGRATED CARE PARTNERSHIP

The potential scope of integration could align to the following principles:

1. Those services that can and should be delivered in a neighbourhood vs. those that need to be delivered at scale and/or require acute or hospital settings
2. Those services that practices would need access to in order to deliver the 'next step' of care for any need that may present itself during a clinic (e.g. diagnostics or expert knowledge)
3. Any care that can reasonably be provided in an 'extended primary care' environment, if that environment could include specialist consultant opinion

Example elements which would align with each design principles at each level of care:



Adopting this approach would lead to a scope for integration that would cover many services that are presently delivered in outpatients, a significant array of diagnostics, a range of day case work, the full range of community-based health and care services (mental and physical health), provided by the NHS and local government, and a new range of services from the voluntary sector.

Primary Care Blueprint

BURY INTEGRATED CARE PARTNERSHIP

General Practice Strategy

Purpose: To look specifically at general practice and describe a clear vision of the future, shaped to meet the ever-increasing demands.

Vision:

- A strong, resilient collaborative general practice that interacts effectively as a partner across the health and care system.
- To provide holistic care across the neighbourhood in which the Practices operate, with the aim of reducing inequity & variation in access, quality of care, & outcomes.
- To be open to innovative ways of working.
- To embrace collaboration with other Practices when opportunities present.
- To work effectively with system partners.
- To provide a workplace that is satisfying, safe & inclusive to employees.
- To contribute to the offer of Bury being the best place to live, work & study.
- To provide a quality learning environment to trainees of all health & care disciplines as well as opportunities for mentoring, coaching & lifelong learning.

Goals:

- **Develop & promote a new model of general practice**
- **Have a resilient workforce & an attractive place to work**
- **Increase capacity within general practice & meet appropriate demand**
- **Strengthen the relationship between provider partners across the Bury system**
- **Improve outcomes for patients by reducing inequity & variation in access & quality of care**

Example Measures:

- Reduce inappropriate demand on general practice by increasing self-referral options for patients
- Reduce the carbon footprint of prescribed inhalers
- Reduce the % of patients waiting over 28days (all modes all HCPs)
- Reduce in the % of inconsistent categorisation mapping
- Increase utilisation of Enhanced Access capacity across Bury
- Increase the % of patients enabled to order repeat prescriptions online
- Increase the % of patients enabled to view their detailed coded record online
- Increase in the % of appointments where time from booking to appointment was <2wks

Programmes:

- Alternative at Scale Solutions
- Communication & Engagement
- Data & Digital Ambition
- Effective Pathway Navigation
- Estates, Current & Future Need
- Integration Wider PC, PSR, Neighbourhood
- Quality & Assurance
- System Leadership
- Workforce, Recruitment, Development & Retention

Standardising Community Services

There are several programmes of work developing for Community Services across the Greater Manchester System.

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

The NHS GM ICB Community Programme of work has several aims which will collectively create a vision for Community Services that aligns to the Greater Manchester(GM) strategy, delivers the GM Operating Model and raises the profile of community services as an essential part of our system and fundamental to meeting our population health need, reducing demand in acute settings, and contributing to the sustainability of our system. There are five pillars addressing Data, Core standards, Integrated Service delivery, Workforce and Collaboration.

To support this area of work further Bury Locality has commenced work with Locality Partners across Four Localities (Bury, Oldham, Heywood Middleton & Rochdale (HMR) and Salford forming two key partnerships (FLP) with providers of Community Services known as:-

- Manchester Foundation Trust (MFT)- MFT FLP
- Northern Care Alliance (NCA) – NCA FLP

Early work has commenced to review and align Locality services across the NCA FLP. This work is focusing on contract alignment across NCA FLP footprint to reduce variation and address inequalities and will support service transformation.

The NCA has commenced a series of Community Services Reviews looking at demand management and pathway improvement. Aiming to standardise service delivery and reduce any variation. Six reviews have been completed to date on - Dietetics ,Paediatric Speech and Language Therapy (SALT), District Nursing ,Community Diabetes, Adult SALT, Intermediate Care and planned future review for Muscular Skeletal Services (MSK).

HIU's and Care Planning

BURY INTEGRATED CARE PARTNERSHIP

High Intensity Use of A&E is closely associated with deprivation and inequalities. NHS England's aim was to achieve 100% coverage of A&Es to have access to a HIU service by 2024. Locally we have been working with colleagues from NHSE and GM to adopt areas of good practice and to identify what we have locally so we can build upon this and further improve the offer to people in Bury linked to national and ICB guidance on HISU. To support this work locally, we commenced discussions with system partners in October 2024 and implemented the following work:

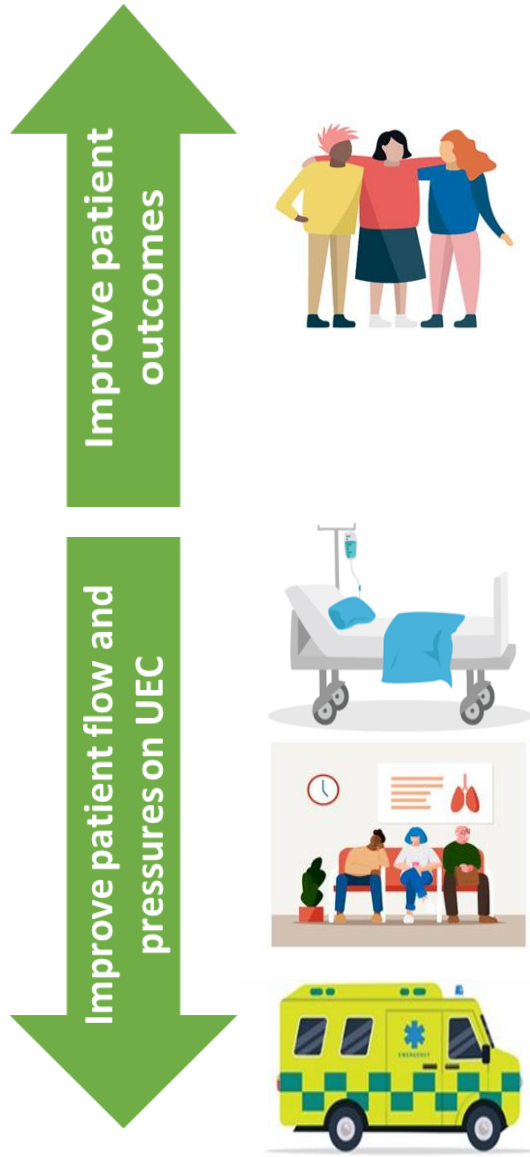
☑ Held a HISU system workshop to obtain a shared understanding of HISU, understand our current approach to manage HISU and how we start to identify opportunities for improvement. Supported by NHSE and NWAS.

☑ A HISU stocktake has been compiled locally to understand what offers are in place to support and manage HISU within ED, Primary Care, Mental Health, Neighbourhoods, Drug and Alcohol and NWAS. This highlighted that there are significant gaps in Bury to managing people accessing services intensely and reinforced that we do not have a local Commissioned service for HISU or designated full time resource to support HISUs.

- **ED** - Part B7 role in ED to support Frequent Flyers
- **NWAS** - 2 x WTE mental health nurses. 1 x part time paramedic. 1 x part time admin. This is for the whole of the north-west.
- **Mental Health** – No resource for HISU
- **Neighbourhoods/ ACM** – No resource but support HISU through ACM process
- **Primary Care** – No dedicated HISU resource, ACM process utilised to manage HISUs
- **Drug & Alcohol** – Don't have a specific team and individuals move between levels of complexity as needs change

☑ Wanting to improve models of care for HISU, we commenced with a 6-month test of change to reduce High Intensity Service Use at Fairfield hospital through integrated MDT working, personalised care planning and outreach into the community for patients referred to as high intensity service users.

❑ **We are now evaluating the learning, looking to gain momentum and financial support locally for 2025-26 to implement a HISU commissioned model in Bury with designated roles. The evidence has demonstrated a significantly reduced pressures on UEC services and improved quality of life for patients, enabling them to receive the right care that they need.**



Integrated Intermediate Tier

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

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

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

Outcomes between April 2024 and now:

- Numbers on DKAFH : Reduced from 60 to 44
- Total Days on DKAFH list :Reduced from 1000 to 534
- 95% to be discharged to their own home - over 65 years from medical wards : increased from 91% to 93%
- % of beds occupied by patients with a LoS over 21 days : reduced from 23.5% to 12.5%

Urgent Neighbourhood Services

We are already have a strong a foundation of an urgent neighbourhood service within our intermediate tier of services. Our Rapid Response Team provide our Urgent Crisis Response (UCR) service. December saw the highest number of referrals come into UCR (Rapid Response and Hospital at Home) with circa 500 referrals .Of the circa 500 referrals, nearly 50 came from Care Homes. The ability to receive referrals via Adastra has now been activated, and we are consistently overachieving the GM and National 2-hour response measure. We will continue to work with NWAS to improve referral activity via Adastra and will explore further options for reducing the variation in service usage between mid-week and weekends.

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

Our hospital at home service was established in 2022 as part of our Intermediate Tier of services. We have seen a positive increase in weekly referral activity into the service, with more than 70 patients per day being managed through hospital at home on some days.

The Consultant Nurse role was a new role established within the Community Division and has been integral to the development of the Hospital at Home Service. As well as managing an increased numbers of patients in the service, the team working across hospital and community services have built confidence with hospital team to manage higher acuity patients within their own homes who would previously have required admission to hospital. The Hospital at Home programme treats people at home, if it is safe to do so, with visiting health professionals and remote monitoring devices, including video conversations with consultants.

And we have wider public services increasingly aligned on the same 5 neighbourhood footprint

BURY INTEGRATED CARE PARTNERSHIP

LET's *Live Well* in Bury

Joined up services in identified neighbourhoods, working with communities, relentlessly focusing on prevention and earlier early intervention; maximising local assets and spaces in each neighbourhood to enable people to thrive

LOCAL **network of Live Well spaces and offers to support people where they live**	***ENTERPRISING*** **approach to relentlessly focus on Prevention**	**Collaborative and connected communities working *TOGETHER* with integrated public and community services**	**Building on the collective *STRENGTHS* of neighbourhoods and communities to enable people to thrive**
• *Live Well* centres, spaces and offers connecting local residents; local practitioners; local assets in each of 5 neighbourhoods – including libraries, wellness centres, Bury Neighbourhub, Family hubs and community centres • Population health, growth opportunities and physical place shaping together (people and places) to create condition for 'good lives' • Identification, targeting and tackling of inequalities (health, social, economic) through a community first approach	• Innovative approach to targeted prevention and earlier early intervention (avoiding high cost interventions with poor outcomes) • Identification of localised cohorts of risk and vulnerability with local practitioners working differently on a multiagency basis • Positive risk taking to be creative, including maximising use of new technologies to further integrate and collaborate on prevention	• Joined up public services, working with communities delivering a person centred 'Team Around' approach • Shared understanding of collective place (communities and their strengths) • Single 'neighbourhood' lens through which to have alignment of resources and integrating 'integrated' support – health, housing, employment	• Empowered, informed and connected communities • Strong VCFSE ecosystem including infrastructure – local MOU building on VCFSE accord • Asset based LETS behaviours considering the whole person/ family and their networks • Shift in power as close to those affected by decisions [nothing about you without you]

LET'S do it!
Shared success across Bury

Our Wider Neighbourhood Model Focus

BURY INTEGRATED CARE PARTNERSHIP

- Comprehensive Implementation of the Living Well model of Early intervention and prevention for mental health conditions aligned to neighbourhoods
- Final articulation of the family hubs model framed by neighbourhood working, and accelerated delivering
- Finalisation of community hub infrastructure in each of 5 places
- Full realisation of the Bury Housing leadership of the public service leadership teams
- Strengthened participation of GMP and schools into the Public Service Leadership Teams.

Our Framework for Engaging Differently

BURY INTEGRATED CARE PARTNERSHIP

Local neighbourhoods

- Community asset mapping
- Neighbourhood and Ward level insight
- Community conversations to harness local capacity
- Bury Directory
- Commissioning; funding; grants; social investment

Enterprising Spirit

- Community Wealth Building
- Sustained social and community enterprise

Delivering **Together**

- Develop the VCFA and associated networks
- Participatory budgeting
- Co-design/co-production
- Transparency of record keeping
- One Community
- Social Prescribing
- Listening events

Strengths based approach

- Community development
- Ethnographic skills and training
- Strengths based assessments
- Person centred conversations
- Personal budgets
- Community Asset Transfer
- Community Champions

4.4 Priority 4 – Optimising Care

BURY INTEGRATED CARE PARTNERSHIP

Summary:

Regardless of the success of our work on population health, on prevention and demand reduction, and on the outcomes of transformed community-based care, people will still need specialist health care services in hospitals, mental health services and care homes. This section describes the design principles that we use to seek to optimise care delivery.

Part of Greater Manchester Integrated Care Partnership

Urgent Care

Over the past few years significant developments have taken place creating the building blocks for further improvement have been established at FGH across the Urgent and Emergency Care pathway including:

- Rebuild of A&E/SDEC/Hospital At Home/Streaming/Acuity Tool/Staff Recruitment Drive/BCO Flow Collaborative/System wide approach to UEC in the community and the hospital setting/shared planning.

Over the next year this work will continue to evolve and developed whilst remaining focused on local/regional and national targets. Priorities for 2025/26 will include:

- Further improvements to 4-hour performance/the re-launch of the BCO Collaborative work programme/continued staffing developments/UTC accreditation/review of front door streaming/admission avoidance from care homes/reductions in HIUS/reduction in DKAFH patient numbers/improved discharge ready date performance/ambulance handover improvements.

Over the next 3 years the priorities will include:

- Adoption of national and GM must do's as they arise/completion of build works/continuous of staffing, flow and acuity/mainstreaming of the home first approach across site/further system integration/transfer of services off site into neighbourhood models where appropriate/mainstreaming achievement of the 4-hour target.

As a locality UEC system leaders will also continue to maintain a grip of UEC performance outside of NCA working with system partners including NMGH.

Cancer

We will work with our partners to deliver the priorities set out by the Greater Manchester Cancer Alliance. The key aims are to reduce the risks of developing cancer, diagnosing more people at an early stage of the disease and provide better treatment and support people to live well with and beyond cancer.

Priority work areas:

- **Early Diagnosis:**
  - Early diagnosis Direct Enhanced Service -All PCNs have developed an action plan which is appropriate for the needs of their population.
  - Increase early detection of lung cancer e.g. Targeted Lung Cancer Screening and self-referral to chest X-Ray initiatives.
  - Deliver GM Cancer Alliance timely presentation funding – Live Well Service - addressing health inequalities.
  - Monitor FIT to achieve the 65% - 80% and support any PCNs who are not achieving the upper threshold.
  - Work with Trusts to achieve 28-day faster diagnosis standard - Support implementation of NCA Cancer Improvement Plan

- **Personalised Care:**
  - Support the stratified personalised follow up through strengthening collaboration between community and secondary care cancer services
  - Support the pre-hab4cancer review.

Elective Care

Part of elective pathway transformation will be through a series of pathway reviews. Initial reviews included Ear Nose and Throat (ENT, Trauma & Orthopaedics (T & O), and Cardiology service pathways.

Localities and Providers will work together on the outputs from the reviews to formulate recommendations for the next steps to prioritise transformation in these areas.

Further significant programmes of work which have commenced, and support pathway transformation are –

NCA

- The NCA Outpatient Excellence Programme which is exploring various aspects to improving the secondary care journey alongside the opportunities for Care Closer at home with Primary care and Community services pathway work

GM

- GM Care Gateway - a project focused on one model across GM of a Care Gateway (access into services following referral).
- GM Specialist Advice Model aiming for mobilisation early April 2025 which will ensure referral and demand management for Right Care, Right Place Right Time, by clinical triage for the GM population which includes Bury. Model currently being worked up.
- GM Dermatology – One GM Model of Care being implemented for Community Dermatological Services.

Three further areas of early work for community transformation are –

- Single Point of Access commencing with Wound care and Lymphoedema referrals pathways
- Self-referral – Improving access to Primary Care- adopting mechanisms to promote self-referral
- Diagnostics – development of community diagnostics within Bury

Mental Health

We will work with our partners to deliver the missions set out in the five-year Greater Manchester Mental Health and Wellbeing Strategy. The pace and scale will be largely led by GM priorities and plans and subject to available investment.

Priorities:

Enabling more people with mental health problems to have timely access to appropriate high-quality mental health information, support and services by:

- Working with PCFT to increase access to NHS Talking Therapies.
- Implementing the Living Well model in our Neighbourhoods.
- Progressing the transformation of Community Mental Health Services.
- Implementing clear pathways for adults who require a neuro-developmental assessment.
- Completing the funded expansion of core CAMHS and the implementation of I-Thrive to ensure early support to Children and young people.
- Implementing the CYP Neurodevelopment MDT Hub with an enhanced pre and post diagnostic support offer.
- Implementing a graduated approach to assessment and support to families with children with sensory processing difficulties.

Reducing pressures in our acute system by:

- Ensuring we have integrated, safe and effective community-based crisis response provision.
- Improving flow – reducing average length of stay and the number of bed days occupied by people who are clinically ready for discharge to enable the elimination of inappropriate out of area placements.
- Bringing on stream additional supported housing provision for people with mental health problems.

Care Home Provision

Locally one of our ambitions has been to strengthen our health and care offer into care homes. This has been linked to the Enhanced Health in Care Home Framework to ensure that care home residents are receiving the right care, at the right time in the right place through providing, clear referral pathways, a confident trained workforce and by providing an integrated system approach to proactive care.

What have we done?

- ☑ Developed a one-page document for Care Home Staff advising them who to contact in the first instance when a resident becomes unwell.
- ☑ Bury care homes and primary care participated in a proof of value led by Health Innovation Manchester Re: SafeSteps Falls prevention app and Restore. This work in Bury received a "Health Tech Award 2024 for "Best use of digital for Social Care.
- ☑ System workshop held on 30th October 2024 represented by FGH consultants, care home managers, commissioning, general practice, community and HMR and NMGH colleagues. This workshop was scheduled to enable colleagues to come together to build relationships, connections and strengthen system thinking/ working in relation to the enhanced health in care homes framework [EHCH]. Highlighting any potential collaborative opportunities to strengthen our current system model, supporting people in our care homes.

What Next - Care Home Test of Change

- ☑ Identified two care homes to improve pro-active and personalised care into Care Homes and to provide training and development support for care home staff in line with the EHICH framework, working with the education facilitator.
- ☑ Tests of change to be established as an integrated approach with consultant in-reach into the community, supported by primary care, Mental Health and Community services.
- ☑ Review learning and consider models for the future.

Complex Care

BURY INTEGRATED CARE PARTNERSHIP

Performance

Improving and sustaining data quality through database cleansing and management.

GM ICB Standardised policies and procedures; implement and support development.

Ensuring national guidance is followed within nationally set timeframes.

Increased use of patient experience data through PEACH.

Commissioning

Working across and supporting GM ICB on improving commissioning processes.

Budget alignment, grip and control.

Lead and support development of GM ICB standardised policies.

Strength-based commissioning.

High-needs cases and Mental Health S117 improvement plan.

Workforce

Sustainable workforce.

Training and development of workforce, improved access to development opportunities.

GM ICB recruitment to any vacant posts including business continuity mutual aid.

Standardisation with the Local Authority e.g., using the same approaches - Progression Model

5. Priorities Delivered Through our programmes

BURY INTEGRATED CARE PARTNERSHIP

Summary:

Our 4 priorities should be visible through the 12 thematic programmes of transformation we have as a Bury Integrated Care Partnership – urgent care, childrens services, mental health, adult care, palliative and end of life care. We will challenge all programmes on this, including identifying outcomes /key indicators, for each priority within the programme.

Part of Greater Manchester Integrated Care Partnership

Strategic Delivery Priorities

BURY INTEGRATED CARE PARTNERSHIP

- A new model of frailty and respiratory management : predicated on 5 integrated neighbourhood teams
- A community orientated stroke service, with greater clarity of unique role of each hospital site in NCA
- A redesigned SDEC service and fuller utilisation of primary care expertise through pre-ED and SDEC, enabling further bed base reductions
- Extended Integrated Neighbourhood Team functionality to build Childrens MDTs on same footprint – NCA/Pennine/council/GP.
- Shared roles across primary and secondary care: GP in-reach and Consultant outreach supporting SDEC and expansion of the virtual ward
- Further implementation of national front runner discharge programme including complex dementia and promotion of mobilisation
- Clarification of future ED function as part of GM urgent Care review
- A community based diagnostic provision in the middle of Bury town centre as per previously developed
- The transfer of a range of outpatient services to Bury town centre, and strengthened A&G offer
- Strengthened surgical capability specifically T&O, utilising freed up G&A beds from the left shift of medicine/stroke care
- Deployment of EPR prioritising connection to primary and community services, reflecting the primary/secondary care interface
- Shared ownership of RBMS functionality extended to include community services.
- Clarification of dovetailing with future of North Mcr.
- CAMHS outpatient services off FGH site

Our Programmes of Care and Measures of Success

BURY INTEGRATED CARE PARTNERSHIP

Programme	Deliverables	Metrics
Population Health	Further development of Live Well, VCSE development, Workwell vanguard, Local Delivery of GM Moving, Implementation of GM Make Smoking History and GM Alcohol reduction plan, Delivery of statutory public health duties, provision to reduce HIV through sexual health services	• **Reduce inequalities in line with the Core20PLUS5 approach for adults and children and young people** • Increase annual physical activity for adults and children • Reduce smoking prevalence • Reduce alcohol consumption rates • Reduce HIV and viral hepatitis • Improve school readiness • Reduce childhood obesity • Improve immunization rates
Primary care, neighbourhoods and major conditions	• Primary Care: Local implementation of blueprint (back-office functions, minor surgery, estate, workforce, comms and engagement, data, online consultations, cloud telephony) • Diagnostic provision: Quality Assured Spirometry • CVD and diabetes prevention plan • Neighbourhood working: implementation of national neighbourhood guidance with Consultant support for frailty and respiratory, neighbourhood priorities (CVD, respiratory and frailty) and PSR integration	• 14-day access to a GP • **Improve patient experience of access to general practice as measured by the ONS Health Insights Survey** • **Increase the % of patients with hypertension treated according to NICE guidance, and the % of patients with GP recorded CVD, who have their cholesterol levels managed to NICE guidance** • % of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins • Pharmacy first uptake • % diabetics receiving 8 processes of care • Neighbourhood indicators: CVD, frailty and respiratory • Number of people assessed through Active Case Management • Dementia diagnosis rates • NHS app uptake • Risk stratification tool in use

Indicators in bold are taken directly form the Operating Plan guidance for 25/26

Our Programmes of Care and Measures of Success

BURY INTEGRATED CARE PARTNERSHIP

Programme	Deliverables	Metrics
Urgent and emergency care	Locality: • Attendance and admission avoidance (including hospital at home GP in-reach and Consultant outreach, Integrated Care Coordination Centre and Ambulance Collaborative high intensity service user pathways, care home MDT's and review of new acuity tool /streaming /UTC) • Internal flow (build development, SDEC expansion, ward 24/25 model stabilisation, embedding discharge frontrunner) GM: Service reconfiguration, out of hours procurement and transport procurements	• **Improve A&E waiting times, with a minimum of 78% of patients admitted, discharged and transferred from ED within 4 hours in March 2026 and a higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/2** • **Improve Category 2 ambulance response times to an average of 30 minutes across 2025/26** • Reduce numbers of patients who are clinically ready for home • Maintain number of A&E attends and admissions - • Increase hospital at home occupancy • Maintain urgent community response times • Reduce average length of stay • Reduce % of patients on higher discharge pathways • Improve SDEC utlilisation • Reduce readmission rates • Improve performance on GIRFT metrics
Mental health (MH) and emotional wellbeing	Suicide prevention, mental wellbeing – coping and thriving, children's and young people's (CYP) mental health, community provision, crisis response, ADHD/ASD, dementia, maintaining low levels of Out of Area placements	• **Reduce average length of stay in adult acute mental health beds** • **Increase the number of CYP accessing services to achieve the national ambition for 345,000 additional CYP aged 0–25 compared to 2019** • **Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, delivering a minimum 10% reduction** • Reduce waiting times for children and young people in CAMHS services. • Reduce out of area placements in mental health • Reduce 12 hour waits in ED for MH patients • Reduce numbers of patients who are clinically ready for home • Improving NHS Talking therapies recovery rate • Improving SMI health check uptake

Our Priority Programmes and Measures of Success

BURY INTEGRATED CARE PARTNERSHIP

Locality Board Programme	Deliverables	Metrics
Planned care and community services	• Elective: Advice and guidance, OP transformation, role and function of Booking Management Service, ENT/T&O/Cardiology/Dermatology pathways, primary care/ secondary care interface, EUR and weight management services • Community: alignment of funding and specifications to support neighbourhood working and out of hospital care, including OP activity in the community, supported by appropriate diagnostics (CDC business case) • Closer integration of stroke pathways between acute and community: • Cancer: Targeted lung health checks, patient stratified follow up, prehab and behaviour change • GM: Strategic reviews	• **Improve the percentage of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement*** • **Improve the percentage of patients waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement*** • **Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026** • **Improve performance against the headline 62-day cancer standard to 75% by March 2026** • **Improve performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026** • Reduce referral no's • Reduce waiting times for community services • Increase advice and guidance rates • Increase compliance with interface standards • Increase number of clinics in the community and diagnostic capability in the community • Improve stroke standards
End of life and palliative care	End of life: care planning, education and support, improving transfer from hospital to community	• Reducing % people with more than 3 admissions in their last 90 days • Increasing % of people dying in preferred place

Our Priority Programmes and Measures of Success

BURY INTEGRATED CARE PARTNERSHIP

Locality Board Programme	Deliverables	Metrics
Children and young people	First 1000 days, Neurodiversity model, prevention of childhood obesity, long term condition management, SEND, school nursing, implementation of children's MDT guidance	• Increasing immunisation rates • Reducing childhood obesity rates • Reducing waiting times for specialist health services for children (including neurodevelopmental pathways) • Increasing Health visiting 2-year checks • I**mproving the safety in maternity and neonatal services, delivering the key actions of the of the three year delivery plan**
Adult Social Care (ASC)	• **ASC:** Social work quality, social work workforce, finance, CQC readiness • LD: Transformation, better homes, training and employment, better health	• Increasing the number of people leaving IMCs services and living independently • Increasing the number of people accessing care and support information and advice that promotes people's wellbeing and independence • Increasing the % of people with LD who have their own front door and employment • Increasing the % people with LD having health checks • Increasing the % carers having health checks
Enablers	• **Digital:** baseline capability, online consultations, EPAACS and dementia plans, preparation for EPR deployment • **Workforce:** Growing and developing the workforce, workforce integration, good employment charter • **Estates:** Four LP programme	• % population with care plans • Number of organisations signed up for Good Employment Charter
Finance	Complex care, medicines management, Better Care Fund review, contract reductions	• **Deliver a balanced net system financial position for 2025/26** • **Reduce agency expenditure as far as possible, with a minimum 30% reduction on current spending across all systems** • **Close the activity/ WTE gap against pre-Covid levels (adjusted for case mix)** • % market share of spend by sector

Throughout April and May, we will finalise our key metrics with Locality Board members. We will also undertake further prioritisation of the projects outlined above

6. Strategic Risks

BURY INTEGRATED CARE PARTNERSHIP

Summary:

We are mindful of the significant risks to the delivery of our ambition and these are managed through our Integrated Delivery Board and reported to the Locality Board.

Part of Greater Manchester Integrated Care Partnership

Our Contextual Risks

- The need to strengthen our model of neighbourhood working
- The need for more confidence in our work on the first 1000 days and in the NHS response to the SEND partnership improvements
- The need to address some of the legacy service gaps in Bury caused by historic underfunding of Bury PCT/CCG e.g in mental health
- The need to invest in capacity and capability of primary and community services to affect the ‘left shift’ away from unnecessary secondary care
- Bury being relatively ‘under GP’d’ compared to most other parts of GM
- The need to ensure the prioritisation of prevention and early intervention.
- The need to ensure greater engagement of people in co-design and co-production
- The opportunity of the voluntary and community sector
- Balancing accessibility of secondary care with clinical sustainability/critical mass
- Addressing challenging waiting times for NHS services (urgent, mental health, community and elective care)
- Financial stability within locality budgets

Our Current Strategic Risks

BURY INTEGRATED CARE PARTNERSHIP

	Theme	Risk Description
1	Strategy and transformational change	**BECAUSE** of the partnership-wide, organisational and GM ICP breadth of transformational ambition, **THEN** there is a risk that there is insufficient finance, capacity and focus to deliver health and care strategic change locally.
2	Finance: System Finance Position	**BECAUSE** of the risk that the financial position of all partners, **THEN** there is a risk that this challenges the model of partnership working in the Bury Integrated Care Partnership by inducing actions that effectively cost shunt within the system.
3a	Finance: Locality Healthcare budgets ***24/25 only***	**BECAUSE** the locality is currently overspent by approx. £6.8m vs a budget of £71m and the locality does not have many options to reduce spend other than mental health, individualised commissioning (including CHC and children), Better Care Fund and charities; and additionally, must find 5% CIP, and the overall NHS GM position and that of statutory partners in Bury is also very challenged THEN there is a high risk that financial balance will not be achieved.
3b	Finance: Locality Healthcare budgets ***Recurrent position***	**BECAUSE** the locality is currently overspent by approx. £6.8m vs a budget of £71m and the locality does not have many options to reduce spend other than mental health, individualised commissioning (including CHC and children), Better Care Fund and charities; and additionally, must find 5% CIP, and the overall NHS GM position and that of statutory partners in Bury is also very challenged **THEN** there is a high risk that recurrent financial balance will not be achieved.
4	Finance: Locality Operating costs budgets	The locality currently has a budget of £3.4m and is forecasting to break even in 2024/25. This is primarily due to £0.13m of non-recurrent funding and a significant number of vacancies that are not being recruited to **BECAUSE** there is a difference between the budget and the planned establishment, **THEN** there is a risk to delivering transformation projects and staff wellbeing.
5	Data and insight	**BECAUSE** of a loss of locality analytics and data sharing solutions since the formation of the ICB, THEN there is a risk that data and insights are not adequately shared and used across all partners and sectors, resulting in a lack of ability to make real time and longer-term changes and improvements for the benefit of our communities.
6	Urgent and Emergency Care	**BECAUSE** of limited flow of patients out of the ED and hospital, the number of patients in ED is greater than the staff's capacity to safely manage, **THEN** there is a risk that this could lead to a compromised quality of care given to patients. Also, IF the number of patients on the Days Kept Away from Home (DKAFH) list do not reduce, **THEN** patients will be kept in hospital unnecessarily leading to potential increased harm for those patients (e.g. increased risk of infection, deconditioning) and for other patients attending the emergency department and requiring admission to an acute bed (e.g. reduced ED capacity, trolley waits in ED).

Our Current Strategic Risks cont/d

BURY INTEGRATED CARE PARTNERSHIP

	Theme	Risk Description
7	Elective Care and Community Care	**BECAUSE** of the waiting times created by the pandemic and on-going staffing challenges, including junior doctors industrial action, **THEN** there is a risk that patients have delayed treatment, are at risk of harm and have a poor experience which could affect their health and wellbeing.
8	Services for Children, including SEND	**BECAUSE** the Bury system is not delivering in-line with the SEND national framework expectations, **THEN** there is a risk that the children, young people, families, and carers do not get the right support from health services, Children's Social Care and Education to ensure they reach as good outcomes as all children.
9	Sustainable General Practice	**BECAUSE** the apportionment of delegated monies into Primary Care is not equitable to that across GM **THEN** there is a risk that the whole of PC will be limited as to what they can support/deliver which could lead to the local general practice strategy and GM PC Blueprint not being delivered in full and ultimately poorer outcomes for the patients of Bury.
10	The delivery of the Uplands practice estate solution	**BECAUSE** an affordable scheme cannot be achieved to enable move of Uplands practice from current premises, **THEN** there is a risk that patients will have a poor experience of healthcare due to the condition of the estates.
11	GP collective action	**Risk:** There is a risk that GP Collective action **Cause:** in response to the BMA ballot outcome will **Impact:** withdrawal from supporting non-contractual services that support requests from the hospitals as well as community services.
12	Mental health programme	If patient flow is not improved in MH inpatient wards this will lead to delayed discharge of patients to more appropriate placements, drive demand for inappropriate Out of Area Placements and increase the risk of 12-hour breaches in ED
13	Mental health programme	If Bury (and the other NES localities) are unable to commission a provider of adult ASD assessment and ADHD assessment and treatment there will be complete reliance on the right to choose pathway resulting in: • inability to implement a managed pathways of care. • reliance on right to choose with the associated inequality in access and cost pressures. ongoing reputational impact.
14	Mental health programme	If the number of referrals for adult neurodevelopmental assessments via the right to choose pathways continues to increase this will lead to potentially inequitable provision and significant financial pressures on the locality budget.
15	Mental health programme	If demand and waiting times for CYP neurodevelopmental assessments are not reduced this will lead to continued delays in diagnosis and follow up treatment and support for children and families, and risk of further poor OFSTED / CQC inspection outcomes.

Locality Financial Risks: Strategic

Risk	Programme impact	Mitigation
Lack of money to invest in left shift of services to support reduction in hospital infrastructure: we are under resourced for primary care and community services currently	All	-As a locality we need to determine how we might support the shift in spend from other sectors -Levelling up conversation at GM - 4LP /PCFT footprint opportunities -
Primary Care sustainability: Gap from GM funding levels	All	
Increasing levels of frailty in the population	All	
Asks of Mental Health services which cannot always be met to support pressures being seen in all parts of the system, including A&E	All	
Lack of VCSE contractual commitments on a long term basis impacted further by NI issues	All	
New NHS planning guidance of 'must do's' without funding and/ or instability of non-recurrent funds	All	

Locality Financial Risks : Operational

Risk	Programme impact	Mitigation
Staying well /live well are not funded by PCN's	Population Health Primary care and neighbourhoods Planned care, community services and major conditions Urgent and Emergency Care	Some resource identified to mitigate risks around staying well , dependent upon spend over winter Some resource identified for continuation of Live Well for circa 4 months which will allow us time for business case development
GM does not support longer term funding for hospital at home	Urgent and Emergency Care Primary care and neighbourhoods Planned care, community services and major conditions	This risk here is unknown at present however risks the traction we are gaining with culture change
Lack of Quality assured spirometry	Planned care, community services and major conditions Primary care and neighbourhoods	Some capacity provided in other Boroughs - discussions with GM re local CDC
Request to implement Advice and Guidance	Planned care, community services and major conditions	GM priority and needs to be funded at GM level
Asks regarding prevalence / proactive care which are already under funded in the Borough, and may reduce potential investment in local neighbourhood priorities	All	Articulated need for additional primary care investment in Bury Discussions at an early stage between PCN's and neighbourhoods to discuss% investment in neighbourhood priorities from AARS

7. Assuring delivery

BURY INTEGRATED CARE PARTNERSHIP

Summary

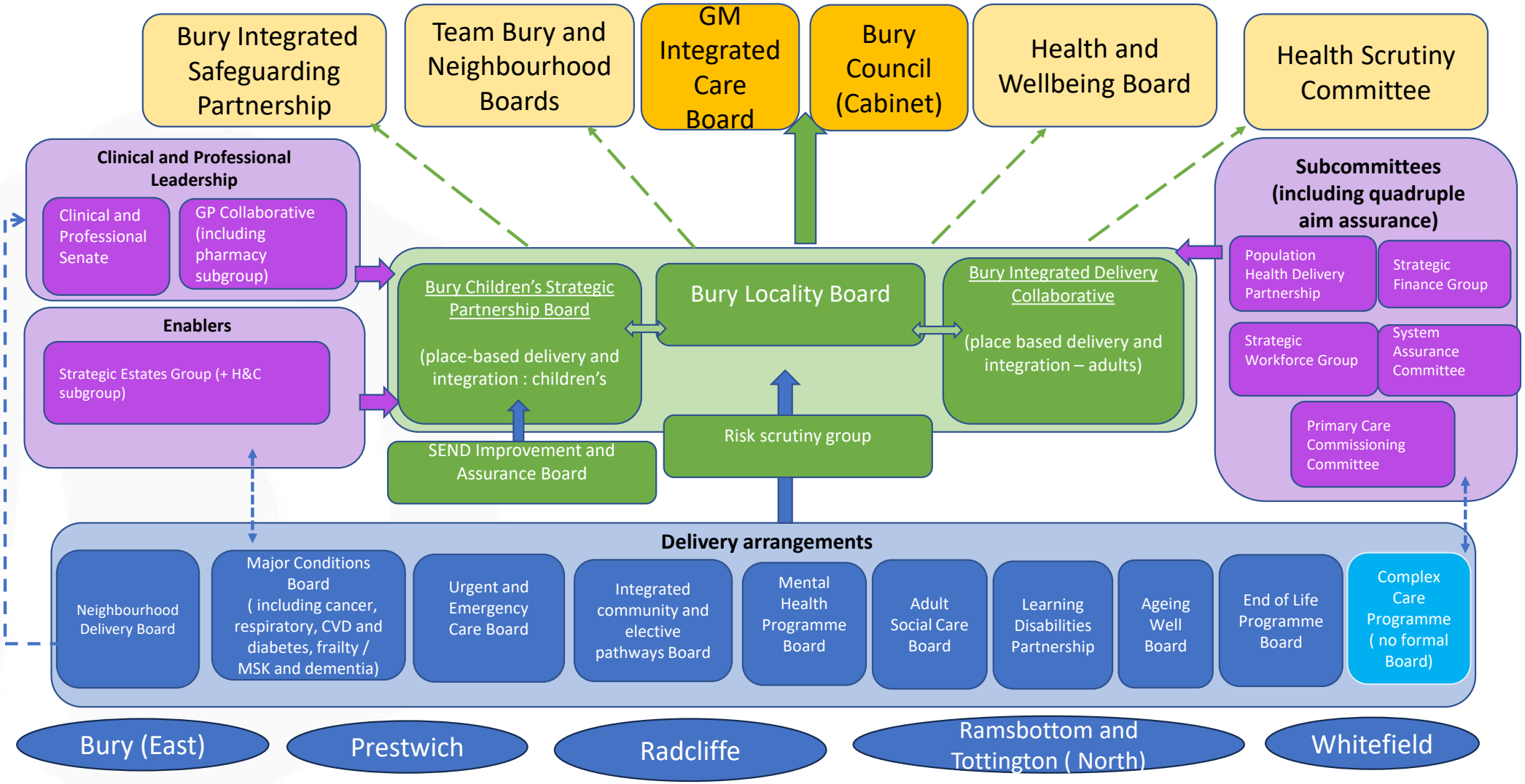
Through our already established governance processes, we will assure the delivery of this plan and associated risks through the IDC Board and the Locality Board.

Part of Greater Manchester Integrated Care Partnership

We have partnership governance to assure our delivery

BURY INTEGRATED CARE PARTNERSHIP

Bury Integrated Care Partnership – Partnership Arrangements



Priority 1 – Population Health Management

Source: Public Health outcomes Framework - Marmot indicators – our obsessions

BURY INTEGRATED CARE PARTNERSHIP

	Indicators
Early years, children and young people	School readiness: percentage of children achieving a good level of development at the end of Reception
	Psychological Wellbeing
	Percentage of residents dissatisfied with their life nowadays
	Pupil absences
	Average Attainment 8 Score among children eligible for Free School Meals (FSM)
Work and employment	16 to 17 year olds not in education, employment or training (NEET) or whose activity is not known
	Unemployment rate (model-based)
	Low earning key workers
	Proportion of all employment in non-permanent employment
Income poverty and debt	Number of children in relative low income families (under 16s)
	Proportion of residents reporting difficulty dealing with their current levels of debt
Housing, transport and the environment	Housing affordability ratio: Ratio of house price to earnings
	Homelessness: households in temporary accommodation
	Average public transport payments per mile traveled
	Air pollution: fine particulate matter (new method - concentrations of total PM2.5)
Communities and place	Crime rate per 1000 population
	% of people who feel their community is a place where people from multiple backgrounds get along
	Antisocial behaviour
Public Health	Proportion of residents reporting bad or very bad health (age-standardised)
	Self reported wellbeing: people with a low satisfaction score
	Numbers on NHS waiting list for 18 weeks
	Emergency readmissions for ambulatory sensitive conditions
	Percentage of adults (aged 18 plus) classified as overweight or obese
	Smoking in routine and manual occupations 18-64 (current smokers (APS))

Priority 1 – Population Health Management

- Reduce inequalities in line with the Core20PLUS5 approach for adults and children and young people
- Increase annual physical activity for adults and children
- Reduce smoking prevalence
- Reduce alcohol consumption rates
- Reduce HIV and viral hepatitis
- Improve school readiness
- Reduce childhood obesity
- Improve immunisation and vaccination rates
- % market share of spend by sector: Aim to increase VCSE share
- Number of organisations signed up for Good Employment Charter

Priority 2 – Prevention, reducing prevalence and proactive care

- **Increase the % of patients with hypertension treated according to NICE guidance, and the % of patients with GP recorded CVD, who have their cholesterol levels managed to NICE guidance**
- % of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins
- % diabetics receiving 8 processes of care
- Reducing Falls admissions to hospital
- Reducing number of CYP in CAMHS services.
- Reducing waiting times for children and young people in CAMHS services.
- Increasing dementia diagnosis rates and % of people in Bury with Dementia with home-based dementia care plan
- Increasing health visiting 2-year checks
- Improving talking therapies access and outcome rates
- Improving uptake of all screening, immunisation, and vaccination
- Improving SMI health check uptake
- Improving carer's health check uptake
- Increasing the % of people with LD who have their own front door and employment
- Increasing the % people with LD having health checks

Indicators in bold are part of national planning guidance

Priority 3 – Transforming Community Care in Neighbourhoods

- Increasing 14-day access to a GP
- Improve patient experience of access to general practice as measured by the ONS Health Insights Survey
- Increasing pharmacy first uptake
- Delivering neighbourhood indicators: CVD, frailty and respiratory
- Increasing number of people assessed through Active Case Management
- Increasing NHS app uptake
- Risk stratification tool in use
- Maintain number of A&E attends -
- Increase hospital at home occupancy
- Maintain urgent community response times
- % population with EPACCS care plans
- Reducing % people with more than 3 admissions in their last 90 days
- Increasing % of people dying in preferred place

- Increasing the number of people who leave IMCs services and live independently
- Reduced waiting times for specialist health services for children
- Reduce referral no's
- Reduce waiting times for community services
- Increase advice and guidance rates
- Increase compliance with interface standards
- Increase number of clinics in the community
- Increase diagnostic capability in the community
- Improving stroke standards
- Increasing the number of people accessing care and support information and advice that promotes people's wellbeing and independence

Priority 4 - Optimising Care

BURY INTEGRATED CARE PARTNERSHIP

Urgent Care

- Improve A&E waiting times, with a minimum of 78% of patients admitted, discharged and transferred from ED within 4 hours in March 2026 and a higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/25
- Improve Category 2 ambulance response times to an average of 30 minutes across 2025/26
- Reduce numbers of patients who are clinically ready for home
- Maintain number of A&E attends and admissions
- Increase hospital at home occupancy
- Maintain urgent community response times
- Reduce average length of stay
- Reduce % of patients on higher discharge pathways
- Improve SDEC utilisation
- Reduce readmission rates
- Improve performance on GIRFT metrics

Elective Care and Cancer

- Improve the percentage of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5%-point improvement
- Improve the percentage of patients waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026, with every trust expected to deliver a minimum 5%-point improvement*
- Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026
- Improve performance against the headline 62-day cancer standard to 75% by March 2026
- Improve performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026

Maternity

- Improving the safety in maternity and neonatal services, delivering the key actions of the of the three-year delivery plan

Mental Health

- Reduce average length of stay in adult acute mental health beds
- Increase the number of CYP accessing services to achieve the national ambition for 345,000 additional CYP aged 0–25 compared to 2019
- Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, delivering a minimum 10% reduction
- Reduce out of area placements in mental health
- Reduce 12 hour waits in ED for MH patients
- Reduce numbers of patients who are clinically ready for home

Finance and Quality

- CQC ratings of providers
- Deliver a balanced net system financial position for 2025/26
- Reduce agency expenditure as far as possible, with a minimum 30% reduction on current spending across all systems
- Close the activity/ WTE gap against pre-Covid levels (adjusted for case mix)

Appendix 1 – Building on Success of 24/25

BURY INTEGRATED CARE PARTNERSHIP

Summary

24/25 saw a step change in the transformation of the health and care system in Bury as the effect of the pandemic began to unwind, providing a strong platform from which we can deliver future priorities. We should gain confidence that the list of successes suggests a system that is transforming, working in partnership, and effecting a ‘left shift’ towards prevention and a reduced reliance on institutional care.

Part of Greater Manchester Integrated Care Partnership

Bury Integrated Care Partnership 2024 Successes

Prevention and Neighbourhood Working

- Work has continued to cement neighbourhoods as our basis for working within the Locality.
- Neighbourhood Leads have been actively involved in the development of Neighbourhood People and Communities Plans with other public service partners.
- For 24/25 neighbourhoods have continued to have a focus on CVD. Neighbourhood targets have been agreed for frailty within Whitefield, Prestwich and North, and Respiratory within East And Radcliffe.
- A multi-agency education session was held on respiratory health to support delivery of the East and West Neighbourhood priorities.
- The award winning safesteps falls prevention and restore digital tool piloted within Bury care homes and supported by Primary Care, has resulted in a 57% reduction of ambulance call outs.
- Best breast screening coverage in GM.
- 2nd/3rd best update in GM on flu and covid vaccination.
- Recognition of population health leadership from the King's fund review of population in GM.
- Referrals for active case management have remained high in 2024 with average of 99 per month.
- Each neighbourhood has seen a strengthening of collaborative working across health, MH, care and VCSE services.
- strong emphasis on workforce development as part of the Neighbourhood plans has seen the delivery of a wide range of training sessions to staff across the workforce including bowel cancer, ACE and trauma informed practice, working with people with co-occurring conditions and respiratory disease.

Primary Care

- Establishment of Women's Health Hub in Prestwich in October 2024.
- Establishment of 4 Respiratory Hubs in November 2024.
- 34% increase in CVD health checks in this year compared to 2023.
- Increase in staying well referrals since April 2024 which has increased from circa 90 per month to 182 in October 2024. This means that 182 patients will have proactive care planning in place to reduce the risk of needing primary care or hospital support.
- 5000 more GP appointments in the last 12 months compared to the year prior.
- Bury are ranked eighth out of 27 localities within the Northwest for the highest rate of NHS App uptake.
- Work at neighbourhood level in the North and Prestwich neighbourhoods to strengthen relationships between GP Practices and Community Pharmacy. This is having a positive impact on working relationships.
- Governance arrangement now in place with NCA to support implementation of the Primary Care/Secondary Care interface principles.
- Attendance at GP Webinars and Masterclasses continues to be strong, supporting engagement with our GP Practice colleagues.

Bury Integrated Care Partnership 2024 Successes

Elective & Community Care

- The Community Café was an initiative led by Katy Alcock and Adele Hughes at FGH, supported by the Bury IDC, to bring system partners together to promote and share information with hospital staff around community provision and offers available. The aim of this café was to raise awareness of service offers amongst NCA staff, to build repour with system partners and to support enable our Bury population to live independently, receiving the right care in the right place.

- Sustained the e-derma tele dermatology pathway project. The pathway allows the early diagnosis of skin cancer through medical photo clinics, photos are then clinically triaged by Dermatology Consultant.
- Bury selected as a forerunner/ early adopter for the implementation of the GM Single Point of Access for Dermatology , as part of the GM Dermatology model of Care.
- Implementation of the GM Dermatology transformation programme within the locality.
- Significant improvement work has taken place across many community services (nursing and therapy services) to improve waiting times and user experience, using quality improvement methodologies. These have been recently shared and celebrated at the community services away day.
- A celebration event was held at Bury Town Hall for four nurses from Community Division who were awarded the National Cavell Nursing Star Award.
- Queens Nursing Award—four nurses from Community Division were awarded the Queens Nurses Award.
- Nina Parekh, Divisional Managing Director of Bury Community Services has been named as the inaugural “Finance Champion of the Year” a new award acknowledging the contribution made by those working outside of finance departments to the effective management of NHS Finances.

Mental Health & Dementia

- The first phase of Living Well Services has been successfully mobilised as a partnership between, PCFT, BIG and the Creative Living Centre.
- A new mental health supported living scheme will open in January. Saxon House on The Rock, offers step-down support in 13 apartments with support from Northern Healthcare. 3 new supported housing schemes for people with Mental Health problems, totalling 33 places, have been commissioned.
- BIG peer Led Crisis Service is now fully operational in new premises offering both open access drop-ins and 1:1 appts
- Mobilisation of 24/7 adult Home Treatment Team and older people’s Home Treatment Team by PCFT.
- Positive Progression in CAMHs expansion to work with young people up to 18 by January 2025.
- Co production and engagement of people with lived experience has informed both developments in CYP MH services and the Living Well model.
- Latest data shows a 25% decrease in suicide registered deaths in Bury in 2022-2023 (ONS).
- Very low numbers of out of area mental health inpatients with 0 or 1 patient over the last 2 months placed out of area.
- 3rd best Dementia diagnosis rate in GM.
- The locality has been recognised as an exemplar relating to the roll out of the GM Care Record storing Dementia Care Plans in North Neighbourhood.

Bury Integrated Care Partnership 2024 Successes

Learning Disabilities

- There is a strong pipeline of new housing for those with additional needs, in development.
- Best ever performance on LD health checks in 23/24.
- Best transforming care (reducing institutional care for LD) performance in GM.

Palliative & end of Life Care

- Bury has consistently had the highest proportion of deaths in usual place of residence in GM since July 2023.
- Bury had the second lowest percentage of patients with 3+ admissions in the last 12 months of life since the start of 2024 and the lowest proportion in GM for the last quarter
- Bury Hospice were awarded from the MCA 'highly commended' for work with NECS that delivered night sitting, help line and outreach over 7 days.
- Bury Hospice were awarded Outstanding at the North West in Bloom event held in October.
- The Hospice received an honorary award by Bury College to recognise the Hospice's outstanding contributions to the local community that have had a significant positive impact on peoples' lives. The Hospice is known for providing compassion and support to people at what is often one of the darkest times of their lives and has been supportive of students, in offering them work experience and live project opportunities, that help to embody the College values.
- Work has commenced on the implementation of EPaCCS with support from Health Innovation Manchester. A training session for health care professionals is planned for 16th January.
- Bury Hospice are working with the FGH high intensity service user lead to identify patients suitable for the involvement of the Hospice Outreach/Liaison team in their support package to improve community support and prevent avoidable A&E attendances.
- A rapid discharge QI project has commenced at FGH to support more timely discharge of patients at the end of life.
- Commencement of test of change in two Neighbourhoods with senior nurses from the Specialist Community Palliative Care Team completing DNACPR forms [where appropriate] signed off by consultant and communicated to GP.
- In 2024 Programme of in-reach to general practice from the Specialist community Palliative Care Team was established supporting fold standards framework meetings in primary care and improving integrated working across primary and community care.
- The co-production of the revised Bury PEoLC Strategy and delivery plan 2024-28, includes the co-designed/produced a Specialist Palliative care SPoA – currently developing the implementation plan.

Bury Integrated Care Partnership 2024 Successes

Urgent Care

- We have reduced A&E attendances from last year's rate in all months except 1 so far in 2024. We have the 2nd lowest A&E attendance rates in GM and relatively low levels of unplanned admissions compared to GM.
- All ECIST recommendations have now been implemented within the Integrated Discharge Team, which has resulted in a significant reduction in patient numbers and associated bed days for those who are clinically ready to go Home .
- We have seen an increase in the percentage of patients over 65 who are discharged home as opposed to a care setting pathway, which is better from a service user and economic perspective. We have seen a 3% rise in people returning to usual place of residence since the start of the programme in March 2024.
- The Hospital at Home service was set up in October 2022 including new roles such as the Consultant Nurse and OT advanced clinical practitioners.
- 2293 patients have been managed since the service began in September 2024, the majority of these patients being step up patients ie those what would have been admitted to hospital. The Service is giving confidence to the Consultant teams about the potential for management of patients in their own homes, which will support our bed reduction plan at FGH, alongside the implementation of same day emergency care on the Fairfield site.
- Outstanding performance on urgent community referrals responded to within 2 hours
- Since August 2024, there has been a monthly decrease in care home attendance at Fairfield General Hospital (FGH) in comparison to 2023 data. Bury is positioned 3rd within GM on having the lowest number of calls into North West Ambulance Service (NWAS) resulting in fewer ambulances being despatched and conveyed. This data is based on 100,000 population.
- Significant improvement in flow and performance across the FGH site as a result of an improvement collaborative including the work outlined above, the expansion of same day emergency care and the continued success of streaming.
- Discharge Front Runner —A Dementia Discharge option has been developed for people who live alone, which includes 24hr care at home to enable patients to remain in their own home. After 4 weeks there has been a 0% conversion to long term care home at point of discharge from scheme. Previously all of these patients would have been in longer term care.
- The Discharge Frontrunner Team won the HSJ award for the best integrated partnership working for improving care of people with dementia in hospital.
- Recruitment of additional workforce at FGH to support 7 day working.
- New pathway in place to support Mental Health patients who have high attendances at FGH A&E.

Bury Integrated Care Partnership 2024 Successes

Quality & Safeguarding

- Best performing locality in GM for antimicrobial resistance in antibiotic prescribing.
- Janine Campbell, GMICB, Designated Nurse for Adult Safeguarding has been nominated under the category of Partnership Champion for her continued commitment to Safeguarding Adults in Bury.

Adult Social Care

- We are 2nd in the North West for the percentage of beds in Good and outstanding CQC rated Care Homes.
- 90.9% of care homes are rated Good or Outstanding.
- No care home providers are rated Inadequate.
- Over the last 12-months, Bury IDC have been supporting a number of initiatives within Bury Care Homes to improve integration amongst system partners and to ensure that the care home resident is receiving the right care, at the right time, in the right place. We have Introduced a one-page document to support care home staff contacting the right service, when a resident becomes unwell.

Workforce

- Joint MOU in development between IDC partners and the VCSE to support different ways of working.
- Strengths based awareness training is now available to all partners to roll out.
- Adult Social Care have been working in collaboration with UTS, to provide support to providers to help with recruitment, retention and leadership development. This has been recognised by Local Government Association as an example of good practice. In the last 12 months we have seen an additional 400 staff working in Adult Social Care in Bury, a decrease in vacancy rates from 12.9% to 8.5% this year, a decrease in leaver rates from 44% to 27.1% and a decrease in agency usage.

Bury Integrated Care Partnership 2024 Successes

Children & Young People

- Strong uptake of mental health in schools programme.
- Core CAMHS waiting time reduced to 9 weeks.
- Reception and Year 6 children we have seen a year on year reduction in prevalence of children being overweight and obese. For year 6, Bury has seen the best rate of reduction in Greater Manchester.
- Emotional mental health and well being offers are driving a reduction in Education, Health and Care Plans (EHCPs) in Bury in the last 4 months.
- We now have comprehensive roll out of the award winning "***myhappymind***". We have conducted a local evaluation, and assuming the cost of a CAMHS referral is £3,784, this indicates a potential saving of £1,0114,000 across all Bury schools, a 5.6 times return on investment on CAMHs referrals alone.
- The Bury Health Visiting service has received 3 Green CAAS inspections.
- Essential parent digital resources have been sent to all parents and carers inclusive of fathers.
- The safeguarding teams locally had a stall on Bury Market and a social media campaign to inform people about abusive head trauma (AHT) in babies and raised awareness of the risk of shaking babies in line with ICON week 2024. This relates to one of our key safeguarding priorities, keeping babies safe.

Meeting: Bury Locality Board			
Meeting Date	07 April 2025	**Action**	Consider
Item No.	8	**Confidential**	No
Title	Pennine Care NHS Foundation Trust - Service Mapping 2024/25		
Presented By	Sarah Preedy, Chief Operating Officer		
Author	Heather Bell, Deputy Director of Strategy		
Clinical Lead			

Executive Summary

Pennine Care have recently refreshed our Trust Strategy which outlines our future vision for clinical models of care and sets the ambition and plans for services. The direction of travel is to change the shape of services, moving from a bed-based model of care to a significantly developed community offer. The aim is to drive out the unwarranted variation, improve outcomes, increase access, reduce waiting times and increase efficiency. However, it is essential that all our services are safely staffed and the gaps in core services are addressed.

The purpose of this presentation is to provide an updated summary (further to the work undertaken in 2023) of the level of variation in services across the PCFT footprint to inform service and investment planning. Variation is identified as where we are:

- Not compliant/fully compliant against a LTP/national standard
- Have significant variation against national benchmarks for services
- Have identified significant gaps in the demand and available capacity in services through local service planning.

The headline variances/gaps identified during the exercise are:

- Staffing levels within our inpatient wards;
- Alternatives to admission services – specifically crisis resolution and home treatment
- Increased and growing pressure on CAMHs capacity
- Neurodevelopment pathway leading to increased waiting lists
- Parent and infant mental health service offer
- Insufficient funding for memory assessment aervices

- Staffing gaps for talking therapies
- Physical Health services
- Care Home Liaison/Day Hospital service
- Section 136 suites
- Medicines and prescribing shared care arrangements

The identified service variation is in the context of generally low levels of spend compared to national benchmark information, and a significant underlying deficit. Therefore, we recognise that a full solution to reducing variation requires a different commissioning approach and further investment to address current gaps, 'level up' services across our five localities and significantly increase community capacity (in partnership with our communities and VSCE).

Internally within the Trust we are working on a set of consistent service models to support the reduction in unwarranted variation. We are also working closely with provider partners to ensure greater standardisation of pathways across GM, address workforce challenges and increase the opportunities for research and innovation.

Recommendations

Locality Board colleagues are asked to consider the information and discuss the position as pertinent to the Bury locality.

OUTCOME REQUIRED *(Please Indicate)*	**Approval** ☐	**Assurance** ☐	**Discussion** ☒	**Information** ☐
APPROVAL ONLY; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	**Pooled Budget** ☐	**Non-Pooled Budget** ☐		

Links to Locality Plan outcomes	
To support a local population that is living healthier for longer and where healthy expectancy matches or exceeds the national average by 2025.	☒
To achieve a reduction in inequalities (including health inequality) in Bury, that is greater than the national rate of reduction.	☒
To deliver a local health and social care system that provides high quality services which are financially sustainable and clinically safe.	☒

Links to Locality Plan outcomes	
To ensure that a greater proportion of local people are playing an active role in managing their own health and supporting those around them.	☒

Implications						
Are the risks already included on the Locality Risk Register?	Yes	☐	No	☒	N/A	☐
Are there any risks of 15 and above that need to be considered for escalation via an NHS GM Statutory Committee or Board in line with the Risk Escalation process ?	Yes	☐	No	☒	N/A	☐
Are there any quality, safeguarding or patient experience implications?	Yes	☒	No	☐	N/A	☐
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☐	N/A	☒
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☐	N/A	☒
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☒	N/A	☐
Are there any financial Implications?	Yes	☒	No	☐	N/A	☐
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☒	N/A	☐
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☐
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☒	N/A	☐

Governance and Reporting		
Meeting	**Date**	**Outcome**
N/A		

Pennine Care
NHS Foundation Trust

Pennine Care NHS Foundation Trust Service Mapping 2024/25

Maximising potential

Introduction

Pennine Care
NHS Foundation Trust

The purpose of this slide deck is to provide an updated summary of the level of variation in services across the PCFT footprint to inform service and investment planning. Service variation is in the context of generally low levels of spend compared to national benchmark information, and an underlying deficit of c£20m.

As with the previous service mapping exercise, variation is identified as where we are:

- Not compliant/fully compliant against a LTP/national standard
- Have significant variation against national benchmarks for services
- Have identified significant gaps in the demand and available capacity in services through local service planning

Current shape of services / Benchmarking

Pennine Care NHS Foundation Trust

- Cost per adult acute bed has **increased** from £144k (2023) to £149k (2024), however, this continues to be **significantly lower** than the national average which has risen over the previous 5 years to £229k (2024).
- Adult acute beds per 100,000 resident population remains **considerably higher** (30) than the national average (23).
- Adult generic CMHT cost per patient on caseload is **now lower** (£3933) than the national average (£4545).
- Adult CAMHS services continue to be in the **lower quartile** for cost per patient contact

Source - 'NHSBN Adults & Older People Inpatients and Community Benchmarking Report 2023/24'

Service variation

Pennine Care NHS Foundation Trust

Identified significant variation in levels of services across our five localities, (detailed in tables on next slides), specifically:

- Significant staffing gaps identified for in-patient wards, with a significant over-spend due to the use of bank and agency (business case for investment developed following MHOST assessment). Within our male PICU we have identified some safer staffing gaps.
- Variation in alternatives to admission services; particularly out of hours. The CRHTs are not operating at core fidelity. The recent MEN-SAT audit identified that crisis assessment and home treatment teams are not available across GM ICB. Providers can offer a home treatment function, however no crisis resolution function is operational across GM. Services are not integrated and not providing 24/7 service.

Service variation, continued

NHS
Pennine Care
NHS Foundation Trust

- Significant gaps in CAMHs capacity due to baseline levels and increased demand. Only fully funded 0-5yrs Parent Infant Mental Health service in Tameside. Other boroughs only commissioned to provide 0-2yrs service.
- Significant gaps in commissioned neurodevelopment pathway, leading to long waits. Only offer adult ADHD/Autism services in Tameside & Stockport. Service in Business Continuity due to large waiting lists. Significant variation in the CYP pathway with increased demand and high waiting times.
- Significant variation in funding and commissioned models across Memory Assessment services and very long waits.
- Talking Therapies – models and commissioned levels vary. Significant workforce gaps identified through System Maturity Toolkit, impacting on ability to consistently meet national standards

Service variation, continued

Pennine Care NHS Foundation Trust

- Physical Health – variation in funding across localities leading to inconsistency of physical health offer. This is an area we will seek to address as investment is available for new models of care
- Care Home Liaison Team/Day Hospital services only available in two localities
- Section 136 suites – partial funding made available in 25/26 however there is a significant gap in resources to fully operationalise this service. This impacts significantly on liaison team compliance.
- Significant variation in medicines and prescribing shared care arrangements across and between localities, impacting on efficiency and delivery and creating pressure in both primary and secondary care.

Service Variation – Key Issues Adults and Older People's services

Pennine Care
NHS Foundation Trust

Service	Bury	Oldham	HMR	Stockport	Tameside
ADULTS					
Community mental health team - adults	◔	◔	●	◔	○
Inpatient services - adults	●	●	●	●	●
Crisis resolution home treatment teams	●	●	●	●	●
Psychological therapies for severe mental illness - (national programme) – adults	●	●	●	●	●
OLDER PEOPLE					
Community mental health team – older people	●	◔	◔	◔	◔
Home intervention team – older people	○	○	◔	◔	◔
Memory assessment services	●	◔	◔	◔	●
Inpatient services – older people	●	●	●	●	●
Psychological therapies for severe mental illness - (national programme) - older people	●	●	●	●	●
Crisis services – 111 / helpline	Trust / Greater Manchester wide ○				
Crisis services – mental health urgent triage – (MHUT)	Trust / Greater Manchester wide ◔				
Mental health crisis response vehicles (ambulance)	Trust wide ○				

Key

- ● significant gap
- ◔ partial compliance/ funding
- ○ compliant/funding received

Blank - not commissioned

Service Variation – Key Issues Adults and Older People's services continued

NHS
Pennine Care
NHS Foundation Trust

Service	Bury	Oldham	HMR	Stockport	Tameside
Living well	◔	●	◔	◔	◔
Talking therapies	●	●	◔	●	●
Step 3.5		○		○	○
Care home liaison team / day hospital		○			○
Psychiatric intensive care units (PICU)	Trust wide ○				
Mental health liaison teams	◔	◔	◔	◔	◔
Section 136	Trust wide ●				
Electroconvulsive therapy (ECT)	North ◔			South ◔	
Clozapine in the community	◔	◔	◔	◔	◔
Olanzapine depot in the community					
Shared care	●	●	●	●	●
Early intervention in psychosis	◔	◔	◔	◔	◔
Health and wellbeing college	Service development				

Key

- ● significant gap
- ◔ partial compliance/ funding
- ○ compliant/funding received
- Blank - not commissioned

Service Variation – Key Issues – CAMHS Services

NHS
Pennine Care
NHS Foundation Trust

Service	Bury	Oldham	HMR	Stockport	Tameside
CAMHS					
Core CAMHS	◔	◔	◔	◔	◔
Neurodevelopment	●	●	●	●	●
Core CAMHS 16-18 services	◔	◔	○	◔	◔
CAMHS - learning disability					
CAMHS inpatients	Trust wide ○				
CAMHS crisis service	North ○			South ○	
CAMHS - children and young people crisis pathway / Greater Manchester assessment and in-reach centre (GMAIC)	Trust wide ○				
CAMHS - Young people specialist support team – (YPSS)	Trust wide ◔				
CAMHS – Mental health support team – (MHST)	◔	◔	◔	◔	◔
Children and young people eating disorders	North ○			South ○	
Parent and infant mental health services (PIMH) – 0-2 years	●	●	●	●	○
Parent and infant mental health services (PIMH) – 2-5 years	○	○	○	○	○
Cared for children and care leavers	◔	◔	◔	◔	◔

Key

- ● significant gap
- ◔ partial compliance/ funding
- ○ compliant/funding received

Blank - not commissioned

Service Variation – Key Issues – Learning Disability and Rehabilitation and High Support services

NHS
Pennine Care
NHS Foundation Trust

Service	Bury	Oldham	HMR	Stockport	Tameside
LEARNING DISABILITIES					
Learning disability – children and young people community	◔	◔			◔
Learning disability – adults community	◔	◔	◔	◔	◔
Autism/ADHD adults				●	●
Learning disability - Cambeck Close – short stay/ respite			Trust wide ○		
Learning disability - Radcliffe Place – crisis alternative to admission			Trust wide ◔		
Learning disability - health inequalities (learning disability, Greater Manchester work) – Specifically Greater Manchester service development funding for learning disability	◔	◔	◔	◔	◔
REHAB AND HIGH SUPPORT					
Low secure units			Trust wide ○		
Rehab units			Trust wide ◔		
Community rehab			Trust wide ○		
Sexual abuse and assault service (SAAS)			Trust wide ○		
Rehab and high support - psychological therapies	○	○	○	○	○
Military veterans service - Pennine Care NHS Foundation Trust			Trust wide ○		
Military veterans service - Lancashire			Lancashire ◔		
Resilience hub			Trust wide ○		

Key

- ● significant gap
- ◔ partial compliance/ funding
- ○ compliant/funding received

Blank - not commissioned

Future shape of services

Pennine Care
NHS Foundation Trust

- Our refreshed 5-year trust strategy outlines our vision for our clinical models of care and sets the ambition and plans for services.
- We want to change the shape of services, moving from a bed-based model of care (only when required) to a significantly developed community offer. We aim to drive out unwarranted variation, improve outcomes, increase access, reduce waiting times and increase efficiency.
- It is essential that all our services are safely staffed and the gaps in core services are addressed.
- Investment in core services is required to address current gaps, ‘level up’ services across our five localities and significantly increase community capacity (in partnership with our communities and VSCE).
- With investment (including our enablers – people and infrastructure) we will improve our benchmark funding position, improve access and reduce pressure on acute services.
- Working closely with provider partners to ensure greater standardisation of pathways across GM, address workforce challenges and increase the opportunities for research and innovation.

Meeting: Bury Integrated Care Partnership			
Meeting Date	07 April 2025	**Action**	Receive
Item No.	9	**Confidential**	No
Title	Chief Officers Report		
Presented By	Kath Wynne-Jones		
Author	Kath Wynne-Jones		
Clinical Lead	Kiran Patel		

Executive Summary
This paper is intended to provide an update to the Board of progress with the work of the IDC, and progress with the delivery of programmes across the Borough.
Recommendations
The Board are asked to note the progress of the strategic developments, and progress of the programmes.

OUTCOME REQUIRED *(Please Indicate)*	**Approval** ☐	**Assurance** ☐	**Discussion** ☒	**Information** ☐
APPROVAL ONLY; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	**Pooled Budget** ☐	**Non-Pooled Budget** ☐		

Links to Locality Plan outcomes	
To support a local population that is living healthier for longer and where healthy expectancy matches or exceeds the national average by 2025.	☒
To achieve a reduction in inequalities (including health inequality) in Bury, that is greater than the national rate of reduction.	☒
To deliver a local health and social care system that provides high quality services which are financially sustainable and clinically safe.	☒
To ensure that a greater proportion of local people are playing an active role in managing their own health and supporting those around them.	☒

Implications						
Are the risks already included on the Locality Risk Register?	Yes	☒	No	☐	N/A	☐
Are there any risks of 15 and above that need to be considered for escalation via an NHS GM Statutory Committee or Board in line with the Risk Escalation	Yes	☒	No	☐	N/A	☐

Implications						
process?						
Are there any quality, safeguarding or patient experience implications?	Yes	☒	No	☐	N/A	☐
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☐	N/A	☒
Have any departments/organisations who will be affected been consulted?	Yes	☐	No	☐	N/A	☒
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☐	N/A	☒
Are there any financial Implications?	Yes	☒	No	☐	N/A	☐
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☒	N/A	☐
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☒	N/A	☐

Governance and Reporting		
Meeting	**Date**	**Outcome**

Bury Integrated Delivery Collaborative Update

1. Context

This report is intended to outline to the Board progress which has been made with the key programmes of work within the IDC.

2. Key strategic developments

- Portfolio planning to deliver the ambition of the locality plan for 25/26 has continued throughout February and March. The final version of the locality plan will be ratified by the Locality Board in April.

- We have continued to focus on the operational issues raised by GP Collective Action collectively across Bury and HMR with the LMC and our local providers. We are establishing governance from April with the NCA across the 4 localities partnership to progress implementation of the primary / secondary care interface principles, which is very closely linked to the actions that GPs are taking under collective action.

- Major conditions Board:
  - CVD and diabetes: Locality priorities defined associated with planning guidance targets. Proposal developed for our 50K GM allocation relating to population engagement via the VCSE and increasing the proportion of the population up taking patient education via the GP Federation
  - Respiratory: Locality priorities being more closely defined
  - Dementia: Programme plan been drafted with key priorities for implementation identified
  - Cancer: Locality priorities being more closely defined
  - MSK: Review of falls prevention services underway

- Workshop to understand potential for closer alignment of prevention services across the locality, and opportunities for closer integration was explored at a workshop on the 27th February. This will be formulated into a draft prevention strategy which will be brought to the IDC Board.

- Following a workshop to understand all our interventions across the Borough focused on high intensity service users in October, we identified a gap supporting the management of patients who frequently attend A&E for Mental Health issues. Given the volume of demand that this patient group was generating, dedicated staffing resource was put in place to support this patient group. A test of change including active case management, care coordination, an MDT approach and community outreach commenced in FGH led by an A&E Nurse and supported by Pennine Care Trust seconded Mental Health Nurse. Recent data shows that of the 50 high intensity users, 31 patients are having fewer numbers of attendances, resulting in a 17% reduction in FGH A&E activity. We need to consider the longer-term sustainability of this change when the test of change ends in March 2025, which we are discussing with PCFT and the NCA.

- Discussions underway across the system to consider how we re-scope the EOL and palliative care programme to explore given the change in SRO leadership: workshop to be scoped.

- Urgent Care Board received an update on the NWAS/NCA ambulance collaborative project. This will be tested in Bury. A local implementation group is currently being established.

- Proposal developed for a test of change with Burswood and Nazareth House Care homes to trial an EOL education programme and an MDT with GP's, district nurses and Consultant Psychiatrist and Geriatrician input. If this is successful, we will consider how we integrate this approach into the wider active case management approach.

- Better Care Fund proposals finalised and received by Health and Wellbeing Board.

- Work has continued supported by place partners to design the place element of the NCA Clinical Leadership Model. This is due to be presented to the Programme Board in April. There locality is facing a lot of change given this programme of work and recent NHSE/ICB announcements.

Workshops planned: -

- Workshop between neighbourhood and Primary Care Network CD's: 2nd April. The neighbourhood delivery model is a welcome publication for us to support the direction of travel with neighbourhood working and will inform the review of neighbourhood working we are commencing in April.

3. IDC Programme Highlights:

Adult Social Care

- **Service Update**: Although some performance metrics have declined, this is expected for this time of year due to winter pressures and staff absences. However, overall performance remains positive and will continue to be reviewed.

- **Short Term Assessments:** The number of people waiting for allocation for short-term assessments has decreased to 22, and the median waiting period has increased slightly from 33 to 38 days. The average waiting time has decreased from 167 to 158 days. Some anomalies still need to be addressed.

- **Overdue Reviews:** There is a slight increase in the number of overdue reviews, but the overall position was stable.

- **Awaiting Allocations (Care Act Needs):** The number of people awaiting allocation for assessments remained steady with 80 people waiting and there has been a significant improvement in the maximum days waiting from 188 to 102 days. In addition, currently there are only 11 cases over the 56-day target 14% down from 28% last month.

Mental Health:

Suicide prevention:

- Continued development of the suicide prevention conference stakeholder event in June in collaboration with The Big Fandango and Creative Living Centre.
- Planning for more walk and talk sessions in March 2025.
- Working with Blind society around suicide ideation for sensory diagnoses and long-term conditions.
- Promotion of all training offers.
- Suicide survivor work with Creative Living Centre

Mental Wellbeing / *Coping & Thriving:*

- Military Vets Training options now out for consultation
- Honouring Life Event bereavement event took place with positive feedback

Children and Young People:

- Workshops to explore the development of the Bury submission for the CYP Neuro Development Hub have been undertaken.
- Response to Bury2Gether survey on parents' experience of neuro development services delivered to the Joint Commissioning Group.
- iBasis (evidence-based early intervention for neurodivergent children) pathway established and first families enrolled on the programme.
- Commencement of distribution of Ithrive posters.
- Youth Connect 5 delivery.

Community:
- Decision made to delay closure of Getting Helpline to 30th April 2025.
- Lived Experience Partner evaluation.
- Meeting between Living Well Team and INT Leads to align pathways.
- 2nd Living Well Team Day held with Innovation Unit.

Crisis:
- Evaluation of test of change by FGH MH Liaison team to follow up high intensity service users.
- Review and refresh of OAPs and CRFD improvement plan.

ADHD / ASD:
- Approval of application to make an urgent contract award for 2025.26 including commissioning of some ADHD and ASD assessment capacity across the NES.
- Approval by NHSE of GMICB proposal to go to public consultation to inform plans for future commissioned pathway for adult ADHD assessment.

Dementia:
- Approval of Bury Dementia strategy through IDC and Bury Locality Boards.
- Work on business case to extend Frontrunner initiative.

Misc:
- Ongoing work to take contracting proposals through NHSGM governance.
- Publication of tender for Topping Mill support provider procurement.
- Development of draft SOP for management of IFR referrals for Respect for All Counselling.

Neighbourhoods:

- Work over the past month has focused on delivery of the Neighbourhood element of the GP Locally Commissioned Services Framework 2024.25 to try and ensure that the targets relating to COPD and Frailty are met.
- Proposals for the Neighbourhood element of the GP Locally Commissioned Services Framework for 2025.26 have been collated and will be taken to the GP engagement event on 12th March for consideration.
- A case study was presented to the Public Service Reform Steering Group in March highlighting how Active Case Management MDTs are starting to work in a more joined up way with children's services, mental health and wider PSR partners.

Palliative and EoLC:

Programme:
- Ongoing scoping meetings re design of SPOA for specialist tier of services.
- EPaCCS training session has been arranged for January.

For the Hospice:
- The transition to an electronic patient record has started and progressing well. No formal timeframe for completion but I expect our 'Phase 1' will be done by the end of April.
- A new Director of Clinical Services has been appointed following interviews..
- As an extracurricular achievement, in April we come to the end of our involvement in an international research study. After that Dr Dunne (based at the hospice full time) will be beginning the first primary research conducted out of the hospice (for her Master's dissertation) which is a great accolade for the organisation!

FGH Palliative, EOL and Bereavement Team:

Team Projects:

- Bereavement study day/conference held 29th November.
- Anticipatory drug authorisation form sent out to GPs across localities for comments.
- QI Project / Task and Finish group underway for Rapid Discharge checklist review across NCA. Test of change on ARCU.
- Verification of Death work with community and EOL education team planning.
- Bereavement team commenced I-Orbit project with NHS-BT (Blood and Transfusion). This has commenced at Salford Dec/Jan but will roll out to other sites over the 6-12 months. The bereavement nurses will take on the work of approaching bereaved families to discuss potential eye donation for deaths within the hospital.
- Action plan developed from the results of strong opioid transdermal patch audit.
- Muslim end of life care leaflet now revised and in use.
- Training bulletin for Palliative and End of Life care now published for 2025.
- Presenting on Consultant EOL link sessions.

Workforce:

- Associate Specialist Palliative Care Nurse post to be advertised for SPC team.

Staff Development:

- SPC staff member facilitated Sage and Thyme Communications Skills training.
- Team attended Group Reflective Practice.
- Training taken place for identification of potential eye donors within the Bereavement Team.
- All compliant with Interpretation and Translation training.

LD & Autism

- Completed draft of LD & A Team Business plan 25-26

Primary Care

Prog.1 - Alternative at Scale Solutions

- Paediatric Phlebotomy – STAR form in train, awaiting confirmation of approval

Prog.2 – Communications and Engagement

- Member Engagement Session held, outputs to be included in £16ph proposal and Bury LCS 25/26 contract

Prog.3 – Data and Digital Ambition

- New GP contract introduced with changes to online consultation requirement (linked also to CAIP)

Prog.4 – Effective Pathway Navigation

- See GPCA update under leadership

Prog.5 – Current and Future Estate

- Formal notification of request to close Rock Radcliffe branch received
- Whitefield HC – Agreement to lease agreed allowing the ICB to secure and drawdown funds by the required deadline
- Prioritisation of year end capital funding suggestions put forward in line with PCN Toolkit outputs (awaiting feedback)
- Improvement grants – Requests made of practices via GP webinar

Prog.6 – Integration (Wider PC/Neighbourhoods/PSR)

- Continue with scheduled work and roll out North pilot with practices in North neighbourhood including review of current processes and refine for roll out. Plan for remaining neighbourhoods, including proposed go-live dates to be finalised. All approved SOP & paperwork shared with Huntley Mount who have chosen to implement themselves. Bury-wide roll out agreed – meeting with Prestwich NHD & PCN lead arranged. Prestwich to move forward with PLO roll out. Townside/Ribblesdale/Peel will move forward themselves 1st April (all info given).

Prog.7 – Quality and Assurance

- Bury LCS 2024/25 - February data shared with practices
- Bury LCS 25/26 - conversations continue re levelling up monies and proposal submitted for consideration by GM PCCC. Draft spec for 2025/26 shared for comment (including GM specs).
- PCN DES - All PCN Q3 submissions received
    - EA 24/25 – All PCNs performing above contractual offer, however work continues around improving utilisation rates, particularly for Bury PCN practices (January and February data remains outstanding).
    - Prestwich PCN confirmed transition to Modern General Practice Access Model – once queries clarified confirmation will be sent to GM to process payment
- Unwarranted variation - Q3 data & resources sent out to practices for 8 care processes, breast/cervical screening & SMI Health checks
- Medicines Optimisation Team continue to focus on savings plans set out by
- Interpretation and Translation contracts extended for 1 year whilst GM look at pan GM model
- PC Quality Visits all complete for 2024/25 and an update/plan/process for 25/26 will be presented in due course
- CQC visits are in the diary for two practices

Prog. 8 – System Leadership

- GP Collective Action – BMA official action stood down however Primary and Secondary Care interface discussions will continue to address pathway/bureaucracy issues which are raised.
- Beyond Core Contract Review – Discussions regarding potential investment for 25/26 on going

Prog.9 – Workforce (recruitment/development and retention)

- GM workforce return completed in collaboration with practices and submitted
- Attended Bury recruitment event to promote Primary Care and current nonclinical / admin vacancies
- Strategy on for discussion at GPLC in March

<u>Urgent and Elective Care</u>

- GP out of hours commissioning process underway
- Acuity Tool Implementation: Agreed a formal review of front and UTC to take place
- BCO Collaborative Group 1: plan for 25/26 agreed
- FGH UEC Recruitment Plan: Team have recruited 4 senior clinical fellows and 5 junior clinical fellows over the past 3 months. All now in situ and impact beginning to be felt especially with regards to improvements in the wait to be seen figures in the morning (average <1 hour each morning)
- FGH UTC: Agreement to continue towards full accreditation. Further work to be done on the outstanding UTC accreditation process.

Complex Care

Performance good >80% for past 12 months**.**

ADAM data system cleanse complete and management of finance side of database under control.

Transfer of CCP jointly funded cases payments to LA with recharge in place. Prior year reconciliation complete.

Recovery plan in plan for financial recovery in place, challenged due to increasing costs of packages and patient numbers.

4. Performance – March 2025

- LD Health checks 14+ - the percentage of patients aged 14+ having received an LD health check in December 24 was 52.1%, which is an increase on December 23 which was 41.3%. Bury is lower than the GM percentage of 58.8% and has the lowest percentage of the GM localities. For the last two years Bury has delivered the majority of annual checks in months January to March.

- Access to Children and Young People MH Services - there were 3525 accesses to Children and Young Peoples Mental Health Services for Bury registered patients in December 24, higher than December 23 (3475). Bury currently has 77.5 accesses made per 1000 population and has the 5th highest rate per 1000 for localities within GM but is on course against the usual annual trajectory in Bury.

- Dementia: Diagnosis Rate (aged 65+) -the percentage of patients aged 65+ having received a dementia diagnosis as of December 24 is 75.4%, which is the lowest in this financial year. Bury currently has a higher diagnosis rate than GM which has a rate of 74.6% and Bury has the 4th highest dementia diagnosis rate of the GM localities. Bury and GM are both above the national target of 66.7%.

- Inappropriate adult acute mental health out of area placement (OAP bed days) – latest data confirms OAP is zero in Bury and has been either 1 or 0 for the last month. There were 635 inappropriate OAP bed days for Bury registered patients in March 24, higher than March 23 (370). These are subject to real time daily and weekly monitoring by multi-agency teams and there is a slight lag in the formally reported data.

  Bury currently has 3.0 OAP bed days per 1000 population and has the joint 6th highest rate with Wigan per 1000 for localities in GM.

- No Reason/no criteria to reside (NCTR) - percentage for Mental Health patients with NCTR as if January 25 is 16.5%, which is an increase from January 24 which was 7.7%. Bury currently has a higher percentage than GM which is 15%. Bury has the 3rd highest percentage rate of the GM localities.

- Number of MH Patients with no criteria to reside - the number of mental health patients with NCTR as of January 25 is 14 which is higher than the figure for January 24 which was 7. Bury currently has 0.066 mental health patients with NCTR per1000 population and has the 4th highest rate in locality within GM.

- Access to community MH services - there were 1770 people who received two or more contacts from mental health services for adults with severe mental illness for Bury registered patients in December 24 24, higher than December 23 (1560). Bury currently has 10.6 contacts per 1000 population and has the 5h lowest rate per 1000 for localities within GM.

- Talking Therapies Access Rate – there were 190 accesses to Talking Therapies for Bury registered patients in December 24, lower than December 23 (395) Bury currently has 0.9 accesses per 1000 population - the 2nd lowest rate per 1000 for localities within GM.

- Women Accessing Specialist Community Perinatal MH Services – There were 200 women accessing to Perinatal MH Services for Bury registered patients for the rolling 12 months to December 24, higher than December 23 (125). Bury currently has 4.9 accesses per 1000 population – the 2nd highest rate per 1000 for localities within GM.

- Length of stay adults: Mental Health Patients - the proportion of discharges with a long LOS in December 24 was 50.0%, which matches December 23 which was 50.0%. Bury currently has a lower proportion with a long LOS than GM at 58.3% and Bury had the 4th lowest proportion of the GM localities.

- Percentage of Hypertension patients who are treated to target as per NICE Guidance – according to the GM CVDPREVENT Dashboard – CVDP007HYP Bury is currently performing at 66.7% in January 2025. Bury is currently ranked 5th out of the 10 GM localities. GM are performing at 67%.

  CVD P003CHO for Bury is currently performing at 63.7% in January 2025. Bury is currently ranked 2nd out of 10 GM localities with GM performing at 66.7%.

- E. Coli Blood Stream Infections - there were 150 counts of E. coli blood stream infections in the rolling 12 months to December 24 which is higher than December 2023 (149). Bury has 0.71 counts per 1000 population and has the 4th highest rate for GM localities.

- Antimicrobial resistance: total prescribing of antibiotics in Primary Care - the percentage of total prescribing of antibiotics in primary care in November 24 for the Bury populations was 81.7% which is lower than November 23 which was 97%%. Bury currently has the lowest percentage of the GM localities.

- Antimicrobial resistant proportion of broad-spectrum antibiotic prescribing in Primary Care – in November 2024 for Bury population was 5.8% which is a decrease in November 2023 which was 6.2%. Bury currently has the 3rd lowest percentage of the GM localities. Bury is within the 10% target.

- Percentage of patients describing their overall experience of making a GP appointment as good – Bury currently has the 8th lowest percentage of GM localities with 71.4% of patients describing their overall experience of making a GP appointment as good.

- A&E 4-Hour Performance - in January 25 was 64.1%, an increase on the previous month's performance of 61.3%, which is higher than January 24 which was 58.7%.

- A&E Attendances – there were 6732 A&E attendances from Bury registered patients in January 25, lower than January 24 (6966). Bury currently had 31.7 attendances per 1000 population and has the 2nd lowest attendance rate for localities within GM.

- Percentage of Patients with no criteria to reside as % of occupied beds - the percentage of patients with NCTR as of January 25 was 14%, a decrease from January 24 at 20.6%. Bury has a higher percentage than GM which is 13.5% and Bury has the 5th lowest percentage of GM localities.

- Diagnostics Waiting 6 weeks + - December 24 performance of 12.6% of patients waiting more than six weeks, this is a decrease on the December 23 figures (22.3%). Burys performance is better than GMs performance of 16.2% in December 24 and is the 2nd lowest in GM. Bury and GM are both above the less than 1% target.

- RTT Incomplete 65+ weeks – published December 24 data shows a decrease in 65+ week waits from with 22 pathways down from 34 pathways in November 24. There was a significant decrease in pathways in December 24 with 22 pathways, compared to December 23 when there were 602pathways (-580 pathways).

  In December 24, ENT services show the largest decrease in pathways with 0 compared to 4 in November 2024.

  Bury locality currently has the 4th lowest number of 65+ week waits out of all GM localities.

- 28-day wait from referral to faster diagnosis (all patients) - the percentage of patients told of a cancer diagnosis outcome within 28 days of the 2WW referral in December 24 for the Bury population was 80.1% - an increase on November 24 which was 78.6%. Bury locality currently has the 5th lowest performance out of all the GM localities. GM performance is currently 79.5%. Bury is above the target of 75% or greater.

- Breast Screening coverage females 53-70 screened in last 36 months – the 3-year screening coverage to December 24 for Bury populations was 73.3% for eligible females. Bury locality currently has the 2nd highest percentage out of all the GM localities and is higher than the GM percentage of 68.1%.

- Seasonal Flu Vaccine Update: 65 years and over – for Bury populations was 77.5% for those aged 65+. Bury locality currently has the 7th lowest uptake out of all the GM localities and is higher than the GM percentage of 76.2%. Bury and GM are not meeting that national target of 85%

- 2-hour UCR referrals - the percentage of UCR referrals that received a 2-hour response standard for Bury registered patients in December 24 was 98% - an increase on December 23 which was 50%%. Bury currently has the highest percentage in the GM localities and above the national target of 70%. Local Authority reporting shows that 96% of Bury residents received a 2-hour response in January 2025 with 4 patients missing target.

5. Recommendations

The Board are asked to note the progress and risks outlined within this paper.

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March 2025

Locality Performance Report March 2025 Product 2

Part of Greater Manchester Integrated Care Partnership

BURY INTEGRATED CARE PARTNERSHIP

Presentation by:

Bury - Oversight Metrics

Show Definitions

Domain	Code	Measure	Frequency	Date	Latest	Previous	Change	Target/Median	Numerator	Denominator	Quartile
Mental Health & Learning Disabilities	EAS02	Talking Therapies: Recovery Rate	Monthly	Jan 25	53.0%	54.0%	↘	50.%	85	160	Upper
	EH13	% of people with SMI to receive all six physical health checks in the preceding 12 months.	Quarterly	Mar 24	64.9%	50.9%	↗	60.%	1,322	2,036	Inter
	EH01	Talking Therapies: 6 Week Waits	Monthly	Jan 25	88.2%	86.7%	↗	75.%	150	170	Lower
	EH02	Talking Therapies: 18 Week Waits	Monthly	Jan 25	100.0%	96.7%	↗	95.%	170	170	Upper
	EH21	Talking Therapies: Second Treatment Waits	Monthly	Jan 25	44.0%	35.9%	↗	10.%	110	250	Lower
	EH10	CYP Eating Disorders: Routine - % within 4 weeks	Quarterly	Mar 23	91.4%	94.7%	↘	95.%	32	35	Inter
	EH11	CYP Eating Disorders: Urgent - % within 1 week	Quarterly	Mar 23	75.0%	75.0%	→	95.%	3	4	Inter
	EH17	Access to Individual Placement and Support Services	Monthly	Jan 25	90	90	→	258	N/A	N/A	Lower
Community	ET02	Total Patients on the CHS Waiting Lists (NCA)	Monthly	Jan 25	16,812	13,656	↗	N/A	N/A	N/A	N/A
	ET02a	Total CYP on the CHS Waiting Lists (NCA)	Monthly	Jan 25	5,007	4,936	↗	N/A	N/A	N/A	N/A
	ET02b	Total Adults on the CHS Waiting Lists (NCA)	Monthly	Jan 25	11,805	8,720	↗	N/A	N/A	N/A	N/A
	N/A	Total Patients Waiting 52+ Weeks on the CHS Waiting Lists (NCA)	Monthly	Nov 24	699	676	↗	N/A	N/A	N/A	N/A
	N/A	Total Adults Waiting 52+ Weeks on the CHS Waiting Lists (NCA)	Monthly	Nov 24	204	202	↗	N/A	N/A	N/A	N/A
	N/A	Total CYP Waiting 52+ Weeks on the CHS Waiting Lists (NCA)	Monthly	Nov 24	495	474	↗	N/A	N/A	N/A	N/A
	N/A	% of CHC referrals completed within 28 days	Quarterly	Dec 24	89.7%	76.6%	↗	N/A	35	39	Inter
	N/A	% of DST carried out in acute setting	Quarterly	Dec 24	0.0%	0.0%	→	N/A	0	32	Upper
Primary Care	ED19	Appointments in general practice	Monthly	Jan 25	84,833	72,795	↗	207,433	N/A	N/A	Lower
	S001a	Number of GP appointments per 10,000 weighted patients	Monthly	Jan 25	398.8	342.2	↗	517	84,833	212,721	Lower
	N/A	Number of prescriptions dispensed per 1000 patients	Monthly	Dec 24	871	861	↗	N/A	N/A	N/A	Lower
	N/A	Number of extended access appointments	Monthly	Jan 25	67	66	↗	N/A	N/A	N/A	N/A
Adult Social Care	N/A	Number of people in Care Homes	Weekly	Mar 25	1,331	1,322	↗	N/A	N/A	N/A	N/A
	N/A	Number of people in Home Care	Weekly	Mar 25	1,382	1,385	↘	N/A	N/A	N/A	N/A
	N/A	Percentage of Care Homes rated Good or Outstanding	Monthly	Feb 25	84.6%	84.3%	↗	N/A	44	52	N/A
	N/A	Care home beds vacancy rate	Weekly	Mar 25	14.7%	15.3%	↘	N/A	230	1,561	N/A
	N/A	Number of vacant care home beds	Weekly	Mar 25	230	239	↘	N/A	N/A	N/A	N/A

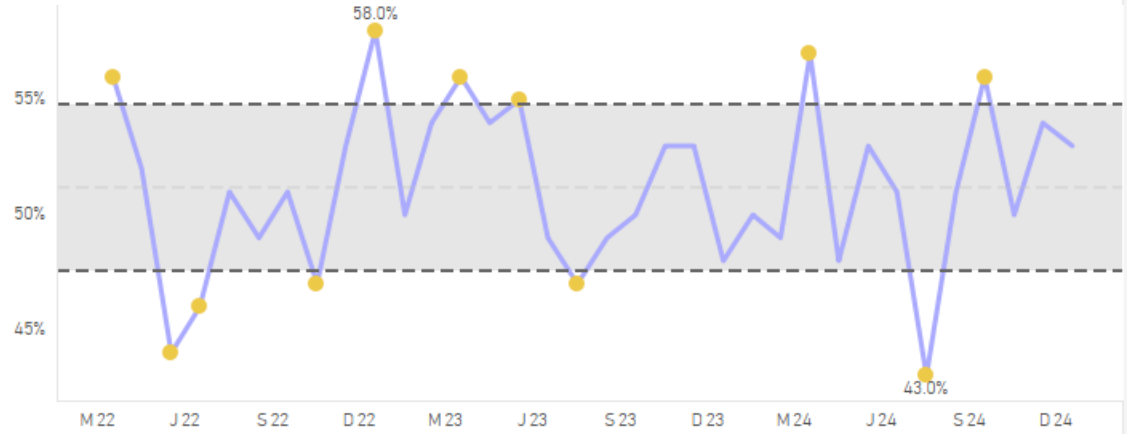
Bury

Talking Therapies: Recovery Rate
The proportion of people who complete treatment who are moving to recovery

Source: Improving Access to Psychological Therapies Data Set (Monthly)

53.0%	54.0%	25/111	50.%
January 2025	December 2024	National Rank Upper Quartile	National Target

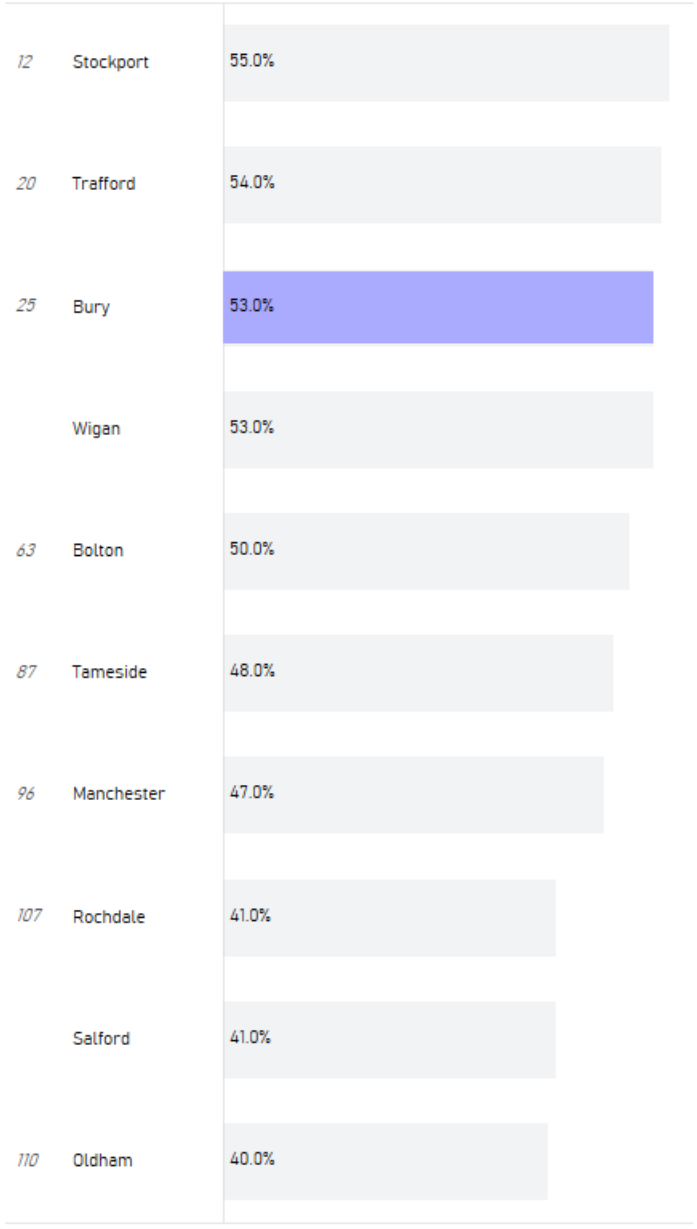
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	56.0%	52.0%	44.0%	46.0%	51.0%	49.0%	51.0%	47.0%	53.0%	58.0%	50.0%	54.0%
2023-24	56.0%	54.0%	55.0%	49.0%	47.0%	49.0%	50.0%	53.0%	53.0%	48.0%	50.0%	49.0%
2024-25	57.0%	48.0%	53.0%	51.0%	43.0%	51.0%	56.0%	50.0%	54.0%	53.0%		

Selected measure at January 2025 has continuously **decreased** for **1** period(s) of time

Latest Value GM Benchmarking
National Rank against other localities



Narrative

- Jan 25 data shows a decrease in Talking Therapies recovery rate with 53.0% in Jan 25 down from 54.0% in Dec 24
- This is an increase from Jan 24 when the rate was 48.0%
- Bury locality currently has the 3rd highest Talking Therapies recovery rate out of all the GM localities.

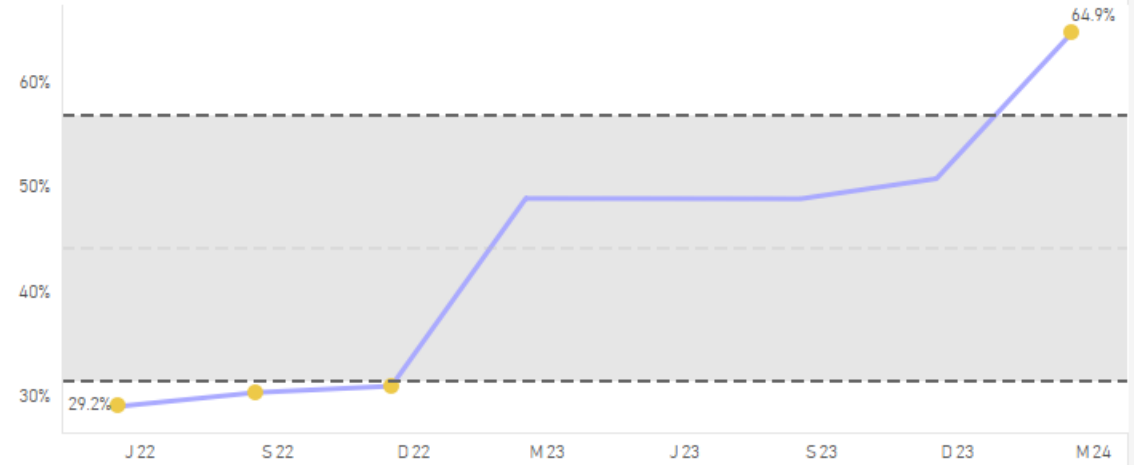
Bury

% of people with SMI to receive all six physical health checks in the preceding 12 months. - Mental Health Patients
People with severe mental illness receiving a full annual physical health check and follow up interventions

Source: Physical Health Checks for people with Severe Mental Illness (Quarterly)

64.9%	50.9%	77/106	60.%
March 2024	December 2023	National Rank Inter Quartile	National Target

Outliers more than 1 standard deviation from the mean



	Jun	Sep	Dec	Mar
2022-23	29.2%	30.5%	31.1%	49.1%
2023-24	49.0%	49.0%	50.9%	64.9%

Selected measure at March 2024 has continuously increased for 2 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities

33	Stockport	73.5%
37	Trafford	72.8%
50	Salford	70.7%
52	Tameside	69.7%
58	Bolton	67.7%
59	Manchester	67.7%
64	Wigan	67.0%
68	Rochdale	66.6%
75	Oldham	65.4%
77	Bury	64.9%
25	NHS Greater Manchester Integrated Care Board	68.5%

Narrative

- Published data shows Bury has completed 56.1% of people with SMI all six health checks in the preceding 12 months up to Feb 25. With 1114 out of the 1987 patients having all six of their SMI health checks.
- GM figures shows that 64.3% had completed all six SMI Health Checks in Feb 25
- Bury has the lowest performance in all the GM localities.

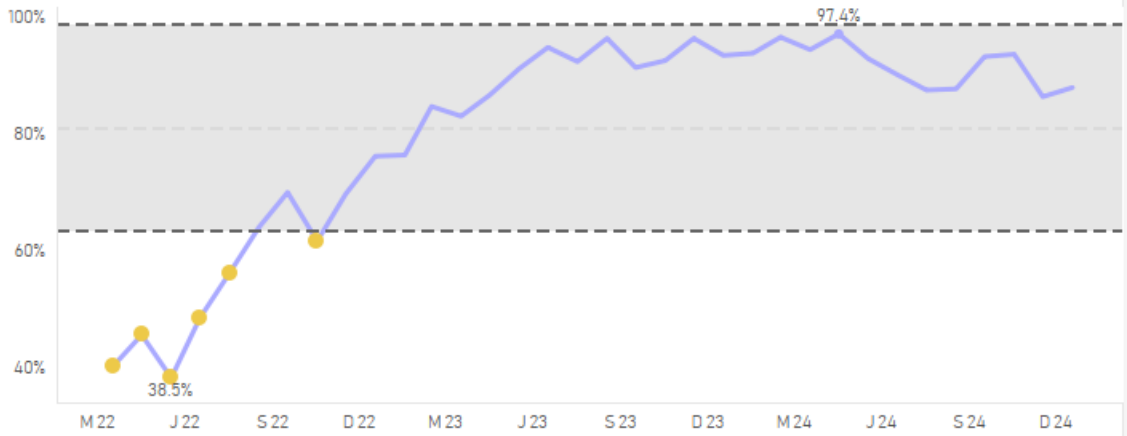
Bury

Talking Therapies: 6 Week Waits
The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period.

Source: Improving Access to Psychological Therapies Data Set (Monthly)

88.2%	86.7%	84/111	75.%
January 2025	December 2024	National Rank Lower Quartile	National Target

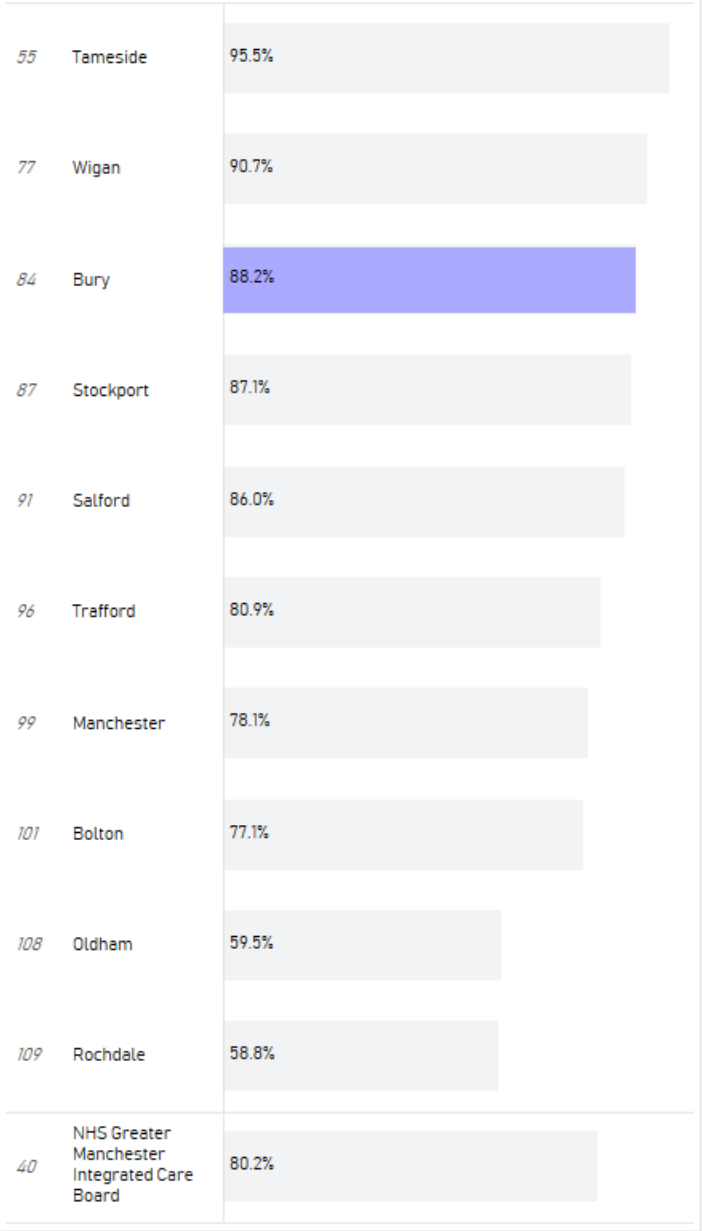
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	40.5%	45.8%	38.5%	48.7%	56.4%	64.3%	70.3%	61.9%	70.0%	76.5%	76.7%	85.0%
2023-24	83.3%	87.0%	91.5%	95.1%	92.7%	96.7%	91.7%	92.9%	96.7%	93.8%	94.1%	96.9%
2024-25	94.7%	97.4%	93.2%	90.5%	87.8%	88.0%	93.5%	93.9%	86.7%	88.2%		

Selected measure at January 2025 has continuously increased for 1 period(s) of time

Latest Value GM Benchmarking
National Rank against other localities



Narrative

- The percentage of patients that wait 6 weeks or less from referral to entering IAPT treatment in Jan 25 is 88.2%, which is a decrease on Jan 24 which was 93.8%.
- Bury is currently higher than the GM percentage of 80.2% and has the 3rd highest percentage of the GM localities.
- Both Bury and GM are above the National Target of 75%

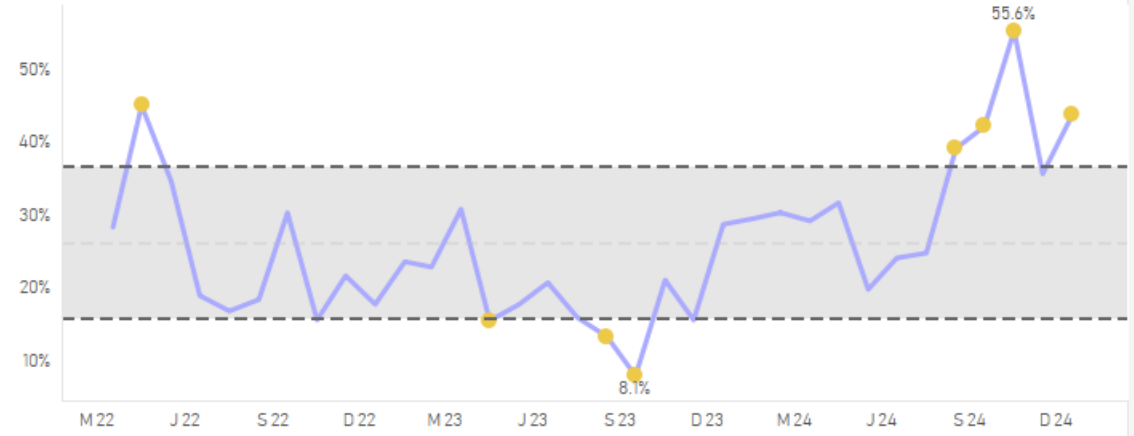
Bury

Talking Therapies: Second Treatment Waits
The proportion of people that waited more than 90 days from their first treatment appointment to their second treatment appointment.

Source: Improving Access to Psychological Therapies Data Set (Monthly)

44.0%	35.9%	89/107	10.%
January 2025	December 2024	National Rank Lower Quartile	National Target

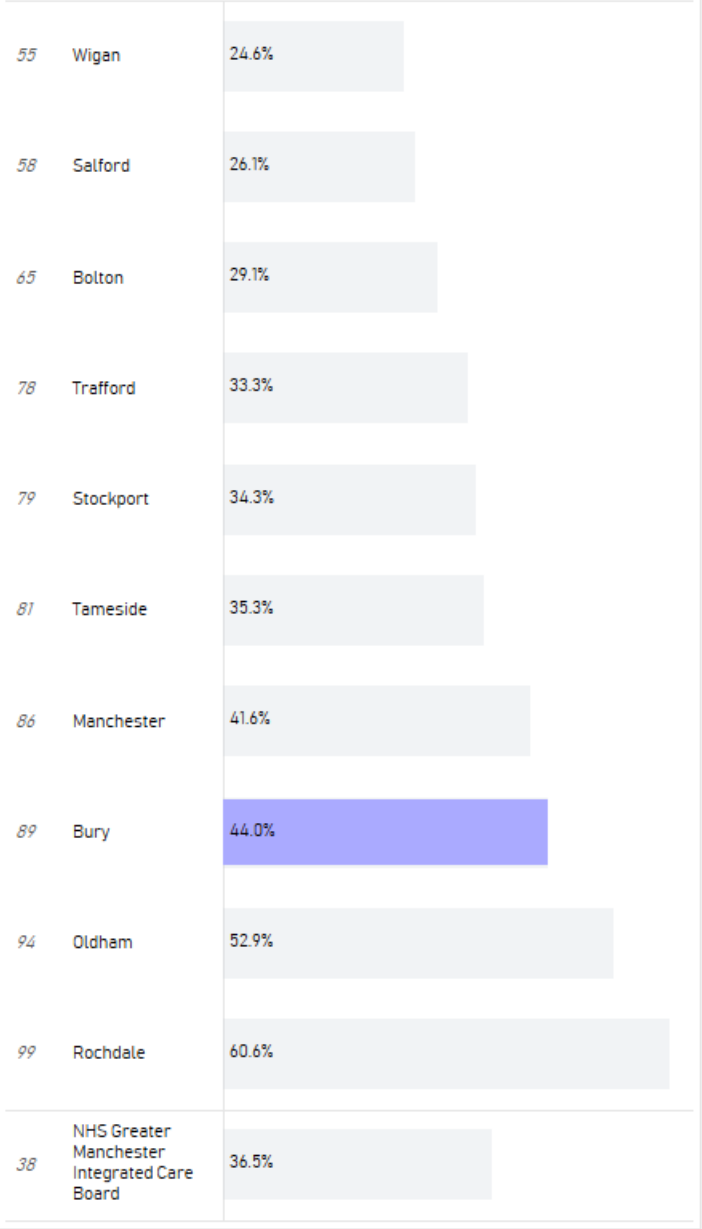
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	28.6%	45.3%	34.9%	19.1%	17.0%	18.6%	30.6%	15.8%	21.9%	17.9%	23.8%	23.1%
2023-24	31.0%	15.7%	17.9%	20.9%	16.1%	13.5%	8.1%	21.3%	15.8%	28.9%	29.7%	30.6%
2024-25	29.4%	31.9%	20.0%	24.3%	25.0%	39.4%	42.4%	55.6%	35.9%	44.0%		

Selected measure at January 2025 has continuously **increased** for **1** period(s) of time

Latest Value GM Benchmarking
National Rank against other localities



Narrative

- The percentage of patients that waited less than 90 days from first appt to second appt in Jan 25 is 44%, which is an increase on Jan 24 which was 28.9%.
- Bury is currently higher than the GM percentage of 36.5% and has the 3rd highest percentage of the GM localities.
- Both Bury and GM are above the National Target of 10%

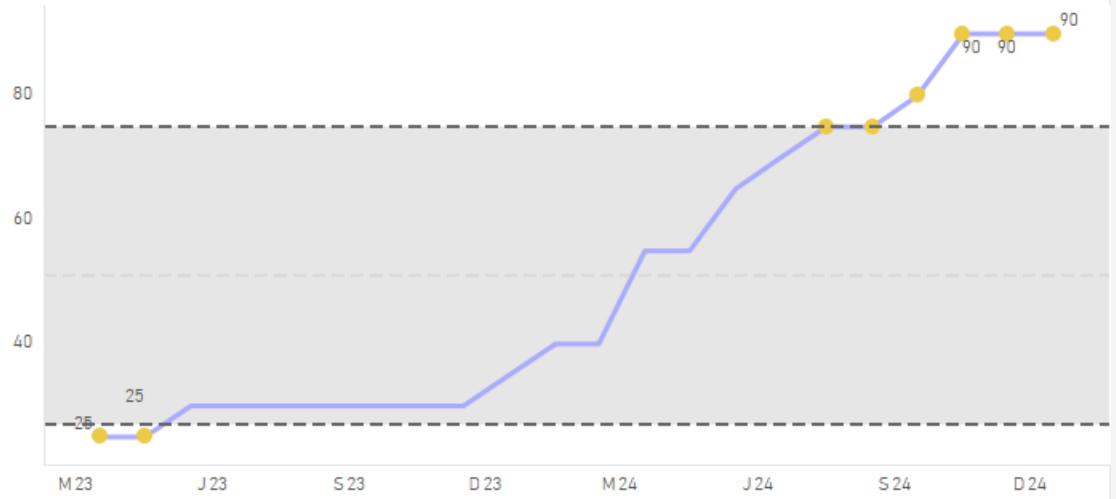
Bury

Access to Individual Placement and Support Services - Mental Health Patients
Access to Individual Placement and Support Services

Source: Published MHSDS (Monthly)

90	90	88/106	257.5
January 2025	December 2024	National Rank Lower Quartile	National Median

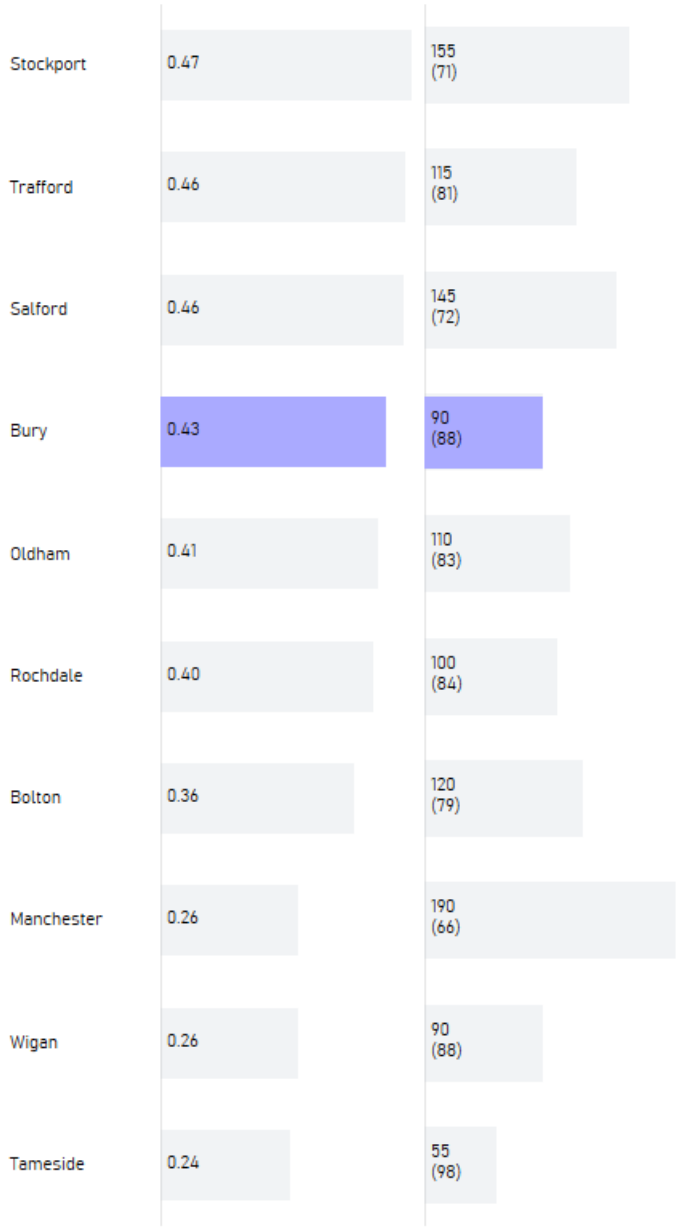
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023-24	25	25	30	30	30	30	30	30	30	35	40	40
2024-25	55	55	65	70	75	75	80	90	90	90		

Selected measure at January 2025 has continuously for **2** period(s) of time

Latest Value GM Benchmarking
Rate Per 1000 / Count (National Rank)



Narrative

- The Access to individual placement & Support Services has remained at 90 in Jan 25, this is higher than Jan 24, when figures show 35 patients.
- Bury is currently at 0.43 rate per 1000 and has the 4th highest percentage of the GM localities.

Bury

% of CHC referrals completed within 28 days
Percentage of referrals completed (including discounted referrals) within 28 Days

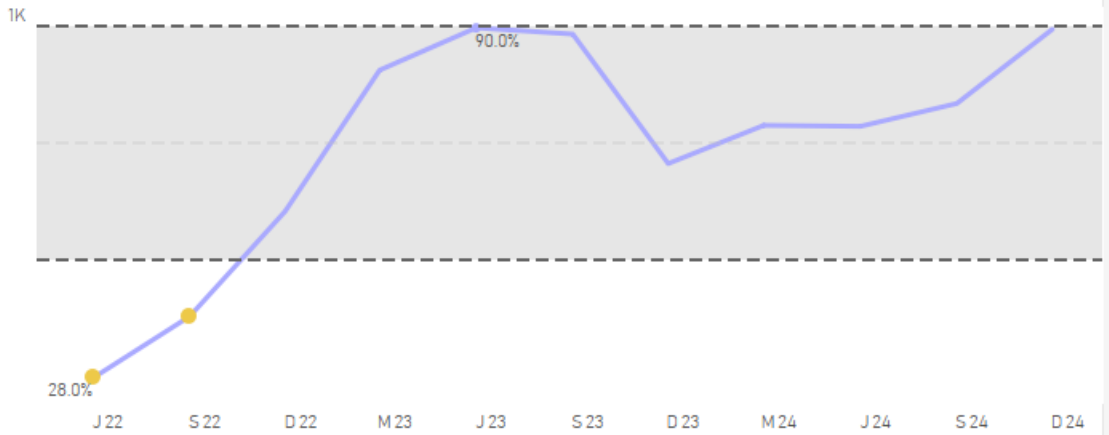
Source: Continuing Healthcare and NHS-funded Nursing Care quarterly published figures (Quarterly)

89.7%
December 2024

76.6%
September 2024

37/106
National Rank
Inter Quartile

Outliers more than 1 standard deviation from the mean

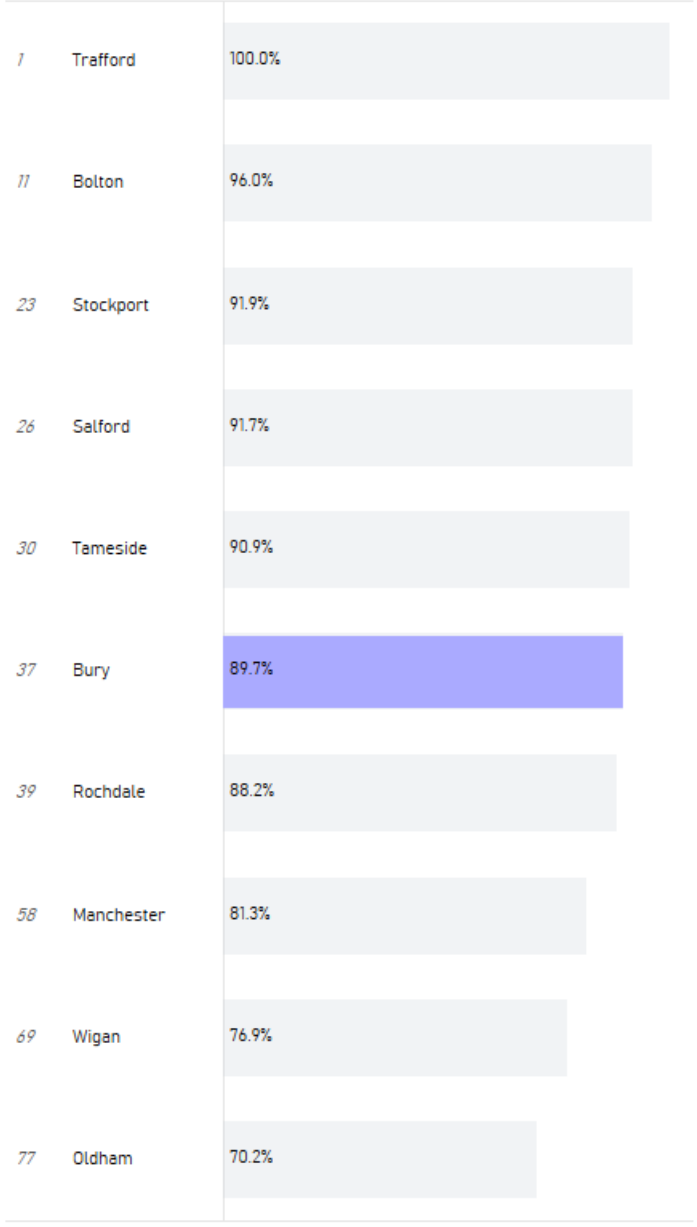


	Jun	Sep	Dec	Mar
2022-23	28.0%	38.9%	57.5%	82.5%
2023-24	90.0%	88.9%	66.0%	72.7%
2024-25	72.5%	76.6%	89.7%	

Selected measure at December 2024 has continuously increased for **2** period(s) of time

Latest Value GM Benchmarking

National Rank against other localities



Narrative

- The percentage of CHC referrals completed within 28 days is 89.7% in Dec 24 which is an increase on Dec 23 which was 66.0%.
- Bury is currently the 6th highest percentage of the GM localities.

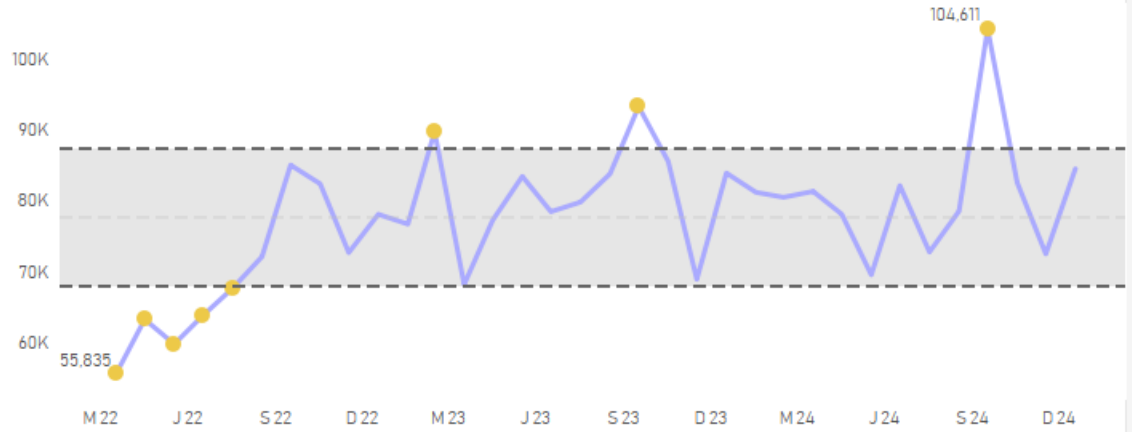
Bury

Appointments in general practice
Planned number of general practice appointments as per
https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice

Source: Appointments in General Practice (Monthly)

84,833	72,795	97/106	207,433
January 2025	December 2024	National Rank Lower Quartile	National Median

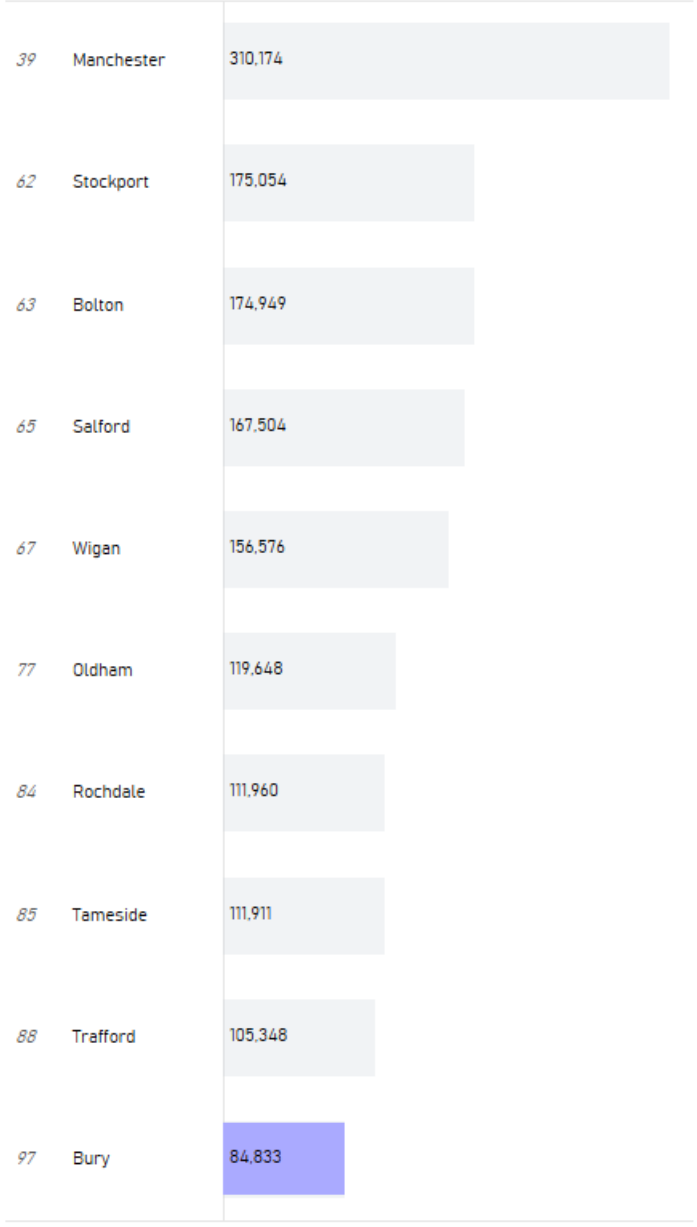
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	55,835	63,543	60,045	64,085	67,914	72,403	85,358	82,715	72,980	78,396	77,007	90,092
2023-24	68,473	77,574	83,761	78,766	80,123	84,117	93,632	85,880	69,195	84,232	81,509	80,803
2024-25	81,636	78,407	69,836	82,456	73,064	78,846	104,611	82,872	72,795	84,833		

Selected measure at January 2025 has continuously increased for 1 period(s) of time

Latest Value GM Benchmarking
National Rank against other localities



Narrative

- The planned number of GP appointments in Jan 25 is 84,833 which is an increase on Dec 24 when there were 72,795.
- This is also an increase on Jan 24 when there were 84,232 appointments.
- **NB This benchmark graph is an inaccurate representation of performance as it is absolute numbers and Bury is the smallest borough. This is being investigated by BI colleagues.**
- This includes all types of appointments, including Face to Face, Home visits, telephone etc

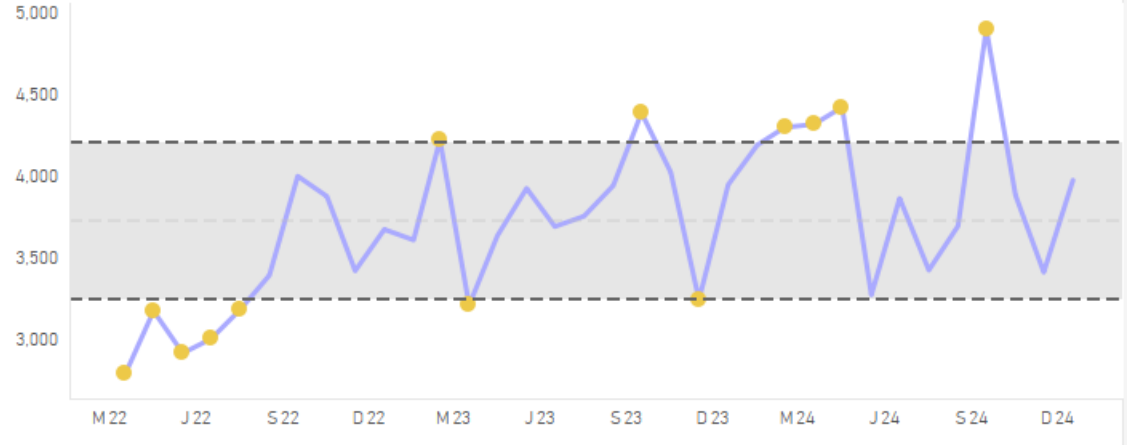
Bury

Number of GP appointments per 10,000 weighted patients
Number of general practice appointments per 10,000 weighted patients

Source: Appointments in General Practice (Monthly)

398.8	342.2	104/106	517.2
January 2025	December 2024	National Rank Lower Quartile	National Median

Outliers more than 1 standard deviation from the mean

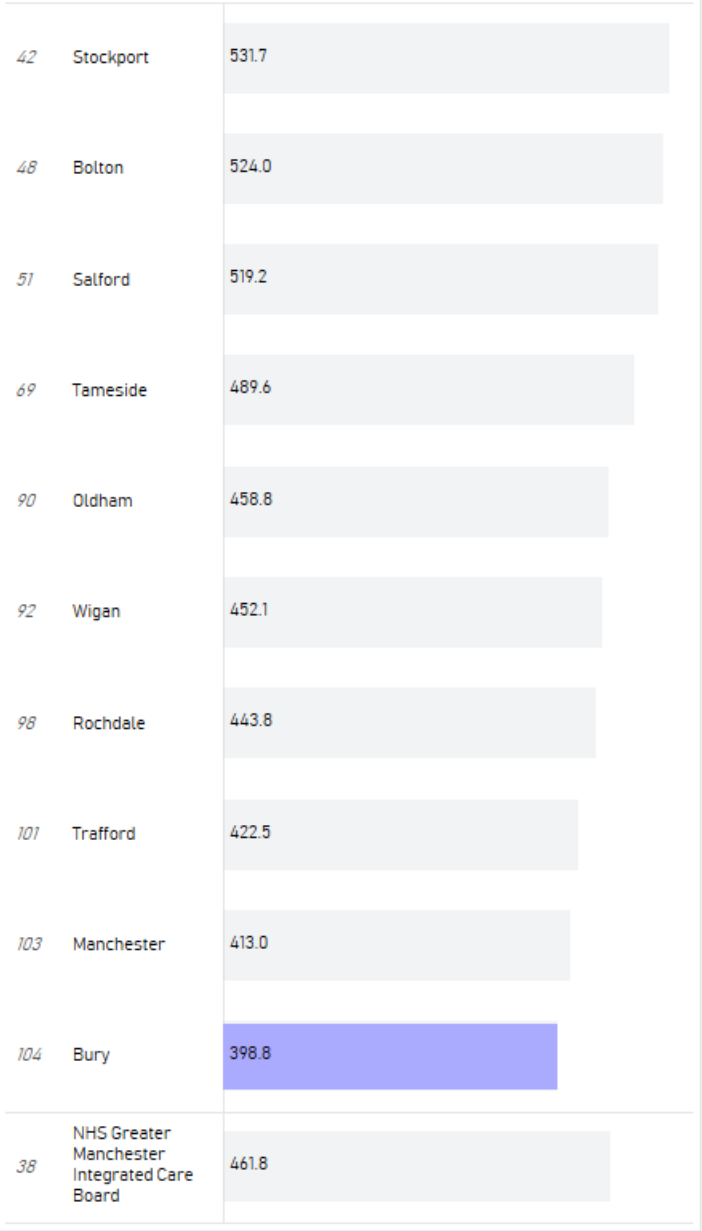


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	279.7	318.4	292.5	301.3	319.3	340.4	401.3	388.8	343.1	368.5	362.0	423.5
2023-24	321.9	364.7	393.8	370.3	376.7	395.4	440.2	403.7	325.3	396.0	420.5	431.2
2024-25	433.1	443.7	328.3	387.6	343.5	370.7	491.8	389.6	342.2	398.8		

Selected measure at January 2025 has continuously increased for 1 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities



Narrative

- The number of GP appointments per 10,000 weighted patients is 398.8 in Jan 25 which is an increase on Dec 24 when there were 342.2.
- This is also an increase in Jan 24 when there were 396.0 appointments.
- Bury is currently ranked the lowest of the GM localities and is lower than the overall GM position.

Bury

Number of prescriptions dispensed per 1000 patients
Number of prescriptions dispensed per 1000 patients

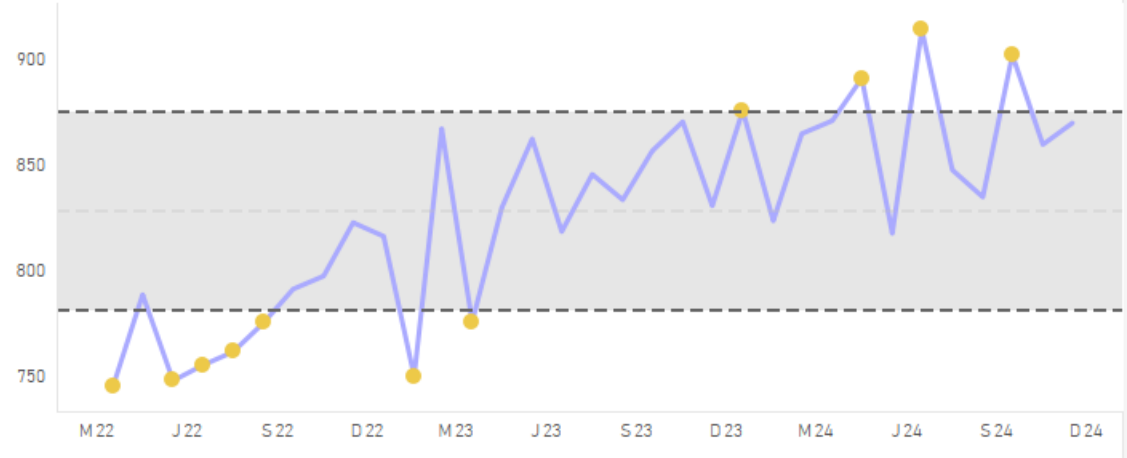
Source: Patient Level Prescribing Data (Monthly)

870.8
December 2024

860.7
November 2024

112/119
National Rank
Lower Quartile

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	746.7	789.8	749.2	756.5	762.9	776.6	792.5	798.6	823.8	817.4	751.3	868.2
2023-24	777.0	830.8	863.4	819.6	846.6	834.6	857.7	871.4	831.8	876.7	824.7	865.8
2024-25	871.9	891.9	818.8	915.0	848.7	835.9	903.0	860.7	870.8			

Selected measure at December 2024 has continuously **increased** for **1** period(s) of time

Latest Value GM Benchmarking

National Rank against other localities

Narrative

- The Number of prescriptions per 1000 patients in Dec 24 is 870.8 which is an increase on Nov 24 when there were 860.7
- This is also an increase from Dec 23 when there were 831.8
- Bury is currently ranked the 4th best of the GM localities but is higher than the GM position of 885.

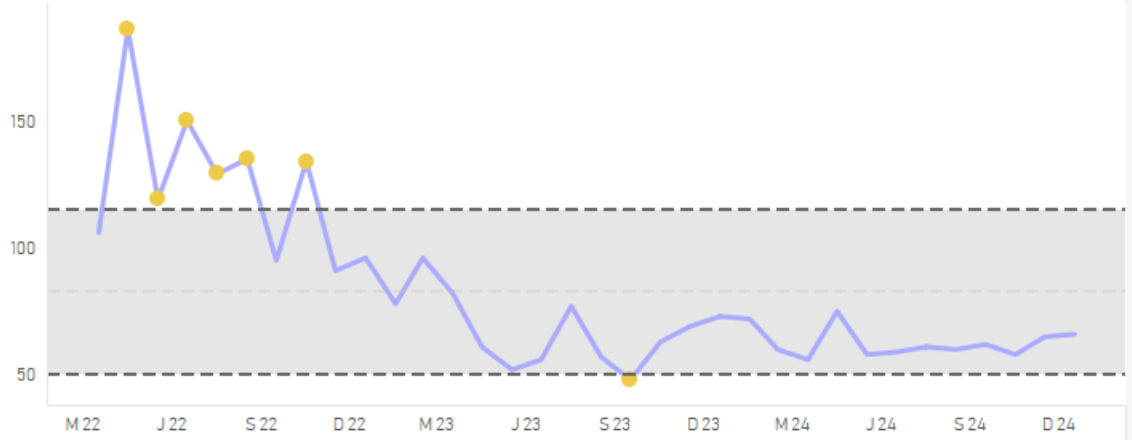
Bury

Number of extended access appointments
Number of extended access appointments

Source: Appointments in General Practice (Monthly)

67	66	104/106
January 2025	December 2024	National Rank Lower Quartile

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	107	187	120	151	130	136	96	135	92	97	79	97
2023-24	83	62	53	57	78	58	49	64	70	74	73	61
2024-25	57	76	59	60	62	61	63	59	66	67		

Selected measure at January 2025 has continuously increased for **2** period(s) of time

Latest Value GM Benchmarking
National Rank against other localities

Narrative

- The Number of extended access appointments in Jan 25 is 67 which is an increase from Dec 24 when there were 66.
- There is a decrease from Jan 24 when there were 74.
- Bury is currently ranked the lowest of the GM localities.
- **NB This benchmark graph is an inaccurate representation of performance as it is absolute numbers and Bury is the smallest borough. This is being investigated by BI colleagues.**

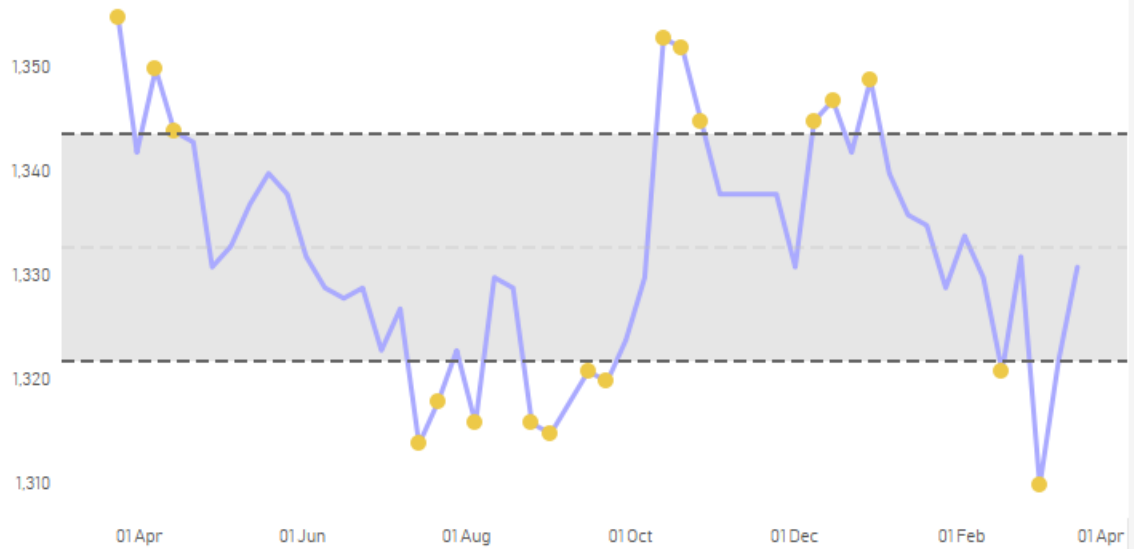
Bury

Number of people in Care Homes
The number of people currently residing in a Care Home at the end of the period

Source: NECS Capacity Tracker (Weekly)

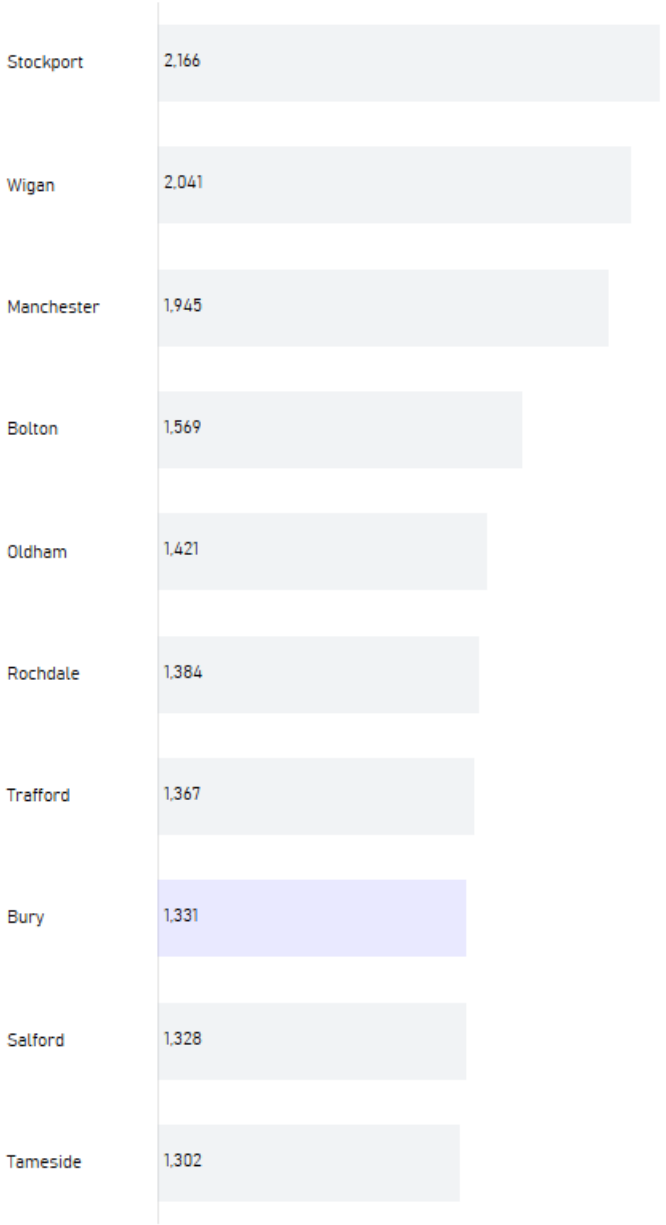
1,331	1,322
16 Mar	09 Mar

Outliers more than 1 standard deviation from the mean



29 Dec	05 Jan	12 Jan	19 Jan	26 Jan	02 Feb	09 Feb	16 Feb	23 Feb	02 Mar	09 Mar	16 Mar
1,349	1,340	1,336	1,335	1,329	1,334	1,330	1,321	1,332	1,310	1,322	1,331

Latest Value GM Benchmarking
Rank against other localities



Narrative

- The Number of people in Care Homes for the week of 16th Mar 25 is 1,331, which is an increase on 9th march when there were 1322.
- Bury is currently ranked the 3rd lowest of the GM localities.

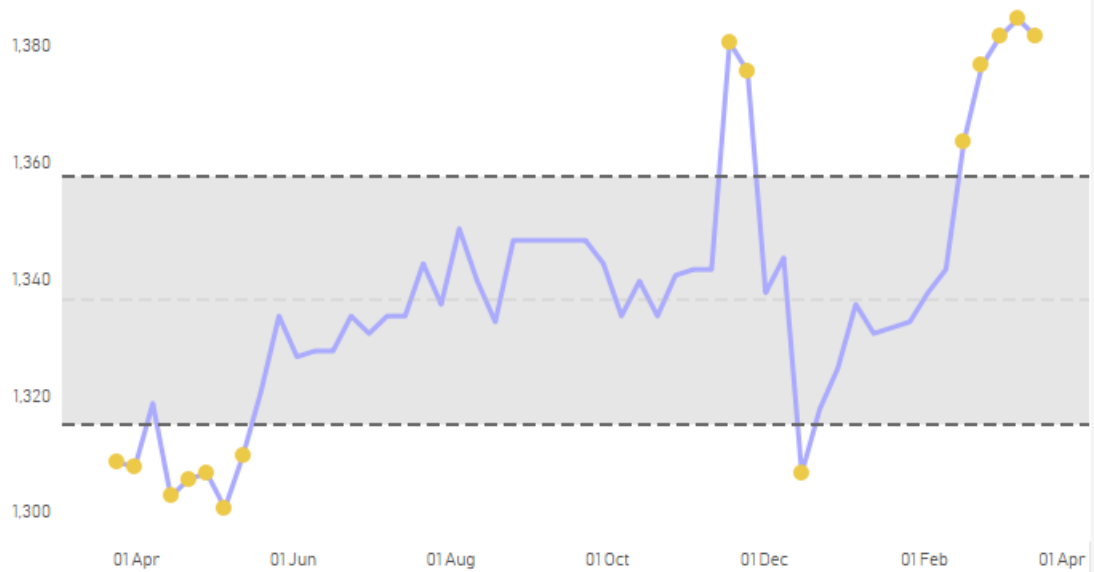
Bury

Number of people in Home Care
The number of people currently receiving Home Care at the end of the period

Source: NECS Capacity Tracker (Weekly)

1,382	1,385
March 2025	March 2025

Outliers more than 1 standard deviation from the mean



29 Dec	05 Jan	12 Jan	19 Jan	26 Jan	02 Feb	09 Feb	16 Feb	23 Feb	02 Mar	09 Mar	16 Mar
1,325	1,336	1,331	1,332	1,333	1,338	1,342	1,364	1,377	1,382	1,385	1,382

Latest Value GM Benchmarking
Rank against other localities

Narrative

- The Number of people receiving Home care during the week of 16th March 25 is 1,382, which is a Decrease on 9th March when there were 1,385.
- Bury is currently ranked the lowest of the GM localities.
- **NB This benchmark graph is an inaccurate representation of performance as it is absolute numbers and Bury is the smallest borough. This is being investigated by BI colleagues.**

Bury

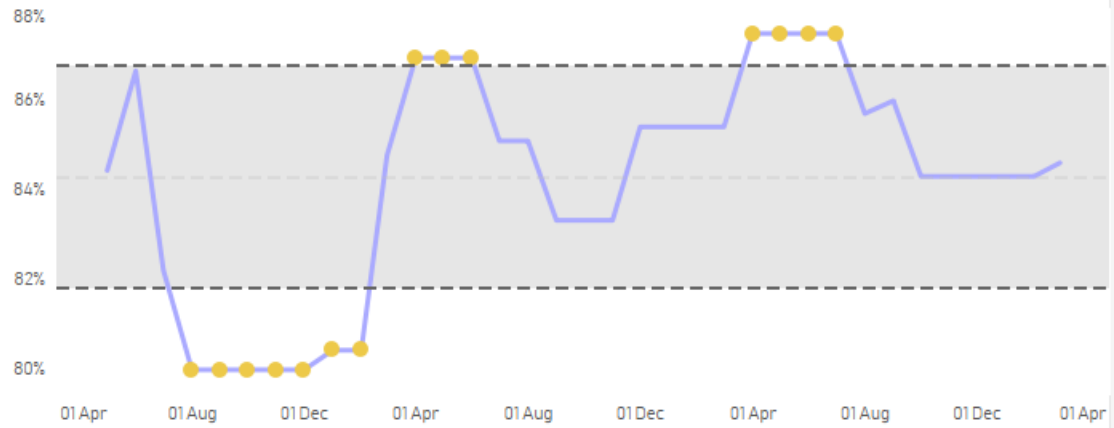
Percentage of Care Homes rated Good or Outstanding
The % of Care Homes rated Good or Outstanding at the end of the period

Source: CQC (Monthly)

84.6%
Feb 25

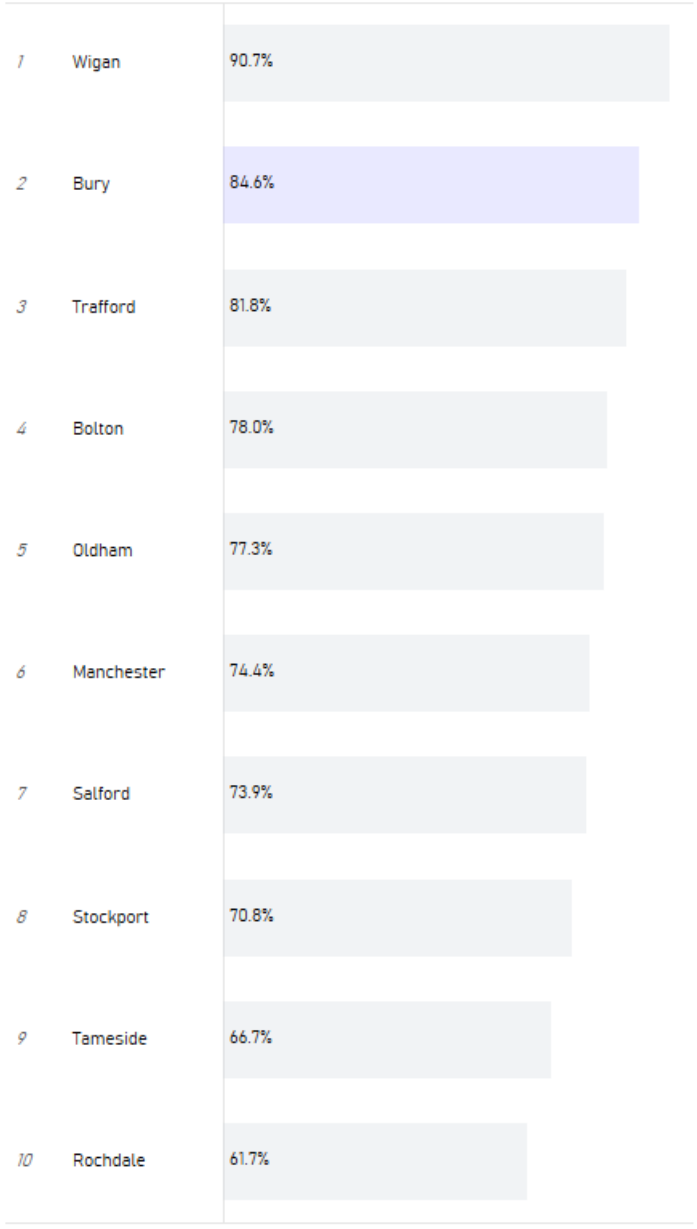
84.3%
Jan 25

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	84.4%	86.7%	82.2%	80.0%	80.0%	80.0%	80.0%	80.0%	80.4%	80.4%	84.8%	87.0%
2023-24	87.0%	87.0%	85.1%	85.1%	83.3%	83.3%	83.3%	85.4%	85.4%	85.4%	85.4%	87.5%
2024-25	87.5%	87.5%	87.5%	85.7%	86.0%	84.3%	84.3%	84.3%	84.3%	84.3%	84.6%	

Latest Value GM Benchmarking
Rank against other localities



Narrative

- The % of Care Home rated Good or Outstanding during Feb 25 is 84.6% which is a slight increase from Jan 25 which was 84.3%
- This is a slight decrease when compared to Feb 24 when the figure was 85.4%
- Bury is currently ranked the 2nd highest of the GM localities.

Bury

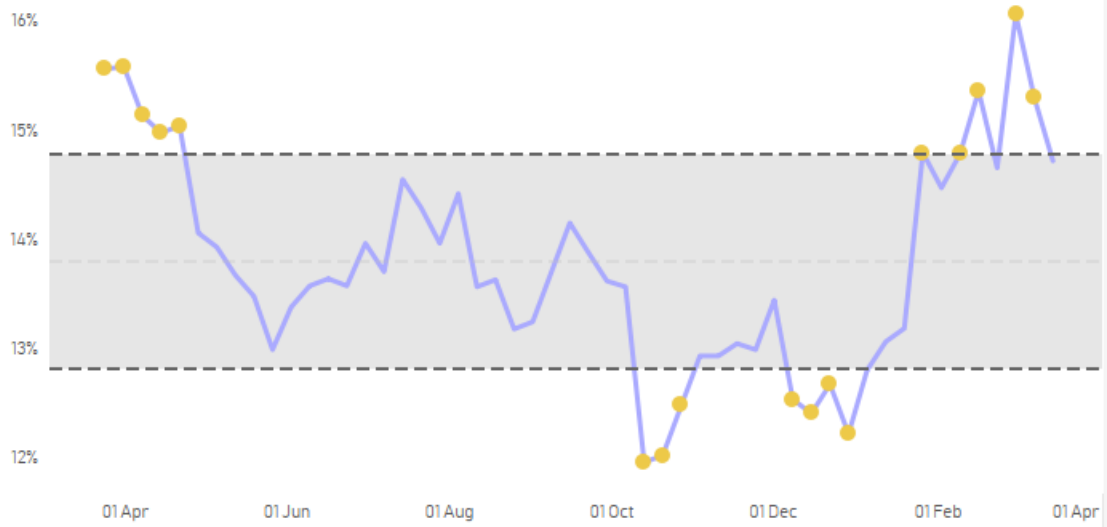
Care home beds vacancy rate
% of care home beds that are vacant

Source: NECS Capacity Tracker (Weekly)

14.7%
16 Mar

15.3%
09 Mar

Outliers more than 1 standard deviation from the mean



29 Dec	05 Jan	12 Jan	19 Jan	26 Jan	02 Feb	09 Feb	16 Feb	23 Feb	02 Mar	09 Mar	16 Mar
12.2%	12.8%	13.1%	13.2%	14.8%	14.5%	14.8%	15.4%	14.7%	16.1%	15.3%	14.7%

Latest Value GM Benchmarking
Rank against other localities

1	Bury	14.7%
2	Trafford	14.0%
3	Rochdale	11.4%
4	Bolton	11.1%
5	Tameside	10.7%
6	Salford	10.4%
7	Manchester	9.8%
8	Wigan	9.7%
9	Oldham	9.6%
10	Stockport	9.0%
1	NHS Greater Manchester Integrated Care Board	10.9%

Narrative

- The % of Care Home that are vacant during the week of 16th Feb is 14.7%, this is a decrease on the previous week when the figures were 15.3%
- Bury is currently ranked the highest of the GM localities. It is also higher than the GM position of 10.9%

PIA Locality Report Product 2

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BURY
INTEGRATED CARE
PARTNERSHIP

Locality Performance Report March 2025

Part of Greater Manchester Integrated Care Partnership

Presentation by:

Bury - Oversight Metrics

Show Definitions

Domain	Code	Measure	Frequency	Date	Latest	Previous	Change	Target/Median	Numerator	Denominator	Quartile
Cancer	N/A	Cancers Diagnosed At Early Stage using Full Registration Data	Annual	Dec 21	53.7%	51.7%	↗	75.0%	514	957	Inter
Mental Health & Learning Disabilities	S030a	% of patients aged 14+ with a completed LD health check	Monthly	Jan 25	63.7%	52.1%	↗	75.%	737	1,157	Inter
	EH09	Access to Children and Young Peoples Mental Health Services	Monthly	Jan 25	3,485	3,525	↘	5,495	N/A	N/A	Lower
	EAS01	Dementia: Diagnosis Rate (Aged 65+) (monthly performance)	Monthly	Jan 25	75.0%	75.4%	↘	66.7%	1,821	2,428	Upper
	S086a	Inappropriate adult acute mental health Out of Area Placement (OAP) bed days (rolling 3 month total)	Monthly	Mar 24	635	685	↘	0	N/A	N/A	Inter
	N/A	Number of MH patients with no criteria to reside - number of beds occupied by mental health patients who are ready to be discharged	Monthly	Feb 25	12	14	↘	N/A	N/A	N/A	Lower
	N/A	Percentage of MH patients with no criteria to reside (NCTR)	Monthly	Feb 25	14.6%	16.5%	↘	N/A	12	82	Lower
	S110a	Overall Access to Community MH Services for Adults and Older Adults with Severe Mental Illnesses	Monthly	Jan 25	1,830	1,770	↗	3,738	N/A	N/A	Lower
	S081a	Talking Therapies: Access Rate	Monthly	Jan 25	235	190	↗	N/A	N/A	N/A	Lower
	S131a	Women Accessing Specialist Community Perinatal Mental Health Services	Quarterly	Jan 25	200	200	→	N/A	N/A	N/A	Lower
	S125a	Long length of stay for adults (60+ days)	Monthly	Jan 25	33.3%	50.0%	↘	0.%	15	45	Inter
Primary Care	S053b	% of hypertension patients who are treated to target as per NICE guidance	Annual	Mar 23	66.6%	54.7%	↗	77.%	19,957	29,979	Lower
	S053c	% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins	Quarterly	Sep 24	63.1%	63.3%	↘	62.2%	6,745	10,685	Inter
	S129a	GP appointments - percentage of regular appointments within 14 days	Monthly	Jan 25	78.8%	77.5%	↗	82.4%	66,890	84,833	Lower
Quality	S042a	E. coli blood stream infections	Monthly	Jan 25	158	150	↗	N/A	N/A	N/A	Upper
	S044a	Antimicrobial resistance: total prescribing of antibiotics in primary care	Monthly	Dec 24	80.0%	81.7%	↘	87.1%	N/A	N/A	Upper
	S044b	Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care	Monthly	Dec 24	5.8%	5.8%	↘	10.%	6,228	107,571	Upper
	S037A	% of patients describing their overall experience of making a GP appointment as good	Annual	Mar 23	71.4%		→	73.9%	N/A	N/A	N/A

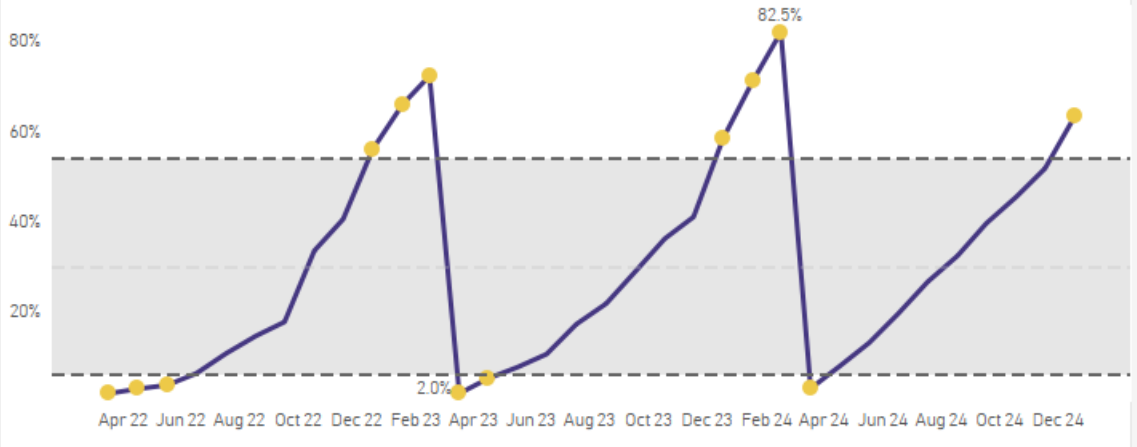
Bury

% of patients aged 14+ with a completed LD health check
The % of people on the QOF Learning Disability Register who received an annual health check between the start of the financial year and the end of the reporting period

Source: Learning Disabilities Health Check Scheme (Monthly)

63.7%	52.1%	39/106	75.%
January 2025	December 2024	National Rank Inter Quartile	National Target

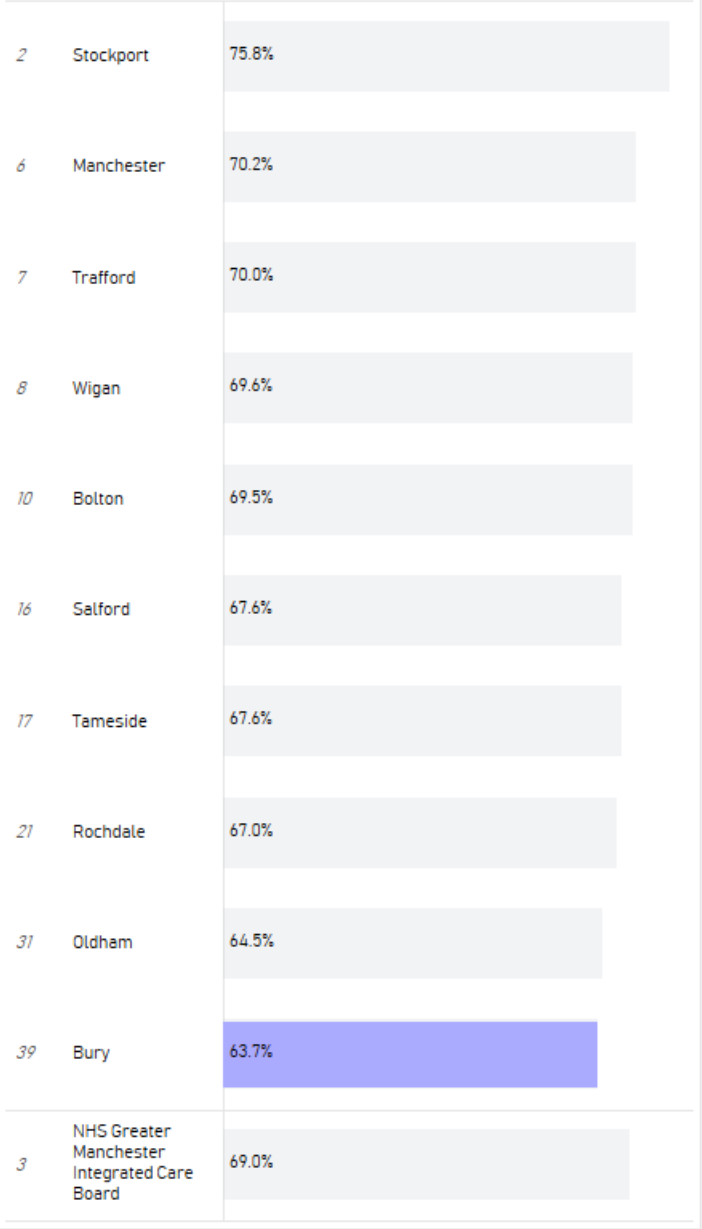
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	2.0%	3.1%	3.9%	6.5%	10.9%	14.8%	18.0%	33.8%	40.8%	56.4%	66.4%	72.7%
2023-24	2.0%	5.4%	7.9%	10.8%	17.5%	22.0%	29.1%	36.5%	41.3%	58.9%	71.7%	82.5%
2024-25	3.2%	8.1%	13.3%	19.8%	26.9%	32.7%	39.9%	45.8%	52.1%	63.7%		

Selected measure at January 2025 has continuously increased for 9 period(s) of time

Latest Value GM Benchmarking
National Rank against other localities



Narrative

- The percentage of patients aged 14+ having received an LD health check in Jan 25 is 63.7%, which is an increase on Jan 24 which was 58.9%.
- Bury is currently reporting lower than the GM percentage of 63.7% and currently has the lowest percentage of the GM localities.
- However, for the last 2 years Bury has delivered the majority of annual health checks in the months Jan to March and our relative performance is expected to improve.

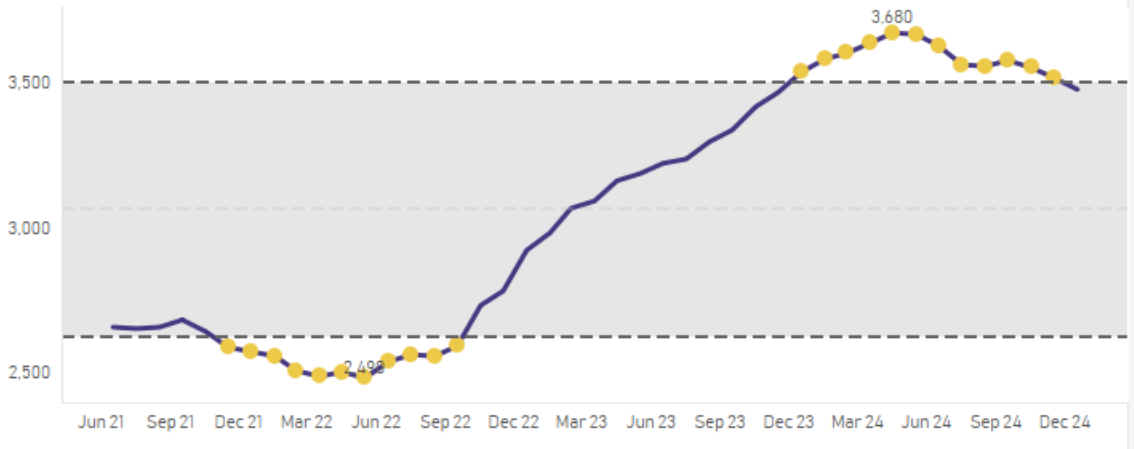
Bury

Access to Children and Young Peoples Mental Health Services
Access to Children and Young Peoples Mental Health Services

Source: Published MHSDS (Monthly)

3,485	3,525	83/106	5,495
January 2025	December 2024	National Rank Lower Quartile	National Median

Outliers more than 1 standard deviation from the mean

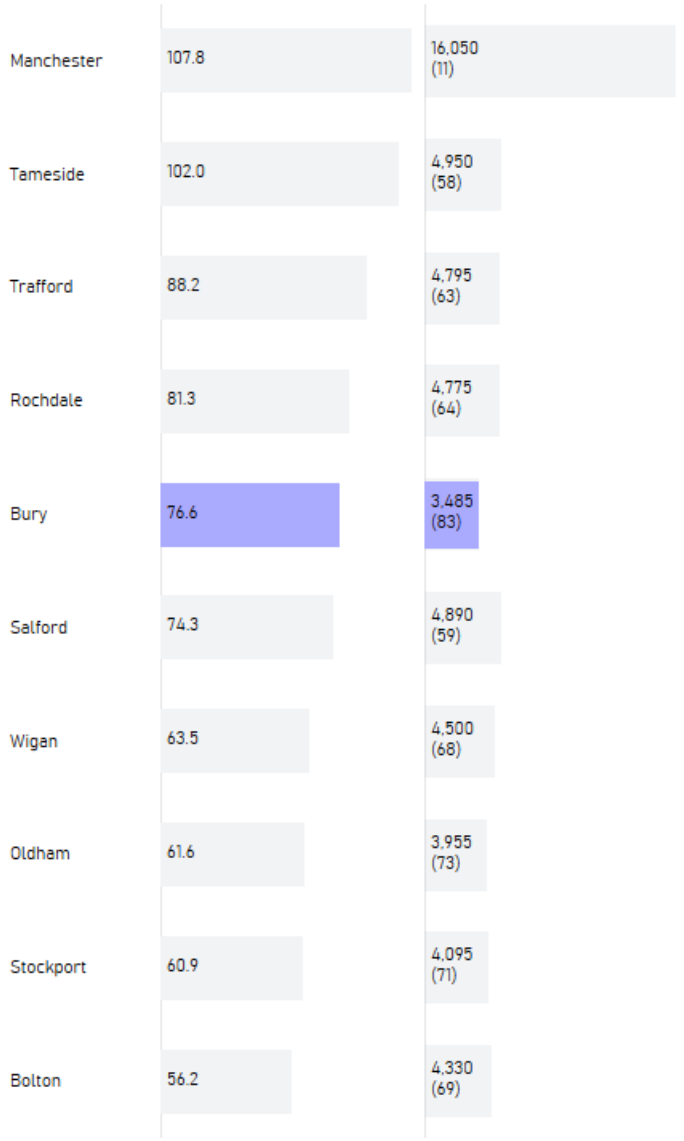


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22				2,665	2,660	2,665	2,690	2,650	2,595	2,580	2,565	2,515
2022-23	2,495	2,510	2,490	2,545	2,570	2,565	2,600	2,740	2,790	2,930	2,990	3,075
2023-24	3,100	3,170	3,195	3,230	3,245	3,305	3,345	3,425	3,475	3,545	3,590	3,610
2024-25	3,645	3,680	3,675	3,635	3,570	3,565	3,585	3,560	3,525	3,485		

Selected measure at January 2025 has continuously **decreased** for **3** period(s) of time

Latest Value GM Benchmarking

Rate per 1000 / Count (National Rank based on count)



The rate is calculated using the 0-17 registered population figure for each locality | Bury: 45,310

Narrative

- There were 3485 accesses to Children and Young Peoples Mental Health Services for Bury registered patients in Jan 25, lower than Jan 24(3545).
- Bury currently has 76.6 accesses made per 1000 population and has the 5th highest rate per 1000 for localities within GM.

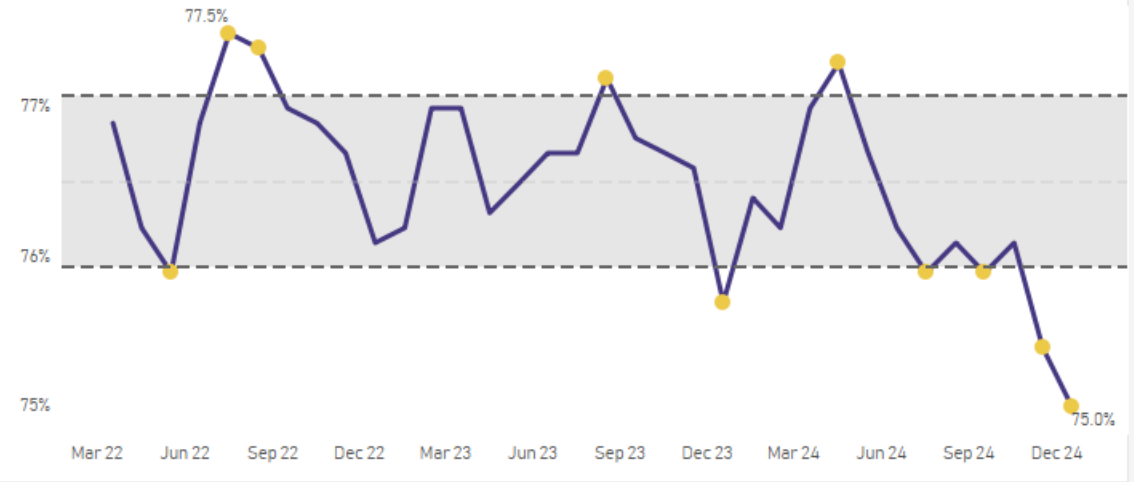
Bury

Dementia: Diagnosis Rate (Aged 65+)
Diagnosis rate for people aged 65 and over, with a diagnosis of dementia recorded in primary care, expressed as a percentage of the estimated prevalence based on GP registered populations.

Source: Primary Care Dementia Data (Monthly)

75.0%	75.4%	11/106	66.7%
January 2025	December 2024	National Rank Upper Quartile	National Target

Outliers more than 1 standard deviation from the mean

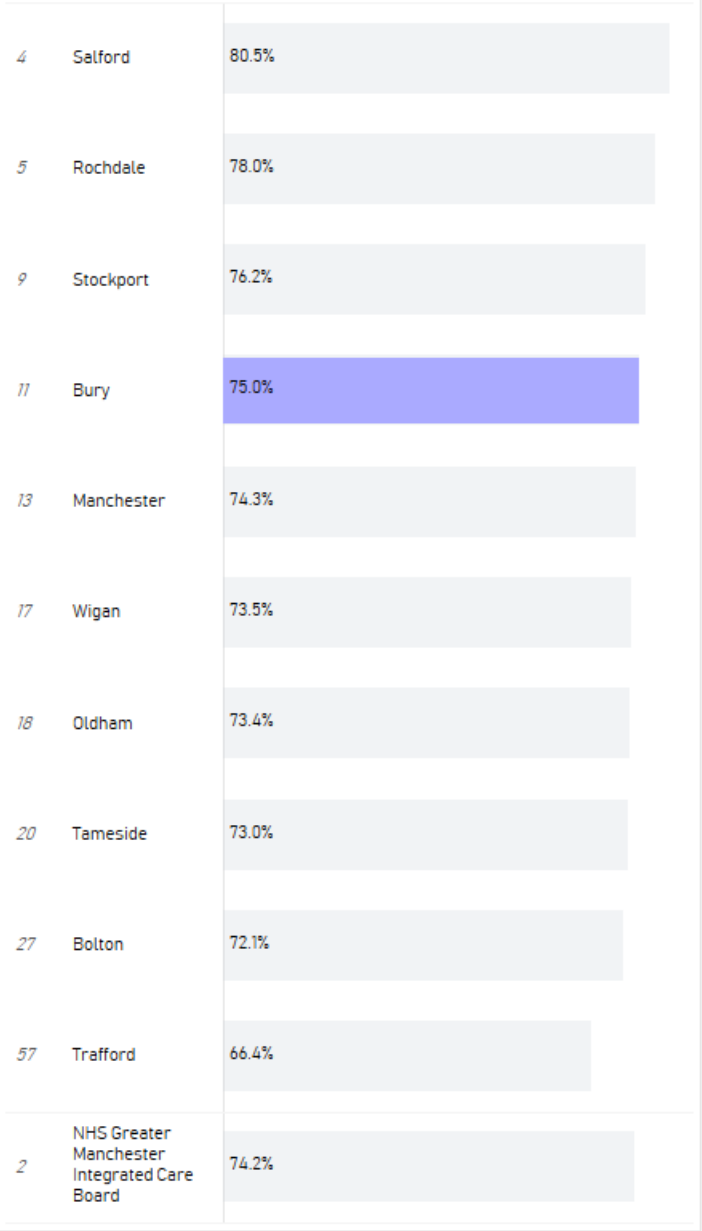


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	76.9%	76.2%	75.9%	76.9%	77.5%	77.4%	77.0%	76.9%	76.7%	76.1%	76.2%	77.0%
2023-24	77.0%	76.3%	76.5%	76.7%	76.7%	77.2%	76.8%	76.7%	76.6%	75.7%	76.4%	76.2%
2024-25	77.0%	77.3%	76.7%	76.2%	75.9%	76.1%	75.9%	76.1%	75.4%	75.0%		

Selected measure at January 2025 has continuously **decreased** for **2** period(s) of time

Latest Value GM Benchmarking

National Rank against other localities



Narrative

- The percentage of patients aged 65+ having received a dementia diagnosis as of Jan 25 is 75%.
- In Jan 25 Bury has a higher diagnosis rate than GM which has a rate of 74.2%. Bury has the 4th highest dementia diagnosis rate of the GM localities.
- Bury and GM are both above the national target of 66.7%.

Bury

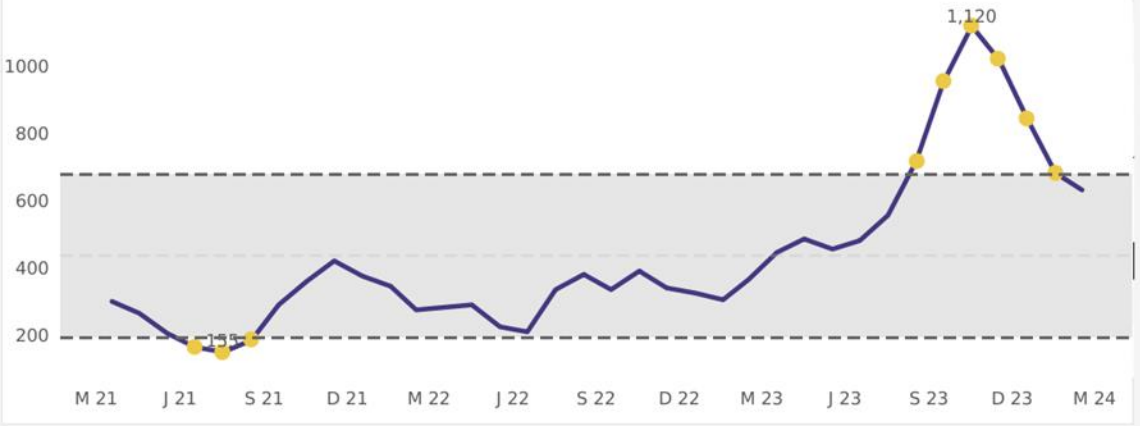
Inappropriate adult acute mental health Out of Area Placement (OAP) bed days

Number of inappropriate OAP bed days for adults that are either 'internal' or 'external' to the sending provider

Source: Out of Area Placements in Mental Health Services Official Statistics (Monthly)

635	685	79/107	0
March 2024	February 2024	National Rank Inter Quartile	National Target

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	305	270	210	170	155	190	295	365	425	380	350	280
2022-23		295	230	215	340	385	340	395	345	330	310	370
2023-24	450	490	460	485	560	720	955	1,120	1,020	845	685	635

Selected measure at March 2024 has continuously decreased for 4 period(s) of time

Latest Value GM Benchmarking

Rate per 1000 | Count (National rank)

1	Salford	0.90	290 (54)
2	Bolton	1.54	515 (73)
3	Trafford	1.88	470 (67)
4	Tameside	2.17	495 (71)
5	Stockport	2.40	790 (87)
6	Bury	2.99	635 (79)
7	Wigan	3.01	1,060 (91)
8	Rochdale	3.75	945 (88)
9	Oldham	4.94	1,330 (95)
10	Manchester	6.01	4,515 (105)

The rate is calculated using the registered population figure for each locality | Bury: 212,567212,721

Narrative

- Displayed data is latest published data available on Curator Locality Report v2, but only covers to March 24.
- This indicator is subject to daily review and for the last 5 months Bury has had either zero or occasionally 1 OAP placement.

Bury

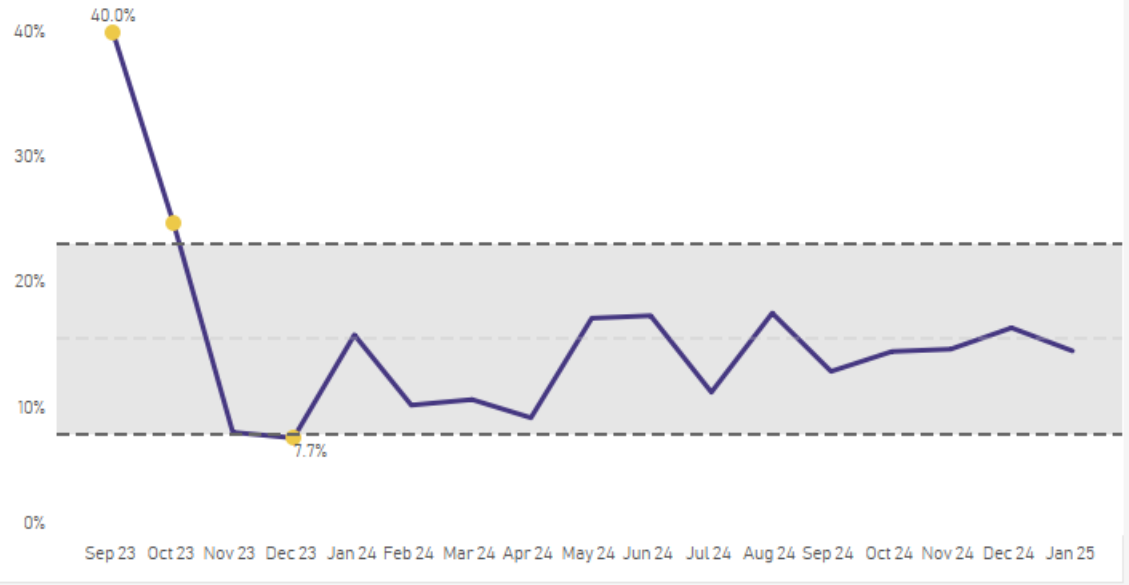
Percentage of MH patients with no criteria to reside (NCTR)
Percentage of beds occupied by MH patients who are ready to be discharged

Source: GM Admissions - Local (Monthly)

14.6%
February 2025

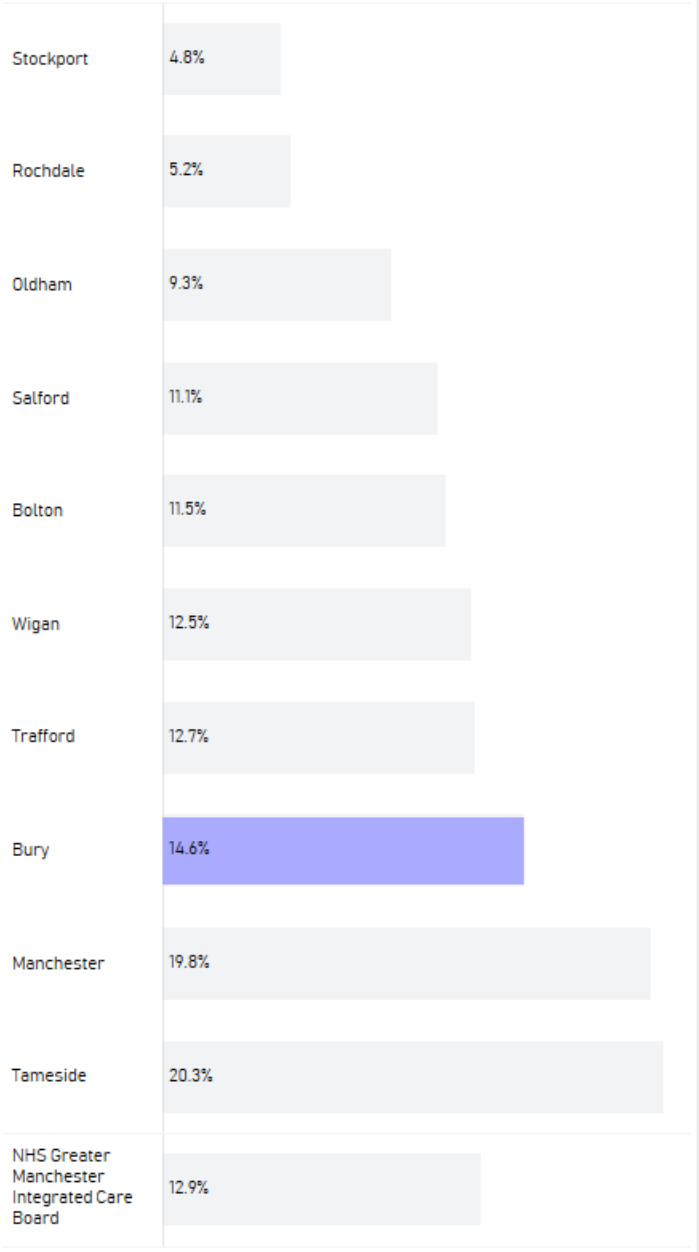
16.5%
January 2025

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023-24							40.0%	24.7%	8.1%	7.7%	15.9%	10.3%
2024-25	10.8%	9.3%	17.2%	17.4%	11.3%	17.6%	13.0%	14.6%	14.8%	16.5%	14.6%	

Latest Value GM Benchmarking



Narrative

- The percentage of mental health patients with NCTR as of Feb 25 is 14.6%, which is a decrease from Feb 24 which was 15.9%
- Bury currently has a higher percentage than GM which is 12.9%.
- Bury has the 3rd highest percentage rate of the GM localities.

Bury

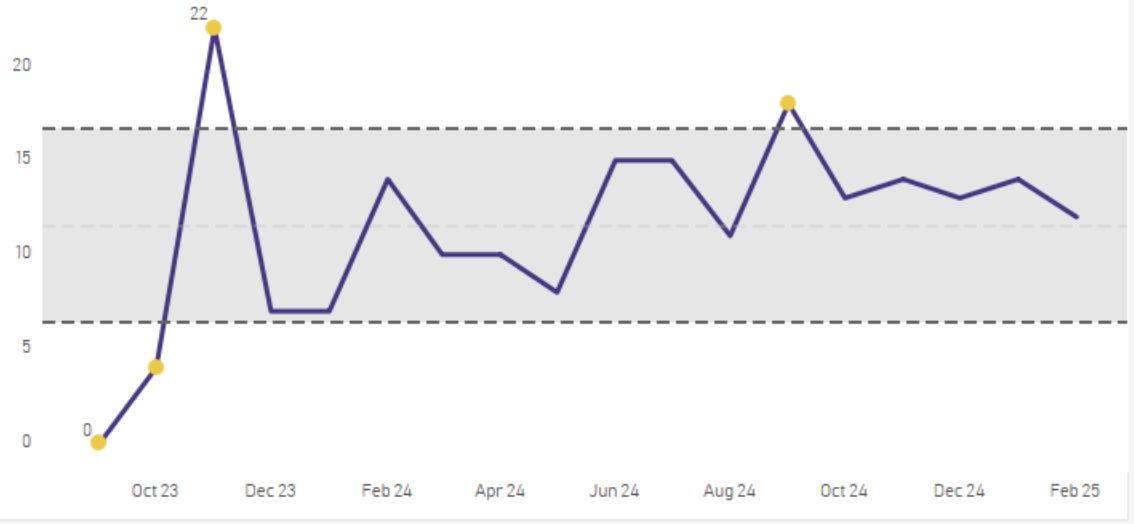
Number of MH patients with no criteria to reside (NCTR)
Number of beds occupied by MH patients who are ready to be discharged

Source: GM Admissions - Local (Monthly)

12
February 2025

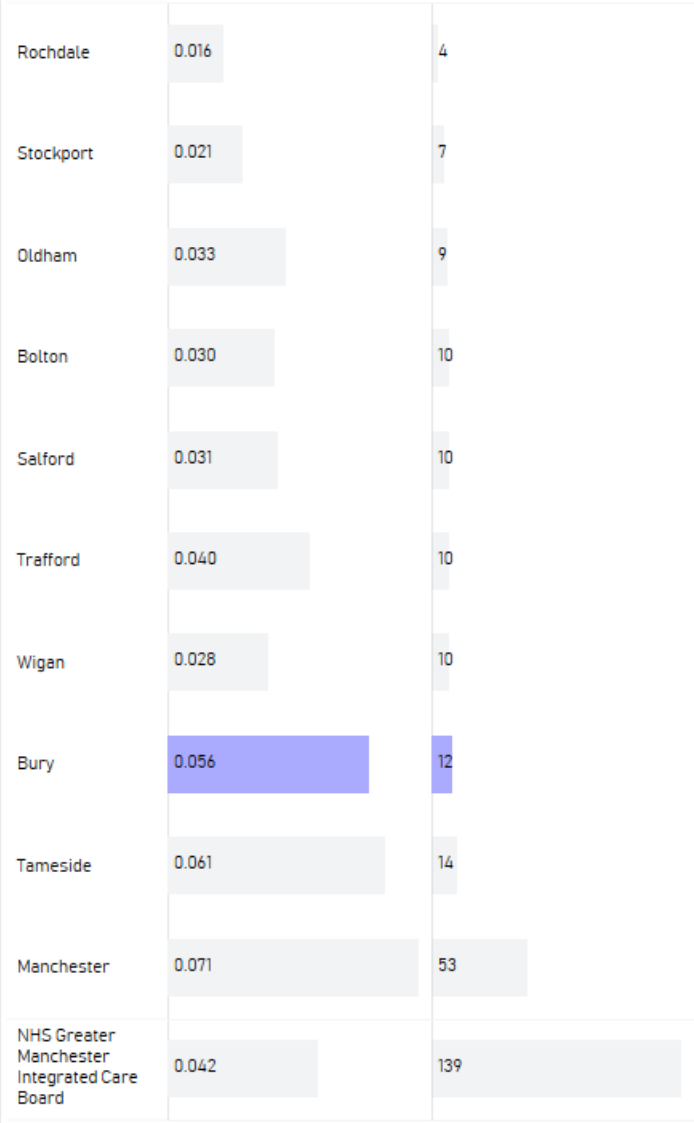
14
January 2025

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023-24						0	4	22	7	7	14	10
2024-25	10	8	15	15	11	18	13	14	13	14	12	

Latest Value GM Benchmarking
Rate per 1000 / Count



The rate is calculated using the registered population figure for each locality | Bury: 212,567212,721

Narrative

- This metric is subject to daily review.
- The number of mental health patients with NCTR as of Feb 25 is 12, which is lower than the figure for Feb 24 which was 14
- Bury currently has 0.056 mental health patients with NCTR per 1000 population and has the 3rd highest rate in locality within GM.

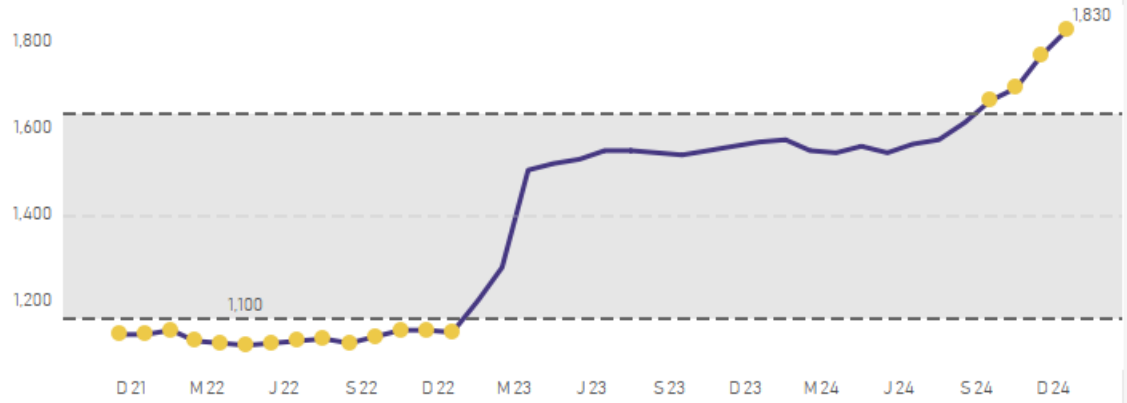
Bury

Overall Access to Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses
Number of people who receive two or more contacts from NHS or NHS commissioned community mental health services (in transformed and non-transformed PCNs) for adults and older adults with severe mental illnesses, in a rolling 12 month period

Source: Published MHSDS (Monthly)

1,830	1,770	84/106	3,738
January 2025	December 2024	National Rank Lower Quartile	National Median

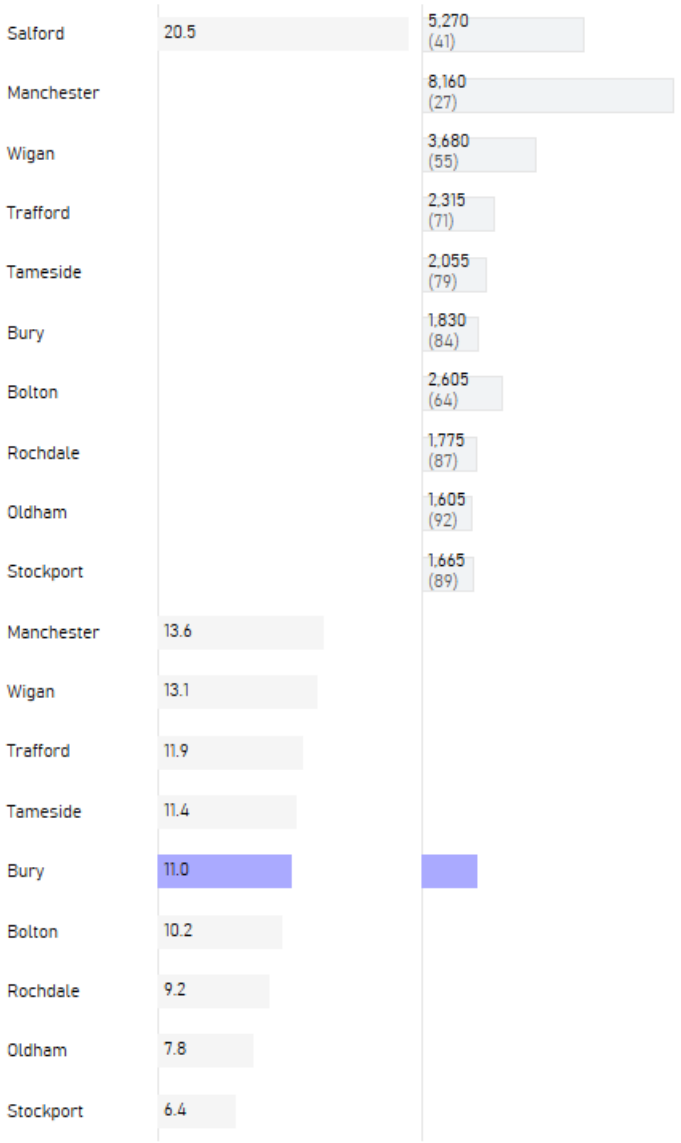
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22									1,125	1,125	1,135	1,110
2022-23	1,105	1,100	1,105	1,110	1,115	1,105	1,120	1,135	1,135	1,130	1,205	1,280
2023-24	1,505	1,520	1,530	1,550	1,550	1,545	1,540	1,550	1,560	1,570	1,575	1,550
2024-25	1,545	1,560	1,545	1,565	1,575	1,615	1,665	1,695	1,770	1,830		

Selected measure at January 2025 has continuously increased for 7 period(s) of time

Latest Value GM Benchmarking
Rate per 1000 / Count (National Rank)



The rate is calculated using the 18+ registered population figure for each locality | Bury: 166,698166,882

Narrative

- There were 1830 people who received two or more contacts from mental health services for adults with severe mental illness for Bury registered patients in Jan 25, higher than Jan 24 (1570).
- Bury currently has 11.0 contacts per 1000 population and has the 5th highest rate per 1000 for localities within GM.

Bury

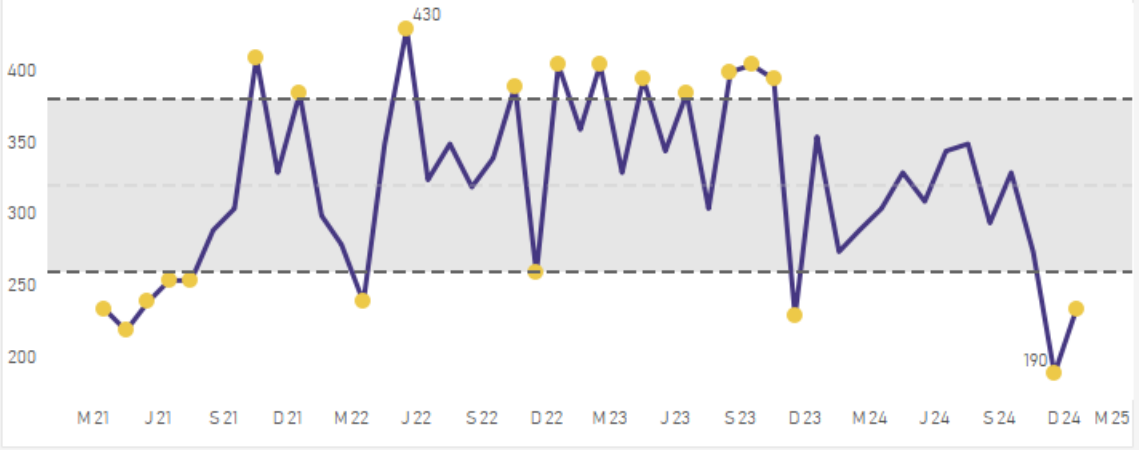
Talking Therapies: Access Rate

This indicator tracks our ambition to expand Improving Access to Psychological Therapies (IAPT) services, also known as NHS Talking Therapies. The primary purpose of this indicator is to measure improvements in access to psychological therapy (via IAPT) for people with depression and/or anxiety disorders.

Source: Improving Access to Psychological Therapies Data Set (Monthly)

235	190	105/111	No Target
January 2025	December 2024	National Rank Lower Quartile	

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	235	220	240	255	255	290	305	410	330	385	300	280
2022-23	240	350	430	325	350	320	340	390	260	405	360	405
2023-24	330	395	345	385	305	400	405	395	230	355	275	290
2024-25	305	330	310	345	350	295	330	275	190	235		

Selected measure at January 2025 has continuously increased for 1 period(s) of time

Latest Value GM Benchmarking

Rate per 1000 | Count (National rank)

The rate is calculated using the registered population figure for each locality | Bury: 212,567212,721

Narrative

- There were 235 accesses to Talking Therapies for Bury registered patients in Jan 25, higher than Dec 24 (190) but lower than Jan 24 (355)
- Bury currently has 1.1 accesses per 1000 population and has the lowest rate per 1000 for localities within GM.
- This position was raised in the Integrated Delivery board meeting March 2025 and a position paper will follow based on further investigation.

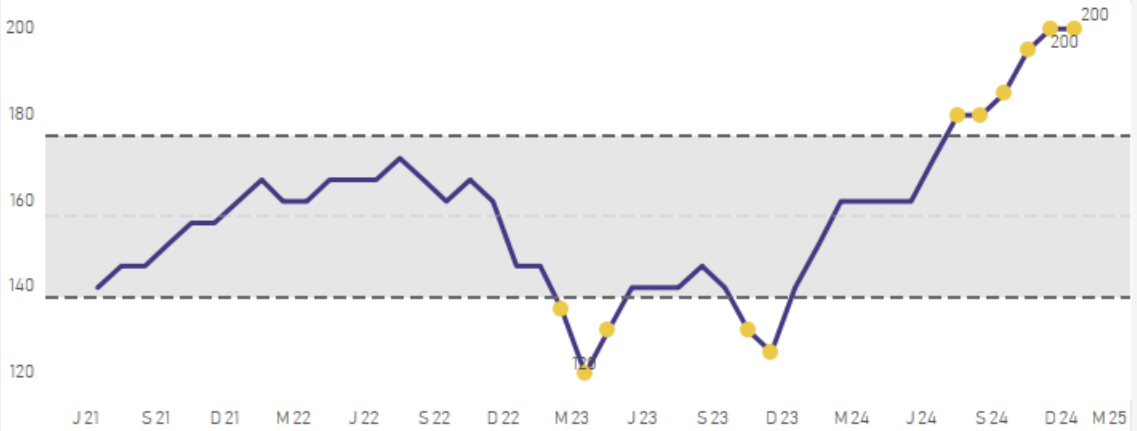
Bury

Women Accessing Specialist Community Perinatal Mental Health Services
Women Accessing Specialist Community Perinatal Mental Health Services (Rolling 12 mths)

Source: Published MHSDS (Quarterly)

200	200	91/107	No Target
January 2025	December 2024	National Rank Lower Quartile	

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22				140	145	145	150	155	155	160	165	160
2022-23	160	165	165	165	170	165	160	165	160	145	145	135
2023-24	120	130	140	140	140	145	140	130	125	140	150	160
2024-25	160	160	160	170	180	180	185	195	200	200		

Selected measure at January 2025 has continuously for 1 period(s) of time

Latest Value GM Benchmarking
Rate per 1000 / Count (National Rank)

1	Stockport	5.1	315 (63)
2	Tameside	4.9	225 (84)
3	Bury	4.9	200 (91)
4	Trafford	4.8	225 (84)
5	Oldham	4.7	260 (76)
6	Wigan	4.7	310 (64)
7	Rochdale	4.4	225 (84)
8	Bolton	4.1	270 (71)
9	Salford	3.2	250 (79)
10	Manchester	2.7	540 (40)

The rate is calculated using the 15-44 female population figure for each locality | Bury 40,95441,078

Narrative

- There were 200 women accessing Perinatal Mental Health Services for Bury registered patients for the rolling 12 months to Jan 25, higher than Jan 24(140).
- Bury currently has 4.9 accesses per 1000 population and has the 3rd highest rate per 1000 for localities within GM.

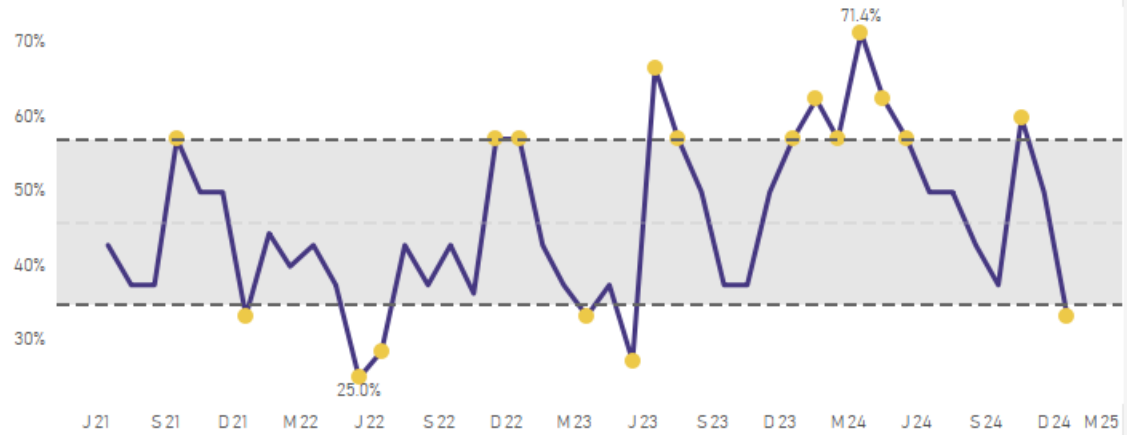
Bury

Long length of stay for adults (60+ days) - Mental Health Patients
Proportion of all discharges from adult acute and older adult acute beds, with a length of stay of over 60 days

Source: Published MHSDS (Monthly)

33.3%	50.0%	23/102	0.%
January 2025	December 2024	National Rank Inter Quartile	National Target

Outliers more than 1 standard deviation from the mean

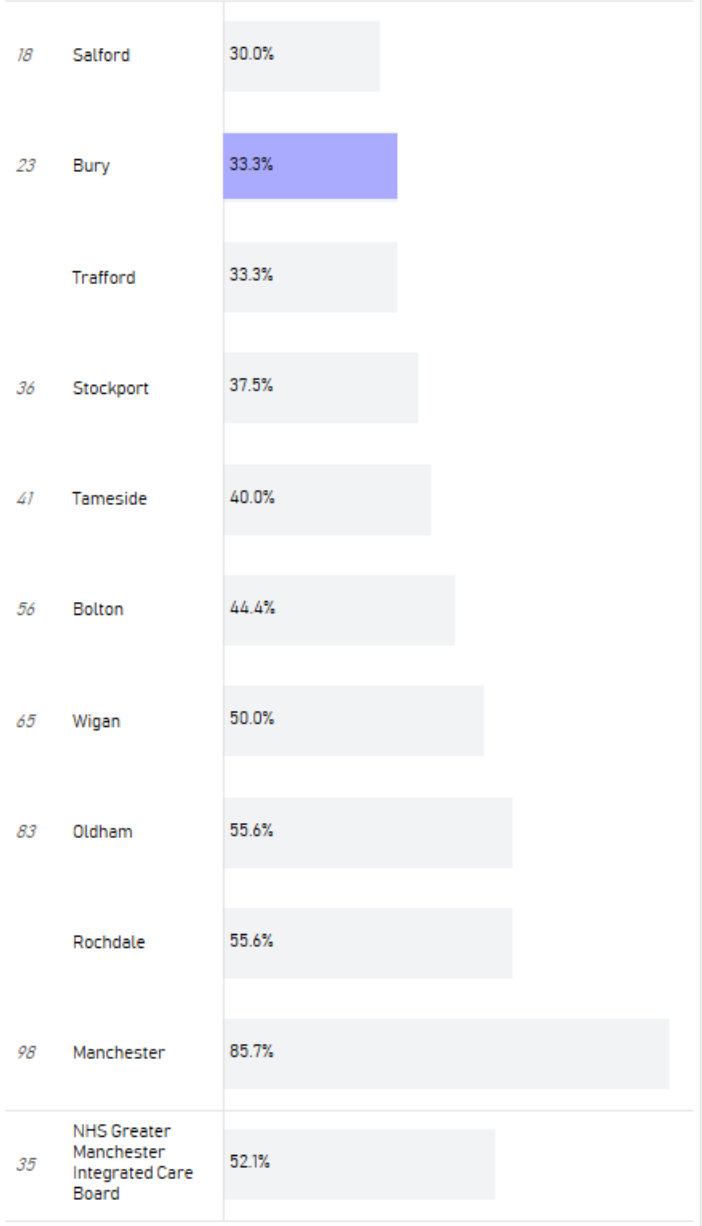


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22				42.9%	37.5%	37.5%	57.1%	50.0%	50.0%	33.3%	44.4%	40.0%
2022-23	42.9%	37.5%	25.0%	28.6%	42.9%	37.5%	42.9%	36.4%	57.1%	57.1%	42.9%	37.5%
2023-24	33.3%	37.5%	27.3%	66.7%	57.1%	50.0%	37.5%	37.5%	50.0%	57.1%	62.5%	57.1%
2024-25	71.4%	62.5%	57.1%	50.0%	50.0%	42.9%	37.5%	60.0%	50.0%	33.3%		

Selected measure at January 2025 has continuously decreased for 2 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities



Narrative

- The proportion of discharges with a long LOS in Jan 25 is 33.3%, which is lower than Jan 24 which was 57.1%.
- Bury currently has a lower proportion with a long LOS than GM which has a proportion of 52.1%. Bury has the 2nd lowest proportion of the GM localities.
- Bury and GM are above the national target of 0%.

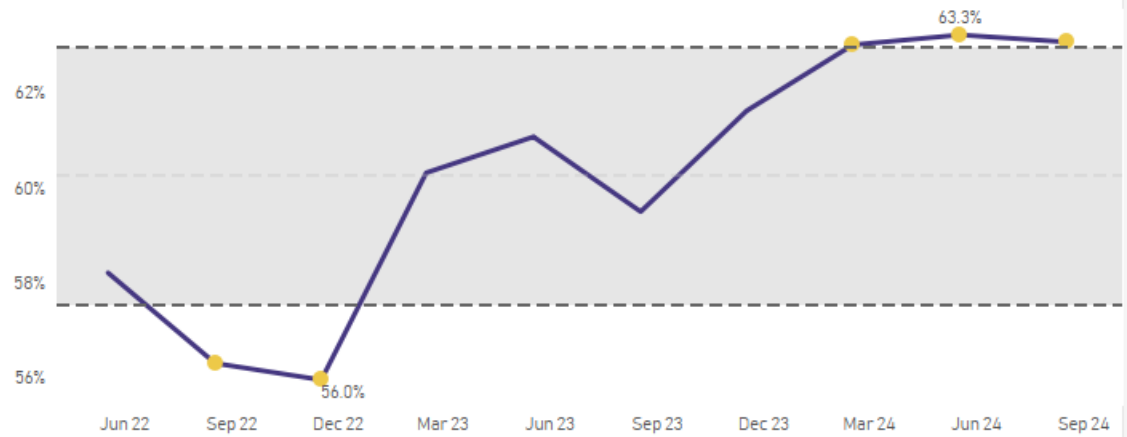
Bury

% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins
% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins

Source: CVD Prevent (Quarterly)

63.1%	63.3%	42/106	62.2%
September 2024	June 2024	National Rank Inter Quartile	National Median

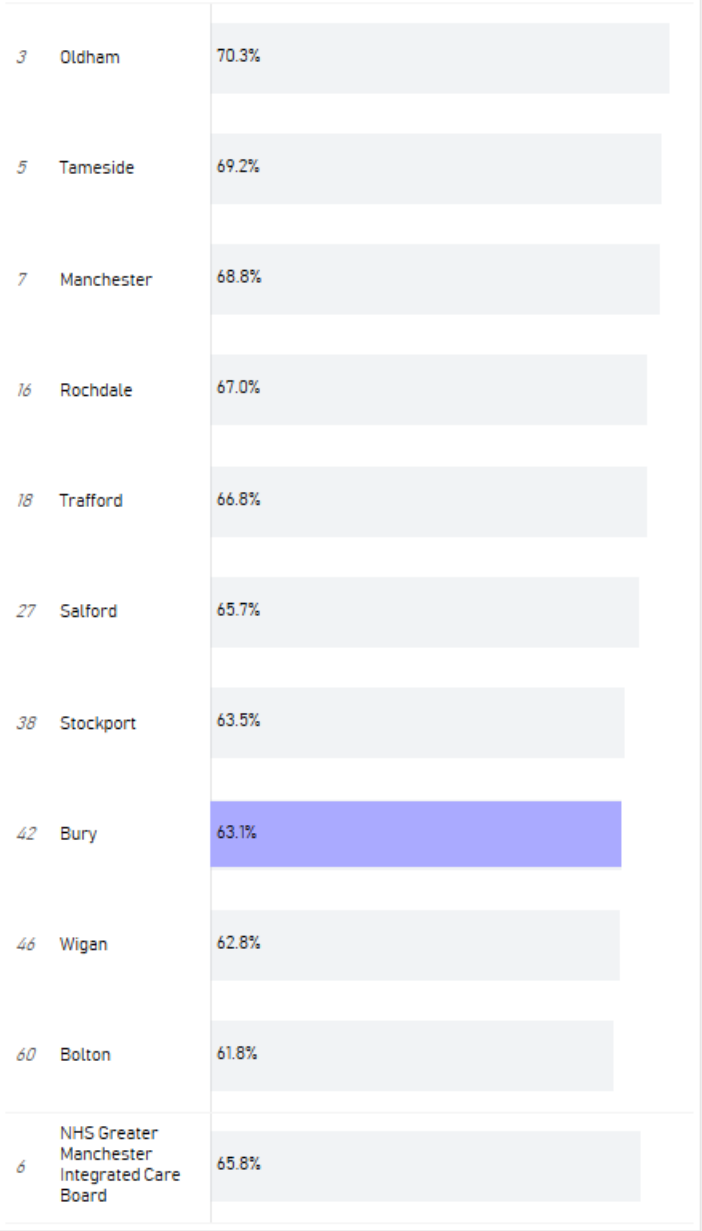
Outliers more than 1 standard deviation from the mean



	Jun	Sep	Dec	Mar
2022-23	58.3%	56.3%	56.0%	60.4%
2023-24	61.1%	59.5%	61.7%	63.1%
2024-25	63.3%	63.1%		

Selected measure at September 2024 has continuously **decreased** for **1** period(s) of time

Latest Value GM Benchmarking
National Rank against other localities



Narrative

- The percentage of patients identified as having 20% or greater 10-year risk of developing CVD as of Sept 24 is 63.1%, which is an increase on Sept 23 which was 59.5%
- Bury currently has a lower percentage than GM which is 65.8% and Bury has the 3rd lowest percentage of the GM localities.
- The Bury Major Conditions Board is reviewing performance of this indicator and developing a recovery plan

Bury

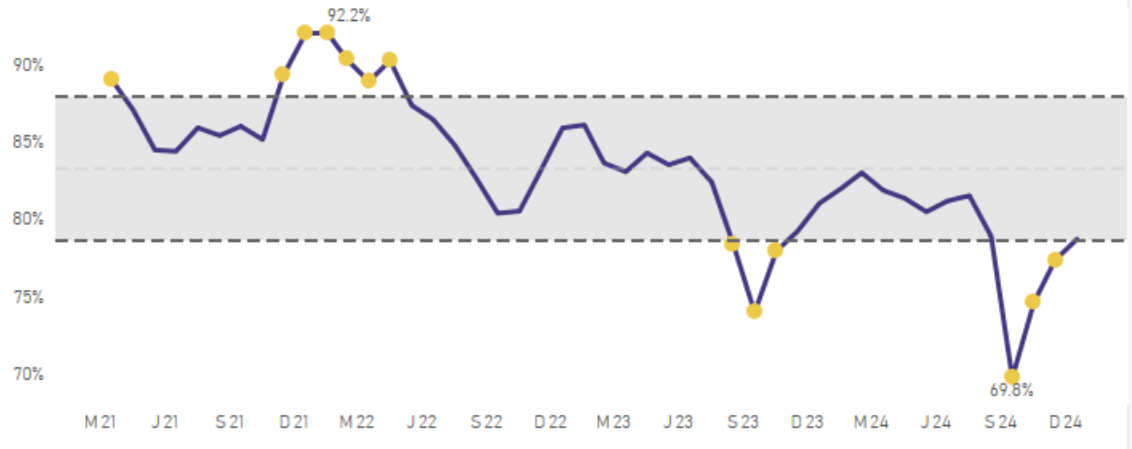
GP appointments - percentage of regular appointments within 14 days

Percentage of appointments where the time between booking and appointment was 'Same day', '1 day', '2 to 7 days' or '8 to 14 days'

Source: Appointments in General Practice (Monthly)

78.8%	77.5%	87/106	82.4%
January 2025	December 2024	National Rank Lower Quartile	National Median

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	89.2%	87.2%	84.6%	84.6%	86.1%	85.6%	86.2%	85.3%	89.5%	92.2%	92.2%	90.5%
2022-23	89.1%	90.5%	87.5%	86.6%	85.0%	82.8%	80.5%	80.7%	83.3%	86.1%	86.3%	83.8%
2023-24	83.2%	84.4%	83.7%	84.1%	82.6%	78.5%	74.1%	78.1%	79.4%	81.2%	82.1%	83.2%
2024-25	82.0%	81.5%	80.6%	81.3%	81.7%	79.0%	69.8%	74.8%	77.5%	78.8%		

Selected measure at January 2025 has continuously increased for 3 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities

16	Manchester	86.7%
27	Trafford	85.4%
33	Stockport	84.8%
37	Wigan	84.3%
40	Rochdale	84.0%
42	Salford	83.8%
53	Bolton	82.4%
56	Oldham	82.1%
63	Tameside	81.5%
87	Bury	78.8%
14	NHS Greater Manchester Integrated Care Board	83.9%

Narrative

- Bury currently has 78.8% of GP Appointments made within 14 days in Jan 25. This is higher than Dec 24 when there were 77.5%.This is lower than Jan 24 when there were 81.2%.
- Bury is currently ranked the lowest in GM localities with 78.8%. Bury has a lower rate when compared to GM who has 83.9%
- Board should note that this includes 'all' appointments, including those that can be pre booked in advance such as annual reviews, smears etc. When filtering this data to just those not typically scheduled in advance 98% of Burys Patients are seen within 14 days in comparison with a GM 87%

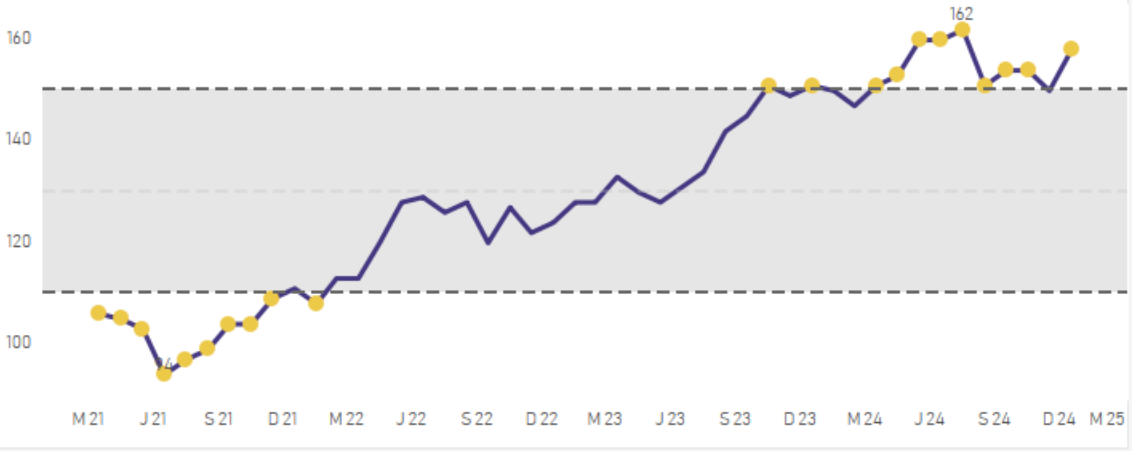
Bury

E. coli blood stream infections
12-month rolling counts of E. coli blood stream infections

Source: National Statistics: E. coli bacteraemia: monthly data by location of onset (Monthly)

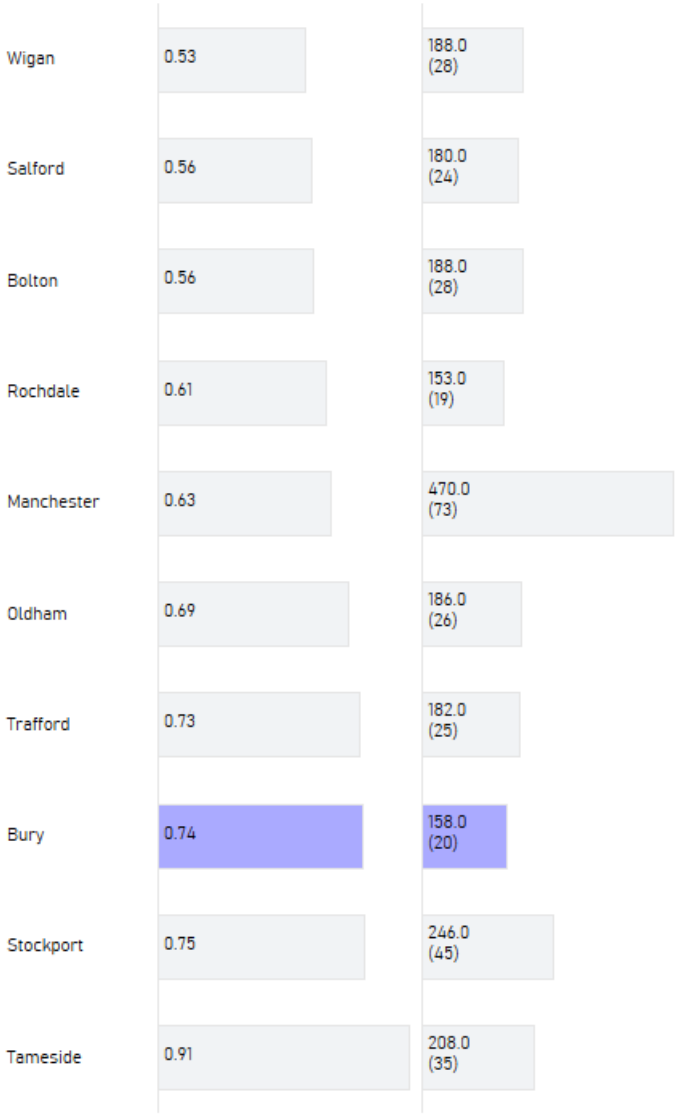
158	150	20/107	No Target
January 2025	December 2024	National Rank Upper Quartile	

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	106	105	103	94	97	99	104	104	109	111	108	113
2022-23	113	120	128	129	126	128	120	127	122	124	128	128
2023-24	133	130	128		134	142	145	151	149	151	150	147
2024-25	151	153	160	160	162	151	154	154	150	158		

Latest Value GM Benchmarking
Rate per 1000 / Count (National Rank)



The rate is calculated using the registered population figure for each locality | Bury: 212,567212,721

Narrative

- There were 158 counts of E. Coli blood stream infections in the rolling 12 months to Jan 25, which is higher than Jan 24 (151).
- Bury currently has 0.74 counts per 1000 population and has the 3rd highest rate per 1000 for localities within GM.

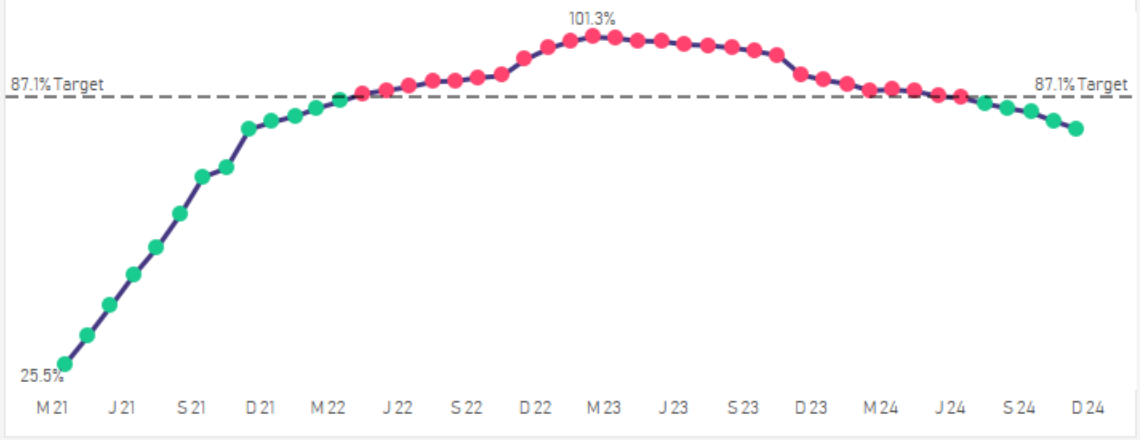
Bury

Antimicrobial resistance: total prescribing of antibiotics in primary care
The number of antibiotic (antibacterial) items prescribed in primary care, divided by the item-based Specific Therapeutic group Age-Sex related Prescribing Unit STAR-PU

Source: EPACT Prescribing Data (Monthly)

80.0%	81.7%	87.1%
December 2024	November 2024	National Target

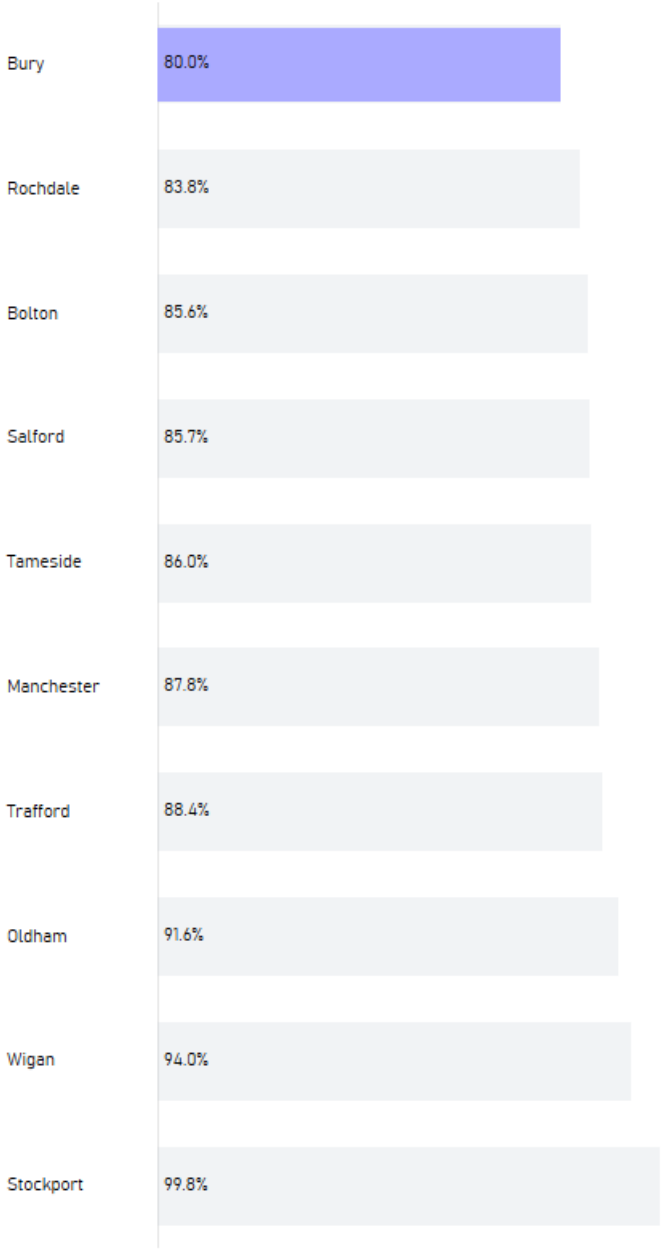
Performance Against National Target of 87.1%



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	25.5%	31.9%	39.0%	46.1%	52.5%	60.2%	68.8%	70.9%	79.9%	81.6%	83.0%	84.8%
2022-23	86.4%	88.1%	88.9%	89.7%	90.9%	91.1%	91.8%	92.3%	96.0%	98.6%	100.3%	101.3%
2023-24	100.9%	100.4%	100.2%	99.5%	99.3%	98.8%	98.0%	97.0%	92.5%	91.3%	90.4%	88.9%
2024-25	89.0%	88.7%	87.5%	87.2%	85.8%	84.7%	83.8%	81.7%	80.0%			

Selected measure at December 2024 has continuously decreased for 8 period(s) of time

Latest Value GM Benchmarking



Narrative

- The percentage of total prescribing of antibiotics in primary care in Dec 24 for the Bury population was 80%, which is lower than Dec 23 which was 92.5%.
- Bury currently has a lowest percentage of the GM localities.

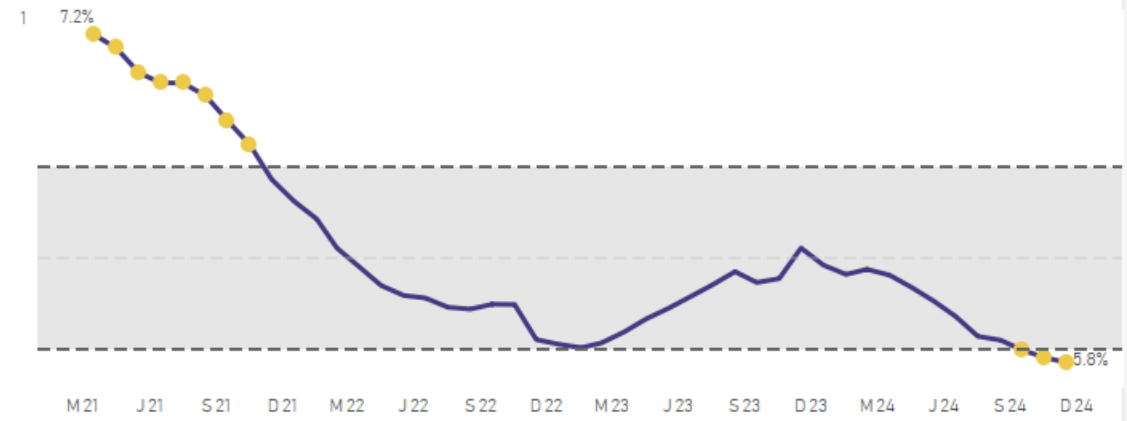
Bury

Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care
The number of broad-spectrum antibiotic (antibacterials) items from co-amoxiclav, cephalosporin class and fluoroquinolone class drugs as a percentage of the total number of antibacterial items prescribed in primary care.

Source: EPACT Prescribing Data (Monthly)

5.8%	5.8%	21/111	10.%
December 2024	November 2024	National Rank Upper Quartile	National Target

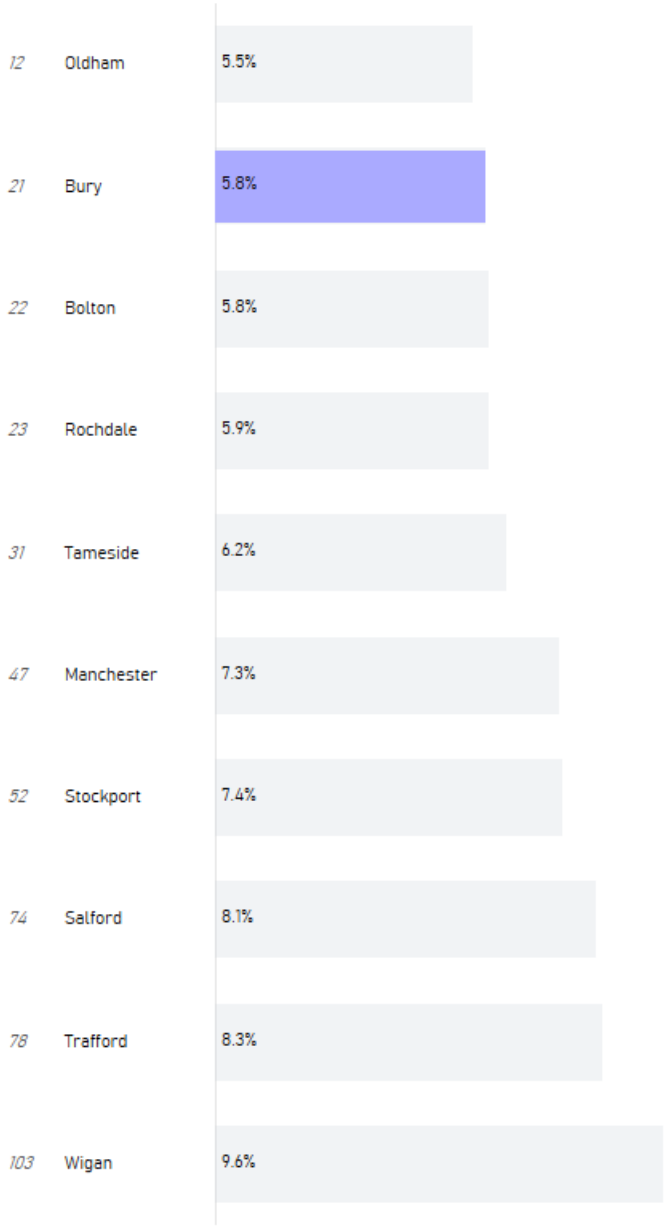
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	7.2%	7.1%	7.0%	7.0%	7.0%	6.9%	6.8%	6.7%	6.6%	6.5%	6.4%	6.3%
2022-23	6.2%	6.1%	6.1%	6.1%	6.0%	6.0%	6.0%	6.0%	5.9%	5.9%	5.9%	5.9%
2023-24	5.9%	6.0%	6.0%	6.1%	6.1%	6.2%	6.1%	6.2%	6.3%	6.2%	6.2%	6.2%
2024-25	6.2%	6.1%	6.1%	6.0%	5.9%	5.9%	5.8%	5.8%	5.8%			

Selected measure at December 2024 has continuously decreased for 9 period(s) of time

Latest Value GM Benchmarking
National Rank against other localities



Narrative

- The proportion of broad-spectrum antibiotic prescribing in primary care in Dec 24 for the Bury population was 5.8%, which is a decrease on Dec 23 which was 6.3%.
- Bury currently has the 2nd lowest percentage of the GM localities.
- Bury is within the less than 10% target.

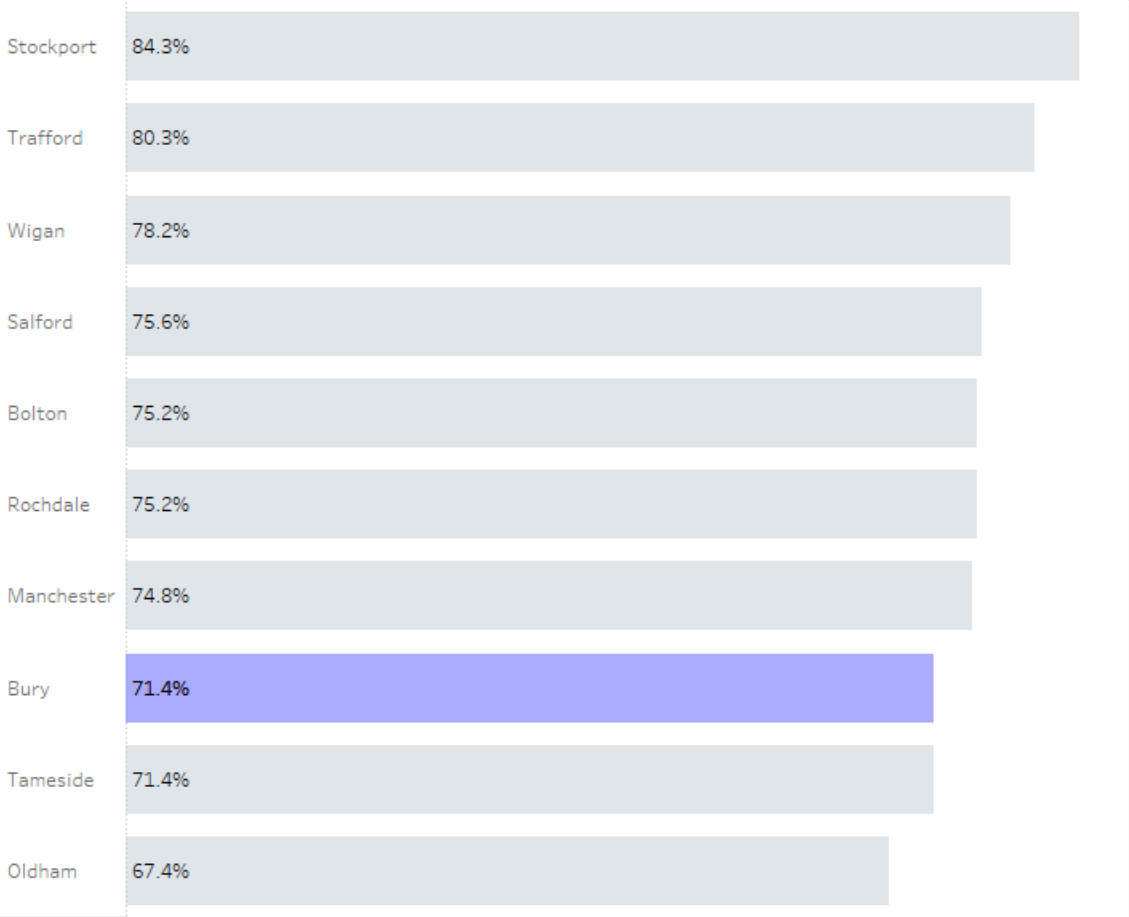
Bury

% of patients describing their overall experience of making a GP appointment as good

The weighted percentage of people who report through the GP Patient Survey their overall experience of their GP practice as 'very good' or 'fairly good'

Source: GP Patient Survey (Annual)

Please note: The publication of the 2024 survey results is the start of a new time series for GPPS. This means that trend data for previous years of the survey is not presented alongside the 2024 results as it would normally be. The 2024 results are not comparable with previous years because of two significant changes which have been made to the survey in 2024



Narrative

- Bury currently has the 8th highest percentage of the GM localities with 71.4% of patients describing their overall experience of making a GP Appointment as good.

- Further work is being undertaken by the Primary Care Improvement Team to review this data at PCN and practice level and to target support appropriately.

Bury - Sight Metrics

Domain	Code	Measure	Frequency	Date	Latest	Previous	Change	Target/Median	Numerator	Denominator	
Urgent Care	N/A	A&E 4 hour performance	Monthly	Feb 25	69.2%	64.6%	↗	78.0%	4,411	6,375	N/A
	N/A	A&E Attendances	Monthly	Feb 25	6,375.0	6,908.0	↘	N/A	6,375	N/A	N/A
	N/A	No Reason/Criteria To Reside patients (NCTR) as % of occupied beds	Monthly	Feb 25	15.8%	14.3%	↗	N/A	1,887	11,917	N/A
	EM11	Total number of specific acute non-elective spells	Monthly	Feb 25	1,600.0	2,110.0	↘	N/A	1,600	N/A	Upper
Elective Care	EB28	Diagnostic 6ww: All	Monthly	Jan 25	14.3%	12.6%	↗	1%	654	4,569	Inter
	EB20	RTT incomplete: 65+ week waits	Monthly	Jan 25	21.00	22.0	↘	0.	21	N/A	Upper
Cancer	S012a	28 Day Wait from Referral to Faster Diagnosis: All Patients	Monthly	Jan 25	75.3%	80.1%	↘	75%	682	906	Inter
Maternity	S104a	Number of neonatal deaths per 1,000 total live births	Annual	Dec 23	1.5	0.0	↗	1.4	3	2,049	Inter
	S022a	Number of stillbirths per 1,000 total births	Annual	Dec 23	5.4	4.0	↗	3.1	11	2,049	Lower
Screening and Immunisations	S049a	Breast screening coverage, females aged 53-70, screened in last 36 months	Annual	Dec 24	73.3%	69.2%	↗	N/A	16,305	22,244	Inter
	S046a	COVER immunisation: MMR2 Uptake at 5 years old	Quarterly	Sep 24	88.1%	83.4%	↗	95%	554	629	Inter
	S050a	Females, 25-64, attending cervical screening within target period (3.5 or 5.5 year coverage, %)	Quarterly	Jun 24	70.3%	70.6%	↘	80%	37,935	53,940	Inter
	S047A	Seasonal Flu Vaccine Uptake: 65 years and over	Monthly	Feb 24	77.5%	77.3%	↗	85%	29,492	38,042	Inter
Community	N/A	% 2-hour Urgent Community Response (UCR) first care contacts	Monthly	Jan 25	96.6%	97.6%	↘	N/A	284	294	N/A

Bury - Sight Metrics

The below metrics are currently missing from the report due to lack of locality level reporting or the measure is currently being built.

Theme	Indicator	
Cancer	Total patients waiting over 62 days to begin cancer treatment vs target	Build in progress
LD and Autism	Inpatients with a learning disability and/or autism per million head of population	Build in progress
Primary Care and Community Services	Proportion of Urgent Community Response referrals reached within two hours	Currently available in the scorecard at trust level but not locality
	Proportion of virtual ward beds occupied	Currently unavailable at locality level due to inaccurate reporting
	Units of Dental Activity delivered as a proportion of all Units of Dental Activity contracted	Build in progress
Screening and immunisation	Bowel screening, aged 60-74, screened in the last 30 months	DQ issues
Urgent and Emergency Care	Reduce adult general and acute bed occupancy below 92%	Currently available in the scorecard at trust level but not locality

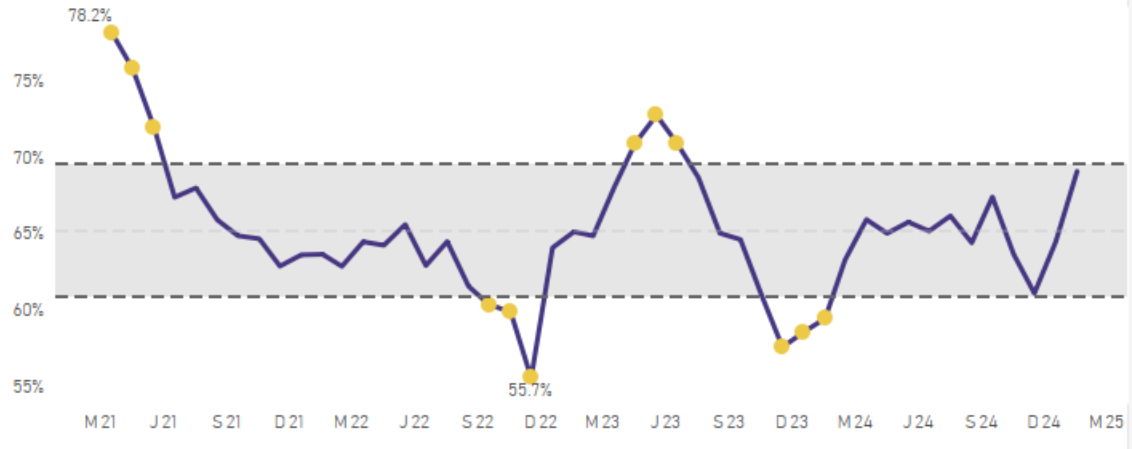
Bury

A&E 4 hour performance
Number of attendances at A&E departments, and of these, the number of attendances where the patient spent less than 4 hours from time of arrival to time of admission, or discharge, or transfer.

Source: Emergency Care Dataset (ECDS) (Monthly)

69.2%	64.6%	78.0%
February 2025	January 2025	National Target

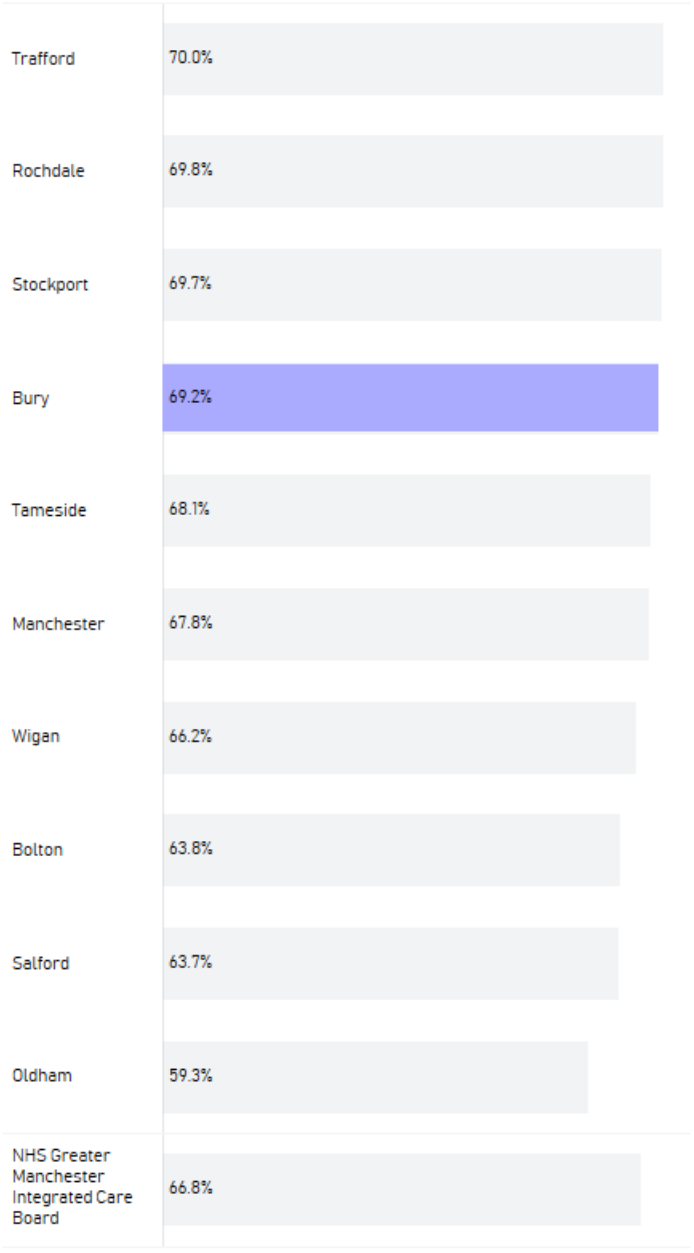
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	78.2%	75.9%	72.1%	67.5%	68.1%	66.0%	65.0%	64.8%	63.0%	63.7%	63.8%	63.0%
2022-23	64.6%	64.4%	65.7%	63.0%	64.6%	61.7%	60.5%	60.0%	55.7%	64.2%	65.2%	65.0%
2023-24	68.2%	71.0%	72.9%	71.0%	68.8%	65.2%	64.7%	61.1%	57.7%	58.7%	59.6%	63.4%
2024-25	66.0%	65.1%	65.9%	65.3%	66.3%	64.5%	67.5%	63.8%	61.2%	64.6%	69.2%	

Selected measure at February 2025 has continuously increased for 2 period(s) of time

Latest Value GM Benchmarking



Narrative

- This metric is subject to daily review.
- 4-hour performance in Feb 25 was 69.2%, an increase on the previous month's performance of 64.6%.
- Feb 25 performance is 69.2% which is higher than Feb 24 which was 59.6%.
- Bury performance is currently above the overall GM performance of 66.8% and is the 4th best performing locality in GM.

Bury

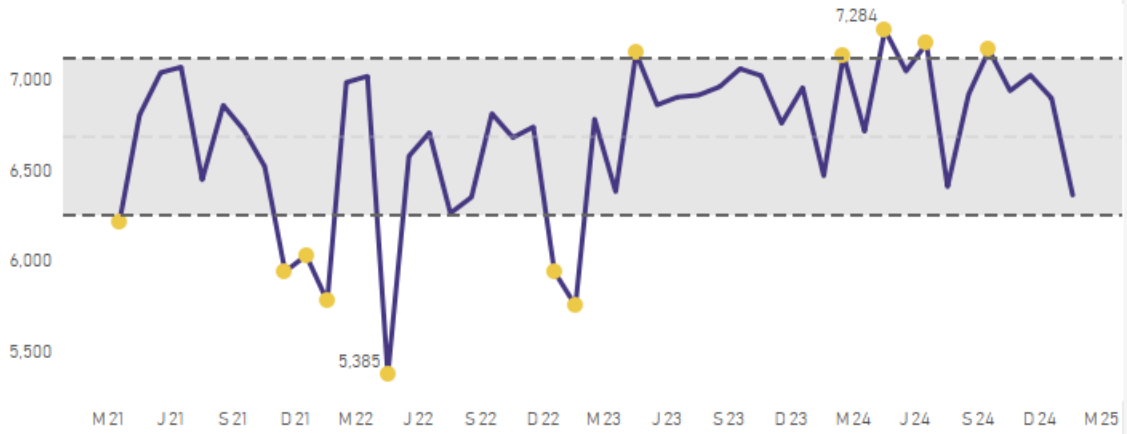
A&E Attendances
Number of attendances at A&E departments

Source: Emergency Care Dataset (ECDS) (Monthly)

6,375
February 2025

6,908
January 2025

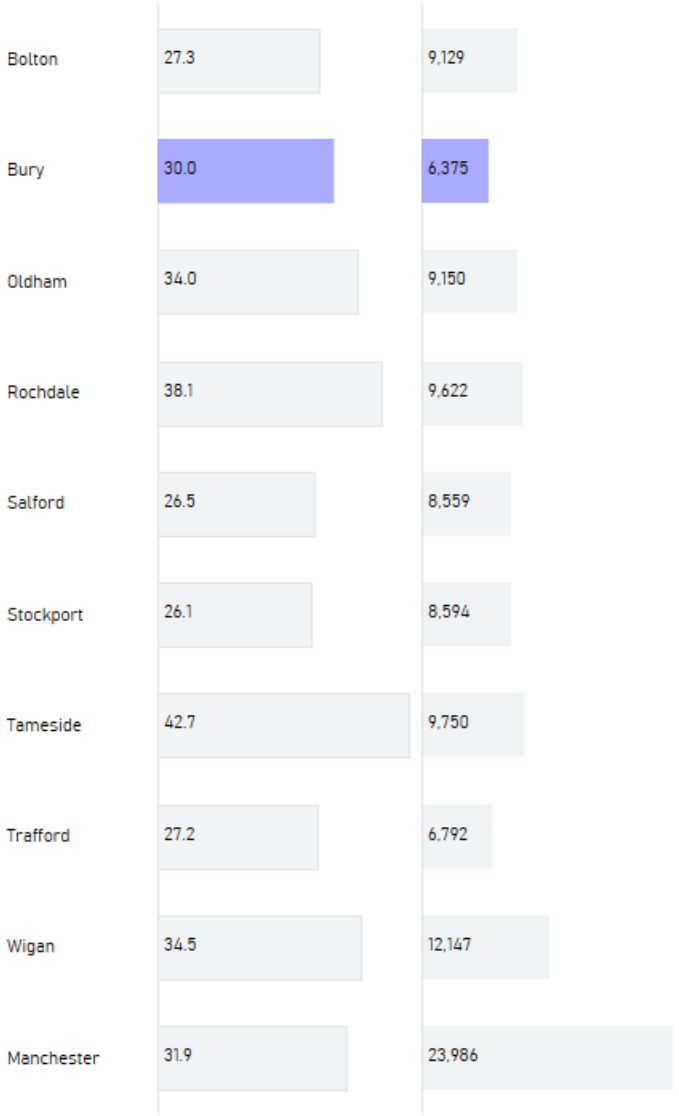
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	6,220	6,816	7,049	7,079	6,459	6,869	6,734	6,532	5,954	6,042	5,791	6,995
2022-23	7,029	5,385	6,589	6,718	6,275	6,363	6,823	6,691	6,750	5,953	5,766	6,793
2023-24	6,394	7,156	6,871	6,914	6,925	6,971	7,070	7,032	6,770	6,966	6,481	7,145
2024-25	6,726	7,284	7,057	7,208	6,421	6,929	7,173	6,949	7,034	6,908	6,375	

Selected measure at February 2025 has continuously decreased for 1 period(s) of time

Latest Value GM Benchmarking
Attendances Rate per 1000 population & Count



The rate is calculated using the registered population figure for each locality | Bury: 212,567212,721

Narrative

- There were 6375 A&E attendances from Bury registered patients in Feb 25, Lower than Jan 25 (6908) and lower than Feb 24 which was 6481
- Bury currently has 30.0 attendances per 1000 population and has the 2nd lowest attendance rate for localities within GM.

Bury

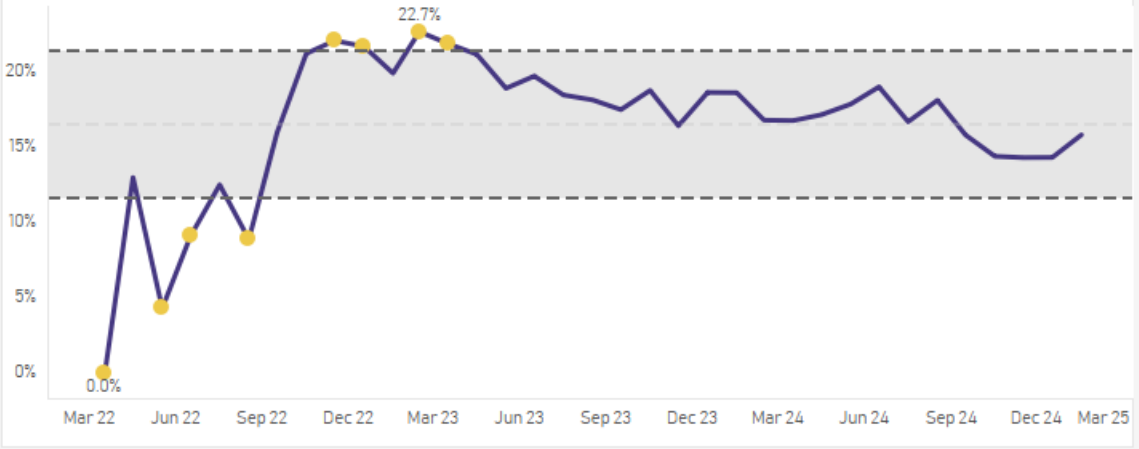
No Reason/Criteria To Reside patients (NCTR) as % of occupied beds
Total occupied beds, and of these, the number of patients who are fit for discharge and have no need to reside in a hospital bed

Source: GM Admissions - Local (Monthly)

15.8%
February 2025

14.3%
January 2025

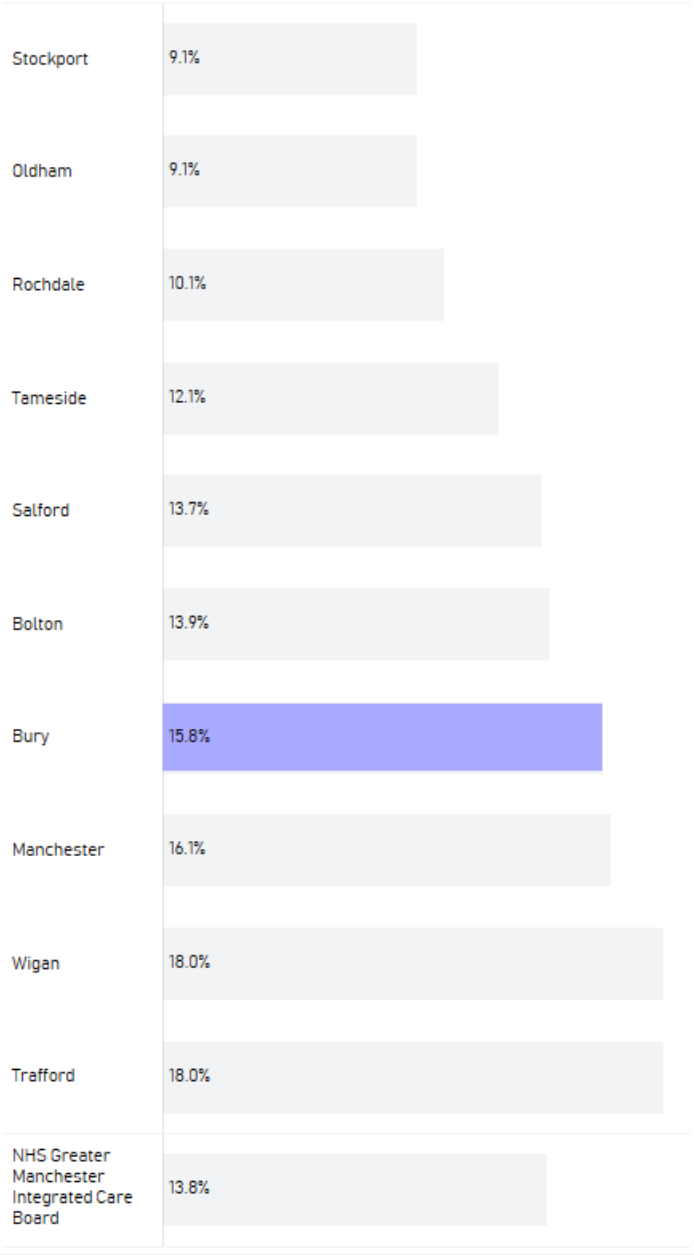
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022-23	0.0%	13.0%	4.3%	9.1%	12.5%	8.9%	16.0%	21.2%	22.1%	21.7%	19.9%	22.7%
2023-24	21.9%	21.2%	18.9%	19.7%	18.5%	18.1%	17.5%	18.8%	16.4%	18.6%	18.6%	16.8%
2024-25	16.8%	17.2%	17.9%	19.0%	16.7%	18.1%	15.8%	14.4%	14.3%	14.3%	15.8%	

Selected measure at February 2025 has continuously **increased** for **2** period(s) of time

Latest Value GM Benchmarking



Narrative

- This metric is subject to daily review.
- NCTR percentage for Bury in Feb 25 is 15.8% which is an increase on Jan 25 which was 14.3%, but lower than Feb 24 which was 18.6%
- Bury is currently higher than the GM percentage of 13.8% and has the 7th lowest percentage of the GM localities.

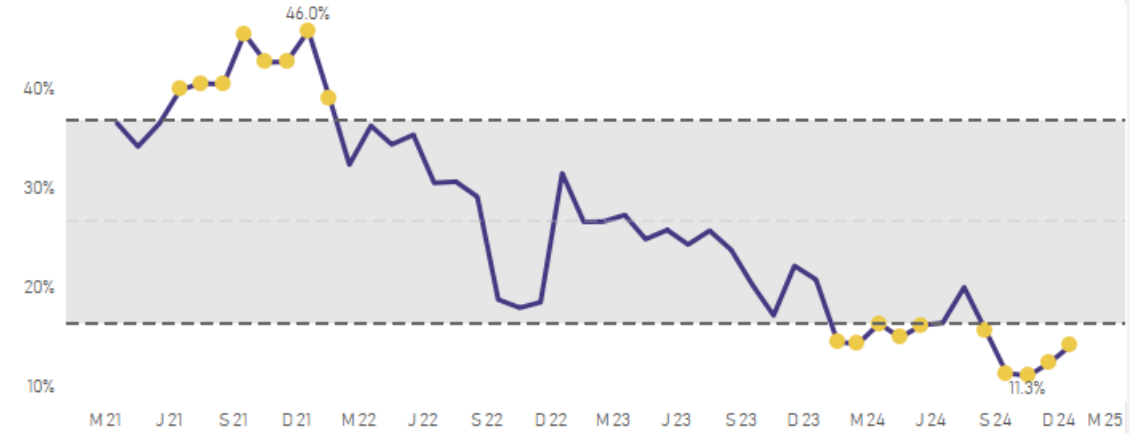
Bury

Diagnostic 6ww: All
% of Patients waiting over 6 weeks for a diagnostic test or procedure

Source: Monthly Diagnostics Waiting Times and Activity Return - DM01 (Monthly)

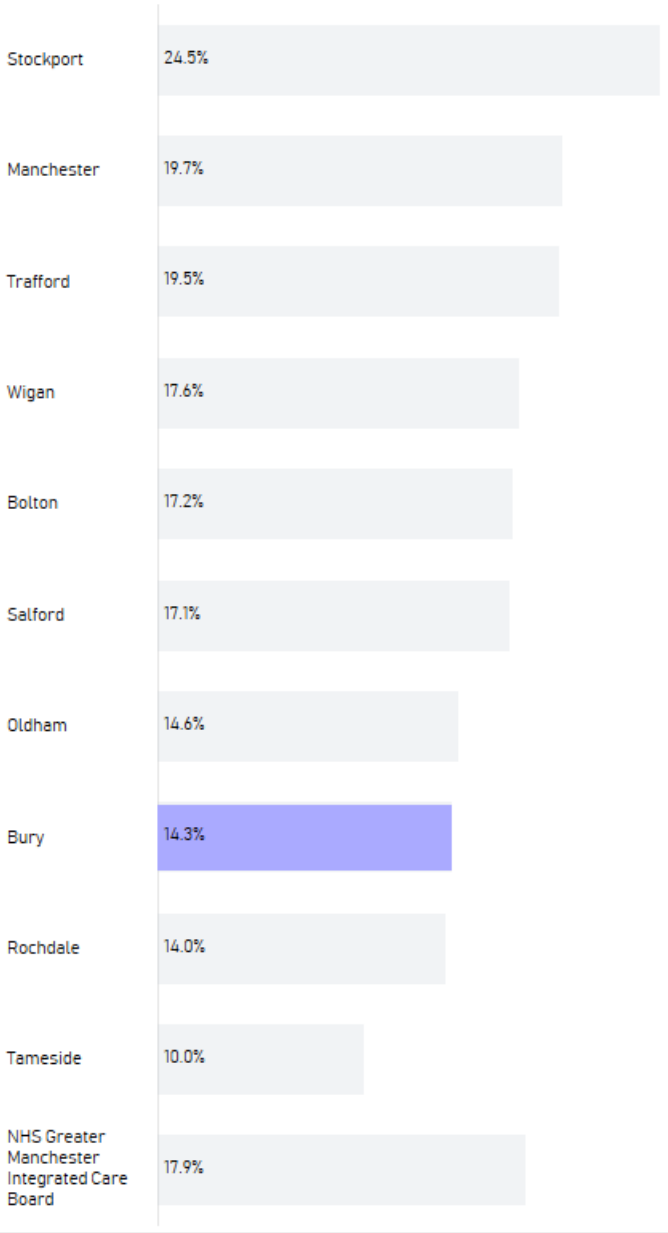
14.3%	12.6%	33/107	1.%
January 2025	December 2024	National Rank Inter Quartile	National Target

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	36.7%	34.4%	36.7%	40.1%	40.7%	40.6%	45.7%	42.8%	42.9%	46.0%	39.1%	32.5%
2022-23	36.4%	34.6%	35.5%	30.7%	30.8%	29.3%	19.0%	18.1%	18.7%	31.7%	26.8%	26.8%
2023-24	27.5%	25.0%	26.0%	24.5%	25.9%	24.0%	20.5%	17.4%	22.3%	21.0%	14.7%	14.5%
2024-25	16.5%	15.1%	16.4%	16.6%	20.2%	15.8%	11.6%	11.3%	12.6%	14.3%		

Latest Value GM Benchmarking
National Rank against other localities



Narrative

- Jan 25 performance of 14.3% of patients waiting more than six weeks, this is a decrease on the Jan 24 figures (21.0%).
- Burys performance is lower than GM's performance of 17.9% in Jan 25.
- Bury performance is the 3rd lowest percentage of the GM localities.
- Bury and GM are both above the less than 1% target.

Bury

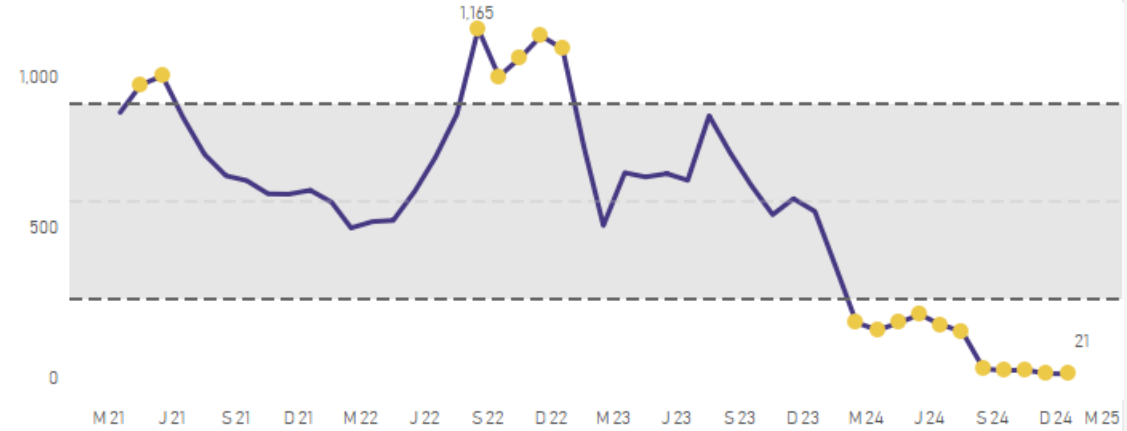
RTT incomplete: 65+ week waits

"The number of 65+ week incomplete RTT pathways based on data provided by NHS and independent sector organisations and reviewed by NHS commissioners via SDCS.
The definitions that apply for RTT waiting times, as well as guidance on recording and reporting RTT data, can be found on the NHS England and NHS Improvement Consultant-led referral to treatment waiting times rules and guidance webpage."

Source: Consultant-led RTT Waiting Times data collection (National Statistics). (Monthly)

21.00	22	17/121	0.
January 2025	December 2024	National Rank Upper Quartile	National Target

Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	888	980	1,009	871	749	678	662	618	617	630	590	505
2022-23	526	530	626	739	882	1,165	1,007	1,070	1,142	1,099	773	513
2023-24	688	674	685	663	877	752	646	549	602	560	371	191
2024-25	166	190	218	184	162	38	32	34	22	21		

Selected measure at January 2025 has continuously decreased for 2 period(s) of time

Latest Value GM Benchmarking

National Rank against other localities

Narrative

- Jan 25 data shows a decrease in 65+ Week Waits with 21 pathways down from 22 pathways in Dec 24.
- There was a significant decrease in pathways from Jan 25 with 21 Pathways, Compared to Jan 24 when there were 560 pathways (- 539 Pathways)
- In Jan 25, Ophthalmology Service shows the largest increase in pathways with 6 pathways compared to 1 in Dec 24
- Bury locality currently has the 4th lowest number of 65+ Week waits out of all the GM localities.

Bury

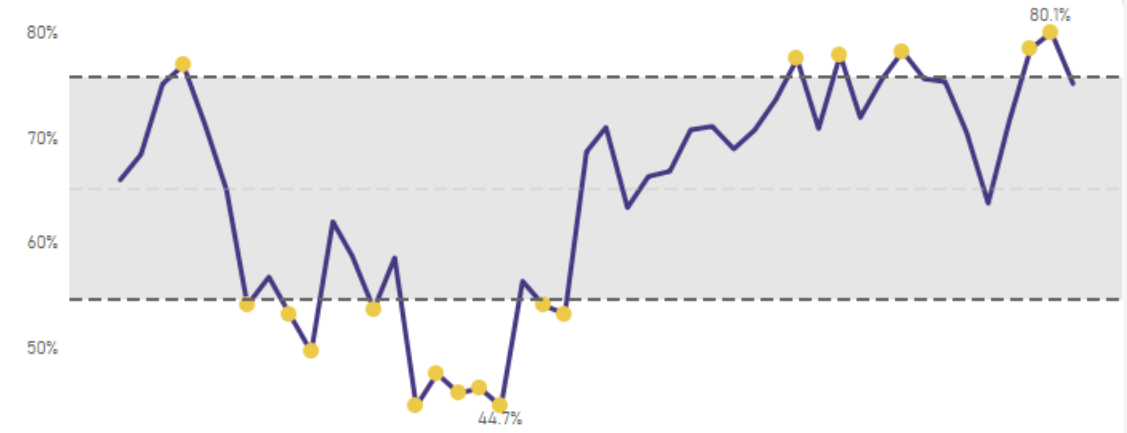
28 Day Wait from Referral to Faster Diagnosis: All Patients

Proportion of patients told cancer diagnosis outcome within 28 days of their TWW referral for suspected cancer, TWW referral for exhibited breast symptoms, or urgent screening referral

Source: National Cancer Waiting Times Monitoring Data Set (CWT) (Monthly)

75.3%	80.1%	43/114	75.%
January 2025	December 2024	National Rank Inter Quartile	National Target

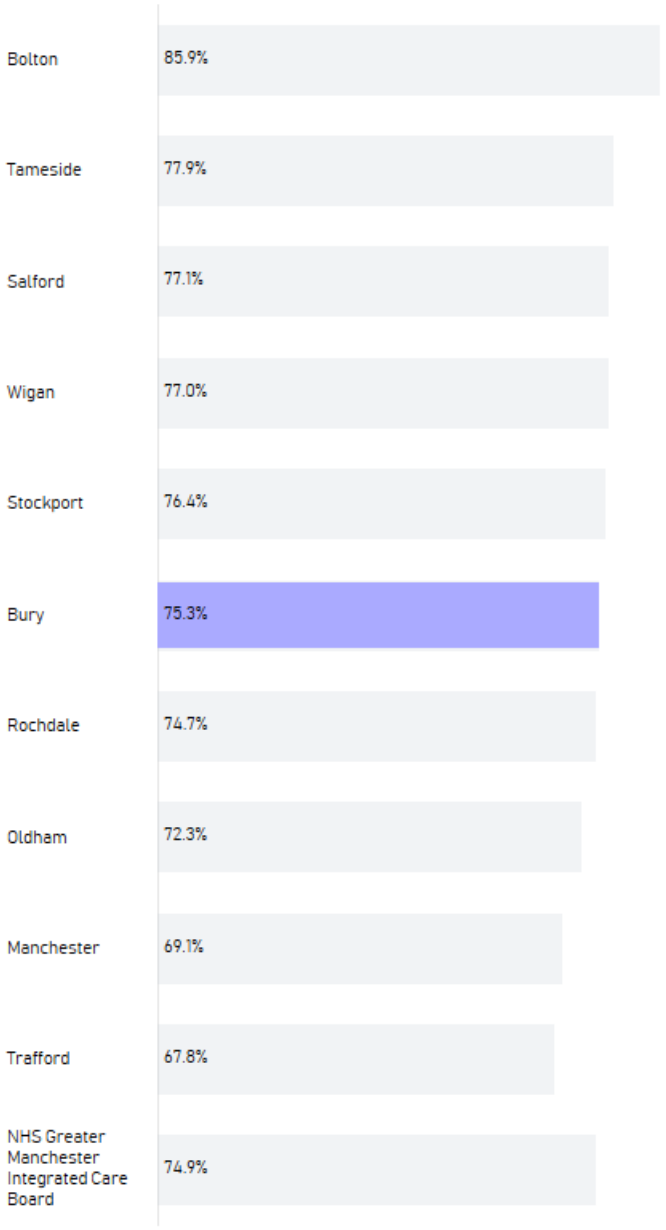
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22	66.2%	68.6%	75.2%	77.0%	71.4%	65.2%	54.3%	57.0%	53.4%	49.9%	62.2%	58.9%
2022-23	53.9%	58.8%	44.7%	47.8%	46.0%	46.4%	44.7%	56.6%	54.3%	53.5%	68.8%	71.1%
2023-24	63.5%	66.5%	67.0%	70.9%	71.2%	69.1%	70.9%	73.8%	77.6%	71.0%	78.0%	72.1%
2024-25	75.7%	78.3%	75.7%	75.5%	70.7%	64.0%	71.6%	78.6%	80.1%	75.3%		

Latest Value GM Benchmarking

National Rank against other localities



Narrative

- The percentage of patients told of a cancer diagnosis outcome within 28 days of the 2WW referral in Jan 25 for the Bury population was 75.3%, which is a decrease on Dec 24 which was 80.1%.
- Bury locality is currently the 5th lowest performance out of all the GM localities.
- GM performance is currently 74.9%
- Bury is above the target of 75% or greater.

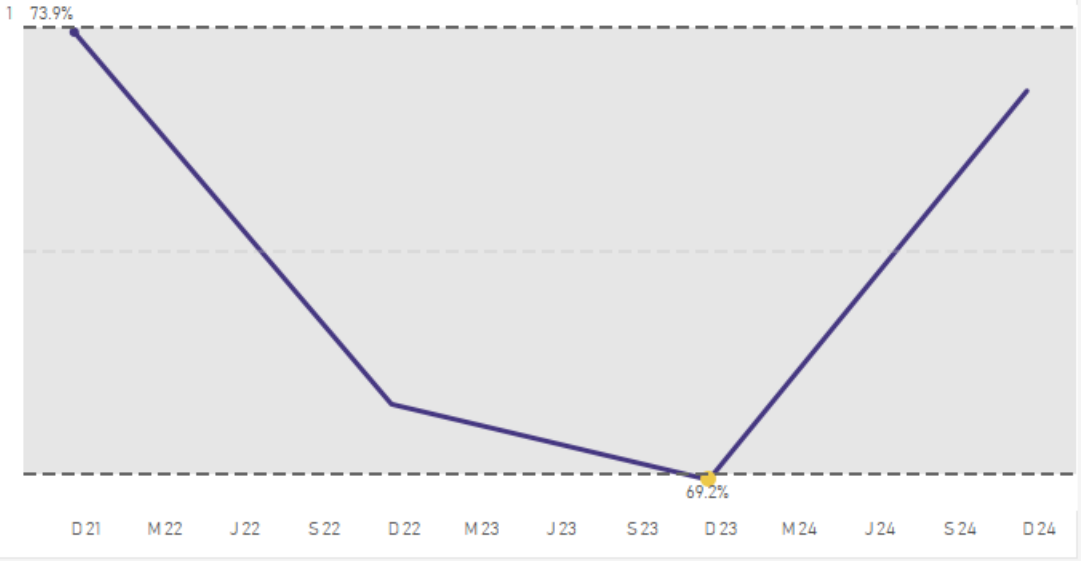
Bury

Breast screening coverage, females aged 53-70, screened in last 36 months
3-year screening coverage %: The number of females registered to the practice screened adequately in previous 36 months divided by the number of eligible females on last day of the review period

Source: Fingertips, Public Health Data, Public Health Outcomes Framework (Annual)

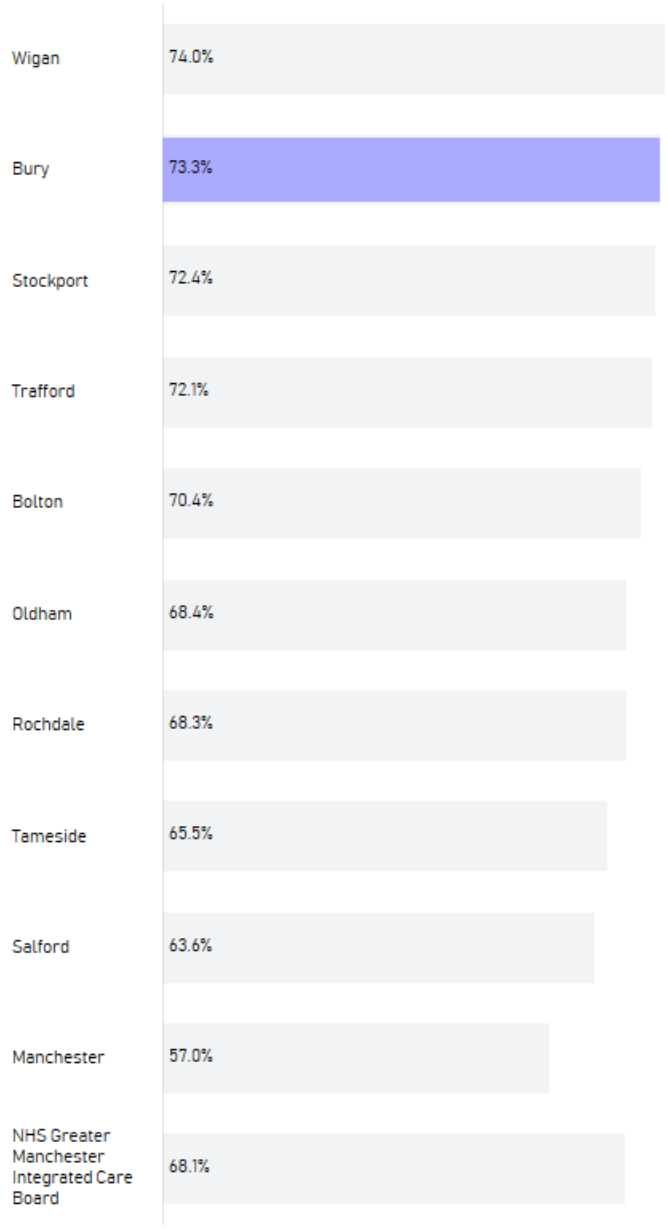
73.3%	69.2%	60%
December 2024	December 2022	No Target

Outliers more than 1 standard deviation from the mean



	Dec
2021-22	73.9%
2022-23	70.0%
2023-24	69.2%
2024-25	73.3%

Latest Value GM Benchmarking
National Rank against other localities



Narrative

- The 3-year breast screening coverage to December 24 for the Bury population was 73.3% for eligible females.
- Bury locality currently has the 2nd highest percentage out of all the GM localities and is higher than the GM percentage of 68.1%.

Bury

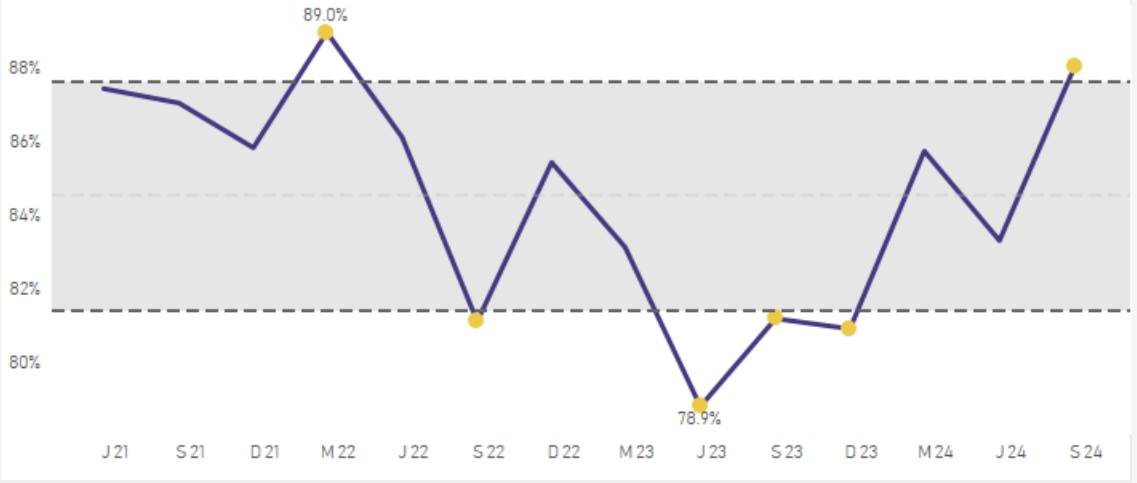
COVER immunisation: MMR2 Uptake at 5 years old
Population vaccination coverage – MMR for two doses (5 years old)

Source: Cover of vaccination evaluated rapidly (COVER) programme (Quarterly)

88.1%
September 2024

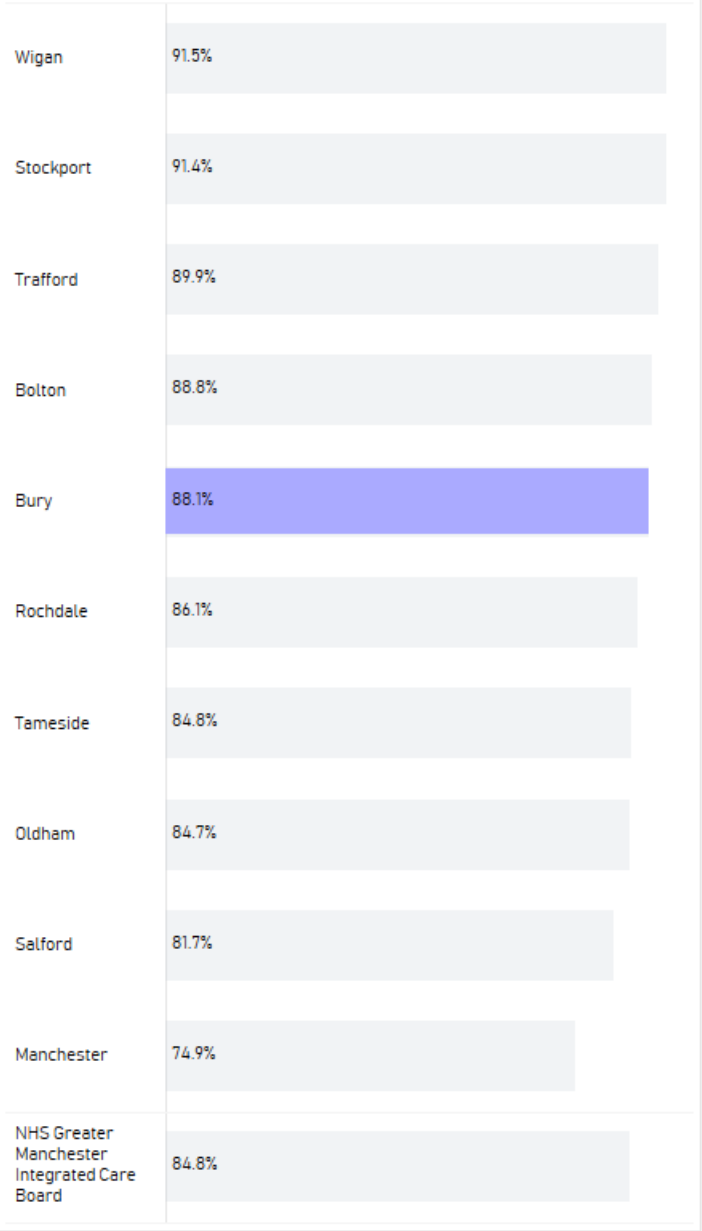
95.%
National Target

Outliers more than 1 standard deviation from the mean



	Jun	Sep	Dec	Mar
2021-22	87.5%	87.1%	85.9%	89.0%
2022-23	86.2%	81.2%	85.5%	83.2%
2023-24	78.9%	81.3%	81.0%	85.8%
2024-25	83.4%	88.1%		

Latest Value GM Benchmarking
National Rank against other localities



Narrative

- The percentage of MMR2 uptake at 5 years old as of Sept 24 is 88.1%, which is an increase on Sept 23 which was 81.3%
- Bury currently has a higher percentage than GM which is 84.8%
- Bury has the 5th best rate of uptake of the GM localities.
- Bury and GM are not meeting the national target of 95%.

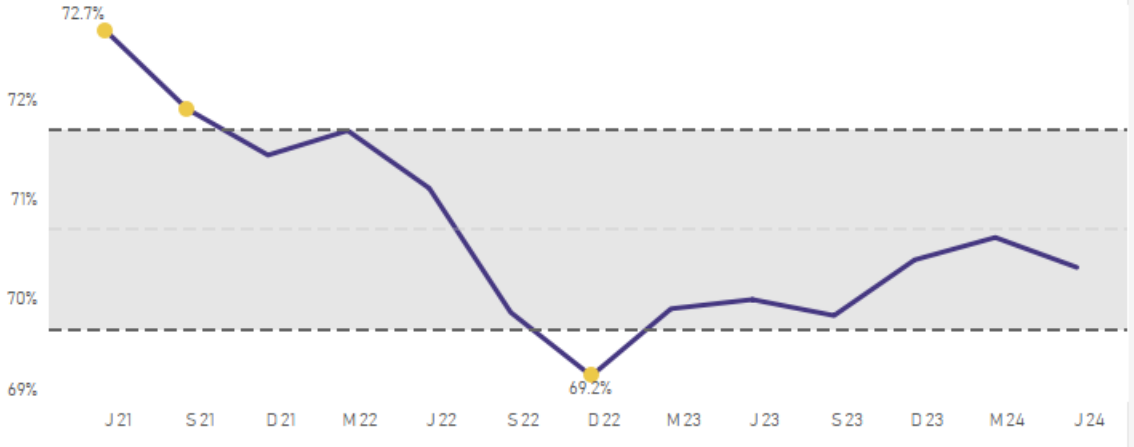
Bury

Females, 25-64, attending cervical screening within target period (3.5 or 5.5 year coverage, %)
The overall cervical screening coverage: the number of women screened adequately in the previous 42 months (if aged 24-49) or 66 months (if aged 50-64) divided by the number of eligible women on last day of review period.

Source: Cervical Screening Programme - Coverage Statistics [Management Information] (Quarterly)

70.3%	70.6%	68/106	80.%
June 2024	March 2024	National Rank Inter Quartile	National Target

Outliers more than 1 standard deviation from the mean

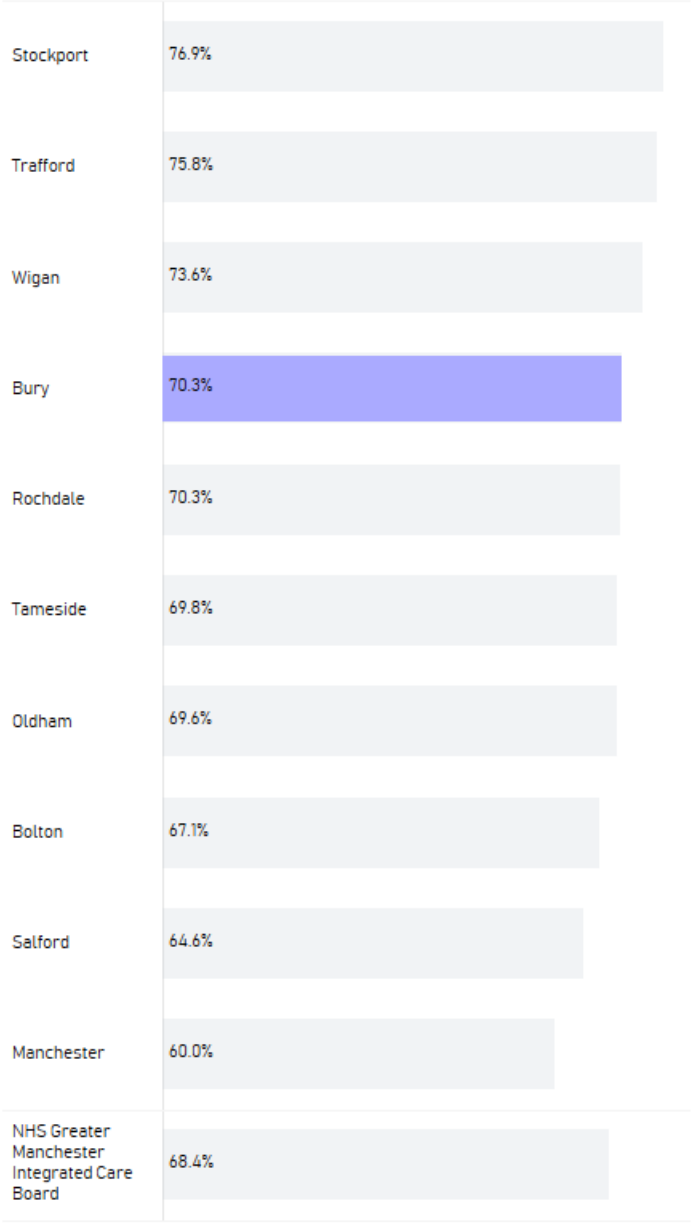


	Jun	Sep	Dec	Mar
2021-22	72.7%	71.9%	71.5%	71.7%
2022-23	71.1%	69.9%	69.2%	69.9%
2023-24	70.0%	69.8%	70.4%	70.6%
2024-25	70.3%			

Selected measure at June 2024 has continuously **decreased** for **1** period(s) of time

Latest Value GM Benchmarking

National Rank against other localities



Narrative

- The cervical screening coverage to June 24 for the Bury population was 70.3% for eligible females.
- Bury locality currently has the 4th highest percentage out of all the GM localities and is higher than the GM percentage of 68.4%.
- Bury and GM are not meeting the national target of 80%.

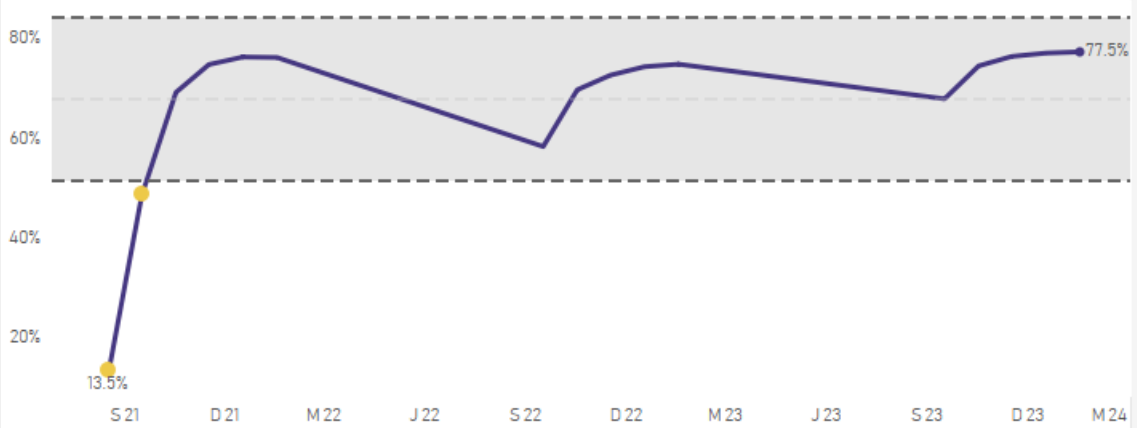
Bury

Seasonal Flu Vaccine Uptake: 65 years and over
The uptake of seasonal influenza vaccination among those aged 65 and over

Source: Seasonal influenza vaccine uptake in GP patients: monthly data, 2022 to 2023 (Monthly)

77.5%	77.3%	71/106	85.%
February 2024	January 2024	National Rank Inter Quartile	National Target

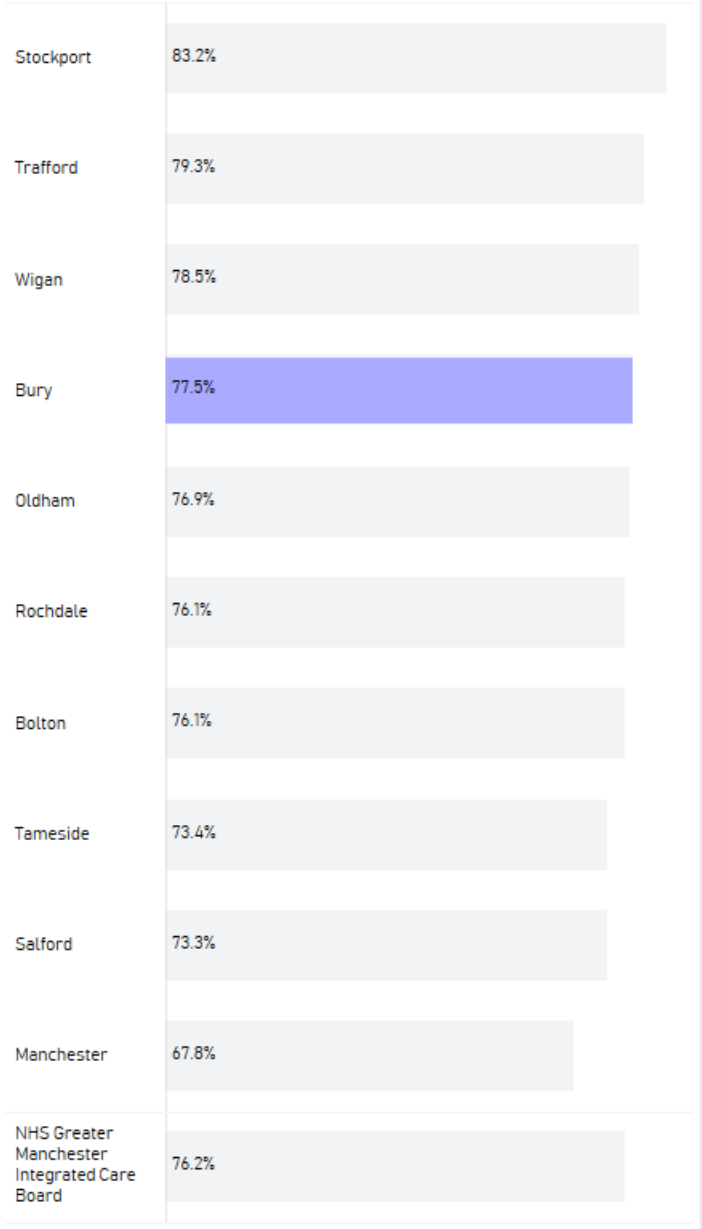
Outliers more than 1 standard deviation from the mean



	Sep	Oct	Nov	Dec	Jan	Feb
2021-22	13.5%	48.8%	69.4%	75.0%	76.5%	76.4%
2022-23		58.5%	69.9%	72.8%	74.6%	75.1%
2023-24		68.1%	74.7%	76.6%	77.3%	77.5%

Selected measure at February 2024 has continuously increased for 4 period(s) of time

Latest Value GM Benchmarking
National Rank against other localities



Narrative

- The seasonal influenza vaccination uptake to February 24 for the Bury population was 77.5% for those aged 65+.
- Bury locality currently has the 4th best uptake out of all the GM localities and is higher than the GM percentage of 76.2%.
- Bury and GM are not meeting the national target of 85%.

Bury

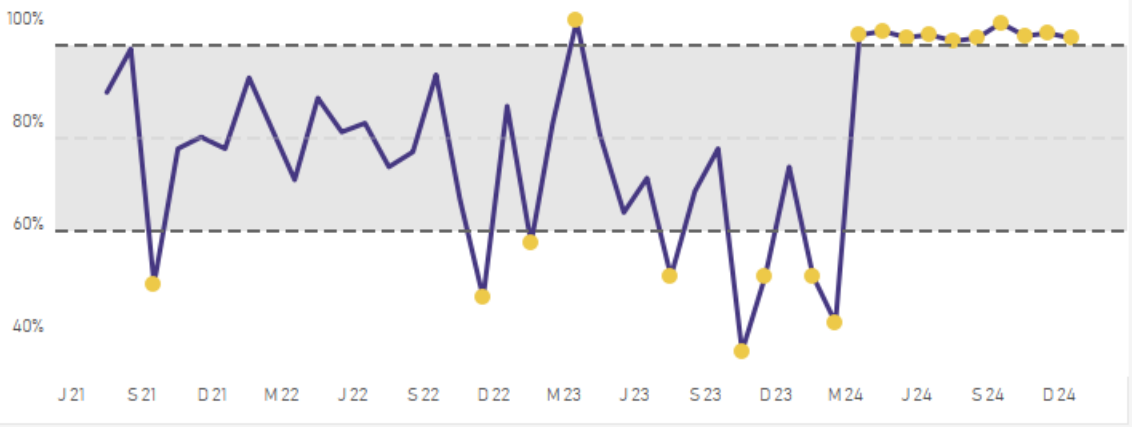
% 2-hour Urgent Community Response (UCR) first care contacts

Percentage of 2-hour UCR referrals subject to the 2-hour response standard (as specified in the UCR technical guidance), with an RTT end date in reporting month, that achieved the 2-hour response standards

Source: Community Services Data Set (CSDS) (Monthly)

96.6%	97.6%	70%
January 2025	December 2024	National Target

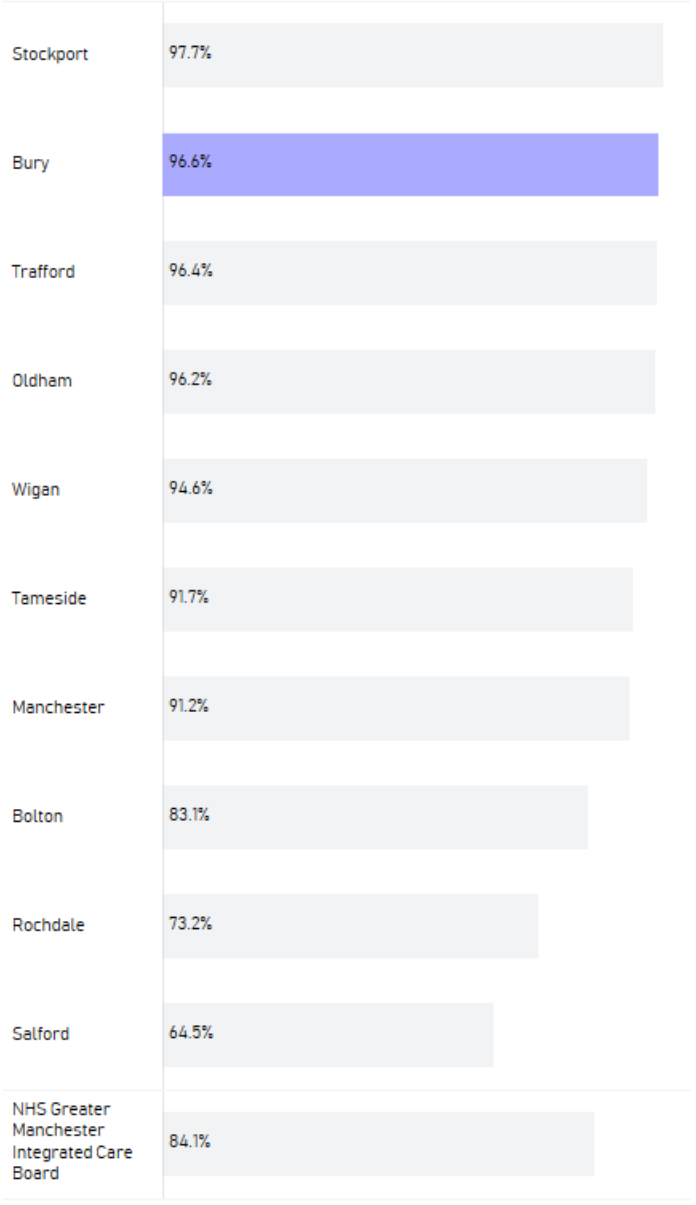
Outliers more than 1 standard deviation from the mean



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021-22					86.0%	94.5%	48.5%	75.0%	77.3%	75.0%	88.9%	79.4%
2022-23	68.9%	84.9%	78.3%	80.0%	71.4%	74.4%	89.5%	65.0%	45.8%	83.3%	56.5%	80.0%
2023-24	100.0%	77.8%	62.5%	69.2%	50.0%	66.7%	75.0%	35.3%	50.0%	71.4%	50.0%	40.9%
2024-25	97.3%	98.0%	96.8%	97.3%	96.1%	96.7%	99.6%	97.1%	97.6%	96.6%		

Selected measure at January 2025 has continuously **decreased** for **1** period(s) of time

Latest Value GM Benchmarking



Narrative

- The percentage of UCR referrals that received a 2-hour response standard for Bury registered patients in Jan 25 was 96.6%, which is an increase on Jan 24 which was 71.4%.
- Bury currently has the 2nd highest percentage in the GM localities and is currently above the National Target of 70%.
- Local authority reporting shows that 95% of Bury residents received a 2-hour response in Jan 25 with 4 patients missing target. That increased to 98% in Feb 25 with only 2 patients missing the target.

Oversight Metrics Glossary

Domain	Code	Measure	Description	Data Source	Frequency	Latest	Updated	RAG rated against	Desired Direc
Cancer	N/A	Cancers Diagnosed At Early Stage using Full Registration Data	Count of cancers diagnosed at stages 1 and 2 divided by count of cancers diagnosed at stages 1, 2, 3, and 4	Cancer Early Staging Data Statistics via The National Disease Registration Service (NDRS)	Annual	Dec 21	2nd Thursday	National Median	Increase
Mental Health & Learning Disabiliti..	S086a	Inappropriate adult acute mental health Out of Area Placement (OAP) bed days	Inappropriate Out of Area Placements	Out of Area Placements in Mental Health Services Official Statistics	Monthly	Mar 24	2nd Thursday	National Target	Decrease
	S081a	Talking Therapies: Access Rate	Number of people accessing first treatment	Improving Access to Psychological Therapies Data Set	Monthly	Jan 25	2nd Thursday	No Target	Increase
	EAS01	Dementia: Diagnosis Rate (Aged 65+)	Dementia: Diagnosis Rate (Aged 65+)	Primary Care Dementia Data	Monthly	Jan 25	2nd Thursday	National Target	Increase
	S030a	% of patients aged 14+ with a completed LD health check	% of patients aged 14+ with a completed LD health check	Learning Disabilities Health Check Scheme	Monthly	Jan 25	2nd Thursday	National Target	Increase
	S110a	Overall Access to Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses	Number of people who receive two or more contacts from NHS or NHS commissioned community mental health services (in transformed and non-transformed PCNs) for adults and older adults with severe mental illnesses, in a rolling 12 month period	Published MHSDS	Monthly	Jan 25	2nd Thursday	National Median	Increase
	S125a	Long length of stay for adults (60+ days)	Number of people for a given CCG discharged from an adult acute inpatient bed with a hospital spell over 60 days (calculated from the point of admission to the point of discharge)	Published MHSDS	Monthly	Jan 25	2nd Thursday	National Target	Decrease
	EH09	Access to Children and Young Peoples Mental Health Services	Number of CYP aged 0-17 supported through NHS funded mental health services receiving at least one contact.	Published MHSDS	Monthly	Jan 25	2nd Thursday	National Median	Increase
	S131a	Women Accessing Specialist Community Perinatal Mental Health Services	Number of women accessing specialist community PMH and MMHS services in the reporting period	Published MHSDS	Quarterly	Jan 25	2nd Thursday	No Target	Increase
	N/A	Number of MH patients with no criteria to reside (NCTR)	Number of MH patients with no criteria to reside	GM Admissions - Local	Monthly	Feb 25	1st	No Target	Decrease
	N/A	Percentage of MH patients with no criteria to reside (NCTR)	Percentage of MH patients with no criteria to reside	GM Admissions - Local	Monthly	Feb 25	1st	No Target	Decrease
Primary Care	S053b	% of hypertension patients who are treated to target as per NICE guidance		NHS Quality Outcome Framework	Annual	Mar 23	2nd Thursday	National Target	Increase
	S129a	GP appointments - percentage of regular appointments within 14 days	Percentage of appointments where the time between booking and appointment was 'Same day', '1 day', '2 to 7 days' or '8 to 14 days'	Appointments in General Practice	Monthly	Jan 25	Last Thursday	National Median	Increase
	S053c	% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins	% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins	CVD Prevent	Quarterly	Sep 24	2nd Thursday	National Median	Increase
Quality	S037A	% of patients describing their overall experience of making a GP appointment as good	The weighted percentage of people who report through the GP Patient Survey their overall experience of their GP practice as 'very good' or 'fairly good'	GP Patient Survey	Annual	Mar 23	2nd Thursday	National Median	Increase
	S042a	E. coli blood stream infections	12-month rolling counts of E. coli	National Statistics: E. coli bacteraemia: monthly data by location of onset	Monthly	Jan 25	1st Wednesday	No Target	Decrease
	S044b	Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care	The proportion of broad-spectrum antibiotic prescribing in primary care	EPACT Prescribing Data	Monthly	Dec 24	2nd Thursday	National Target	Decrease
	S044a	Antimicrobial resistance: total prescribing of antibiotics in primary care	The proportion of antibiotic prescribing in primary care	EPACT Prescribing Data	Monthly	Dec 24	2nd Thursday	National Target	Decrease

Sight Metrics Glossary

Domain	Code	Measure	Description	Data Source	Frequency	Latest	RAG rated against	Target/National
Elective Care	EB20	RTT incomplete: 65+ week waits		Consultant-led RTT Waiting Times data collection (National Statistics).	Monthly	Jan 25	National Target	0.
	EB28	Diagnostic 6ww: All	% of Patients waiting over 6 weeks for a diagnostic test or procedure	Monthly Diagnostics Waiting Times and Activity Return - DM01	Monthly	Jan 25	National Target	1.%
Cancer	S012a	28 Day Wait from Referral to Faster Diagnosis: All Patients	Count of patients told cancer diagnosis outcome within 28 days divided by total count of patients told cancer diagnosis outcome following their TWW referral for suspected cancer, TWW referral for exhibited breast symptoms, or urgent screening referral	National Cancer Waiting Times Monitoring Data Set (CWT)	Monthly	Jan 25	National Target	75.%
Maternity	S022a	Number of stillbirths per 1,000 total births	Count of cancers diagnosed at stages 1 and 2 divided by count of cancers diagnosed at stages 1, 2, 3, and 4	MBRRACE-UK - Perinatal Mortality Surveillance Report	Annual	Dec 23	National Median	3
	S104a	Number of neonatal deaths per 1,000 total live births	Number of neonatal deaths per 1,000 total live births	MBRRACE-UK - Perinatal Mortality Surveillance Report	Annual	Dec 23	National Median	1
Screening and Immunisations	S047A	Seasonal Flu Vaccine Uptake: 65 years and over	number of people over 65 who received the seasonal influenza vaccination divided by the number of eligible people who are aged 65 and over	Seasonal influenza vaccine uptake in GP patients: monthly data, 2022 to 2023	Monthly	Feb 24	National Target	85.%
	S046a	COVER immunisation: MMR2 Uptake at 5 years old	% children whose fifth birthday falls within the time period who have received two doses of MMR vaccination	Cover of vaccination evaluated rapidly (COVER) programme	Quarterly	Sep 24	National Target	95.%
	S050a	Females, 25-64, attending cervical screening within target period (3.5 or 5.5 year coverage, %)	% of females, age 25-64 yrs, attending cervical screening within target period (3.5 yrs if aged 24-49 or 5.5 yrs if aged 50-64)	Cervical Screening Programme - Coverage Statistics [Management Information]	Quarterly	Jun 24	National Target	80.%
	S049a	Breast screening coverage, females aged 53-70, screened in last 36 months	% women eligible for screening who have had a test with a recorded result at least once in the previous 36 months	Fingertips, Public Health Data, Public Health Outcomes Framework	Annual	Dec 24	No Target	
Commun..	N/A	% 2-hour Urgent Community Response (UCR) first care contacts	Percentage of 2-hour Urgent Community Response referrals subject to the 2-hour standard where care was provided within two hours	Community Services Data Set (CSDS)	Monthly	Jan 25	National Target	

PIA Locality Report

File created on: 3/17/2025 1:44:01 PM

Meeting:			
Meeting Date	07 April 2025	**Action**	Receive
Item No.	11	**Confidential**	No
Title	System Finance Group Update – March 2025		
Presented By	Simon O'Hare - Locality Finance Lead – NHS GM (Bury and HMR Localities)		
Author	Simon O'Hare - Locality Finance Lead – NHS GM (Bury and HMR Localities)		
Clinical Lead			

Executive Summary

The purpose of this report is to update the locality board on the financial position of all partners, with specific focus upon the budgets delegated to the locality board by NHS Greater Manchester (GM) both in year in 2024/25 and also with regard to budget setting for 2025/26.

The month 10 NHS GM position is showing a deficit of £74.7m versus an expected deficit of £3.7m, giving an unplanned variance of £71m. Discussions remain ongoing with NHS England on the deliverability of this agreed year end position. Within this position the Bury locality budgets, for which this board is responsible for are forecasting a deficit of £6.16m versus an expected break even annual position.

The Northern Care Alliance (NCA) are £3.9m overspent at month 10 versus a plan of £3.1m and have forecast to achieve their agreed deficit of £4.4m. Pennine Care NHS Foundation Trust (PCFT) are reporting a £0.4m deficit at month 10 versus a break even plan, but continue to forecast a very slight surplus at year end.

As at Month 10 £395m of CIP has been delivered by NHS GM against a £380m plan, the forecast CIP position is delivery of £497.3m versus a £490.3m plan. In terms of month 10 local CIP delivery on delegated budgets, £3.21m has been delivered against a plan of £4.29m, with shortfalls against plan in Medicines Optimisation and Complex Care, this therefore puts a risk of £1.65m on the full delivery of 2024/25 CIP.

All partners are working on budget setting and plans for 2025/26, with the council the most advanced, having formally signed off a balanced budget in late February, due to the regulatory requirements and the release of draft financial settlements before Christmas. NHS budget negotiations continue between NHS England and NHS GM, with a final plan to be submitted week commencing 24th March, the overall spending reduction across the whole of the NHS is making this very, very challenging to balance the costs of service delivery within the allocations available.

The final values for the Bury locality healthcare budgets for 2025/26 show a slight increase in budgets or from 2024/25 forecast out turn of £0.65m or 0.9%, inclusive of inflation, of £71.98m. The total CIP expected from localities is 4% in 2025/26 and local and GM wide discussions are taking place to support locality targets and delivery of these.

Finally the board are asked to retrospectively approve the award of contracts for 2024/25 for Primary Eye Care Services and Community Echocardiography Services. These service are funded from locality budgets and therefore to satisfy governance approval from Locality Board is required.

Recommendations
Locality board members are asked to: • Note the updates on financial positions for 2024/25. • Note the updates for 2025/26 budgets and plans, in particular the proposed settlement for the Bury locality. • Approve the retrospective contract awards for Primary Eye Care Services and Community Echocardiography services.

Links to Strategic Objectives	
SO1 - To support the Borough through a robust emergency response to the Covid-19 pandemic.	☐
SO2 - To deliver our role in the Bury 2030 local industrial strategy priorities and recovery.	☐
SO3 - To deliver improved outcomes through a programme of transformation to establish the capabilities required to deliver the 2030 vision.	☐
SO4 - To secure financial sustainability through the delivery of the agreed budget strategy.	☒
Does this report seek to address any of the risks included on the NHS GM Assurance Framework?	☐

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☐	N/A	☒
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☐	N/A	☒
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☐	N/A	☒
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☐	N/A	☒
Are there any financial Implications?	Yes	☐	No	☐	N/A	☒
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☒
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☒
Are the risks on the NHS GM risk register?	Yes	☐	No	☐	N/A	☒

Governance and Reporting		
Meeting	**Date**	**Outcome**
N/A		

System Finance Group Update – April 2025

1. Introduction

1.1. The purpose of this report is to update members of the locality board on the financial position of the 4 statutory bodies who primarily serve the population of Bury, along with that of NHS Greater Manchester Integrated Care (NHS GM).

2. Background

2.1 The position of all partners continues to be very challenged in 2024/25 with NHS GM in undertakings with NHS England which brings additional scrutiny and rigour around finance, performance and quality.

3.1 Bury Council

3.1.1 The council at the end of quarter 3 is forecasting an overspend of £2.66m against the £224.48m net budget which was set originally with a structural funding gap of £13.15m being met from reserves. The overspend primarily relates to social care and the cost of overnight accommodation for the homeless which are issues common to councils nationally and not unique to Bury.

3.1.2 The council has agreed it's revenue budget and related 4.99% council tax increase for 2025/26 which requires a £5.858m contribution from reserves to meet the funding gap which is significantly less than the c£19.5m gap previously reported in November. The improvement is primarily the result of a better than anticipated finance settlement (c£6m) and additional savings agreed for 2025/26 of £8.3m.

3.1.3 Significant uncertainty remains with regard to future funding levels but a forecast structural funding deficit of c£10m remains in 2026/27 with work being undertaken over the spring and summer to develop proposals which will significantly reduce the reliance on reserves in future years.

3.2 NHS Greater Manchester

3.2.1 The month 10 NHS GM position is showing a deficit of £74.7m versus an expected deficit of £3.7m, giving an unplanned variance of £71m adverse to plan, and remains forecasting recovery of this position by 31st March 2025 to break even, to allow delivery of the agreed £175m deficit. Discussions remain ongoing with NHS England on the deliverability of this agreed year end position. This position is shown below in table 1

Table 1

Month 10 2024/25 (£m)	YTD Plan	YTD Actual	YTD Variance	Full Year Plan	Full Year Forecast	Full Year Variance
GM NHS Providers	-£3.7	-£32.8	-£29.1	£0.0	£0.0	£0.0
NHS GM	£0.0	-£41.9	-£41.9	£0.0	£0.0	£0.0
ICS total	-£3.7	-£74.7	-£71.0	£0.0	£0.0	£0.0

3.2.2 This unplanned deficit is split £29m for NHS GM providers and £42m for non provider budgets. The primary drivers of the deficit for NHS Providers in GM are costs in relation to industrial action and a shortfall on funding for the 2024/25 staff pay award. The main drivers of the deficit on non provider budgets are mental health and continuing care placements and the costs of prescribing drug and medicines.

3.2.3 As at Month 10 £395m of CIP has been delivered by NHS GM against a plan of £380m, an over delivery of £15m. The forecast CIP position is delivery of £497.3m against a target of £490.3m, again an

overachievement but this delivery does have a level of risk attached.

3.3 NHS GM – Bury Locality

3.3.1 At month 10, the the Bury locality budgets, for which this board is responsible for are forecasting a deficit of £6.16m versus an expected break even annual position. This position has been stable since month 9 and is shown in table 2 below.

Table 2

Bury Locality Month 10 Finance position						
Directorate	**YTD Budget**	**YTD Actual**	**YTD Variance**	**Annual Budget**	**Forecast Outturn**	**Forecast Variance**
Acute	£1,816,054	£1,814,303	-£1,751	£2,185,306	£2,182,404	-£2,902
Complex Care	£16,828,078	£20,763,100	£3,935,022	£20,195,649	£22,898,249	£2,702,600
Community	£14,694,400	£14,821,716	£127,316	£17,487,634	£17,656,813	£169,179
Mental Health	£13,725,897	£16,318,167	£2,592,270	£16,534,190	£19,867,078	£3,332,888
Other	£2,396,900	£2,449,627	£52,727	£2,933,174	£3,012,217	£79,043
Primary Care	£4,572,701	£4,451,348	-£121,353	£5,472,615	£5,355,756	-£116,859
Grand Total	**£54,034,030**	**£60,618,261**	**£6,584,231**	**£64,808,568**	**£70,972,517**	**£6,163,948**

3.3.2 As can be seen the primary causes of this deficit position are in Complex Care (CHC and Mental Health) and the main drivers of the deficit are:

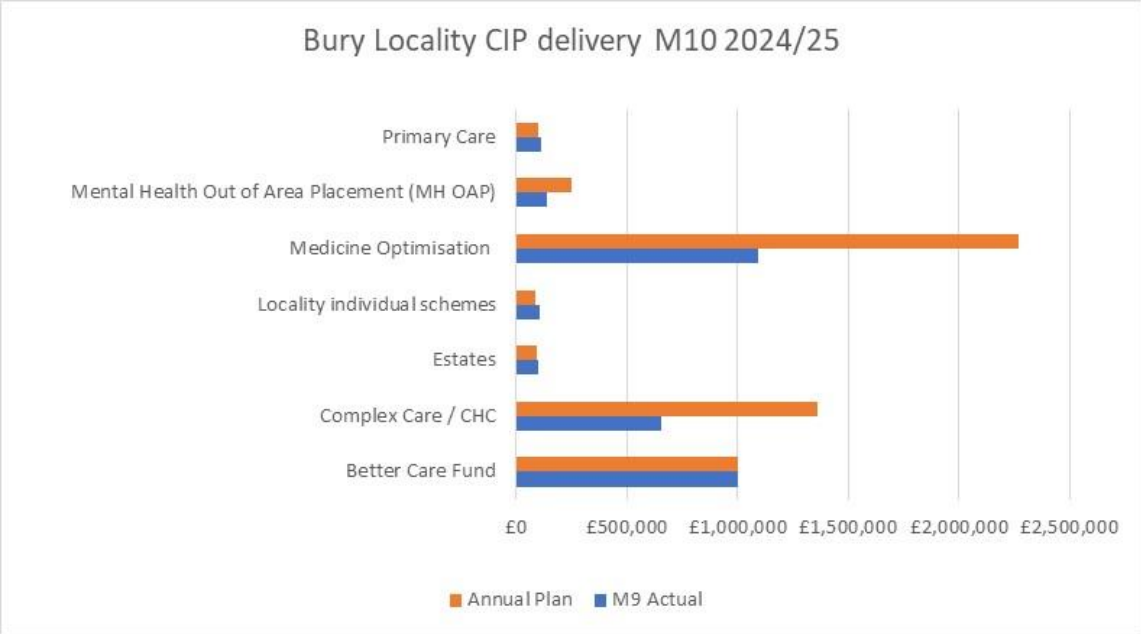
- Increases in the cost and number of Complex Case packages, shared 50:50 with the council
- Increases in the costs and number of Complex Case packages solely funded by the NHS
- Prior year pressures brought forward
- The impact of changes to the discharge pathway from acute hospital which has caused greater costs to the locality
- High performance with regard to discharges of residents of the borough with a learning disability or autism, from hospital settings into the community.

The locality is focussed upon delivery of an action plan, has received support from Price Waterhouse Cooper and is the subject of monthly intervention meetings from NHS GM Executive colleagues to address and reduce this deficit in Complex Care. This has been successful in driving out just short of £3m from the forecast since month 4.

3.3.3 Alongside these very significant pressures there are also smaller pressures with regard ADHD / ASD assessments (£0.6m), with this being particularly volatile as more providers are being approved nationally to delivered services.

3.3.4 With regard to CIP achievement at month 10, the locality has achieved £3.21m of CIP delivery which is 63% of the annual target but there is only 17% of the year remaining and delivery is behind plan in terms of Medicines Optimisation and CHC / Complex Care. There are risks associated with full delivery of the Medicines Optimisation target due to staffing pressures and historic excellent performance by this team, meaning the opportunity for savings is less than in other localities. There are £1.65m of risks associated with CHC / Complex Care delivery due to demand and inflationary pressure. It should also be noted that alongside the £400k costs reduction savings the Complex Care / CHC team have also delivered over £1.5m of savings that have avoided increased costs. CIP delivery and annual plan values are shown overleaf in graph 1.

Graph 1



3.4 Northern Care Alliance and Pennine Care

3.4.1 The Northern Care Alliance (NCA) are £3.9m overspent at month 10 versus a plan of £3.1m and have forecast to achieve their agreed deficit of £4.4m. Pennine Care NHS Foundation Trust (PCFT) are reporting a £0.4m deficit at month 10 versus a break even plan, but continue to forecast a very slight surplus at year end.

4.0 2025/26 financial plans

4.1 All partners are working on budget setting and plans for 2025/26, with the council the most advanced, having formally signed off a balanced budget in late February, due to the regulatory requirements and the release of draft financial settlements before Christmas.

4.2 2025/26 NHS planning guidance and financial allocations were received in late January and the impacts of this upon NHS GM have been quantified. Conversations with NHS England are ongoing and a final agreed plan is to be submitted before the end of March but the overall spending reduction across the whole of the NHS is making this very, very challenging to balance the costs of service delivery within the allocations available.

4.3 NHS GM - Bury Locality budgets

4.3.1 A number of submissions and iterations of the locality budgets that this board is responsible for have taken place and these are intrinisically linked to the overall NHS GM 2025/26 budget discussions with NHS England.

4.3.2 The final values for the Bury locality healthcare budgets for 2025/26 show a slight increase in budgets or from 2024/25 forecast out turn of £0.65m or 0.9%, inclusive of inflation, of £71.98m. This increase recognises that £1.5m of the 2024/25 out turn was recurrent and that the majority of the over performance for 2024/25 has been funded.

4.3.3 The CIP allocation across all localities is 4% of total locality budgets, discussions are taking place across localities as to the allocation of this and plans have been and continue to be developed internally and

with partners to deliver CIP in 2025/26. As stated in 4.2 the financial settlement for NHS GM and in turn all localities is very very challenging

4.3.4 In terms of the locality staffing and operating costs budgets, the 2024/25 recurrent values are plannined to be rolled over, with permanent resolution still required to resolve 2 outstanding issues across NHS GM localities. These are live issue and remains under discussion with NHS GM colleagues. A small savings target was to be applied to these overall staffing and operating costs budgets but the wholesale changes to ICBs announced recently mean that this exercise is being paused until the impact of these much wider changes are known and understood.

5.0 Locality Contract Agreements

5.1 Within these locality budgets there are a number of contracts for services that the locality commissions each year in line with the Public Sector Reform (PSR) contractual regulations. As the responsible body for these budgets, the Locality Board as sign off responsibility for these contracts.

5.2 Locality commissioners and finance colleagues have work with central NHS GM contracted colleagues and have successfully navigated the required governance and PSR processes with the final step being agreement from the Locality Board.

5.3 Primary Eye Care Services

5.3.1 This is a 12-month direct award contract to Primary Eyecare Services Ltd to deliver the Community Urgent Eyecare Service, Pre / Post Cataract Assessment Service and Glaucoma Repeat Reading / Glaucoma Enhanced Referral Refinement Scheme / Glaucoma Community Monitoring in Bury Locality from 1st April 2025 to 31st March 2026. The Bury Locality service is part of a GM wide contract and once approved a request for financial approval will go to GM STAR panel and approval of a new contract will be sought via direct award C under the provider selection regime (PSR) regulations. The indicative cost of this service to the locality for the 2024/25 financial year is:£527,359.

5.4 Community Echocardiography Service

5.4.1 Manchester Locality are leading the PSR Submission for the Community Echocardiography Service which is proposing an additional contract for 1 year with no extension to 31st March 2025, as the existing contract has expired 31 March 2024 and is being delivered on implied terms, the contract value for 2024/25 is £171,000.

5.5 The Locality Board are asked to retrospectively approve the award of these contracts for 2024/25

5.0 Conclusion

5.1 Locality board members are asked to:

- Note the updates on financial positions for 2024/25.
- Note the updates for 2025/26 budgets and plans, in particular the settlement for the Bury locality.
- Approve the retrospective contract awards for Primary Eye Care Services and Community Echocardiography services.

Simon O'Hare
Locality Finance Lead – NHS GM (Bury and HMR Localities)
s.ohare@nhs.net
April 2025

Meeting:			
Meeting Date	07 April 2025	**Action**	Receive
Item No.	11.2	**Confidential**	No
Title	2025/26 Better Care Fund		
Presented By	Simon O'Hare - Locality Finance Lead – NHS GM (Bury and HMR Localities)		
Author	Hannah Dixon – Commissioning Manager NHS GM (Bury Locality) Shirley Allen – Commissioning Manager Bury Council		
Clinical Lead			

Executive Summary

The purpose of this report is to update the locality board on the plans for the deployment of the Better Care Fund (BCF) in 2025/26, which has been jointly worked up between the council and health partners.

The BCF has been in existence for a number of years and supports local systems to successfully deliver the integration of health and social care in a way that supports person-centred care, sustainability and better outcomes for people and carers. In Bury the BCF aligns to the Health and Well Being Strategy and the Let's Do It! 2030 Strategy along with the Bury Health and Care Locality Plan, the NHS Greater Manchester (GM) Operating Plan and the NHS Long Term Plan.

The intention is to ensure that individuals and families are at the centre of their care and support, and that their needs are met in a holistic way by providing the right support and care, at the right time, supporting residents to be healthier and have a higher quality of life for longer.

The 2025/26 BCF has seen 2024/25 values uplifted nationally and it has been mandated that all of this uplift is to flow to Adult Social Care. This has required additional money to be added to the BCF for non council services and whilst this commitment is sound, the values and mechanism are not fully worked through at this stage but they will be by the end of April 2025. The 2025/26 BCF has also seen the funding for the BCF discharge fund that ran in 2023/24 and 2024/25 now brought in to the core BCF.

Contributions to the BCF are as follows:

£19.58m NHS minimum contribution
£2.14m NHS additional contribution
£9.41m Local Authority Better Care Grant
£2.58m Local Authority Disable Facilities Grant
£33.70m Total

There have been no significant changes to the schemes funded in 2024/25 in this 2025/26 plan, as the 2024/25 plan was already delivering to the key metrics laid out in the 2025/26 guidance. This plan was approved by the Health and Well Being Board in March and will also be approved by the NHS GM Board. Quarterly updates will be brought to the Locality Board on progress of the delivery of key metrics and expenditure.

Recommendations
Locality board members are asked to: • Note the contents of the paper and the attachments regarding the detail of the BCF. • Expect quarterly updates on progress versus metrics and expenditure.

Links to Strategic Objectives	
SO1 - To support the Borough through a robust emergency response to the Covid-19 pandemic.	☐
SO2 - To deliver our role in the Bury 2030 local industrial strategy priorities and recovery.	☐
SO3 - To deliver improved outcomes through a programme of transformation to establish the capabilities required to deliver the 2030 vision.	☐
SO4 - To secure financial sustainability through the delivery of the agreed budget strategy.	☒
Does this report seek to address any of the risks included on the NHS GM Assurance Framework?	☐

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☐	N/A	☒
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☐	N/A	☒
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☐	N/A	☒
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☐	N/A	☒
Are there any financial Implications?	Yes	☐	No	☐	N/A	☒
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☒
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☒
Are the risks on the NHS GM risk register?	Yes	☐	No	☐	N/A	☒

Governance and Reporting		
Meeting	**Date**	**Outcome**
N/A		

Better Care Fund 2025/26

1. Introduction

1.1 The purpose of this report is to update the locality board on the plans for the deployment of the Better Care Fund (BCF) in 2025/26, which has been jointly worked up between the council and health partners.

2. Purpose & Objectives

2.1 The BCF has been in existence for a number of years and supports local systems to successfully deliver the integration of health and social care in a way that supports person-centred care, sustainability and better outcomes for people and carers. In Bury the BCF aligns to the Health and Well Being Strategy and the Let's Do It! 2030 Strategy along with the Bury Health and Care Locality Plan, the NHS Greater Manchester (GM) Operating Plan and the NHS Long Term Plan.

2.2 The intention is to ensure that individuals and families are at the centre of their care and support, and that their needs are met in a holistic way by providing the right support and care, at the right time, supporting residents to be healthier and have a higher quality of life for longer.

2.3 There are 2 objectives for the BCF:

- 1: Reform to support the shift from sickness to prevention
- 2: Reform to support people living independently and the shift from hospital to home

and 3 primary metrics

- emergency admissions to hospital for people aged over 65 per 100,000 population
- average length of discharge delay for all acute adult patients
- long-term admissions to residential care homes and nursing homes for people aged 65 and over per 100,000 population

2.4 A more detailed narrative on the BCF giving further information on the process, the objectives and the metrics is attached at appendix 1.

3. Schemes & Funding

3.1 The 2025/26 BCF has seen 2024/25 values uplifted nationally and it has been mandated that all of this uplift is to flow to Adult Social Care. This has required additional money to be added to the BCF for non council services and whilst this commitment is sound, the values and mechanism are not fully worked through at this stage but they will be by the end of April 2025.

3.2 The 2025/26 BCF has also seen the funding for the BCF discharge fund that ran in 2023/24 and 2024/25 now brought in to the core BCF.

3.3 There have been no significant changes to the schemes funded in 2024/25 in this 2025/26 plan, as the 2024/25 plan was already delivering to the key metrics laid out in the 2025/26 guidance.

3.4 Organisational contributions to the BCF are as follows:

£19.58m NHS minimum contribution
£2.14m NHS additional contribution
£9.41m Local Authority Better Care Grant
£2.58m Local Authority Disable Facilities Grant
£33.70m Total

3.5 In 2025/26 the minimum NHS contribution to Adult Social Care through the BCF is £10.56m and the funding to Adult Social Care from the NHS minimum contribution in Bury is £11.26m, with a further £2.09m Adult Social Care funding in the NHS additional contribution, giving a total £13.35m NHS contribution to Adult Social Care in Bury.

3.6 Table 1, below, shows the areas of expenditure for the 2025/26 BCF, with further detail on this in appendix 2.

Bury Locality 2025/26 BCF	
Social Care	£13,347,864
NHS Community	£5,846,408
NHS Mental Health	£837,192
Primary Care	£446,529
NHS Acute	£359,868
Hospice & Palliative Care	£339,209
Voluntary Sector	£258,425
Other	£277,934
NHS Total Contribution	**£21,713,429**
Local Authority Better Care Grant	£9,410,943
Local Authority Disabled Facilities Grant	£2,576,737
LA Total Contribution	**£11,987,680**
Total BCF	**£33,701,109**

4.0 Approvals and updates

4.1 This plan was approved by the Health and Well Being Board in March and will also be approved by the NHS GM Board. Quarterly updates will be brought to the Locality Board on progress of the delivery of key metrics and expenditure.

5.0 Conclusion

5.1 Locality board members are asked to:

- Note the contents of the paper and the attachments regarding the detail of the BCF.
- Expect quarterly updates on progress versus metrics and expenditure.

Hannah Dixon
Commissioning Manager
NHS GM – Bury Locality
April 2025

Shirley Allen
Commissioning Manager
Bury Council

BETTER CARE FUND 2025-26 HWB SUBMISSION

	HWB Area
HWB	Bury
ICB	Bury

Section 1: Overview of BCF Plan

Priorities for 2025/26:

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.

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

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.

Key Changes Since Previous Plan:

There are no changes to the previous plan as we were already delivering against the 2 new objectives
The allocated funding is already directed towards activities and services that underpin the following objectives;

Timely, proactive and joined up support for people with more complex health and care needs
Use of home adaptations and technology
Support for unpaid carers
Funded services are aligned to help prevent hospital admissions
Services are already aligned to achieve more timely and effective discharge from hospital settings, supporting more people to recover in their own homes, or usual place of residence
The focus is targeted to reduce the proportion of people who need long term residential or nursing home care.

Approach to Joint Planning & Governance:

Health and Well Being Board

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

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

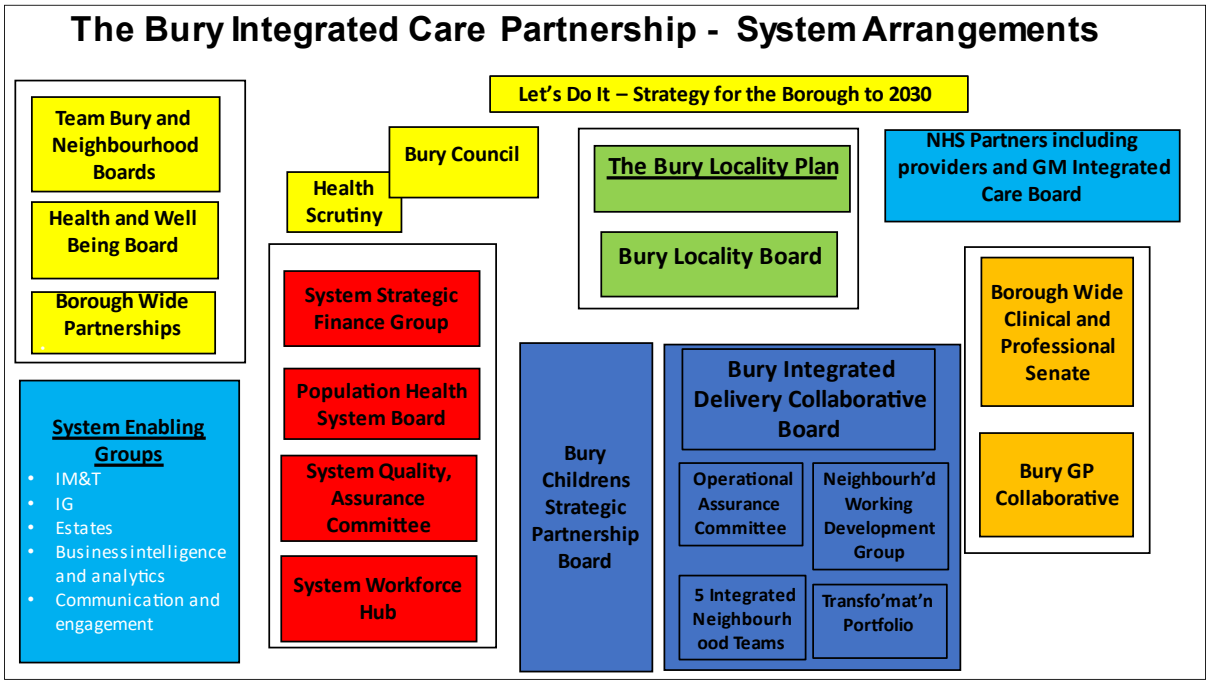
- The Wider Determinants of Health
- Health Related Behaviours
- An Integrated Health and Care System
- The Places and Communities we live in and with

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 LabourCabinet 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 Six Town Housing



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 the 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

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.

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.

Quarterly reports on BCF will be submitted to the Health and Well Being Board and the Locality board for approval at the same time.

Alignment with Improvement of UEC Flow:

The Bury Locality has a track record of system wide working. Whilst there are numerous actions within Fairfield General Hospital to improve flow in Urgent and Emergency Care (UEC) Services, our community partners also engage in a range of actions to assist.

Whilst there are numerous actions within the main locality hospital at Fairfield General Hospital (FGH) to improve flow in Urgent and Emergency Care (UEC) services which include; increased use of Same Day Emergency Care (SDEC), further development of the Hospital at Home (H@H) service and initiatives such as My Next Patient, Board Round improvement and preventing deconditioning within hospital, our community-based system partners also engage in a range of actions to assist. There are multiple admission avoidance activities such as; an alternative to transfer scheme between our out-of-hours provider BARDOC and the North West Ambulance Service (NWAS), Falls response service, Hospice outreach, education sessions for care homes and system wide, multidisciplinary (MDT) case management for service attenders with complex, multifactorial needs.

Much of this system wide work is brought together in the Bury Care Organisation Discharge and Flow Collaborative which was a series of working groups to improve flow in urgent and emergency care. The groups forming this collaborative programme were:

1. Avoiding needless inpatient and emergency care - Deflection pre-ED
2. Right Place, Right Time – Emergency Department Streaming
3. More people home on the same day – Same Day Emergency Care
4. Why not home? Why not today? – Wards
5. Discharge Pathways – Days Kept Away from Home (No Criteria to Reside)

Services from across the Health and Social Care system from Bury locality were involved in all these groups but particularly Groups 1 and 5 which related to admission avoidance and discharge.

These groups are now being reviewed, with new and existing areas of focus being identified for groups to be relaunched as part of the 2025/26 Discharge and Flow collaborative programme in 2025/6.

If admission avoidance is not possible and admission to a hospital bed is clinically appropriate, there are several initiatives to support timely and appropriate discharge as soon as a patient is medically optimised. There has been significant development in the Home First ethos across all services and this has been further supported by; an increased in multidisciplinary roles within the Integrated Discharge Team, work with the Discharge Front Runner Programme e.g. a pilot to develop an enhanced home care offer for people living with dementia as an alternative to discharge to a care home.

There is also a system wide escalation process in Bury where all system partners meet at least twice a week, to review flow and ensure mutual support across organisational boundaries.
The use of the Intermediate Care, Technology Enabled Care , has been significant in improving outcomes for people to remain at home. This is now a part of Bury's care act assessment as well as in

use in the Discharge Frontrunner and all IMC customers. The tech offer in Bury is now improved as investment has been made into developing resources, services and training to keep up to date on the new developments in service. Tech champions have been established in teams to widen the knowledge base.

The elements of the BCF plan that relate to UEC services have been taken through local governance arrangements in both the LA and the NHS.

Intermediate Care:

The therapy offer in the IMC services has extended by investment within the intermediate tier to introduce technical instructors to work alongside reablement staff allowing therapists to see more cases and review for independence from the bed base to home based service and then discharge to independence as a priority or complete intensive therapeutic interventions in bed based services to maximise independence Additionally the Principal Therapy Lead will now support community equipment and community therapy teams to reduce waits in the community for therapy and keep people safe at home and widening the scope for 1 handed care by investing in equipment that supports this, this making capacity in home based rehabilitation and care at home.

Further support for IMC therapeutic improvements are to

Reduce the wait list in the community for access to therapy to six weeks maximum and work with VSFA and voluntary sector for signposting. A benchmarking exercise is planned per head of population to ascertain needs, remedy with preventative access to aids and adaptations and support self-management. We will work with Foundations to complete this benchmarking, and make use of the disabled facilities grant to improve the local offer

Upskill community and IMC teams to complete specialist moving and handling assessments, blended roles to include venepuncture, advanced clinical skills and non-medical prescribing. This will be across IMC and Community therapy to align competence and skills.

We will continue to our Otago classes, Virtual Falls Clinic, and Activity Group

Full compliance and Implementation of EDDNA safer staffing and contact for therapy and target from analysis the following KPI's. to ensure capacity meets demand.

Initial Assessment time new customers 65 minutes in bed base and 99 minutes for home based., Follow up sessions and contacts, we will aim for a performance target of 13-14 per person to maximise independence to discharge with reduced care and support needs. 22.2 Hours of therapy in bed-based services, 17.5 in home-based services alongside other interventions.

There will be support from newly established Exercise and Independence Therapy in the community. There is also a system wide escalation process in Bury, where all system partners meet at least twice a week depending on pressures; to review flow and ensure mutual support across organisational boundaries, and system flow lead within the IMC tier alongside Brokerage and the SPOA manage care navigation, escalation and flow for hospital, IMC and community teams

Rapid Response Team will continue to provide a responsive service to prevent the need for admission to acute services on a step up and step-down basis and support people wo may be at risk from hospitalisation.

The intermediate tier will continue to be involved in Care Home support

The VCFA Sector working with Age UK on Home from hospital has been fundamentally supportive in reducing delays for people who do not need statutory care or reablement and rehabilitation but need support to return home and signposting to community teams to prevent further acute admissions.

The Staying well team also offer a service to prevent admission to acute services and support people to manage health and social care issues in the community that if left without access to appropriate services, could lead to acute admission.

The Intermediate Tier services (IMC) have recorded all referrals and outcomes for people who are referred to services. An analysis of the data shows that there must be significant investment in the IMC services not only to sustain what we have now but to manage the demand as other teams get to the home first model such as out of area hospitals on a step-down pathway but to also make necessary changes to step up from community. This will be further extended in capacity and demand.

Priorities for developing intermediate care

Reablement and Rehabilitation at home

Investment made to review of structure of reablement workforce to include increased workforce to manage hours of support required to reduce delayed discharges, and use of additional stepdown.

Investment to develop 2 new posts to support the flow, performance and scheduling of reablement to allow co coordinators to concentrate on regular reviews to reduce Length of Stay in service and increasing output. Improve time taken on from referral to start date by case opening within 72 hours of escalation, and time to close cases with a view that long term needs are reduced through rehabilitation or referred to appropriate service by assessment and care management to prevent cyclical returners to acute.

Improve step up offer for those inappropriately assessed, increase screening by manager developing SPOA admissions.

Take action on performance data to manage therapeutic interventions and make further improvements.

Bed based IMC

Implemented Board round that asks the key 3 questions daily to manage change to return to home opposed to further bed-based community services.

Improved escalation and validation of SITREP and twice weekly reports to Senior Leadership.

Restructure working hours and job descriptions to maximise workforce availability at key points in the day.

Continually review Length of stay,

Collaborate with integrated neighbourhood teams, Age UK, Staying Well and self-referrers to service to step up and take customers via Rapid Response off the NWAS stack and GP's who continue to refer post review of GP contract consultation.

Brokerage and Admission coordinators screen referrals to look at dependency needs and appropriateness of assessment for IMC, Stepdown, Step Up, and community teams to support overarching flow for locality and manage escalation, and improve admission criteria to services through joint working and to extend current support for MH and LD acute delays by implementation of referral pathways for support and attend delays meetings to work proactively and prevent escalation rather than reactively which would reduce LOS, High OPEL, Delayed Days and Long Length of Stay within system flow

We will continue to provide a falls service within the locality to prevent unnecessary hospital admissions.

IMT services delivered:

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 .Intermediate care services support people in the community, helping to promote independence and providing care, therapies, and rehabilitation.

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. 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.

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.

We also commission 13 IMC beds at Elmhurst which is a part of Personna, the council owned arm's length company. This service is for people with lower level reablement and rehabilitation needs but which are too complex to be managed by reablement at home.

Hospital at Home (sometimes called virtual wards) is a service that allows people to receive hospital care, in the comfort of their own home. It is tailored to specific needs and means people can go back to the place they call home more quickly but still receive care and treatment. We know people can recover better and more quickly at home. When using the service, people are monitored by a team of health and care professionals matched to their needs. People might be given some easy-to-use equipment to use at home.

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

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 has been reviewed and has now 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.

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.

Section 2: National Condition 2 – Implementing BCF Objectives

Sickness to Prevention:

The schemes in the table below are those that are aligned to achieving this objective.

Scheme	**Outcomes**
Domiciliary Care Packages	Reducing the need for long term residential Care Preventing Hospital Admissions Preventing readmission to hospital Promoting independence and well being
Residential Care Packages	Preventing unnecessary hospital admissions and readmissions Promoting wellbeing and quality of life
Nursing Home Care Packages	Preventing unnecessary hospital admissions and readmissions Promoting wellbeing and quality of life
Supported Living Care Packages	Reducing the need for long term residential Care Preventing Hospital Admissions Preventing readmission to hospital Promoting independence and well being
Short Term residential care	Reducing the need for long term residential Care Preventing Hospital Admissions Preventing readmission to hospital Promoting independence and well being
Home Based Reablement	Reducing the need for long term residential Care Preventing Hospital Admissions Preventing readmission to hospital Promoting independence and well being
Integrated Health and Social Care Teams	Reducing the need for long term residential Care Preventing Hospital Admissions Preventing readmission to hospital Promoting independence and well being
Assistive Technology	Reducing the need for long term care packages Reducing the need for long term residential Care Preventing Hospital Admissions Preventing readmission to hospital Promoting independence and well being

Rapid Community Response	Reducing the need for long term care packages Reducing the need for long term residential Care Preventing Hospital Admissions Preventing readmission to hospital Promoting independence and well being
Staying Well Service – targeted support to over 65's	Reducing the need for long term care packages Reducing the need for long term residential Care Preventing Hospital Admissions Preventing readmission to hospital Promoting independence and well being
Falls Service	Reducing the need for long term care packages Reducing the need for long term residential Care Preventing Hospital Admissions Preventing readmission to hospital Promoting independence and well being
Disabled Facilities Grants	Reducing the need for long term care packages Reducing the need for long term residential Care Preventing Hospital Admissions Preventing readmission to hospital Promoting independence and well being
Alzheimer's Society	Reducing the need for long term care packages Reducing the need for long term residential Care Preventing Hospital Admissions Preventing readmission to hospital Promoting independence and well being
Additional Support to Primary care – increased GP appointments	Reducing the need for long term care packages Reducing the need for long term residential Care Preventing Hospital Admissions Preventing readmission to hospital Promoting independence and well being
Home From Hospital	Reducing the need for long term residential Care Preventing Hospital Admissions Preventing readmission to hospital Promoting independence and well being
Stroke Association	Reducing the need for long term residential Care Preventing Hospital Admissions Preventing readmission to hospital Promoting independence and well being
VCSE Housing	Reducing the need for long term residential Care Preventing Hospital Admissions

	Preventing readmission to hospital Promoting independence and well being
SDEC Frailty	Reducing the need for long term care packages Reducing the need for long term residential Care Preventing Hospital Admissions Preventing readmission to hospital Promoting independence and well being

Hospital to Home:

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.

Days Kept Away From Home Group

Multi- disciplinary team comes together twice a week to support flow from the hospital to community.

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 centred formal care.
- Providers able to deliver a level of reablement when there is insufficient capacity, or it is inappropriate for them to be referred to the Bury Council Reablement Team.

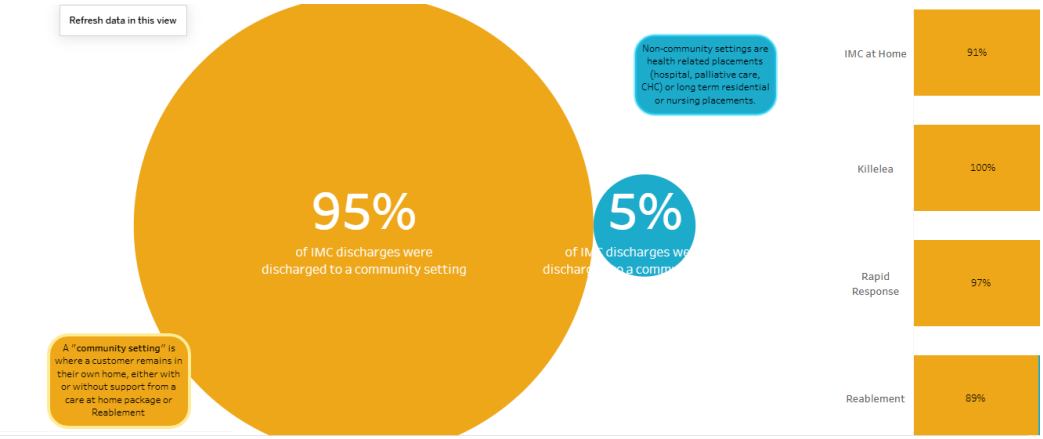
Metrics Ambitions Support Alignment to System Partner Plans/Capacity & Demand:

Capacity and Demand

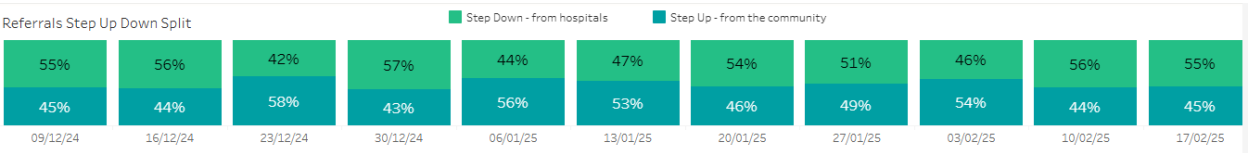
As you will see from the capacity and demand informatics, demand outweighs funded capacity. There have been significant shortfalls in the capacity that has been met as outlined later in the figures section. We anticipate that further Step down will also be I place for the next 12 months as out of area hospitals start to follow a home first model, as well as required step up. Until this is fully established there will always be a predominance for step down.

Customers by nature will take time to prevent self-admission to acute services until there are fully established services that are tried and trusted, and we cannot expect a change beyond an 18-20% in increase of what we step up currently in the first year. As figures have continually increased in terms of demand year on year, we can predict this will continue.

In IMC we achieve superb rolling weekly targets which is a KPI and measures how our intervention supports independence and supports capacity and demand. We are aiming to improve on step up and make improvements with our excellent targets



<u>The split of referrals from step up & step down demand is shown as</u>



Bed based services.

We currently have 49 beds within the intermediate tier and the average is 38 admissions per month with significant increases March, May and October, a comparison with 2023/24, 2024/5 shows the same trend. As well as the IMC beds the locality has had to spot purchase 234 additional beds across a 12-month period to manage demand. The main model is step down. We do need to improve Length of Stay where adapted housing has been an issue so we can target 49 admissions per month but by increasing LOS by 4 days from 28-32 in exceptional circumstances we have achieved people going home independent.

There is a 31% variance in beds required under spot purchase compared to previous year from hospitals. Where there is no rehabilitation potential and subject to future funding can improve on this with the Discharge Frontrunner.

Actuals have been taken from data held in the locality, within the Intermediate Tier, Tableau, Brokerage, Commissioning, Staying well, Age UK and Hospital Referral and Assessment data, Delayed discharge informatics and expenditure data. This has been coupled with Contact Data EDDNA safer staffing and contacts for therapy, and call monitoring and workforce data

By using alternative funding to mitigate increase in provision that has been managed but not sustainable until the BCF capacity and demand funding is comparable and takes into account an 18% increase for service provision.

Therapy interventions are enacted into all care and support referrals accepted to the services in IMC use of expertise is paramount.

Each person referred has an initial assessment and between 13-14 follow up contacts of therapy per person. The only exception to this are people who have been referred to a bed base with no rehabilitation potential and these are within calculated IMC at home data figures.

In considering the figures in the Capacity and Demand template relating to the time period for reablement and rehabilitation in a bedded setting (step down – pathway 2), other short term bedded care (step down-pathway 2) and reablement in a bedded setting (step up) , the forecast is based upon the funded time period that has been reduced from 6 weeks to 28 days which is an improvement. We will on occasion be able to reduce this time period but to ensure that 90%+ people who are rehabilitated and leave our services with no ongoing support this, in our opinion, is an appropriate time period.

Metric 8.1

Our forecast out turn for 24/25 is based upon month 1-5 of 24/25, as provided, and month 6-12 of 23/24 actual outturn.

We feel that the 24/25 months 6-8 as provided may be incomplete

Our plan for 25/26 is based upon arresting any growth in the activity from the previous year, due to potential increases in population and presenting acuity, within better care fund allocations.

Metric 8.2

The baseline information for the new measure is incomplete, with only 3 months of activity reported. Of the 3 months our 2 main providers data is not included for the months of October and November meaning the data is less than 45% complete.

As a result, we have instead used the average LOS information available from NCTR submissions to calculate for adult patients not discharged on DRD and the average number of days from DRD to discharge

Due to the incompleteness of the baseline data provided we also believe that the proportion of patients discharged on their discharge ready date is actually higher than actual. We have therefore put what we believe is a more realistic 60% performance in for 25/26 plan based on local intelligence.

As a locality we will work with our local providers to ensure that the data required for this metric is reported in an acceptable format. The aim is to ensure that we are able to set a 26/27 plan based on more robust data. The level of confidence with regards to the plan for 25/26 is therefore considered to be low. We will continue to monitor this throughout the year and reset the plan if possible/appropriate.

Metric 8.3

We are not looking to stretch this target given the current economic circumstances and our plan for 25/26 is based upon arresting any growth in the activity from the previous year, due to potential increases in population and presenting acuity, within better care fund allocations.

Home First Approach:

There is an increased focus across the system on transfers of care and patients currently waiting in hospital 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.

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 focusing on; interdisciplinary working, more streamlined pathways, rebranding of team as a discharge hub, improved lines of accountability 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 e.g. numbers and days spent on the DKAFH list, discharge pathways. This has taken some time to 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 the 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 recommendations made by ECIST for the discharge hub was increased therapy involvement. Two 'Home First Therapist' posts have just been recruited to increase mobilization of patients in the hospital environment and to embed the therapy role into the IDT alongside with the current nursing and social work roles, in order to maximise efficiency and the skills of the team. A 'Home First Pathway Co-Ordinator' has also been developed and this role has been integrated into the discharge hub.

The new Home from Hospital Team run by Age UK is now based in the discharge hub .

Home First / D2A

Bury has been involved in the National Discharge Frontrunner Programme. The focus of this programme within the Northern Care Alliance NHS Trust was to improve dementia care, prevent deconditioning in

hospital and increase discharge to a person's home or familiar place. Fairfield General Hospital and the wider Bury locality services took part in the Northern Care Alliances Days Kept Away from Home (DKAfH) Collaborative which focused on Discharge Pathways, Strength Based Conversations and Preventing Deconditioning.

As part of the Discharge Front Runner, Bury also piloted an Enhanced Home Care offer for patients with Dementia who came in from their own home but were at risk of their discharge destination being a care home setting. This scheme offered enhanced 24-hour home care at the point of discharge with assessments and support services being put into place from the patient's own home.

The initial findings from this work showed good outcomes both on terms of patients remaining in their own home as well as patient and family feedback. Going forward, we hope to roll out this enhanced home care offer from the pilot phase.

The development of the Integrated Discharge Team has involved work to create a more multidisciplinary team in line with Emergency Care Improvement Support Team (ECIST) review recommendations and GM Care Transfer Hubs criteria. The team was originally made up of Nurses and Social Workers but now consists of new roles including Therapists, Home First Facilitators and an Age UK Home from Hospital support team. The team will also work with new roles of Exercise and Independence Facilitators who will support ward nursing and therapy teams to develop person specific exercise programmes and activities to prevent deconditioning and support independence and, in doing so, support home first discharge and prevent readmission. The multidisciplinary make up of the team supports the increase focus on Home First discharge with recovery, rehabilitation, reablement continuing within the patient's own home.

With these changes to the Integrated Discharge Team and the wider system changes, Bury's Care Transfer Hub has demonstrated progress and development against the GM Care Transfer Hub maturity matrix.

The Home First ethos is not limited to hospital discharge and is also seen in the move to admission avoidance where patients can remain in their own home to receive hospital level care and support via the Hospital at Home service or, if required, can attend SDEC for their required care before returning home with support from any required community services.

These 3 Home First pillars – Hospital at Home, SDEC and Days Kept Away from Home have been key in driving a Home First culture change across all areas of the Bury system.

The results of this can be seen in the number of Discharge to a person's home or familiar place showing significant improvement over a period of time. As well as improving outcomes for patients by facilitating them to return to their own home or familiar place, these changes have also meant more timely discharge and therefore flow through the hospital system to ease pressure on urgent and emergency care. This has been demonstrated by the decreased number of the DKAFH (NC2R) list at Fairfield General hospital, again as an ongoing trend and also if compared with the same monthly period in previous months.

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 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 e.g. fitting of key safes. However, housing does remain a challenge including less minor adaptations, de-cluttering, furniture removal to support downstairs living, mobility and function around the home. Improved links within the local housing team will be explored and established.

A frailty 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.

Improved discharge to care homes

The Rapid Response Team have established close links with care homes in the Bury locality and are engaged in education, advice and awareness raising work with care homes. 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 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.

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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.

Consolidated Discharge Funding:

We do not envisage making any changes to the services we commission to support hospital discharge. We will continue to fund the following:

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
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
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 Stroke Association Alzheimer's Society VCSE Housing	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

Intermediate Care Capacity & Demand:

There is an increased focus across the system on transfers of care and patients currently waiting in hospital 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.

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 focusing on; interdisciplinary working, more streamlined pathways, rebranding of team as a discharge hub, improved lines of accountability 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 e.g. 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 the DKAFH meetings, long length of stay and out of area meetings will be reviewed to ensure that they are fit for purpose.

Actuals have been taken from data held in the locality, within the Intermediate Tier, Tableau, Brokerage, Commissioning, Staying well, Age UK and Hospital Referral and Assessment data, Delayed discharge

informatics and expenditure data. This has been coupled with Contact Data EDDNA safer staffing and contacts for therapy, and call monitoring and workforce data

By using alternative funding to mitigate increase in provision that has been managed but not sustainable until the BCF capacity and demand funding is comparable and takes into account an 18% increase for service provision.

Therapy interventions are enacted into all care and support referrals accepted to the services in IMC use of expertise is paramount.

Each person referred has an initial assessment and between 13-14 follow up contacts of therapy per person. The only exception to this are people who have been referred to a bed base with no rehabilitation potential and these are within calculated IMC at home data figures.

Bed based services.

We currently have 49 beds within the intermediate tier and the average is 38 admissions per month with significant increases March, May and October, a comparison with 2023/24, 2024/5 shows the same trend. As well as the IMC beds the locality has had to spot purchase 234 additional beds across a 12-month period to manage demand. The main model is step down. We do need to improve Length of Stay where adapted housing has been an issue so we can target 49 admissions per month but by increasing LOS by 4 days from 28-32 in exceptional circumstances we have achieved people going home independent.

There is a 31% variance in beds required under spot purchase compared to previous year from hospitals. Where there is no rehabilitation potential and subject to future funding can improve on this with the Discharge Frontrunner.

Section 3: Local Priorities and Duties

Promoting Equality & Reducing Inequalities: *Please describe how these duties have been met as part of developing this plan*

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.

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 council is taking several actions to identify and address barriers to care and support and inequality in experience and outcomes and has adopted addressing inequality as one of its core strategies and our Let's Do It! strategy is based on improving inequality and addressing the building blocks of health and wellbeing. We carry out Equality Impact Assessments to ensure our policies, procedures, strategies and services are inclusive by preventing prejudice or discrimination within our communities. This is enshrined in our LETs values, which ensure inclusion is at the forefront of all that we do. We are proud to recognise carers as a protected characteristic in Bury which means we are committed to considering the implications of all our policies and decisions on carers and taking action to improve the experience and outcomes of people living in our borough and our workforce.

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.

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 year 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.

Engaging or Consulting:

Co-production Charter

The Community Commissioning Division has recently published the new Co-production Charter. This charter will positively drive our approach to foster collaboration and partnership between the residents of Bury and our various partners.

It is designed to ensure that the voices of our communities and partners are heard and valued in the commissioning process, leading to more effective and responsive services.

By working closely with residents and stakeholders, we can better understand their needs and priorities, which will help us to design and deliver services that truly meet their expectations. This collaborative approach will not only enhance the quality of services but also build stronger relationships and trust between the community and our partners.

The Community Commissioning Division has developed and maintained a number of networks where local people can be engaged and involved in developing services with the Council. Currently the Council funds:

Older People's Network for all people living in Bury who are aged 50 plus.
Learning Disability Partnership Board
Neuro Divergent Network
Mental Health Partnership
Carers Network.

Bury Council also maintains and supports the following groups of providers where we can share information about current performance, practical information and listen to what providers think about our services and what they would like to see improve.

Care at Home Provider forum
Care Home Provider forum
Supported Living Provider forum
Extra Care Provider forum

Meetings which include a mix of important information, changes to our services, development of new services and peer networking are held regularly throughout the year.

Some examples of recent engagement, co-operation and co-design.

The Council was keen to engage with carers and stakeholders to understand what the Strategy and future commissioning intentions should look like for the future. Therefore, an engagement programme was developed that used a range of tools.

The first stage of the engagement was to create a baseline of information, understanding and developing the commitments to form the draft Strategy. The second stage of engagement involved review and feedback on the proposed commitments and ideas on how to deliver the commitments.

This included:

- insight from gathering data and published information.
- a review of the previous Carers Strategy
- an online survey designed to use on computers and smart phone via a QR code.
- having conversations with carers by attending the carer drop-in's and weekly carers coffee mornings.
- two face-to-face sessions were undertaken with carers from the South Asian community.
- a carers co-production workshop.

The Council is currently developing a new specification for care at home services. The new Care at Home service will move away from the current rigid 'time and task' model. Service providers will be given budgeted hours and they will use these hours to plan with people how they should use the hours to help them achieve the outcomes which matter most to them.

Engagement and consultation has taken place with:

Care at Home providers
Care at Home customers and friends and family
Bury Older People's Network
Cabinet members
Social Workers
Health Colleagues
Healthwatch
Bury VCFA.

Respite Framework
Local carers, at a coffee morning, had told the commissioning team that the current respite offer was not flexible enough to support them, it had to be booked too far in advance, they had to have two weeks respite at a time and it was only available in one location in Bury. It was not flexible enough to give them the support they needed for attending hospital appointments or in patient treatment. Further detailed engagement took place with carers to discuss how they needed respite to work for them. As a result of this discussion, we are now looking at developing a new respite framework, involving both residential, nursing and care at home providers across the borough. Once the framework is drafted, further consultation will take place with carers before the new framework goes to governance systems for approval.

Reducing Inequality in Access to NHS Services:
GM NHS – Bury Locality, is part of the GM ICB infrastructure and as such at a GM level and locality level the duty to promote equality, reduce inequality, consults with people affected by proposals, support and involve unpaid carers in line with the legislation such as the NHS Act 2006 and the Health Care Act 2022 is fully recognised.

At a GM level there is a dedicated resource to support GM and localities in respect to these requirements

Supporting and Involving Unpaid Carers

As a locality we are fully aware that the Health and Care Act 2022 puts duties on ICBs to involve unpaid carers and those they care for in decision-making.
To support this every practice in Bury is encouraged to display relevant information on a 'carer notice board'.
In previous years practices have been incentivised to increase identification of carers and unpaid and ensure these are detailed on practice registers. Practices continue to be encouraged in this respect. Where unpaid carers are identified, practices are encouraged to ensure that all appropriate sign posting to available support is priorities.

In Bury, we have decided to focus on a small number of areas which we call our 'obsessions', by having a real impact on these areas we will have a positive knock-on effect on all areas.

Our Obsessions for Unpaid Carers

The Bury Carers' Hub

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

The service is shaped on the main themes identified, following significant consultation and engagement with carers, the community, providers and partners.

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

The council is taking several actions to identify and address barriers to care and support and inequality in experience and outcomes and has adopted addressing inequality as one of its core strategies and our Let's Do It! strategy is based on improving inequality and addressing the building blocks of health and wellbeing. We carry out Equality Impact Assessments to ensure our policies, procedures, strategies and services are inclusive by preventing prejudice or discrimination within our communities. This is enshrined in our LETs values, which ensure inclusion is at the forefront of all that we do. We are proud to recognise carers as a protected characteristic in Bury which means we are committed to considering the implications of all our policies and decisions on carers and taking action to improve the experience and outcomes of carers in our borough and workforce.

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

Working with our carers has delivered a brand-new carers strategy to define new commissioning intentions for 2025-2029. Over the past five years our support to carers has evolved and developed

in ways that carers told us are important to them. We need to build on those things that have worked well and align the future offer of support with what carers told us is needed.

The Council was keen to engage with carers and stakeholders to understand what the Strategy and future commissioning intentions should look like for the future. Therefore, an engagement programme was developed that used a range of tools.

The first stage of the engagement was to create a baseline of information, understanding and developing the commitments to form the draft Strategy. The second stage of engagement involved review and feedback on the proposed commitments and ideas on how to deliver the commitments.

This included:

- insight from gathering data and published information.
- a review of the previous Carers Strategy
- an online survey designed to use on computers and smart phone via a QR code.
- having conversations with carers by attending the carer drop-in's and weekly carers coffee mornings.
- two face-to-face sessions were undertaken with carers from the South Asian community.
- a carers co-production workshop.

In addition to what we must do legally to support carers, the demographic information of new carers registered with the commissioned carers service over the past three years, along with the demographic information of carers who have accessed a Carers Assessment during the period March 2023 to August 2024 has played a central role in the development of the Strategy.

Accelerating Reform Fund (ARF)
ARF is a national initiative launched by the Department of Health and Social Care to support innovation in adult social care. We are profiling the Accelerated Reform Fund to connect and support carers through the hospital discharge process. This is a partnership project between Bury, Rochdale and Oldham Council.

Assessments
Our strengths-based approach to assessment with outcome focused support planning for both those with eligible need and their carers is in place across our services with staff being trained in strength-based assessment, support planning and ethnographic conversation.

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

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

The FED Volunteer Service – Time for You Project

The Time For You project, based within The Fed's Volunteer services, supports carers in the Jewish Community. This project has been providing this culturally appropriate service to carers for over 20 years. The service aims to provide carers with a much-needed break from their caring role. They recruit, train and support volunteers who sit with or take out the person being cared for, enabling the carer to have some time away from their caring responsibilities.

Better Care Fund 2025-26 Planning Template

5. Expenditure

Selected Health and Wellbeing Board: Bury

<< Link to summary sheet

Running Balances	2025-26 Income	Expenditure	Balance
DFG	£2,576,737	£2,576,737	£0
NHS Minimum Contribution	£19,577,112	£19,577,112	£0
Local Authority Better Care Grant	£9,410,943	£9,410,943	£0
Additional LA contribution	£0	£0	£0
Additional NHS contribution	£2,136,317	£2,136,317	£0
Total	**£33,701,109**	**£33,701,109**	**£0**

Required Spend

This is in relation to National Conditions 3 only. It does NOT make up the total NHS Minimum Contribution (on row 10 above).

	2025-26 Minimum Required Spend	Planned Spend	Unallocated
Adult Social Care services spend from the NHS minimum allocations	£10,567,752	£11,260,624	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes

Scheme ID	Activity	Description of Scheme	Primary Objective	Area of Spend	Provider	Source of Funding	Expenditure for 2025-26 (£)	Comments (optional)
1	Long-term home-based social care services	Domicillary Care Packages	6. Reducing the need for long term residential care	Social Care	Private Sector	Additional NHS Contribution	£ 950,317	
2	Long-term residential/nursing home care	Residential care packages	4. Preventing unnecessary hospital admissions	Social Care	Private Sector	Additional NHS Contribution	£ 950,317	
2a	Long-term residential/nursing home care	Residential care packages	4. Preventing unnecessary hospital admissions	Social Care	Private Sector	NHS Minimum Contribution	£ 36,765	
3	Long-term residential/nursing home care	Nursing Home Care Packages	4. Preventing unnecessary hospital admissions	Social Care	Private Sector	NHS Minimum Contribution	£ 987,379	
4	Long-term home-based social care services	Supported Housing care Packages	6. Reducing the need for long term residential care	Social Care	Private Sector	NHS Minimum Contribution	£ 987,379	
5	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and recovery services)	Short Stay Residential Care (i.e following time in hospital or emergency home vacation where there is a need for a period of recovery/rehabilitation)	6. Reducing the need for long term residential care	Social Care	Local Authority	NHS Minimum Contribution	£ 122,766	
6	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and recovery services)	Staffingt to Support Short Term Residential Care	6. Reducing the need for long term residential care	Social Care	Local Authority	NHS Minimum Contribution	£ 404,030	
7	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and recovery services)	Short Stay Residential Care (i.e following time in hospital or emergency home vacation where there is a need for a period of recovery/rehabilitation)	6. Reducing the need for long term residential care	Social Care	Local Authority	NHS Minimum Contribution	£ 1,356,640	
8	Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	Short term adult rehabilitation and reablement support	6. Reducing the need for long term residential care	Social Care	Local Authority	NHS Minimum Contribution	£ 3,725,426	
9	Wider local support to promote prevention and independence	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	6. Reducing the need for long term residential care	Social Care	Local Authority	NHS Minimum Contribution	£ 546,932	

10	Assistive technologies and equipment	Carelink is 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	2. Home adaptations and tech	Social Care	Local Authority	NHS Minimum Contribution	£ 78,652	
11	Other	Programme manangment support to co-ordinate BCF and wider transformation programmes	6. Reducing the need for long term residential care	Social Care	Local Authority	NHS Minimum Contribution	£ 138,332	
12	Urgent community response	A rapid community response team providing short term, intensive, holistic support for people at risk of hospitalisation	4. Preventing unnecessary hospital admissions	Social Care	Local Authority	NHS Minimum Contribution	£ 943,743	
13	Wider local support to promote prevention and independence	Integrated Neighbourhood Teams - MDT case mangement supporting adults particularly at risk of admission or readmission into hospital or permamnat admission into nursing or residentail care as well as high intensity users of various services	4. Preventing unnecessary hospital admissions	Social Care	Local Authority	Additional NHS Contribution	£ 186,606	
13a	Wider local support to promote prevention and independence	Integrated Neighbourhood Teams - MDT case mangement supporting adults particularly at risk of admission or readmission into hospital or permamnat admission into nursing or residentail care as well as high intensity users of various services	4. Preventing unnecessary hospital admissions	Social Care	Local Authority	NHS Minimum Contribution	£ 1,841,044	
14	Wider local support to promote prevention and independence	Staying Well Service deploying systematic identification and support of older people aged 65+ at risk of needing social care	1. Proactive care to those with complex needs	Social Care	Local Authority	NHS Minimum Contribution	£ 91,536	
15	Long-term home-based social care services	Deployment of resourec to enebalem contiued whole system flow	6. Reducing the need for long term residential care	Social Care	Private Sector	Local Authority Better Care Grant	£ 5,781,386	
16	Wider local support to promote prevention and independence	Integrated Care Planning & Navigation -MDT case management supporting adults particularly at risk of admission or readmission into hospita	4. Preventing unnecessary hospital admissions	Social Care	Local Authority	Local Authority Better Care Grant	£ 313,846	
17	Wider local support to promote prevention and independence	Risk Stratufication -MDT case management supporting adults particularly at risk of admission or readmission into hospita	4. Preventing unnecessary hospital admissions	Social Care	Local Authority	Local Authority Better Care Grant	£ 1,533,217	
18	Long-term home-based social care services	Domicillary Care Packages	6. Reducing the need for long term residential care	Social Care	Private Sector	Local Authority Better Care Grant	£ 274,912	
19	Long-term residential/nursing home care	Residential care packages	4. Preventing unnecessary hospital admissions	Social Care	Private Sector	Local Authority Better Care Grant	£ 274,912	
20	Long-term residential/nursing home care	Nursing Home Care Packages	4. Preventing unnecessary hospital admissions	Social Care	Private Sector	Local Authority Better Care Grant	£ 274,912	
21	Long-term home-based social care services	Supported Housing care Packages	6. Reducing the need for long term residential care	Social Care	Private Sector	Local Authority Better Care Grant	£ 274,912	
22	Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	Short term adult rehabilitation and reablement support	6. Reducing the need for long term residential care	Social Care	Local Authority	Local Authority Better Care Grant	£ 682,846	
23	Disabled Facilities Grant related schemes	Meeting the costs of adapting homes to enable people to stay independent in their homes	2. Home adaptations and tech	Social Care	Local Authority	DFG	£ 2,576,737	
24	Other	Core 24 Liasion	4. Preventing unnecessary hospital admissions	Mental Health	NHS Mental Health Provider	NHS Minimum Contribution	£ 711,109	y
25	Wider local support to promote prevention and independence	Alzheimers Socety	3. Supporting unpaid carers	Other	Charity / Voluntary Sector	NHS Minimum Contribution	£ 82,765	
26	Long-term residential/nursing home care	Nursing Home Training	4. Preventing unnecessary hospital admissions	Other	NHS Acute Provider	NHS Minimum Contribution	£ 20,091	
27	Long-term residential/nursing home care	Nursing Home Training	4. Preventing unnecessary hospital admissions	Other	NHS Acute Provider	Additional NHS Contribution	£ 49,077	
28	Urgent community response	Crisis Response Community (incs rapid response)	4. Preventing unnecessary hospital admissions	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 1,784,192	

29	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and recovery services)	Intermediate Tier	5. Timely discharge from hospital	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 2,713,282	
30	Wider local support to promote prevention and independence	Integrated Neighbourhood Teams	4. Preventing unnecessary hospital admissions	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 571,312	
31	Urgent community response	Falls	4. Preventing unnecessary hospital admissions	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 226,272	
32	Evaluation and enabling integration	LCO Costs	5. Timely discharge from hospital	Other	NHS Community Provider	NHS Minimum Contribution	£ 551,350	
33	Other	Primary Care Additional Support	4. Preventing unnecessary hospital admissions	Primary Care	Private Sector	NHS Minimum Contribution	£ 404,029	
34	Discharge support and infrastructure	GP Inreach to Intermediate Care	6. Reducing the need for long term residential care	Primary Care	Private Sector	NHS Minimum Contribution	£ 42,500	
35	Discharge support and infrastructure	Home From Hospital (Increasing voluntary sector capacity)	5. Timely discharge from hospital	Other	Charity / Voluntary Sector	NHS Minimum Contribution	£ 105,660	
36	End of life care	Hospice Services 2023/24	4. Preventing unnecessary hospital admissions	Other	Charity / Voluntary Sector	NHS Minimum Contribution	£ 104,603	
37	End of life care	Hospice Services 2024/25	4. Preventing unnecessary hospital admissions	Other	Charity / Voluntary Sector	NHS Minimum Contribution	£ 100,000	
38	End of life care	Palliative Care Consultant	4. Preventing unnecessary hospital admissions	Other	Charity / Voluntary Sector	NHS Minimum Contribution	£ 134,606	
39	Wider local support to promote prevention and independence	Stroke Association	4. Preventing unnecessary hospital admissions	Other	Charity / Voluntary Sector	NHS Minimum Contribution	£ 70,000	
40	Other	Intermediate Care	4. Preventing unnecessary hospital admissions	Other	Private Sector	NHS Minimum Contribution	£ 277,934	
41	Discharge support and infrastructure	VCSE Housing	4. Preventing unnecessary hospital admissions	Mental Health	NHS Mental Health Provider	NHS Minimum Contribution	£ 40,000	
42	Other	SDEC Frailty	4. Preventing unnecessary hospital admissions	Acute	NHS Acute Provider	NHS Minimum Contribution	£ 290,700	
43	Other	Rapid Response Vehicle (PCFT)	4. Preventing unnecessary hospital admissions	Mental Health	NHS Mental Health Provider	NHS Minimum Contribution	£ 86,083	

Meeting:			
Meeting Date	07 April 2025	**Action**	Receive
Item No.	12	**Confidential**	No
Title	Population Health update		
Presented By	Jon Hobday – Director of Public Health		
Author	Jon Hobday – Director of Public Health		
Clinical Lead	N/A		

Executive Summary
An overview of the work discussed and planned in key population health/public health meetings.
Recommendations
To note the work being discussed.

OUTCOME REQUIRED *(Please Indicate)*	**Approval** ☐	**Assurance** ☐	**Discussion** ☐	**Information** ☒
APPROVAL ONLY; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	**Pooled Budget** ☐	**Non-Pooled Budget** ☐		

Links to Locality Plan outcomes	
To support a local population that is living healthier for longer and where healthy expectancy matches or exceeds the national average by 2025.	☒
To achieve a reduction in inequalities (including health inequality) in Bury, that is greater than the national rate of reduction.	☒
To deliver a local health and social care system that provides high quality services which are financially sustainable and clinically safe.	☐
To ensure that a greater proportion of local people are playing an active role in managing their own health and supporting those around them.	☒

Implications						
Are the risks already included on the Locality Risk Register?	Yes	☐	No	☐	N/A	☒
Are there any risks of 15 and above that need to be considered for escalation via an NHS GM Statutory Committee or Board in line with the Risk Escalation process ?	Yes	☐	No	☐	N/A	☒
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☐	N/A	☒
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☐	N/A	☒
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☐	N/A	☒
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☐	N/A	☒
Are there any financial Implications?	Yes	☐	No	☐	N/A	☒
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If yes, please give details below:						
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Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☒

Governance and Reporting		
Meeting	**Date**	**Outcome**
N/A		

BURY INTEGRATED CARE PARTNERSHIP

Population Health and Wellbeing update

1. Introduction

1.1. This paper sets out recent population health updates and discussions from key meetings locally and in Greater Manchester (GM).

2. GM Population Health Committee

3.1 A GM Population Health Committee meeting was held on 18th March. Key items discussed included reviewing achievements of 24/25, the draft reducing prevalance and proactive care plans.

4 Bury Health and Wellbeing Board

4.1 At the most recent Health and Wellbeing Board the key items discussed included the Crime and Safety Plans, The Better Care Fund Progress and planning reports, an overview of the Bury Physical Activity Framework, VCSE contribution to health and an update the outcomes framework.

4.2 The crime and safety plan provided an overview of the 5 key priorities which include tackling offences against children, prevention of serious violence, domestic abuse in the context of the trio of vulnerability, supporting and safeguarding cohesive communities and ensuring resilient and safer spaces and how these contribute to supporting positive health and wellbeing and reducing inequalities.

4.3 The VCSE contribution to health item was presented by the VCFA and looked at the breadth of the work the voluntary sector does and outlined how this supported health and wellbeing and contributed to reducing inequalities.

4.4 Finally, the outcomes framework provided a focus on key outcomes where performance was above national and regional average including the percentage of youth not in employement or education, prevalance of overweight and obese children in reception, smoking rates in adults and breast screening coverage. It also included outcomes where we were performing less well than national and regional levels including the number of children in low-income families, vaccination coverage for 1 year old immunisations, cervical screening coverage and under 75 mortality rates.

Jon Hobday
Director of Public Health
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February 2025

Meeting: Locality Board			
Meeting Date	07 April 2025	**Action**	Receive
Item No.	13	**Confidential**	No
Title	Clinical & Professional Senate Update		
Presented By	Dr Kiran Patel		
Author	Dr Kiran Patel		
Clinical Lead	Dr Kiran Patel		

Executive Summary
This report provides the Locality Board with a summary from the Clinical and Professional Senate meeting that took place in March 2025.
Recommendations
The Locality Board is asked to receive the report and share any feedback to the Clinical and Professional Senate for action.

OUTCOME REQUIRED *(Please Indicate)*	**Approval** ☐	**Assurance** ☐	**Discussion** ☐	**Information** ☒
APPROVAL ONLY; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	**Pooled Budget** ☐	**Non-Pooled Budget** ☐		

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Are there any associated risks including Conflicts of Interest?	Yes	☒	No	☐	N/A	☐

Governance and Reporting		
Meeting	**Date**	**Outcome**
N/A		

Clinical and Professional Senate Highlight Report – March 2025

1. Introduction

This report provides the Locality Board with a summary from the Clinical and Professional Senate meeting that took place on 26 March 2025.

2. Headlines from the Clinical and Professional Senate

2a. Clinical Leadership Update – Dr Liane Harris

- Dr Liane Harris delivered a Bury Locality Cancer Update.
- The presentation included the priorities for the coming year, the two main priority areas are operational performance and early diagnosis.
- Dr Harris talked through the GM Cancer Commissioning Intentions, the Bury Locality Cancer Action Plan, challenges and achievements. More information and data are contained within the presentation. Dr Harris also fedback from a recent Locality Visit with the GM Cancer Alliance.

2c. Partner Update

- NCA – Prakash Kamath
    - Vicki Howarth was not in attendance and so the update was delivered by Prakash Kamath.
    - Several performance figures were reported including A&E performance, SDEC uptake, the hospital standardised mortality rate and the 28-day and 62-day cancer targets. All of which were positive.
    - Mr Kamath did raise some issues with Community Paediatrics specifically for children with neurodiverse issues. The NCA has conducted a capacity and demand GAP assessment and capacity has been increased by 30%. This provides 80 new slots and 160 follow up slots, this is a huge increase but still not enough to meet demand. The biggest improvement has been in Speech and Language Therapy (SLT) where performance was 33% in February, is currently 88%, and the aim is for this to increase to 95% by April 2025.
    - Richard Bulman also discussed a specific issue with a rise in the number of patients with eating disorders attending A&E, it was decided that a discussion take place with NCA, Cygnet and Kez Hayat to discuss this further.

- Pennine Care - Ankur Khanna
    - No update provided from PCFT, no attendees from PCFT were present at the meeting.

- GP Update – Dr Cathy Fines

- Collective Action - there has been a settlement agreed with the Government meaning the Collective Action has been stood down, although no formal correspondence has been released. The programme of activity will continue through the primary care and secondary care interface group. Dr Fines highlighted that there have been many positive effects following on from the Collective Action, irrespective of the settlement. Locally the Collective Action has had a positive impact on working relationships.
- The Locally Commissioned Service (LCS) – There has been a recent engagement event to discuss what activity can go in this, however, this has not yet been finalised.
- ADHD Right to Choose –this is still causing issues for Primary Care, and this requires a GM solution. Not only will this be a huge financial burden, but this is also going to mean there will be large numbers of patients who will be under private providers on controlled drugs and there will

be quality concerns with this for a number of years to come. Additionally, this is causing a large number of patient complaints which is in turn impacting Primary Care further.

2d. Specialist Weight Management Services Presentation – Damian Aston

- Damian Aston gave a presentation on the Specialist Weight Management Service. The presentation was based on a paper which was presented at the ICB Exec committee in February 2025. The paper was regarding improving outcomes for people with obesity and the GM plan. The paper also covered the pressures facing tier 3 specialist weight management services and recommendations.
- There has been a GM tier 3 review, localities remain responsible for commissioning and funding tier 3 specialist weight management service. Guidance is still awaited from NHS England regarding the commissioning intentions. The MoreLife contract is due to expire on 31 March 2025, however there are bridging arrangements in place for a further 6-12 months. There is a significant backlog of tier 3 patients across GM, approx. 10,000 patients. Bury has a backlog of 307 patients.
- The proposal is that GM will develop a service specification which would be standardised across GM, how it is funded will still be up to each locality.
- Dr Patel summarised the views of the Senate that the there is consensus that a GM Service Specification around weight management would be beneficial, the funding should also be at a GM level so that there is not differential provision for patients of GM. The provision needs to be equal across all the 10 localities.
- Dr Cathy Fines noted it is important that Bury can identify colleagues who will be able to feed into the conversations at a GM Level, as Bury does not have a weight management clinical lead.

2e. Women's Health Hub – Dr Cathy Fines

- Dr Fines advised that in October last year, the Bury Women's Health Hub opened its virtual doors, as part of the 10-year national Women's Health strategy. The strategy was to have a Women's Health hub in every ICS by the end of 2024.
- NHS GM took the view that they wanted a Women's Health Hub in each of the localities, localities were given a small amount of money to this up and Bury chose long-acting reversible contraception (LARC) as our first offer.
- This was decided as there was inequality across the locality, with some GP practices not offering LARC. It was decided that the clinic would be offered from Prestwich as in Whitefield there were no practices delivering LARC. The service has been very well received.
- However, the hub will close on 31st March 2025, as there is no longer any funding for the Women's Health Hub.
- Over recent months at the GM GP Board discussions have taken place regarding how to provide more standardised gynaecology services into primary care. A service specification has been developed but is currently still in draft. The proposal is for primary care to deliver for community gynaecology, the idea being primary care will triage all the referrals to gynaecology, referrals that would have previously gone directly via the ERS into secondary care, other than two week waits. All of these referrals will now go through the new community gynaecology service, which will be run by primary care and delivered by appropriately trained GP's. These GPs will triage all referrals and the outcomes will either:
    1. Information will be sent back to the primary care referrer with advice on how to manage in primary care.
    2. The referral will be sent on to secondary care because it requires a diagnosis or care that is only available in secondary care.
    3. The community gynaecology service will deliver the service themselves.
- As the service specification has not yet been agreed, we therefore do not know when this will start. Bury is the first wave.
- From the 31st March, as there will no longer be a Women's Health Hub, which means the patients who were not able to access LARC prior to October, will once again be no longer

able to access it. This is not for contraception as patients can access this from the sexual health service, this is for patients who require LARC for HRT or menorrhagia.

2f. Menopause – Shelley Caulfield

- Shelley Caulfield gave a presentation regarding Menopause and the work that Shelley and her team have done in the borough.
- Shelley explained that Manchester University have agreed to conduct research into UTI's and localised Estrogen and discussed that she will be contacting GPs with an ask so would appreciate GP support with this.
- Shelley confirmed that by August all of the team will be fully trained.
- Shelley also explained that for the past two years the GP Federation have paid for Live Well support through ARRS. This is for Prestwich, Whitefield and Horizon PCN's. Bury PCN did not do this and as a result have had limited access to Live Well support since August 2024. Prestwich PCN has now given notice, and therefore from 1st April 2025, Live Well will only be able to offer limited support
- Dr Fines, Dr Harris and Will Blandamer thanked Shelly for all of the hard work that she has done on this and other areas.

2g. Terms of Reference Review – Will Blandamer

- The Senate members were asked to review the proposed TOR, no significant changes have been made to the previous TOR.

2h. Medicines Optimisation Function Review – Salina Callighan

- Salina Callighan advised the presentation is for information only and it has been circulated with the meeting papers.

2i. Associate Medical Director (AMD) Update – Dr Cathy Fines

- The CEG for March took place on the same day at the Senate and so Dr Cathy Fines advised she would provide an update at the next Clinical and Professional senate in April.

2j. Commissioning Oversight Group Feedback – Will Blandamer

- The minutes from the Commissioning Oversight Group were circulated to members within the Clinical & Professional Senate meeting paper pack.

2k. GMMMG Update - Salina Callighan

- No drug safety notices this month
- Drug Safety updates and Medical Supply Notice, these are now being managed at a GM level rather than locality level.
- The GMMMG meeting was stood down this month.
- Open consultations on GMMMG:
    - Significant PERT (Pancreatic Enzyme Therapy) shortage. There was a MPSA Alert and also within that NPSA alert. There was an ask of NHS GM to plan for how patients were going to access PERT during the shortage. A pathway for primary care is out for consultation. There is also a helpline from Creon, one of the manufacturers. This helps to advises patients where their supplies are with each particular pharmacy.
    - Patients leaving hospital with Opioid medications for pain - there is a leaflet hat has been developed from a working group of GM Medicines Safety Subgroup.
    - Topiramate – This is mainly used for Epilepsy. There is a safety measures FAQ.
    - Secondary prevention lipid pathway – this update aims to gain consensus on the appropriate use of lipid lowering medications. It also aims to resolve issues related to

medication sequences, patient management pathways and uncertainty regarding treatment targets.

2l. AOB

- None.

3.The Locality Board is asked to receive the report and share any feedback to the Clinical and Professional Senate for action.

Kiran Patel
Medical Director IDCB
kiran.patel5@nhs.net
March 2025

Meeting: Locality Board			
Meeting Date	07 April 2025	**Action**	Receive
Item No.	14	**Confidential**	No
Title	Primary Care Commissioning Committee update		
Presented By	Adrian Crook, Director of Adult Social Services and Community Commissioning		
Author	Faith Farnworth-Collinge, Governance Support Officer		
Clinical Lead			

Executive Summary
The Primary Care Commissioning update is provided as a highlight report from the meeting held on the 31st March 2025.
Recommendations
The Locality Board is asked to note the highlight report from the last Primary Care Commissioning Committee.

OUTCOME REQUIRED *(Please Indicate)*	**Approval** ☐	**Assurance** ☐	**Discussion** ☐	**Information** ☒
APPROVAL ONLY; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	**Pooled Budget** ☐	**Non-Pooled Budget** ☐		

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Implications						
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Governance and Reporting		
Meeting	**Date**	**Outcome**
Primary Care Commissioning Committee	28/01/2025	Highlight report attached.

Bury Primary Care Commissioning Committee (PCCC) Highlight Report

Chair: Will Blandamer
Reporting period: March 2025
Attendance: Acceptable

This report updates / informs the NHS Greater Manchester PCCC on the Bury PCCC work to date. It also provides an opportunity to raise any issues and inform of any changes that may affect the progression of work.

Key updates:

Rock Healthcare proposed move from Radcliffe – PCCC was provided with the outcome of engagement process and provided with two options to consider. Option 1 - Approve the application and allow the branch site at Radcliffe to close and move all operations to the Moorgate site. Any patients who do not wish to travel to Moorgate will be given details on how to reregister with a practice of their choosing. Option 2 - Reject the application for branch closure, resulting in two possible outcome responses by the practice: Outcome 1: the practice continues to operate over 2 sites and work to take place with the practice to reduce the practice estates footprint at the Radcliffe branch to reduce overheads to a minimum and work with the practice to maximise income from its contracts. Outcome 2: the practice hands the APMS contract back meaning there would have to be a procurement exercise undertaken over both sites removing the contract from the Rock Healthcare in its entirety. With the preferred option being option 1.

GP Contract Update – PCCC was provided with an update regarding the changes to the GP contract for 2025/26. These include an overall increase of £889 million across core contract practice, a 7.2% cash growth on the funding envelope, a new enhanced service for advice and guidance and the retirement permanently of 32 QOF indicators to name a few.

Highlight Report and Risks – the Acute Respiratory Hub, the Winter Surge Clinics, Women's Health Hub and Quality Assured Spirometry services have all ended as of 31 March 2025.

Bury LCS 2025/2026 – The PCCC was provided with a paper detailing a fully costed service specification to be contracted for 2025/26. This included potential future inclusions and associated risks.

In addition, PCCC were presented with updates regarding:

- Workforce Strategy
- General Practice Leadership Collaborative update
- Terms of Reference Review

Priority actions in coming period:

Rock Healthcare: To ensure Rock Healthcare complete all outstanding actions prior to closure of Radcliffe site

GP Collective Action: GPCA complete however ongoing work between PC/SC Interface Group locally to maintain momentum

GP Strategy Update – end of year update to be presented

BeCCoR – Discussion around both 25/26 and 26/27 contracts in train in order to consider local commissioning arrangements re any in year variations needed and direction of travel for next year

Decisions made:

Rock Healthcare Proposed Move from Radcliffe – PCCC supported the recommendation for Rock Healthcare to be allowed to close the Radcliffe site and move all operations to the Moorgate site in Bury.

Bury LCS 2025/2026 – PCCC supported recommendations to approve the specification presented whilst noting and supporting an in-year variation should it be needed subject to the availability of the funding and further discussion on some aspects of consistency across the neighbourhoods.

Workforce Strategy - PCCC approved the task and finish groups to look at the priority areas such as recruitment and retention, training and development and staff wellbeing. With the purpose to develop a co-designed strategy which can be brought to a future PCCC Meeting, this will enable the support of the strategy plan and its implementation.

Terms of Reference – PCCC supported the proposed Terms of Reference. There were no changes to the existing Terms of Reference, this was an annual review.

Top 3 risks & mitigation:	RAG rating
Investment into General Practice – Impacting our commissioning options e.g. LCS and Spirometry, WHH etc. Discussions are ongoing via BeCCoR and GM Boards	

Meeting:			
Meeting Date	07 April 2025	**Action**	Receive
Item No.	15	**Confidential**	No
Title	Minutes of the SEND Improvement Board Meeting		
Presented By	Will Blandamer, Executive Director, Health and Adult Care - Bury Council and Deputy Place Lead - NHS GM (Bury)		
Author			
Clinical Lead			

Executive Summary
The attached minutes are from the SEND Improvement and Assurance Board Meeting held on the 26th March 2025 for Locality Board members information.
Recommendations
The Locality Board is asked to note the minutes.

OUTCOME REQUIRED *(Please Indicate)*	**Approval** ☐	**Assurance** ☐	**Discussion** ☐	**Information** ☒
APPROVAL ONLY; (please indicate) whether this is required from the pooled (S75) budget or non-pooled budget	**Pooled Budget** ☐	**Non-Pooled Budget** ☐		

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Governance and Reporting		
Meeting	**Date**	**Outcome**
N/A		

Bury Council
Department of Children & Young People

Minutes

SEND Improvement & Assurance Board Meeting
26th March 2025

	ATTENDANCE	**ROLE**
	Deborah Glassbrook	Independent Chair
	Cllr Lucy Smith	Lead Member for Children & Young People
	Scout Stirling	SEND Youth Ambassador
	Gemma Parkes	Virtual Headteacher
	Kathryn Mort	Headteacher, East Ward Primary School
	Collette Radcliffe	Early Years Service Manager
	Finlay Olivier	SEND Case Lead – Vulnerable Children's Unit, DfE
	Kevin Burns	DfE SEND Adviser
	Cllr Tamoor Tariq	Lead Member for Health
	Will Blandamer	Executive Director, Health and Adult Care - Bury Council and Deputy Place Lead - NHS GM (Bury)
	Stephen Holden	Director of Education & Skills
	Robert Arrowsmith	Head of Strategy, Assurance and Reform
	Wendy Young	Head of Service, SEND & Inclusion
	Nick Bell	Secondary Inclusion Lead
	Gemma Parkes	Virtual Headteacher
	Andy Bradburn	Service Manager – Skills Children Services
	Bridget Aherne	Interim Head of Communications
	Jo Kingston	Communications Manager
	Martin McAndrew	Bury2gether
	Dr Cathy Fines	Associate Medical Director, NHS GM
	David Segal	PPL
	Pippa Quincey	PPL
	APOLOGIES	

	Jeanette Richards	Executive Director for Children, Young People & Education
	Kate Waterhouse	Executive Director of Strategy & Transformation
	Jon Hobday	Director of Public Health
	Jane Case	Programme Manager, NHS GM
	Janet Wray	NHSE Adviser
	Louise Hayes	NHS
	Linda Evans	Director of Children's Social Care & Early Help
	Cllr. Bernstein	Conservatives Leader and Shadow Cabinet Member
	Catherine Jackson	Associate Director of Nursing, Quality & Safeguarding (Bury), NHS GM
	Adrian Crook	Director for Adult Social Care
	Alex Fair	Unsworth Academy Principal
	Jane Bernhardt	Chair, Parent Carer Forum, Bury2gether

1	**INTRODUCTIONS & MINUTES**
	The Chair welcomed everyone to the SEND Improvement and Assurance Board meeting and acknowledged the presence of Board members joining online and apologies given. The Chair emphasised the importance of Board development sessions and proposed small group or one-on-one meetings to collect diverse viewpoints. A sign-up sheet was circulated for members to select their preferred time slots for the one to one. The objective of these development sessions is to identify the Board's strengths and areas requiring improvement.
2.	**ACTIONS & DECISION LOG**
	Nearly all actions are in progress, with one outstanding action regarding sharing papers with parents – this action is dependant on the wider programme of work to improve the Local Offer and will be commenced as part of the development plan for this area. A request was made from the chair to ensure prompt updates to the Action Log from all members of the Board; either directly to the action log or to be sent to the PPL PMO lead. The actions from the log will be updated in the minutes and the copy will be sent to members via email for approval.
3	**Contributions from, and engagement with, Children and Young People**
	<u>Presentation</u> Highlights from the presentation were given by Scout Stirling The Change Makers Group provided feedback on the SEND strategy. They expressed a preference for more visual data, requested a key be included to

explain BRAG rating, and were pleased to see the inclusion of an acronym glossary but requested this was included more consistently and there is less use of acronyms in the reports.

Youth Voice Network Meetings:
The Change Makers Group had two meetings since the last Board meeting, on March 11th and March 25th. The Youth Voice Network had one meeting earlier in the week with three schools in attendance.
Feedback from these meetings highlighted the importance of smooth and supportive transitions for primary school children, while teenagers and older young people emphasised the need for timely and efficient support from services.

Co-production Day Announcement:
Scout announced the upcoming Co-production day, scheduled for Tuesday, April 15th from 10:00 to 14:00. The event will be held in the Peel room, and Scout requested the attendance of 3 or 4 Board members. Several members volunteered to attend.
The event aims to gather feedback from young people and other stakeholders to collaborate on the SEND strategy. Scout hopes for a busy day, like the previous Co-production day in June 2024, which had about 25 young people in attendance.

Session Plan and Feedback:
The session plan developed last month to gather initial thoughts has been delivered to around several Children groups since the last Board meeting. All feedback has been fed into the SEND Strategy Development Group, and findings will be documented after the Co-production day.
Key insights from the feedback include the need for early identification of support needs and the importance of adults recognizing when young people need support.
Bridge discussed strategies for improving communication between the Board and young people. The focus was on utilising social media effectively, with provisional ideas being developed.
The Change Makers Group will conduct more focused sessions on the local offer and the SEND newsletter after the Easter break.

Vlog Feedback:
Young people provided feedback on vlog content, suggesting the inclusion of a faded-out ending, subtitles, and whiteboard animations to emphasise key points. They also recommended more enthusiasm from the speaker. It was noted in the room that the vlog had added a very positive aspect to communication at that while there are areas of improvement as noted from the Children's feedback, that this was a positive addition to communications.
Topics for other videos were discussed, including introductory videos about the PIPS, Instagram reels, and short videos. The length of videos was also considered, with suggestions for quick updates to be about a minute long and in-depth topics to be 2-3 minutes.

Social Media Engagement:
The idea of creating a social media account, such as an Instagram page, was discussed. The goal is to provide regular updates and engage with young people

through various content formats. The previous Facebook page is being revisited to understand if this would be beneficial to re-launch.
The importance of celebrating and acknowledging the contributions of young people was emphasised. Ideas for recognition included awards, certificates, and reward trips.

What do young people want from the SIAB?
Young people want their work to be recognised and appreciated. They suggested receiving formal acknowledgment, such as a letter, for their contributions and reflections.
They desire more communication between the Council and schools, ensuring that teachers listen to students. They also want Council members to visit schools in casual clothes to see what is happening.
They want the opportunity to attend more meetings like the ones held by the Board.
They also suggested having Councillors and other senior members of the Council visit their schools and talk to them.
They hope the Council can enforce actions on the things discussed in meetings.
They want the Council to address issues such as uniforms and ensure that schools listen and let students speak.
They want more opportunities for entertainment and engagement, such as trips to the cinema and other activities.

An update on the "You Said We Are Doing" initiative was provided, which is a running document for Board members to answer any questions that young people have. The document is already uploaded onto Teams, and the Board was encouraged to have a look at it. The questions will be added by Scout following all meetings with young people and shared with all viewing meetings. Board members are responsible for answering these questions, which will then be shared back with the young people.
The importance of regularly checking the document was emphasised to ensure that questions are being answered promptly. This initiative aims to keep the communication transparent and ensure that young people's voices are heard, and their questions are addressed. Scout will be checking the document every week to make sure that the questions are being answered, and the feedback is being incorporated into the Board's actions.

Some questions young people asked are:

How can young people get involved in staff training?
How long will it take for new training to be rolled out and how long will it take until we see the effect?

Scout also asked young people about their views on the Council's efforts, specifically:

What do you think Bury Council is doing well for young people with disabilities?
Young people think the Council is working hard to help young people who are struggling in school and making them feel safer.

One person mentioned that their voice is being heard, and their thoughts and feelings are validated. Another person commented on the youth service groups, saying that the Council is taking their feedback into consideration.

What is the most important thing Bury Council should do?
Young people hope the Council can enforce actions on the things discussed in meetings.
Some young people feel that the Council is not doing enough with schools, but they appreciate the helpful teachers and other support provided. They want more communication between the Council and schools, ensuring that teachers listen to students.
They also mentioned issues with uniforms and the need for Council members to visit schools in casual clothes to see what is happening.

Discussion
The Board asked what young people like to do? Young people would like to do video interviews with Board members, and for there to be regular updates on social media page and blogs.
The Board discussed the potential of creating a social media account, specifically an Instagram page, to enhance communication and engagement with young people. The idea is to provide regular updates through short posts, reels, and stories. The young people suggested that the account should include a mix of updates from the Board, engaging content, and interactive elements like memory hooks and whiteboard-style animations. They also emphasised the importance of subtitles and more enthusiasm in the videos.
The Board considered the logistics of maintaining the account, including the frequency of posts (3-4 posts a week), the type of content, and the metrics for evaluating success (number of followers, views on reels, etc.). They discussed the need for a conversation about populating and evaluating the content to ensure it meets the needs and interests of young people. The Board acknowledged the positive feedback from young people and their desire for more engaging and interactive content.

The Board also discussed the approach of the Corporate Parenting Board, which also has a strategy for engaging young people including them attending the meetings, where they review and rate reports. They also write summary versions of reports for young people to read and provide feedback on. This approach ensures that young people's voices are heard and considered in decision-making processes.
The Board noted that the Corporate Parenting Board's method of involving young people could be a model to follow. They discussed the importance of recognising young people's contributions and suggested drafting a letter or certificate to acknowledge their efforts. This would help young people feel valued and appreciated for their input.

The Board discussed the issue of uniforms as raised by young people. They mentioned that uniforms are a common issue in schools and that students often feel not listened to regarding this matter. The Board acknowledged these concerns and emphasised the importance of ensuring that schools listen to students and address their feedback about uniforms. This discussion was part of a broader conversation about improving communication between the Council and schools and making sure that students' voices are heard and considered in decision-making processes.

It was noted that feedback on staff was referring specifically to Council staff, but that a broader question and response on wider staff would be useful. The Board is considering a draft of a workforce strategy plan that outlines different levels and types of training for various staff members. This plan aims to ensure that staff at different levels of engagement and proximity to young people receive appropriate training.

The Board discussed the importance of involving young people in the development and delivery of staff training. They emphasised that young people could provide valuable insights and perspectives that can enhance the training content and make it more relevant and effective.
The Board mentioned a previous example where young people were involved in delivering training on mindful practice. This training was well-received and highlighted the benefits of having young people directly involved in training initiatives.
The Board agreed that they need to provide young people with clear information about the training being developed and explore opportunities for their involvement. They also emphasised the need to respond to young people's questions about staff training with detailed answers.

The discussion focused on the importance of smooth and supportive transitions for young people, particularly those moving between different educational stages. Members emphasised the need for clear communication and adequate support during these transitions.

Concerns were raised about the early recognition of support needs. Members stressed that adults should be able to identify when young people need support and provide timely and efficient assistance.
The Board asked how can we improve the early recognition of support needs? And response received was by developing training programs for schools that focus on identifying and supporting young people earlier.
The development of training for schools to help identify and support young people earlier was discussed. Updates on this training will be provided in the next term.
Members emphasised the importance of including feedback from children and young people in the training development process. Concerns were raised about the potential challenges in implementing this training effectively.
Members discussed the importance of ensuring that staff working with young people are adequately trained and supported. The strategy aims to address these concerns by providing comprehensive training programs.

The Board asked about the progress on the slides for the Co-production Day and how the engagement notice was being handled, preparations and the level of engagement expected for the event and progress with EOTAS (Education Otherwise Than At School). Preparations for the Co-production Day are ongoing. Scout also informed the Board that she was reaching out to primary schools and other organisations to improve engagement with those children and young people who have education other than in school (EOTAS). They acknowledged the challenges but emphasised the importance of gathering feedback from young people with additional needs who are supported outside of school including those who are electively home educated (EHE).

	Nick was identified as the person to link up with Scout regarding EOTAS. They will work together to engage with EOTAS providers and gather feedback to inform the Board's strategies and actions. **Actions** 1. Wendy Young, Will Blandamer or Jane Case, Scout Stirling and one staff member from the youth service will attend Co production day on the 15th of April (Due date: April) 2. Chair will draft a letter to young people to acknowledge their contributions and express gratitude for their efforts. This letter will be given to Scout to present to them. This initiative aims to help young people feel valued and appreciated for their input (Due date: May) 3. Will and Martin will work on providing detailed answers regarding the timeline and impact of new training to young people and contribute to the workforce strategy plan; ensuring feedback from children and young people in the training development process and providing updates on the training development in the next term (Due date: May) 4. Scout will liaise with Katherine Mort about school visits to gather feedback (Due date: May)
4	**DEEP DIVE UPDATE**
	Presentation Wendy Young provided feedback on the recent deep dive into the graduated approach as follows **Key Findings:** There are numerous activities and services supporting the Graduated Approach, particularly around early identification and assessment of needs. Early stages and indications of progress were observed in the use of the Graduated Toolkit, with some evidence of changing practices. However, the Graduated Approach is not well communicated across the local area partnership. It lacks a format that allows consistent advocacy across education, social care, and other services. The need for an integrated offer to support holistic assessment and meeting of children's needs was identified. The toolkit is predominantly utilised to support schools in meeting needs, but there is a lack of confidence in the system regarding available support and how to access it. A high reliance on statutory support was observed, with a need for a better-understood and implementation of the graduated approach at the point of request for access and assessment. Feedback from Bury2gether and outcomes from the questionnaire highlighted the need for the Graduated Approach to align with principles of strength-based working and promotion of independence. The graduated approach should continually monitor children's progress and support the development of independence, particularly at key points of transition. **Next Steps**

There will be a rapid review of the Graduated Approach offer across Education, Health, and Social Care. This review aims to ensure the approach is described simply, widely available, and communicated effectively, for example, on the Local Offer and Graduated Approach Toolkit.
Focusing on target groups to move the Graduated Approach forward is essential. This includes headteachers, SENCOs, teaching assistants, pastoral support, and school nursing support. Engaging better with SENCOs by bringing SENCO networks together will help target and work cooperatively with schools across the partnership to influence content and detail of required actions.
Establishing a design group to map out the holistic support available and ensure a key understanding of the Graduated Approach is necessary. This group will bring together the services recognised in the deep dive to provide a coordinated and comprehensive support system.

Discussion

The preparations over the past six months have been commendable, with the partnership working well together and engaging in challenging financial conversations. The Board has discussed the next steps and is pleased with the progress made. The summary of the meeting and the intentions were clearly communicated, which is appreciated.
The Board noted that feedback has underscored the critical importance of effective communication. While a substantial amount of impactful work is being undertaken, it is imperative that these efforts are communicated clearly and effectively. This deliberate communication strategy will ensure that all stakeholders, including young people, fully comprehend the objectives. There appears to be a disconnect between the perceptions of young people and the actual efforts being made by the Council, which highlights the necessity for clear and consistent communication.
Members stated that the Deep Dive has provided an opportunity to understand the Graduated Approach better. It has been noted that the Graduated Approach has been overlooked nationally in the implementation of the SEND Code of Practice from the Children Family Act 2014 and requested that the focus should be on early identification rather than relying solely on education, health, and care plans. The partnership needs to move towards a comprehensive understanding and implementation of the Graduated Approach.
Everyone should be able to describe and understand it. The session was productive, with appropriate challenges and reflections from various organisations. The set of actions agreed upon within the day is a positive outcome.
The Board noted that the Local Offer needs significant improvement in terms of investment, creativity, functionality, and content. It is one of the keyways to communicate effectively and must be prioritised. There is a need for a clear understanding of the Local Offer within the partnership to tell the story accurately.
A question was raised about the training during the onboarding of new staff regarding the Graduated Approach. It was acknowledged that currently, there is no specific training; this needs to be addressed. Social care has some specific induction elements around children with additional needs, and it was suggested to check if the Graduated Approach is included.

	The discussion also highlighted the need for strategic support from communicators to provide a clear explanation of the Graduated Approach. Finding alternative explanations that are easy to understand will be beneficial. **Actions** 1. Communications to lead on a project of improvement for the local offer looking at both the accessibility/presentation and the content (Due date for next update: April) 2. Social Care members to check if the social care induction includes the graduated approach and ensure it is integrated (Due date: May) 3. Health leadership to work on articulating the graduated approach clearly within the wider health and care partnership (Due date: May)
5	**SEND STRATEGIC VISION AND WORKFORCE STRATEGY DRAFTS**
	Presentation Two documents were presented by Will for the Board's consideration: the Workforce Strategy and the SEND Strategic Vision. **Workforce Strategy** The development of the Workforce Strategy involved a process of communication and engagement. A version of the strategy was presented at the January meeting, but it was deemed cumbersome and not sharp enough. The current version has been thoroughly edited to deliver on the feedback. This sets out the key workforce outcomes against key workforce groups; with the recognition that the current focus are statutory services but that a future focus will be on school staff and the unpaid workforce (e.g. carers and families). It was emphasised that strategic frameworks like the Workforce Strategy should never be considered complete; they need to be kept under review and developed continuously. The Board's consideration was sought on whether the revised strategy is better and tighter than the previous version, if the content addresses the local need, and if the Board could endorse the approach to move forward with the implementation model. The importance of incorporating feedback from children and young people about their opportunity to engage in the training was also mentioned. **Discussion** The Board noted that the document is clear and a significant improvement to the previous addition and is significantly more concise. The question was raised on how to ensure Primary Care understands their responsibilities without being able to mandate training to staff who are in independent organisations. There is a need to include primary care in the strategy explicitly, as they are often the first point of contact for parents. The strategy will continue to be developed and improved, and it was emphasised that it must incorporate input from children and young people. The Board members unanimously agreed to approve the strategy.

Actions

1. Inclusion of an explicit statement in the strategy about the inclusion of primary care and the ongoing work to address this (Due date: April)

2. Proceed with the implementation planning for the workforce strategy (Due date: May)

3. Further engagement with children and young people on the progress of the workforce strategy (Due date: May)

Presentation

SEND Strategic Vision

The development of the strategic vision for SEND in the borough is a complex undertaking. In January, the SIAB discussed the necessity for a broader strategic framework. Previous iterations of strategic frameworks were reviewed, but they lacked traction with all partners. In February, a small representative group of the Board convened to consider the approach for developing the strategy. This group reflected on good practices from elsewhere in the country, with advice from DfE and NHSE.

The group reviewed various strategy documents, ranging from 80 page documents to single slides, and everything in between. They concluded that the strategy should be accessible, brief, tight, but meaningful. The framework aims to address SIAB priority improvement areas and reflect good work done previously, as well as using outcomes identified by children and young people to inform the strategy.

The current draft of the strategic vision was presented for consideration. The draft includes an opening statement slide written by children and young people, a single strategy page that can be extracted and used in isolation and clarifies the purpose and commitment to co-production.

There is an opportunity for further feedback from the children and young people during the Co-production day on April 15th.

Key Points:

- The strategy should be accessible, brief, and meaningful.
- It should reflect previous good work and outcomes identified by children and young people.
- The draft is presented for feedback and further development.
- Co-production is a key element, with feedback opportunities on April 15th and April 29th.

Areas for Improvement:

There are a couple of gaps in the draft that need to be addressed. Particularly, the outcome for children and young people to have fun needs more focus, as it has not been consistently presented in the programme of work.

Discussion

The Board noted that the document is clear and concise. They appreciated the structure but felt it lacked a sense of overall achievement, focusing more on individual achievements. They suggested making the goals more aspirational.

	The Board acknowledged the significant progress made on the document. However, they also recognised the complexity arising from the inclusion of multiple goals, priorities, aspirations, and programs. They recommended simplifying and aligning these elements for greater coherence. It was raised that discussions with parents focused on the implementation and use of the strategy rather than the strategy itself. The importance of using the strategy as an evolving working document was emphasised. The Chair suggested that the strategy should capture aspirations and have a focus on early identification and support. It was pointed out that the language on Slide 9 changes from focusing on young people to focusing on services. The Board suggested rethreading the language to maintain focus on children and young people and clearly defining the impact. **Actions** 1. Simplify and align the goals, priorities, and programmes to create a clear and cohesive strategy (Due date: April) 2. Make the goals more aspirational and clearer about how to achieve them (Due date: April) 3. Capture individual aspirations and focus on early identification and support (Due date: April) 4. Ensure the language throughout the document remains consistent and focused on children and young people (Due date: April) 5. Clearly define the difference we want to make and how we will measure impact (Due date: May) 6. Incorporate feedback and present a refined document (Due date: May)
6	**THEME 3 UPDATE**
	Presentation The discussion focused on bringing together the three priority areas: Preparation for Adulthood, Transition, and Alternative Provision. The aim is to understand how these areas link together, and the emerging impacts and differences being made in relation to the actions completed within these areas. Andy Bradburn, Stephen Holden, Wendy Young and Nick Bell gave their respective reports as follows: **Andy Bradburn provided the highlight for PIP 4 –Preparing for Adulthood** The report highlighted the ongoing work in Preparing for Adulthood, driven by the audits conducted a few months ago and the needs analysis. The current focus is on developing provision within Bury and engaging with existing providers to explore opportunities for better post-16 provision. The discussion also covered alternative provision, with efforts to engage with providers who have post-16 provision. Meetings and projects in Radcliffe and collaboration with Manchester City Council were mentioned. The goal is to find providers who can offer suitable premises and staff to support young people in transition.

The importance of partnership engagement was emphasised, including opportunities for work experience within the Council, health, and schools. The need for a broad range of opportunities and support for young people in transition was highlighted.

Discussion

Members asked about the opportunities for work experience within the Council, Health, and Schools, and how the partnership is engaged in finding opportunities for young people. Response received was that there are opportunities for internships and employment forums working with supporting bodies. The challenge is finding suitable provision for young people aged 16-17 who are not in college but not necessarily high needs.

Questions were raised including further information about different cohorts and the progress being made in the report and Will stated that the report includes information about different cohorts, but it would be helpful to have standalone documents with more detailed information about the offer for children with different needs.

Members emphasised the importance of understanding the pathways and options available for young people, reflecting on the last deep dive and the need for clarity in the partnership.

The Board agreed on the need for clarity and mapping out available options for young people. The next report will include this information.

Members also highlighted the need for data to understand the numbers, ages, gender, and ethnicity of young people being supported.

Members discussed the idea of collecting feedback from parents and young people, with support from schools and other partners.

Actions

1. Include further information about different cohorts and the progress being made in the report (Due date: May)

2. Develop standalone information sets with detailed information about the offer for children with different needs; to be included in appendices (Due date: May)

3. Include contextual data on numbers, ages, gender, and ethnicity of young people being supported in future reports (Due date: May)

4. Look at ways to collect feedback from parents and young people, with support from schools and other partners (Due date: April)

5. Ensure reports are responding to the key outcome indicators agreed as part of the Priority Impact Plan (Due date: April)

Presentation

Stephen Holden provided the highlight for PIP 5 Transitions

An update on the progress of transitions from nursery into school, school into high school, and high school into college was given. The key focus was on the year six to year seven transition, and the digital solution "6 into 7."

Strong progress has been made in the year six to year seven transition. All schools have signed up to “6 into 7”. The data is expected to be received on time, and a staged approach to information dissemination has been

implemented. SEND information will be made available earlier to high schools to facilitate additional planning for SEND children.
Additional support includes home visits, events at the Elizabethan Suite, and drop-ins at family hubs. Over 200 home visits were conducted last year, and this practice will continue. The transition process is enhanced by the digital solution but this is only available for 6 into 7 – an alternative is being investigated for other years, with additional support in the interim being provided.
For other transitions, such as from nurseries to primary schools and from high school to college, enhanced non-digital solutions will be used this year. Briefings with PBI nurseries have started, and early years advisors are providing information and advice on quality transitions. Face-to-face transition events and training are planned to support access to primary schools.
The transition from high school to college will not use the "6 into 7" digital platform this year. However, robust systems are in place, and colleges are actively participating in transition events. The transition work is strong, and there have been no issues reported.

Discussion

The Board asked about the assurance that there is no detriment to children and young people due to the lack of a digital platform and response received was that the transitions last year were positively received, and there has been no negative feedback from SEND parents and families. Enhanced feedback mechanisms are being discussed to ensure continuous improvement.
The Board recommended including more quality assurance and feedback from schools, parents, and young people in future reports.
The Board raised the idea of retiring the term "SEND" and using "children with individual needs" instead. Mixed feelings were expressed about changing the term due to legislative implications. The focus should be on actions rather than names, and any change should come from the top down.
The Board emphasised the importance of capturing the impact and differences made by the transition work and for future reports to include this information.
The importance of ensuring that the transition process is seamless and that all stakeholders are engaged in providing opportunities for young people was highlighted and it was noted that there are ongoing efforts to engage with various stakeholders, including schools, health services, and the Council, to provide a comprehensive support system for young people in transition.
It was suggested that the strategy should reflect the broader goals and aspirations for young people, not just the immediate transition needs. Stephen informed the Board that the strategy aims to be aspirational and comprehensive, addressing both immediate and long-term needs of young people. Future iterations of the strategy will include broader goals and aspirations.
Questions were raised about the specific measures in place to support young people who are not in college, but also not high needs and it was stated that there are ongoing efforts to provide support for young people in this category, including internships, employment forums, and collaboration with existing providers to offer suitable opportunities.
The Board emphasised the need for clear communication and consistent language throughout the paper to ensure all stakeholders understand the goals and objectives and for future reports and strategy documents to ensure this clarity.

Actions

- Include more comprehensive feedback and quality assurance from schools, parents, and young people in future reports (Due date: June)
- Enhance feedback mechanisms to ensure continuous improvement (Due date: June)
- Capture the impact and differences made by the transition work in future reports (Due date: July)
- Consider the implications of changing the term "SEND" to "children with individual needs" and discuss further with stakeholders (Due date: August)

Presentation

Nick Bell provided the highlight for Report on EOTAS and Alternative Provision:

The report provided an update on the Educated Other Than at School (EOTAS) provision and alternative provision. The key points included definitions, current practices, and future plans.

EOTAS refers to education provided for young people who might not otherwise receive it due to permanent exclusion, medical reasons, or other circumstances. It is distinct from alternative provision, which is education provided by the local authority within a different framework. The new guidance from the DfE states that EOTAS is not considered alternative provision, although there is some overlap.

Efforts have been made to clearly identify and categorize cohorts of children receiving EOTAS and alternative provision. This includes ensuring secure oversight and tightening processes around these provisions. Schools are required to inform the local authority about children in alternative provision, and data collection sheets are used to maintain oversight.

The policy for EOTAS has been completed and shared with parent forums for feedback. Amendments have been made based on this feedback, and the policy is ready for approval. An ongoing EOTAS Parents Forum will be established to discuss issues and collect feedback regularly. Efforts are also being made to ensure that children in EOTAS have access to services and support typically available in schools.

Discussion

Board Members asked for definitions of EOTAS and alternative provision to be emailed for reference.

Board Member suggested having a breakdown of all children with SEN support and an education, health, and care plan by provision, including alternative provision, EOTAS, missing education, and elective home education.

Members asked if the local authority has a full understanding of where all children are, including those in alternative provision commissioned through schools.

There are checks and balances in place, and schools are required to provide information about children in alternative provision. Data collection sheets are used to maintain oversight.

The Chair highlighted the importance of knowing about all children in Bury, including those in unregistered schools and the need for cross-referencing data

with health and social care to ensure all children are accounted for. In the same vein, the number of children currently in EOTAS and the main cohorts were requested for. Nick reported that there are currently 41 children in EOTAS, with 70% in year 11 or post-16. The main cohorts are children with Social Emotional Mental Health and Autism.
The Board suggested establishing ongoing forums to discuss issues and collect feedback from EOTAS parents and emphasised the importance of ensuring children in EOTAS have access to services and support typically available in schools. Nick reported that efforts are being made to ensure access to services, including educational psychology services, to support children in EOTAS and facilitate their return to the school system where possible.
Questions were asked if children and young people have seen the policy and provided feedback and it was confirmed that he policy has been shared with parent forums, but feedback from children and young people is still needed. Efforts will be made to gather this feedback through various channels.
The Board Member suggested having a register of all strategies to ensure a clear strategic framework.

Actions

- Nick Bell to email definitions of EOTAS and alternative provision (Due date: April)
- Robert Arrowsmith to provide a breakdown of children with SEN support and education, health, and care plans by provision, including those outside the maintained sector, and cross-referencing with health and social care data (Due date: May)
- Nick Bell to establish EOTAS Parents Forum to meet regularly (Due date: April)
- Nick Bell to gather feedback from children and young people on the policy (Due date: July)
- PPL to create a register of all strategies (Due date: April)

Presentation

Wend Young provided the highlight for Report on EHC Process:
The report provided an update on the progress of the annual review recovery plan for Education, Health, and Care (EHC) plans. The focus remains on delivering the annual review-based recovery plan, with progress being made despite significant barriers related to data management.
One of the major barriers to developing the recovery plan beyond the initial phases is the management of annual review data. The systems are currently being updated to hold annual review data effectively, including information on who has had an annual review, who hasn't, and who has been waiting. The data cleansing process is underway, with staff being trained to ensure accurate data management.
Progress and Achievements:

- Achieved a 94% compliance rate (completion within 20 weeks of due date) for transfers by the 15th of February, with 76% of placements named according to parental preference.

- On track to ensure every year 11 plan includes a preparing for adulthood element by the 31st of March deadline. Quality remains a focus, but statutory compliance is being maintained.

Next Steps
The next phase of the recovery plan will focus on year 11 transitions and ensuring statutory compliance. The goal is to address reviews and move to a position of no back log. This will take longer than 12 months due to the scale of the challenge.

Discussion
There was a discussion on the roles of providers and how they have evidenced outcomes, and the extent to which providers can recognise and advocate for improvements. Efforts are being made to improve relationships and communication with providers.
Concerns were raised about prioritisation of EHC plan reviews in the staging of the recovery, particularly those outside of transition points and asked how parents can trigger the process for prioritizing their child's review. Wendy explained that an Annual Review triage has been established to manage the high volume of reviews. The triage process prioritizes reviews based on risk factors such as crisis situations, exclusions, and other urgent needs. Further refinement of the process is needed to ensure seamless management.
There was a suggestion to include all providers in the annual SEND survey to capture feedback from all services that children and young people touch. Wendy agreed and emphasised the importance of capturing feedback from a broad range of stakeholders.
The importance of understanding the whole position of children with SEND, including those outside the maintained sector was discussed by members.

The current approach delivers on bringing different but related elements together. There is a need to better bring together and describe the whole experience of transitions in the executive summary, highlighting key challenges and questions for the Board.
The report includes tables with red RAG ratings. It is important to explain these ratings in the report and reset dates for those that have not been met. The Board needs to approve new dates to ensure they are achievable.
The report indicates that outcome measures are to be confirmed. The Board looks forward to having these measures completed by the next meeting.

The importance of building a partnership approach and thinking about children holistically was highlighted as the reason for bringing together these areas in to one report, so that should be the focus, not just a better report. Suggested that the delivery group should ensure joined-up work.
It was suggested that the Executive Summary could be sharper and that in doing this we may also deliver on the action at the beginning of the report on how to communicate key messages to families, children, and young people.
It was agreed that further audits of plans should be conducted to identify progress on inclusion of the Preparing for Adult elements.

The Board emphasised the importance of engagement of parents, children, and young people but that we should think about the impact on parents.

	Actions • Reset request for overdue milestones to be brought to the future Boards (Due date: April) • Audits of plans to look at quality of preparing for adulthood elements and provide an update (Due date: May) • Development of an approach to engage parents and carers (Due date: April)
7	**ANY OTHER BUSINESS**
	Thoughts from the days meeting: Strengthening within the partnership across the Board. Quality of reports is improving, with expectations for further enhancement through data and quality assurance. There is greater challenge and support among partners. Positive feedback from children, emphasising the importance of early identification of needs. Finlay announced that Gary Llewelyn will be taking over his role within the DfE. The Chair acknowledged Finlay's contributions over the years, particularly during the intervention. he Board wished him the best for the future.
11	**DATE OF NEXT MEETING**
	29th April 10.00 – 13.00 Town Hall Committee Room A & B 28th May 10.00 – 13.00 Town Hall Committee Room A & B 24th June 10.00 – 13.00 Town Hall Peel Room 22nd July 10.00 – 13.00 Town Hall Peel Room 23rd September 10.00 – 13.00 Town Hall Peel Room 21st October 10.00 – 13.00 Town Hall Peel Room 25th November 10.00 – 13.00 Town Hall Peel Room 16th December 10.00 – 13.00 Town Hall Peel Room