Agenda

Locality Board – Meeting in Public (on Teams)

Date: 1st June 2026

Time: 4.00 pm – 6.00 pm

Venue: Microsoft Teams

Chair: Dr 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 13th April 2026 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
6.0	4.20 – 4.30	10 mins	VCFE Focus - Homestart	Verbal	Discussion	Sarah Cook
Locality Board Priorities						
7.0	4.30 – 4.40	10 mins	Place Documentation update	Paper	Discussion	Will Blandamer
8.0	4.40 - 4.50	10 mins	Draft SEND Reform submission	Paper	Discussion	Ben Dunne/Will Blandamer
Integrated Delivery Collaborative Update						
9.0	4.50 - 5.00	10 mins	Integrated Delivery Board Update	Paper	Discussion	Kath Wynne-Jones
10.0	5.00 – 5.10	10 mins	Older People/Falls Frailty	Paper	Discussion	Clare Hunter/Katy Alcock
11.0	5.10 - 5.20	10 mins	BCF update	Paper	information	Will Blandamer
Updates						

Committee/Meeting updates						
12.0	5.20 - 5.30	10 mins	Population Health and Wellbeing update	Paper	Information	Jon Hobday
13.0	5.30 - 5.35	5 mins	Performance & Quality Group update	Paper	Information	Kath Wynne-Jones/Catherine Jackson
14.0	5.35 – 5.40	5 mins	SEND Improvement and Assurance Board Minutes	Paper	Information	Will Blandamer

Closing Items				
14.0	5.40	5 mins	Any Other Business	Verbal
15.0	__________	_________	**Date and time of next meeting in public - Monday, 6th July 2026, 4.00 - 6.00pm in Committee Rooms A and B, Bury Town Hall**	___________

		5 mins	Post Meeting Reflection	Verbal/All

Meeting: Locality Board			
Meeting Date	01 June 2026	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 1st June 2026 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 priorities	
Scale our work on Population Health Management - Improve population health and reduce health inequality of those in the most disadvantaged areas	☒
Drive prevention, reducing prevalence and proactive care – supporting Demand Reduction through primary intervention, secondary preventions and tertiary prevention	☒
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	☒
Optimise Care in institutional settings and prioritising the key characteristics of reform.	☒

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	☒

Implications						
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		

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	O'Brien	Eamonn	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		15/01/2025			
				No Barriers Foundation		X		Direct	Trustee		Present			
				CAFOD Salford		X		Direct	Member		Present			
				Catenian Association		X		Direct	Member					
				USDAW		X		Direct	Member					
				Prestwich Methodist Youth		X		Direct	Trustee		Present			
				Unite the Union		X		Direct	Member		Present			
Cllr	Tamoor	Tariq	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	29-Jul-24			
				Pretty Little Thing				Indirect			Present			
				Action Together CIC	X			Direct	Employed		15-Jan-25			
				The Derby High School			X	Direct	Governor	Apr-18	Present			
				St Lukes Primary School		X		Direct	Member		15-Jan-25			
				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		Present			
				Labour Party				Direct	Member		Present			
				Community in the Union				Direct	Member		Present			
				Co-operative Party	X			Direct	Member	Jul-24	Present			
				Socialist Health Association				Direct	Member		Present			
				Good Campaigns Company	X			Direct	Employed	Jul-24	Present			
				Catholics for Labour				Direct	Member		Present			
				GMB Union				Direct	Member		Present		25/11/2022	Y
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)		
	Hepburn	Nicola	Acting Chief Reform and Improvement Officer	Now You're Talking Organisation linked to Talk Listen Change Charity		X		Direct	Clinical board advisor for a profit with purpose	Sep-25	Present	As per policy - see details above (Y,Y,Y,Y,Y)		
				Associate clinical nurse assessor for multi health specialists	X			Direct	Associate clinical nurse assessor	Apr-25	Present			
	Kissock	Neil	Director of Finance/Section 151 Officer	None Declared					Nil Interest	Aug-24	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			
	Parekh	Nina	Divisional Managing Director - Bury Community Services Division	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		17/05/2024	Y
				Host Non Exec of Aqua (Advancing Quality Alliance)		X		Direct	Host Non Exec	Sep-24	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			
				Stockport NHS Trust				Indirect	Daughter is a Foundation Year 1 Doctor	Jul-25	Present			
	Richards	Jeanette	Executive Director of Children and Young People, Bury Council	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 Garrett Anderson programme	X			Direct	Tutor	Oct-22	Present			
	Richardson	Stuart	Chief Executive, Bury Hospice	None Declared					Nil Interest	Mar-25	Present			
	Beesley	Mark	Chief Officer	Bury GP Practices Limited	X			Direct	Chief Officer & Director	Jul-21	Present			
				Greater Manchester GP Federation	X			Direct	Director	Oct-21	Present			
Invited Members														
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)		
				St Philips Community Centre Radcliffe		X		Direct	Member of Sub Committee	Jul-24	Present			
				Anodising Colour		X		Indirect	Spouse is a lab technician	2017	Present			
				Radcliffe First		X		Direct	Leader	2019	Present			
				Radcliffe Market Hall Community Benefit Society		X		Direct	Member	Jul-24	Present			
				Radcliffe Litter Pickers		X		Direct	Member	2019	Present			
				Growing Older Together		X		Direct	Member	2019	Present			
Cllr	Arif	Shahbaz	Cllr Bury Council, Conservative Leader	Conservative Councillor Association		X		Direct	Member	Jun 25	Present			
				Conservative Muslim Forum		X		Direct	Member	June 25	Present			

Meeting: Locality Board			
Meeting Date	01 June 2026	Action	Approve
Item No.	3	Confidential	No
Title	Minutes of the Previous Meeting held on 13th April 2026 and action log		
Presented By	Chair of the Locality Board		
Author	Emma Kennett, Head of Locality Admin and Governance (Bury)		
Clinical Lead	N/A		

Executive Summary
The minutes of the Locality Board meeting held on 13th April 2026 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; • 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 priorities	
Scale our work on Population Health Management - Improve population health and reduce health inequality of those in the most disadvantaged areas	☒
Drive prevention, reducing prevalence and proactive care – supporting Demand Reduction through primary intervention, secondary preventions and tertiary prevention	☒
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	☒
Optimise Care in institutional settings and prioritising the key characteristics of reform.	☒

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 – Meeting in Public – 13th April 2026

Time: 4.00pm – 6.00pm

Venue: Committee Rooms A and B, Bury Town Hall

Title	**Draft Minutes of the Locality Board**
Author	Emma Kennett
Version	0.1
Target Audience	Locality Board
Date Created	13th April 2026
Date of Issue	
To be Agreed	
Document Status (Draft/Final)	Draft
Description	Locality Board Minutes

Document History:

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

Locality Board

MINUTES OF MEETING
Locality Board Meeting in Public Committee Rooms A and B, Bury Town Hall 13th April 2026 4.00 pm until 6.00 pm **Chair – Cllr E O'Brien**

ATTENDANCE

Voting Members
Cllr Eamonn O'Brien, Leader of Bury Council (Chair) Cllr Tamoor Tariq, Executive Member of the Council for Adult Care and Health Cllr Lucy Smith, Executive Member of the Council for Children and Young People Ms Lynne Ridsdale, Place Based Lead Dr Kiran Patel, Medical Director, Bury IDC Ms Lorna Allan, Chief Digital and Information Officer, NCA Ms Sarah Preedy, Chief Operating Officer, Pennine Care Foundation Trust Ms Helen Tomlinson, Chief Officer, Bury VCFA (Voluntary, Community, Faith & Social Enterprise) Mr Will Blandamer, Deputy Place Based Lead, Executive Director of Health and Care (for part) Mr Adrian Crook, Director of Adult Social Services and Community Commissioning Ms Catherine Jackson, Associate Director for Nursing, NHS Greater Manchester (Bury)
Non-Voting Members
Ms Kath Wynne-Jones, Chief Officer, Bury IDC
Invited Members and Observers
Cllr Mike Smith, Leader, Radcliffe First Mrs Emma Kennett, Head of Locality Admin & Governance, NHS Greater Manchester (Bury)

MEETING NARRATIVE & OUTCOMES

1.	Welcome, Apologies and Quoracy
1.1 1.2 1.3	The Chair welcomed all to the meeting. Apologies were received from Dr Cathy Fines, Mr Stuart Richardson, Ms Jeanette Richards, Mr Jon Hobday, Mr Neil Kissock, Dr Vicki Howarth and Ms Ruth Passman. The meeting was not quorate however there were no main agenda items for decision at today's meeting.

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	**There were no new declarations of interest from today's meeting 13th April 2026 and the previous meeting 2nd March 2026.**

ID	Type	The Locality Board	Owner
D/04/01	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 2nd March 2026 were considered as a true and accurate reflection of the meeting.
3.2	Updates were received in respect of the Action Log and noted. Mr Blandamer was particularly asked to secure clarity on the timeline for data reporting at place level for maternity provision

ID	Type	The Locality Board	Owner
D/04/02	Decision	Accepted the minutes from the previous meeting as a true and accurate reflection of the meeting and noted the updates 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/04/03	Decision	Received the update.	

5.	Key Issues in Bury
5.1	Ms Ridsdale presented the latest Place Based Lead update to the Locality Board. It was reported that: - • The reform of the operation of NHS Greater Manchester continued. On the 31st March 2026, NHS Greater Manchester staff received letters confirming the outcomes of local and pan Greater Manchester filling of posts panels, and this confirmed whether staff were slotted into new posts in the organisation or would be part of a next stage of consultation/expressions of interest process. NHS Greater Manchester staff in Bury (whether part of the local structure or as part of pan Greater Manchester arrangements) were commended for their continued hard work during this period of significant personal uncertainty and organisational instability. • The focal point for NHS Greater Manchester was to conclude the restructure process as soon as possible and to move to the operation of the new operating model quickly. It was however noted that a change of this magnitude would take some time to bed down, and the ICB was seeking to move to the new operating model in a way that was safe and careful ensuring no significant organisational risks, particularly where they pertain to statutory duties such as safeguarding. • It is noted that subject to legislation, the new Chair of NHS Greater Manchester would also take on a dedicated health role within the GMCA. Working closely with the Mayor of Greater Manchester. Through the English Devolution and Community Empowerment Bill, the appointee was expected to assume the statutory function of Health Commissioner for Greater Manchester, with oversight of NHS commissioning, performance and delivery across the system. It was noted that the introduction of this role was dependent on the progression and approval of the English Devolution and Community Empowerment Bill. Once the legislation was passed and statutory guidance was issued, further detail on the implementation timelines would be provided. • A really positive meeting took place in March 2026 between Bury colleagues and clinical and operational leads at North Manchester Hospital. While operational relationships were very positive, partners considered there was further value in

	clarifying the range of pathways across the urgent care system both in relation to admissions and avoidance and supported discharge. Through a 'world café' approach we discussed the model of virtual wards, intermediate care, hospice care, INTS and others. We will continue to strengthen the systematic understanding of MFT clinicians to the arrangements in Bury. Mr David Latham and Ms Kath Wynne Jones were thanked for convening the meeting. • Locality Board colleagues would be aware of the new national neighbourhood health framework published by NHSE earlier last month: - https://www.nhsconfed.org/publications/neighbourhood-health-framework-what-you-need-know The Bury Locality Board and through the Integrated Delivery Board had worked hard on the model of neighbourhood working in Bury and we have had external validation of the maturity of these arrangements (for example by the LGA). • In relation to estates, the future of Radcliffe Primary Care Centre had been secured and opportunities for securing additional funding in Prestwich were still being progressed.
5.2	The following comments/observations were made by Locality Board members: - • It was important for legislation being required in relation to the new Chair of NHS Greater Manchester taking on a dedicated health role within the GMCA and the importance of localities being engaged as part of these discussions was highlighted.

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

6.	VCFE focus – Speakeasy
6.1	Ms G Pearl, Chief Executive Officer, Speakeasy was in attendance to provide a presentation in relation to the work of Speakeasy. The presentation highlighted that: - • The purpose of Speakeasy which was to support people with aphasia in order to make a positive difference to their lives and their family and friends. • Speakeasy had been based in Bury since 1985 and were pioneers who influence was happen nationally and internationally. • Aphasia is a language processing disorder which was different for everyone • Most people have never heard of aphasia despite it impacting on more than 300,000 people in the country. • Further details could be found on the website at www.speakeasy-aphasia.org.uk • Speakeasy was led by speech and language therapists and people with aphasia With trained volunteers to help deliver the work • Speakeasy listened to what people wanted and therapy was provided through life participation activities to help people become assets in their community. • Speakeasy was not just about communication as was also about encouraging people to live more healthy which linked to the Public Health agenda. • Use of technology could be difficult for people with aphasia and support was offered in this regard.

6.2	• There was lots of positive feedback that has been received including comments such as 'Speakeasy has given me the bricks to rebuild my life' and 'I am now studying at college and thinking about joining a walking group'. • In terms of finances, the service was set up 40 years ago with support from social services and NHS in Bury and Bolton, Speakeasy sells services – consultation, resources, training for good communication skills, writing aphasia accessible information. Member contributions were important but were challenges in terms of personal budgets and fundraising. This was the last year of national lottery funding. The following comments/observations were made by Locality Board members: - • Speakeasy had attended a recent Council engagement event which had been extremely beneficial in terms of highlighting the areas that organisations can work in partnership and have a positive impact on NHS Services. • A query as to where Speakeasy was based in Bury. It was noted that Speakeasy was based in Ramsbottom and was mainly people from Bury and Bolton who accessed the service. • Whether there were services similar to Speakeasy available in other areas. It was noted that Speakeasy was one of a kind and that there were wider stroke group offerings available but not specific aphasia services in existence. • A question as to whether referrals were received from the Integrated Neighbourhood Teams. It was noted that there were some referrals received from GPs however not everybody utilised the service. It was noted that work was being undertaken with the NCA from a speech therapy perspective and was potentially an opportunity for more innovative ways of working in terms of GPs signposting to speakeasy prior to Speech Therapy. • A query as to whether Speakeasy could be used more from a 'Waiting Well' perspective in order to ensure that people are not deteriorating whilst waiting for NHS or other services. It was highlighted that the role of carers and awareness of Speakeasy was a key element of this. Ms Tomlinson commented that there was an IDC Session taking place next week with VCFE providers and this could be discussed further then. • There were links with agendas such as SEND were communication was key from an early age.

ID	Type	The Locality Board	Owner
D/04/05	Decision	Noted the update.	

7.	Place Partnership Arrangements
7.1	Mr Blandamer presented a paper to provide an update on the pan Greater Manchester development of the place partnership arrangements.
7.2	It was highlighted that: - • The key component parts of the place partnership arrangements described in the NHS Greater Manchester operating model were the place partnership agreement,

	The place outcomes framework, The place financial fund and the employment model for NHS GM staff in places. • In terms of the Place Partnership Agreement, the Greater Manchester Place Agreement Development Group was continuing to finalise the Partnership Agreement and aligning to Greater Manchester Outcomes Framework development to have clear outcomes and metrics for Place. An initial draft has been developed and feedback received to include/refine prior to progressing with broader engagement. The Locality Board in Bury in March endorsed with some additional comments a draft partnership agreement and has therefore contributed to the GM work. It was noted that the services of Mills & Reeves (legal oversight) were being explored, not to legalise the agreement, but to ensure to robustness and precision of the agreement. Work continued on the development of the Agreement and it was expected that Final versions would be completed in the next 2 weeks and would be shared with the Locality Board in due course. • In relation to the Place Outcomes Framework, Locality Board will recognise the substantial NHS GM produced performance and outcomes framework routinely received in this meeting. Further work was underway to develop a refreshed pan Greater Manchester place outcomes framework, and with a particular focus on ensuring the product is reflective of the breadth of the operation of the health and care system, including adult care, children's care, wider population health indicators as well as core NHS standards. Bury colleagues were contributing to this work a further update would be brought back to a future meeting. • In terms of the place financial fund, the Place Fund was one of the pillars of the locality operating model, alongside the Locality Partnership Agreement and the Locality Outcomes Framework. It was designed to support devolved decision-making, collaboration, enable neighbourhood-led investment, and create the conditions for a sustainable left-shift from reactive to preventative care. Systemwide feedback confirmed strong support for the ambition of the Place Fund but highlights several critical gaps that must be addressed before wider partners can provide full endorsement. Partners have been clear that strategic intent requires sharper articulation, the hosting model needs clearer explanation, and greater financial transparency is essential. In particular, partners require assurance around budget flows, delegations, risk management and the mechanics of left-shift. Given the scale of technical work required, 2026/27 would operate as a shadow year, during which the ICB would hold all budgets centrally including the Place Fund, while Place teams I continue to still have responsibility for influencing and controlling all ICB expenditure and support the delivery of outcomes. • In relation to the Place Transfer, Work had progressed to establish a clear and credible foundation for the Place transfer programme. An independent appraisal of the potential options which could support a future transfer of the NHS Greater Manchester employed staff within Place had been commissioned. The areas to be included in the analysis included: - • Strategic and system alignment • Workforce impact and employee experience • Service continuity and quality implications • Legal, HR and governance considerations • Operational feasibility and deliverability

- Financial and resource implications
- Cultural and leadership fit
- Overall risk and resilience

7.3 It was recognised that NHS Greater Manchester colleagues in place continued with some uncertainty in the absence of clarity on their final employment arrangements.

7.4 The following comments/observations were made by Locality Board members: -

- There was a need to ensure that the Place Partnership Agreement wasn't viewed as the end of the process as there would still be a need to be continue, improve and develop as a partnership over the coming months and years.
- There was a need to prioritise concluding the employment model work as soon as possible as this was not a satisfactory position for staff in terms of further uncertainty following the recent staff consultation process and might cast doubt on the capacity of NHS GM to deliver fully its duties in relation to working with partners to deliver left shift at scale
- A question around the options being explored as part of the future employment model for place staff. It was reported that there were currently 18 staff members employed by NHS Greater Manchester who work in Bury who could be potentially affected by these changes. A key driver for these changes was the risk around the ICB running costs which needed to be mitigated. There were potential consistency issues between localities in terms of the transfer with some looking more likely at this stage to have staff employed by providers however this would all need to be worked through as part of the Place transfer programme.
- It was highlighted that given the relatively small numbers involved, the Place transfer work should have been one of the first things to resolve as part of the Consultation process.
- There was a need to ensure that the importance of place working was not lost as the new Operating Model is implemented including the protection of local resources for future delivery. It would be helpful to have a discussion around this matter with the new Health Commissioner for Greater Manchester once appointed.

7.5 Mr Blandamer emphasised that the risks around the Place transfer programme and impact on staff had been raised at a Greater Manchester level. There was a need to ensure that this uncertainty does not impact on the future direction in terms of left shift and other key priorities.

7.6 Mr Blandamer informed members that the timescales for signing off some of the Place Partnership arrangements was likely to be June 2026 which may not fit with the date of the Bury Locality Board meeting which is on the 1st. The exact governance arrangements for this sign off process would need to be explored further, and a discussion would take place at the next Agenda Setting meeting with the Co-chairs on the 5th May 2026.

ID	Type	The Locality Board	Owner
D/04/06	Decision	Noted the update.	
A/04/01	Action	A further update/items for approval on the Place Partnership arrangements to be provided to the Locality Board in June 2026.The specific governance	Mr Blandamer

		arrangements would need to be agreed given the timing of the June meeting.	

8.	Left Shift Strategy
8.1	Ms Wynne-Jones submitted a presentation in relation to the Left Shift Strategy.
8.2	Mr O'Brien commented that was a useful presentation to bring at this point and was not an area that the Locality Board could resolve in a single meeting however would need to be at the forefront of all future discussions and ways of thinking. It would be helpful for this item to generate some ideas and debate from Locality Board members.
8.3	The presentation covered: - • The context in terms of the 10 Year Plan and the 3 radical shifts namely Hospital to community, Analogue to digital and Sickness to prevention. It was noted that in the NHS Ten Year Health Plan, this was referred to as a 'left shift' towards prevention, community and digital care. • The Neighbourhood Health Framework was a key element of this strategy. • The term 'left shift' remains under debate, not least within NHS policy circles. We define the term as the shift of activity out of hospitals to those delivered closer to home – largely provided by primary or community services and wider system partners. • The NHS Confederation principles to Left shift were set out. • The system change that would result from the delivery of the Greate Manchester Strategic Commissioning Plan over 5 Years set out what was meant by the Left Shift in Greater Manchester, the system changes that would occur as a result, the key programmes to drive those changes, How we will commission and invest to enable the change and What the system will look like in 5 years. • How the Locality Plan Priorities for Health and Care linked in with this strategy including the Neighbourhood Model • The Contributing strategies to our Left Shift approach included Development of the NCA Clinical Strategy and emerging Service Led User strategy, Strategy for North Manchester, GP strategy, Locality strategy for Neighbourhood working and the PCFT strategic conversations. • The Desired outcomes of the approach and the Minimum requirements for 2026/27. • The timescales for delivery in this area were somewhat challenging and ambitious with some timescales in the Greater Manchester plan suggesting September 2026 and March 2027 timescales. There was a need to fully understand how these desired outcomes linked with provider plans and the multi locality footprint. • Risks including: - • Lack of shared understanding of the neighbourhood model and left shift approach by all partners • Capacity to implement the model, especially in the midst of organisational change in a number of key partner organisations • Lack of resource to invest in preventative services, and lack of financial strategies to support • Limitations of estates and digital capability to support neighbourhood development: OP focus is key • Communication and engagement capacity and capability

8.4	Ms Wynne-Jones asked members to consider: - • What's our version of 'Left Shift'? • How do we address the key risks as a system to enable our ambition and the asks of the Neighbourhood Health Framework?
8.5	The following comments/observations were made by Locality Board members: - • This was a positive presentation that validated the existing good work within the locality. • There had been a push towards reviewing council estates in conjunction with NHS estates and there was a need to be radical in terms of future requirements. • It was helpful that this strategy linked in with the Pennine Care strategy and opportunities for future funding. • Left Shift could no longer be seen as a 'project' and needed to be the cornerstone of all future locality developments in order to signify a fundamental shift in approach. It was highlighted that future reports submitted to the Locality should include a consistent paragraph to demonstrate how the report contributes to the 5 neighbourhoods and Left Shift strategy. • A question as to whether there the neighbourhood approach in Bury was fully understood across the partnership from a geographical and service delivery perspective given the different organisational priorities that exist. It was noted that there were some challenges around language and organisational culture and ensuring that the NCA reforms align with the direction of travel in respect of place based working going forward. • A general discussion took place regarding some of the current areas of focus such as improving waits in emergency departments with performance of 73.6% for the NCA being viewed for the first time since 2021. • A question as to how public culture and behaviour could be influenced as part of the organisational reforms in terms of where and how people access services. It was noted that there was still often a perception from members of the public that secondary care is the better option for care when that is not necessarily the case. • The need for people to understand that 'Left Shift' does not necessarily mean a physical shift from secondary to primary care as can also mean self care etc. • Discussions in relation to the Left Shift agenda had been taking place within the VCFE sector for the last 18 months and there were clearly some frustrations in relation to funding and the flow of money as this did not appear to be reflective of the direction of travel. There was a question raised regarding the exact level of funding that was provided to the VCFE on an annual basis. Mr Crook agreed to check on the exact funding figure for the VCFE on an annual basis. Mr Blandamer commented that this had likely not increased in recent years which was similar to the Primary Care position.

ID	Type	The Locality Board	Owner
D/04/07	Decision	Noted the update	
A/04/02	Action	Future Locality Board reports to clearly articulate how the report contributes to the 5 neighbourhoods and Left Shift strategy.	Mr Blandamer/All

A/04/03	Action	Mr Crook agreed to check on the exact figure for the VCFE on an annual basis.	Mr Crook

9.	Bury Partnership response to SEND reforms
9.1	Members received copies of a report in relation to the Bury Partnership response to SEND Reforms.
9.2	It was noted that the Education White Paper contained details of intended changes to the SEND system. All partnerships are required to develop a SEND plan in response to the changes to be submitted by 19th June. This paper provides an overview of the arrangements to respond to the opportunity in Bury.

ID	Type	The Locality Board	Owner
D/04/08	Decision	Noted the update.	

10	Integrated Delivery Board update
10.1	Members received the latest Integrated Delivery Board update. The paper 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.

ID	Type	The Locality Board	Owner
D/04/09	Decision	Noted the update	

11.	PCCC Highlight Report
11.1	Members received copies of the latest PCCC Highlight report from the meeting held in March 2026.

ID	Type	The Locality Board	Owner
D/04/10	Decision	Noted the Highlight report.	

12	Performance and Quality Group update
12.1	Item deferred

ID	Type	The Locality Board	Owner
D/04/11	Decision	Noted the update.	

13	SEND Improvement and Assurance Board Minutes
13.1	Members received minutes from the SEND Improvement and Assurance Board meeting held on the 16th February 2026.

ID	Type	The Locality Board	Owner
D/04/12	Decision	Noted the minutes	

14.	Any Other Business
14.1	There were no items raised.

ID	**Type**	**The Locality Board**	**Owner**
D/04/13	Decision	Noted the information	

15.	**Date and time of next meeting**
15.1	**Date and time of next meeting in public - Monday, 1st June 2026, 4.00 - 6.00pm on Microsoft Teams.**

Locality Board Action Log – April 2026

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

Date	Reference		Action	Lead	Status	Due Date	Update
2nd February 2026	A/02/04	Action	Mental Health Gap Analysis to be brought back to future Locality Board meeting.	Ms Preedy/Mr Blandamer		June 2026	
2nd February 2026	A/02/05	Action	A further discussion was required from a Greater Manchester perspective in terms of what information could be provided to localities at a neighbourhood level.	Mr Robinson/Mr Blandamer		March 2026	Update April 2026 – It was noted that new data packs had been released from Greater Manchester which would link in with population health work and would be made available in due course.
2nd March 2026	A/03/01	Action	The questions raised as part of the Maternity item to be raised with the LMNS and the particularly the availability of a workplan/timescales for the Bury specific data being available.	Dr Fines		April 2026	Email sent and response received following the March meeting to state: - The current GM dashboard does not have the capability to break down service user by postcode, although this is an ambition that we would like. The new national maternity E&E dashboard also unfortunately does not break down by locality:Maternity

							and Neonatal Equalities dashboard - NHS England Digital We are currently looking to utilise MSDS data which may give us that functionality. Fingertips is currently the only source I am aware of that provides some specific outcomes for Bury relating to maternity .Child and Maternal Health - Data | Fingertips | Department of Health and Social Care MNVP are aligned to maternity provider however they will be collecting information from all localities and share the demographic breakdown quarterly with the system group. I have copied in Natalie who can advise whether the North Manchester service user feedback is identifiable by post code. Update April 2026 – Members discussed the current gap in relation to the availability of maternity data for Bury residents

							and the need to accelerate process given the links to the first 1001 days and setting the foundations for lifelong emotional and physical wellbeing. There was a query as to whether NHS numbers and home post codes could simply be used to extract some of the Bury maternity data given does not have a single maternity provider in the locality. It was highlighted that other localities would also be in this position as residents may choose to go to other areas for maternity care and vice versa so data still include residents from other areas. It was highlighted that there was still a need to obtain some more definitive timescales for this work and availability of the Bury maternity data. There was also a query as to whether this would link into the Population Health work. It was noted that this was the intention.
2nd March 2026	A/03/02	Action	Mr Blandamer to bring back an updated version	Mr Blandamer		April 2026	

			of the Partnership agreement to the Locality Board meeting at a later stage.				
2nd March 2026	A/03/03	Action	To explore whether there is an opportunity to develop a version of the Urgent Care video with no sound and subtitles that could potentially be played on a loop within GP surgeries.	Ms Wynne-Jones		April 2026	It was noted that a discussion had taken place with the editor of the video and a subtitled version of the video was being produced for practices.
2nd March 2026	A/03/04	Action	Clarity to be obtained in relation to the plans for the 'Patient Voice' being captured as part of the new Greater Manchester Primary Care Commissioning Committee.	Mr Blandamer		April 2026	This still needed to be picked up.
13th April 2026	A/04/01	Action	A further update/items for approval on the Place Partnership arrangements to be provided to the Locality Board in June 2026.The specific governance arrangements would need to be agreed given the timing of the June meeting.	Mr Blandamer		June 2026	

13th April 2026	A/04/02	Action	Future Locality Board reports to clearly articulate how the report contributes to the 5 neighbourhoods and Left Shift strategy.	Mr Blandamer/All		June 2026	
13th April 2026	A/04/03	Action	Mr Crook agreed to check on the exact figure given to the VCFE on an annual basis.	Mr Crook		June 2026	

Meeting: **Locality Board**			
Meeting Date	01 June 2026	**Action**	Receive
Item No.	5	**Confidential**	No
Title	Place Lead Report		
Presented By	Will Blandamer – Executive Director Health and Care, and Deputy place lead		
Clinical Lead	Dr Cathy Fines		

Executive Summary
To provide an update on the pan GM development of the place partnership arrangements
Recommendations
The Locality Board is asked to note the update.

Links to Locality Plan priorities	
Scale our work on Population Health Management - Improve population health and reduce health inequality of those in the most disadvantaged areas.	☒
Drive prevention, reducing prevalence and proactive care – supporting Demand Reduction through primary intervention, secondary preventions and tertiary prevention.	☒
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.	☒
Optimise Care in institutional settings and prioritising the key characteristics of reform.	☒

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	☒

Implications						
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		

1. North Manchester New Hospital Programme

Bury Locality Board has previously been updated on the above programme. MFT have just provided the following update on the programme.

> We're reaching an important milestone in the North Manchester General Hospital New Hospital Project as we move into the design phase.
>
> We now have what's called a 'Preferred Route Forward', which sets the direction for the new hospital. Our plan is for a new main hospital alongside a separate outpatient building, delivered as a single, integrated programme of work.
>
> We're still at an early stage, and plans will continue to develop as design work progresses. Colleagues and teams will be involved in shaping what comes next, helping ensure the new hospital meets the needs of those who use it and work in it every day.
>
> As part of the national New Hospital Programme, announcements about contractor allocation have been this week. Subject to contract, our proposed delivery partnership is Bovis. An article has been published in the HSJ: https://www.hsj.co.uk/finance-and-efficiency/new-hospitals-paired-with-builders-for-projects-worth-14bn/7041746.article

Key Contact is Mike Bacon - Mike Bacon, Project Director, NMGH New Hospital Project

We will invite MFT colleagues to bring further information back to the locality board and will be creating opportunities for MFT to engage with GP colleagues in the south of the borough.

2. NHS GM Staff in Place – Employment Model

At the last locality board there was a discussion about potential next steps in proposing a future employer from currently NHS GM staff in place teams. It was recognised that in the context of emerging and consistent place partnership arrangements in all 10 localities in GM it was a strategic intent of NHS GM to transfer of employment where Place-based teams are hosted locally on behalf of the Place Partnership, while remaining focused on the shared outcomes of the partnership rather than any single organisation.

NHS GM believe that if we are to deliver a more preventative, integrated and locally accountable model of support, the workforce that enables Place leadership needs to sit in arrangements that better align accountability, delivery, funding and day-to-day leadership at Place level.

Place leads and NHS Trusts in GM have been written to by the Chief Executive of NHS GM requesting they work together to consider the following:

> 1. Whether there is an agreed NHS FT at Place that would be willing, in principle, to act as the receiving employer for the NHS GM Place-based workforce on behalf of the partnership.
> 2. Whether that organisation has the organisational willingness and capacity to do so, taking account of HR, governance, financial and operational considerations.
> 3. Whether there is joint local support for this approach as part of the wider Place operating model and partnership arrangements.

NHS GM are asking Place Leads and NHS FT CEOs jointly confirm their position in writing within six weeks of this letter being issued.

3. Bury Council Elections and electoral Purdah.

Following the local council elections held in May the Labour group retained overall control of the Council with 30 seats. Radcliffe First have 6 seats as do Reform. The Locality Board will note that the council remains in electoral purdah due to the forthcoming local council election in the Moorside ward following the untimely death of a candidate prior to the recent election.

The extended period of electoral purdah has had the effect of delaying the publication of the CQC and Ofsted report into the Bury SEND Partnership, and also the CQC report on the Local Authority Adult Care Services. These will be published as soon as possible and considered in the Locality Board.

4. Integrated Neighbourhood Team Working

The Locality Board is sighted on the significant progress made in developing integrated neighbourhood team working in each of the 5 neighbourhoods in the borough in accordance with the Locality Plan and the Borough Lets Do It Strategy

A video has been produced describing the implementation of INTS in Bury. purpose of this video is to raise awareness among health and social care professionals about Integrated Neighbourhood Teams in Bury, who they are, what they do and how they help reduce demand in the wider system. The video highlights the valuable work taking place across our neighbourhoods, showcasing how teams are working collaboratively to deliver person-centred care. It brings to life the impact of integrated working, local relationships and the commitment of colleagues in supporting individuals to remain well, connected and independent within their communities.

The video can be viewed here. https://vimeo.com/1192181988?share=copy&fl=sv&fe=ci

Please take a few minutes to watch the video and share it within your own teams and networks to help raise awareness of this important work.

5. No Space for Racism' campaign video launch

NHS Greater Manchester is an anti-racism campaign developed by the Greater Manchester Integrated Care Partnership (GM ICP).

The 'No Space for Racism' campaign launched internally in March 2026. The public-facing phase of the campaign has now been developed, with a campaign video shown at the ICP Board on Friday 29th May 2026 for sign off.

Nationally, health and care staff have been reporting a significant increase in experiences of racist and discriminatory behaviours.

Around 1 in 4 health and care staff in Greater Manchester have reported that they have experienced racism at work in the past year. This includes racist words, insults, being ignored or left out, being threatened and sometimes even violence. It is coming from the patients they are trying to care for, patients' family and friends and other members of staff.

A meeting between the Mayor of Greater Manchester, Andy Burnham, and the chairs of Pennine Care FT and the NHS North West Black, Asian and minority ethnic Regional Assembly in October

2025, brought forward powerful testimonies from affected staff.
These accounts underlined the severity of the problem, the inconsistency of responses across organisations, and the urgent need for a more visible, coordinated and system wide action.

This collective insight shaped the decision for Greater Manchester to develop the system wide 'No Space for Racism' campaign, alongside wider system actions, including improvements to reporting, Active Bystander Training, Right to Withdraw principles, and embedding anti-racist practice through commissioning and leadership.

The aim of the 'No Space for Racism' campaign is to reinforce a system-wide, zero tolerance stance on racism and abuse, and to better support staff who experience it.

From Monday 1st June, please share the campaign video on your channels.

You can also use the assets and newsletter copy in the 'No Space for Racism' campaign toolkit. This includes a series of powerful quote cards from leaders and colleagues from across the system sharing their support for the campaign.

For queries or further information, email gmhscp.gm-campaigns@nhs.net.

Will Blandamer
Deputy Place Lead NHS GM (Bury)
Executive Director - Bury Council
29/5/26

Meeting:			
Meeting Date	01 June 2026	Action	Receive
Item No.	6	Confidential	No
Title	VCFE Focus - Homestart		
Presented By	Sarah Cook		
Author	Sarah Cook		
Clinical Lead			

Executive Summary
Vision: Every parent has the support they need to give their children the best possible start in life **Mission:** To support parents as they grow in confidence, strengthen their relationship with their children and widen their links with the local community
Recommendations

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 priorities	
Scale our work on Population Health Management - Improve population health and reduce health inequality of those in the most disadvantaged areas	☐
Drive prevention, reducing prevalence and proactive care – supporting Demand Reduction through primary intervention, secondary preventions and tertiary prevention	☐
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	☐

Links to Locality Plan priorities	
Optimise Care in institutional settings and prioritising the key characteristics of reform.	☐

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		

Home-Start HOST:
Oldham
Stockport
Tameside
Bolton
Bury

Sarah Cook
CEO

Vision, Mission & Values…

Vision:

Every parent has the support they need to give their children the best possible start in life

Mission:

To support parents as they grow in confidence, strengthen their relationship with their children and widen their links with the local community

Values:

We are ASPIRATIONAL

We BUILD RELATIONSHIPS

We are CREATIVE

We are EMPOWERING

We are UNDERSTANDING

Home-Start…

- Federated network of independent charities focussed on the 0-5 period
- Supporting families often classed as 'hard to reach' with a wide range of needs, including poor mental health, lack of confidence, social isolation, poverty, poor housing, SEND (children & parents)
- Holistic family support through a peer support model – volunteer home visiting and complimentary services
- Potential to support families in Bury:
  - GLD / School Readiness
  - Family Hubs – Outreach & Peer Support
  - Mental Health (including infant mental health and the developing 2-5 toddler hub)
  - Live Well
  - Neighbourhood Health
  - Families First Partnership
  - Workforce development (health & social care / early education) through volunteer to career developments

Home-Start HOST…

- Established in 1998 – Home-Start Hattersley
- Became Home-Start Tameside in 2005
- Home-Start Tameside & Oldham in 2010
- Merged with Home-Start Stockport in 2014 – became Home-Start Oldham, Stockport & Tameside (HOST for short)
- Started working in Bolton in 2019 – changed name officially to Home-Start HOST
- Working in Bury since April 2025
- One of 4 Home-Starts in GM

Services Delivered…

Services Delivered	Tameside	Oldham	Stockport	Bolton	Bury	GM
‘Core’ work – volunteer home visiting to families with at least one child under 5	✓	✓	✓			
Parent Infant Mental Health (0-2s) Home Visiting	✓	✓	✓	✓	✓	
Infant Feeding Peer Support (Hospital & Community)	✓	✓				
Play, Learn, Grow (8-week School Readiness / Home Learning Environment Project)		✓				Rochdale
Community Genetics		✓				
Perinatal Peer Support Groups	✓	✓	✓	✓		
Dad Matters	✓	✓	✓	✓		✓
Pitter Patter, Play & Natter (0-2 Social Groups)	✓					
Diversity (BAME) Home-Visiting (Bi-Lingual Staff)	✓	✓		✓		
Baby Bank						✓
Multiples Peer Support Group	✓					✓
Dolly Parton Imagination Library	✓	✓	✓	✓	✓	

Family Voice…

- All services are co-designed with families
- Leading way in listening to babies, toddlers and pre-schoolers – recent PhD Studentship into Family Voice & School Readiness - working in partnership with MMU
- For more information: sarahcook@homestarthost.org.uk or www.home-starthost.org.uk

Thank You

Meeting:			
Meeting Date	01 June 2026	Action	Receive
Item No.	7	Confidential	No
Title	Place Documentation update		
Presented By	Will Blandamer		
Author	Will Blandamer		
Clinical Lead	Dr Cathy Fines		

Executive Summary
Place Partnership Document Suite.
Recommendations
• Bury Locality Board has previously reviewed draft iterations of these documents • The documents are due for approval at NHS GM in June and then for consideration in July by each of the 10 Locality Boards • Subject to approval by all we will convert the Locality Board to the Place Partnership Board as descried in the Place Partnership Agreement, and seek endorsement of the partnership agreement from all partners in advance of the September meeting

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 priorities	
Scale our work on Population Health Management - Improve population health and reduce health inequality of those in the most disadvantaged areas	☐
Drive prevention, reducing prevalence and proactive care – supporting Demand Reduction through primary intervention, secondary preventions and tertiary prevention	☐
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	☐

Links to Locality Plan priorities	
Optimise Care in institutional settings and prioritising the key characteristics of reform.	☐

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		

The Place Partnership Document Suite

Documents in Scope

Partnership Agreement

The overarching document that sets out the shared intent, principles and formal basis for place partnership working. It sets the tone, expectation, describes the behaviours and guiderails for how we take this forward, makes us clear on what we're going to do - expectation of how we get contracts together around place and people. It holds the overall framework together and is the primary document for sign-off by colleagues at place.

Financial Framework/Place Fund Framework

- sets out how financial decision-making, commissioning and investment will support place ambitions
- Describes the 2026/27Shadow Year
- The journey toward the desired future state.

Place Outcomes Framework

- Articulates what the place partnership is uniquely accountable for delivering,
- Interdependencies with other partners.

Place Team Framework

- Role of the Place Team
- How it supports integration, delivery of outcomes, and neighbourhood working.
- Who constitutes a place team
- Options for Place Team form

Place Governance Framework

- describes how place partnerships make safe, transparent and accountable decisions, covering partnership governance, financial governance, commissioning, quality and statutory responsibilities.
- What decisions it covers
- Who decides what
- How we avoid duplication or gaps
- How do we ensure statutory responsibilities are met?

Next Steps

- Bury Locality Board has previously reviewed draft iterations of these documents
- The documents are due for approval at NHS GM in June and then for consideration in July by each of the 10 Locality Boards
- We anticipate bringing the final suite of documents to the July Locality Board 6/7/26) for consideration
- NHS GM will be discussing the documentation with multi-locality trusts via the GM provider collaborative forum
- Subject to approval by all we will convert the Locality Board to the Place Partnership Board as descried in the Place Partnership Agreement, and seek endorsement of the partnership agreement from all partners in advance of the September meeting

Meeting:			
Meeting Date	01 June 2026	Action	Receive
Item No.	8	Confidential	No
Title	Local SEND Reform Plan		
Presented By	Ben Dunne/ Will Blandamer		
Author	Louisa Yau		
Clinical Lead	-		

Executive Summary
Greater Manchester partners across education, health and care are committed to a consistent, collaborative approach to delivering SEND reform across all ten localities through a joined-up, sustainable system with strong governance, commissioning and delivery mechanisms to maximise shared resources, reduce duplication, and improve outcomes and experiences for children, young people, and families. Bury's Local SEND Reform Plan sets out a three year transformation programme that builds on the progress made over the past 2 years in addressing local systemic deficits to deliver a sustainable, inclusive 0–25 system where needs are identified early, supported rapidly, and children and young people thrive in local mainstream settings wherever possible.
Recommendations

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 priorities	
Scale our work on Population Health Management - Improve population health and reduce health inequality of those in the most disadvantaged areas	☐
Drive prevention, reducing prevalence and proactive care – supporting Demand Reduction through primary intervention, secondary preventions and tertiary prevention	☐

Links to Locality Plan priorities	
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	☐
Optimise Care in institutional settings and prioritising the key characteristics of reform.	☐

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

Annex A: Local SEND Reform Plan

Name of Local Authority: Bury Borough Council

Name of Integrated Care Board: NHS Greater Manchester Integrated Care Board

Local SEND Reform Plan SRO: Ben Dunne

Signatories

Role	Name	Signature	Email contact	Date
Chief Executive, Bury Council & Place Based Lead for Health and Care, NHS GM Bury	Lynne Ridsdale		L.Ridsdale@bury.gov.uk	
Acting Chief Executive, NHS GM	Professor Colin Scales		colin.scales1@nhs.net	
Executive Director of Children's Services, Bury Council	Jeanette Richards		J.Richards@bury.gov.uk	
Director of Finance, Bury Council	Neil Kissock		N.Kissock@bury.gov.uk	

Plan to be endorsed by Bury Locality Board on 1 June and SEND Improvement and Assurance Board on 11 June.

Executive Summary

A brief summary of your local system 'change story' – your local context, where you are now, where you want to get to in the next 3 years, how you know you are succeeding and how you will know you have achieved your vision for the next 3 years. Please include a brief qualitative summary. This summary should also include your assessment of current and forecast performance against the headline metrics. Please structure your 'change story' using the following aims:

- *Build a 0-25 system where children and young people receive support to achieve and thrive through (a) more inclusive settings and (b) stronger local partnerships*
- *Improve capacity and capability of the mainstream and specialist workforce to identify and meet need*
- *Improve confidence of children, families, and stakeholders in reform and readiness of the system ▪ Stabilise finances and improve value for money*

500 words

Greater Manchester partners across education, health and care are committed to a consistent, collaborative approach to delivering SEND reform across all ten localities through a joined-up, sustainable system with strong governance, commissioning and delivery mechanisms to maximise shared resources, reduce duplication, and improve outcomes and experiences for children, young people, and families. Bury's Local SEND Reform Plan sets out a three-year transformation programme that builds on the progress made over the past 2 years in addressing local systemic deficits to deliver a sustainable, inclusive 0–25 system where needs are identified early, supported rapidly, and children and young people thrive in local mainstream settings wherever possible.

The central pillar of the plan will be the progressive growth and extension of our existing Communities of Practice to fully embrace the **Experts at Hand (EAH) model**. Our Communities of Practice – launched in autumn 2025 – bring schools, families, and professionals together to share ideas, solve challenges, and improve outcomes for children and young people. They are organised on Bury's 5 neighborhood model, which enables seamless connectivity with neighborhood health services. Each Community of Practice area is supported by a wider team of link Local Authority Officers and is facilitated by a Community Educational Psychologist. We will use the opportunity offered by the national reforms to extend this approach to fully include Health services and connect the work of Mental Health Support Teams in Bury's schools.

Our transformation will be driven by the four building blocks outlined by the DfE:

1. **Strengthening inclusion across settings**

2. **Improving access to specialist support & local placements**
3. **System leadership/partnerships and co-production**, and
4. **Inclusive culture and behaviours**, enabled by capital, workforce, and data/digital transformation.

Our local Programme of Work for the next 3 years will be chiefly focused on two key strands:

- Delivery of the full Expert at Hand model locally in Bury, nested in a wider linked officer model designed to simplify the seeking and provision of support to schools
- Development and reconfiguration of local targeted plus and specialist school-based support in Bury

Governance of progress in delivering the transformation plan will sit under the Local Area SEND Partnership Board that we expect will grow from the existing SEND Improvement and Assurance Board (SIAB). The partnership Board will be the collective custodian of system leadership and supporting inclusive culture and behaviour. Its work will be supported by a Data and Performance subgroup and a Joint Commissioning Group.

The recent monitoring inspection of Bury recognized the positive progress made and the significant cultural change achieved locally within the education and health systems over the past two years. Our established SEND partnership infrastructure, leadership, innovative approach to supporting schools; and our track record of working collaboratively with local children and parents puts us in a strong position to turn national design into consistent local delivery. We have delivered substantial positive improvement in Bury through the past two years and are confident that we can continue to drive transformational change to improve the lives of children and their families.

(503 words)

Section 1 – Vision and Goals

1. **What the local area partnership is trying to achieve?**

Please set out your goals for your local system. These should be clear, aligned to the vision set out in the Schools White Paper, small in number and measurable. These goals should include clear reference to:

- Outcomes for children
- Confidence of parents, carers and young people in the system
- Management of finances to secure value for money

250 words

Bury's local area partnership is committed to creating a positive and sustainable future for children and young people with SEND. Our vision is to build a needs-led, inclusive 0-25 system where children and young people are identified early, supported appropriately and enabled to thrive in their local communities. This vision has been co-produced with children and young people with SEND, parents and carers, and education, health and care partners.

Our goal is to work collaboratively so that children, young people and families can take control of their lives, access the right support at the right time, and reach their potential. The outcomes we are striving to deliver are those defined by children and young people themselves: feeling safe; feeling healthy and well; having fun and independence; having a voice and being heard; and feeling being included at home, in school and within their community.

Over the next three years, the partnership will:

- Improve outcomes for children and young people through stronger inclusion in mainstream settings, earlier identification of need and better access to specialist expertise.
- Strengthen and build upon needs led approaches and pathways for families and children and young people
- Increase confidence of parents, carers and young people through consistent co-production, clearer communication and improved lived experience.
- Strengthen system leadership and shared accountability across education, health and care.
- Improve value for money and financial sustainability by investing in early intervention, local capacity and inclusive provision, reducing reliance on high-cost specialist placements.
- Together, these goals continue Bury's transformation of the local SEND system and maintain our strong alignment with the national vision.

(246 words)

Section 2 – Strategy

2. **Where the local area partnership expects to be in the next 3 years**

A description of what your local system would look like in the next 3 years in line with the national vision set out in the Schools White Paper and set within the context of where you are starting from as a local system.

In particular, as commissioning system partners, you should reflect on and agree what your fully fledged **Experts At Hand Offer** model should be and how this will be deployed via mainstream settings and providers (including those not based in your area – e.g. further education colleges attended by your young people) to build their capacity as well as identify and meet the needs of children and young people earlier and without the need for a statutory assessment for Education, Health and Care.

To help you fully consider the scope and scale of change required, you may find it useful to structure your response using these 4 building blocks of an inclusive system, reflecting on what is working well in your system, what you are most worried about, what needs to change, and how the enablers will help you achieve your 3 year vision.

When summarising where your local area partnership currently is, please include an assessment of where you are in reference to the core minimum requirements above and how you bridge the gap, making reference to and attaching additional documents that provide underlying evidence for your summary.

Strengthening inclusion across education settings– organising places and provision to meet as many needs as possible, as close to home as possible, with all settings and providers moving towards a shared understanding and consistent practices around inclusion.

System leadership, local partnership collaboration and co-production – putting in place the enabling conditions across a local area that ensures planning and provision reflects the local area & is joined up, including strategic co-production with parent carers and children and young people.

Access to specialist support and local placements – improving collaboration between settings and deploying expertise from a range of specialist and expert sources, to support schools and settings to meet the needs of children and young people earlier and locally.

Encouraging inclusive culture & behaviours – using funding and shared accountability towards a system that works for children and families while achieving value for money.

Local blueprint for the next 3 years	Where we are	Where we will be in the next 3 years
Building blocks **Strengthening inclusion across settings** • Embed OAIP across all settings • Expand Communities of Practice into Experts at Hand (EAH) • Deliver Inclusion Charter **Access to specialist support and local placements** • Implement single access EAH model • Deliver SEND Sufficiency Strategy and inclusion bases • Strengthening pathways and transitions **System leadership and co-production** • SIAB transition to SEND Partnership Board • Embed co-production and communication **Inclusive culture and behaviours** • Agree and embed Bury inclusion collective values • Cross-phase and cross-sector system-wide leadership • Reduce exclusions and suspensions and improve attendance **Enablers** **Capital:** inclusion bases and adaptations **Workforce:** CPD, outreach, neighbourhood teams **Data:** dashboards and integrated datasets	*(a short summary of where you are now including a reflection on what is working well, what needs to change and the status of the enablers that underpin your system)* Bury has made strong progress over the past two years. **Working well** • Strong partnership governance • Established Communities of Practice • Clear strategy through Education & Inclusion • SEND Strategy • Improved multi-agency working **What needs to improve** • Variability in inclusive practice • Complex access to specialist support • High demand for specialist placements • Variable parental confidence • Workforce pressures **Enablers** • Capital and sufficiency plans not fully developed or fully scaled • Workforce development improving but inconsistent • Data systems require integration (Power BI)	*(a short summary of the vision for your local system in the next 3 years including the system enablers, reflecting how your Experts At Hand Offer model will underpin this vision, helping you scale and enhance what is working well and change what is not working so well)* **By 2029/30 Bury will have a fully integrated 0–25 SEND system** • Families will have access to advice and guidance through a range of digital offers including sleep support • Families' schools and services will have access to coproduced strength-based assessments (Neuro profiling tool kits) • Families will have access to early support offers and evidence-based support without the need for diagnosis. • All education establishments in Bury will have access to MHST in accordance with NHSE expectations • Reduction in waiting times for specialist support and assessments **Experts at Hand** • Fully operational in all neighbourhoods and across all settings • Consistent inclusive mainstream practice embedded • Strong local provision reducing out-of-area placements • Clear pathways and improved transitions **System outcomes** • Improved attendance and reduced exclusions

		• Needs met earlier with less escalation • Increased parental confidence • Skilled and confident workforce • Financial sustainability through early intervention **In summary** • Mainstream-first inclusive system • Strong partnership and co-production • Improved outcomes and value for money
Success measures *System Confidence* 1. Requests for EHCP Assessment (rolling 12 month count) 2. Number of new EHCPs issued (rolling 12 mth count) 3. Number of current EHCPs for children aged under 5 years 4. Number of children with EHCPs outside of school system (EHE, EOTAS) 5. % of new EHCPs issued within 20 weeks 6. Waiting time measures for relevant health therapies *Inclusion* 7. Persistent absence for children with identified SEND (Pri/Sec) 8. Attendance for children with identified SEND (Pri/Sec) 9. Suspensions of children with identified SEND (Pri/Sec)	**Baseline** *System Confidence* 1. Requests for EHCP Assessment (rolling 12 mth count): 647 2. Number of new EHCPs issued (rolling 12 mth count): 457 3. Number of current EHCPs for children aged under 5 years: 100 4. Number of children with EHCPs outside of school system (EHE, EOTAS): 125 5. % of new EHCPs issued within 20 weeks: 85% 6. Waiting time measures for relevant health therapies: TBC *Inclusion* 7. a) Persistent absence for children with identified SEND (Pri) : 21.3% b) Persistent absence for children with identified SEND (Sec) : 39.4% 8. a) Attendance for children with identified SEND (Pri) : 92.4%	*Target Metrics* *(outline the target metrics that will demonstrate you have achieved the vision summarized above – these should be drawn from the metrics in the data template)* **To be considered further following data group modelling workshops (20th & 27th May).**

10. Permanence exclusions for children with identified SEND (Pri/Sec) 11. % of 16- and 17-year-olds with identified SEND who are in education, employment or training (EET). *Outcomes* 12. Children with identified SEND achieving a good level of development at the end of reception year 13. KS2 @ expected in R, W & M for children with identified SEND 14. GCSE – A8 and P8 for children with identified SEND 15. Achievement @ 19 – level 2 and level 3 – for young people with identified SEND at the end of their school career *Value for Money* 16. Number of EHCPs maintained per 1,000 4 to19 year olds. 17. Number of children and young people with EHCPs educated in independent and non-maintained special schools and colleges. 18. Percentage of children with EHCPs educated in a mainstream school or college. 19. Total High needs block spend per head of population (4 to 19 years old).	b) Attendance for children with identified SEND (Sec): 85.3% 9. a) Suspensions of children with identified SEND (Pri) : 6.5 b) Suspension rate per 100 children with identified SEND (Sec): 54.4 10. a) Permanent exclusions for children with identified SEND (Pri): 0.23 b) Permanent exclusions for children with identified SEND (Sec): 0.68 11. % of 16- and 17-year-olds with identified SEND who are in education, employment or training (EET). 78% *Outcomes* 12. Children with identified SEND achieving a good level of development at the end of reception year: TBC 13. a) KS2 @ expected in R, W & M for children with identified SEND – EHCPs: 11% b) KS2 @ expected in R, W & M for children with identified SEND - SEN Support: 30% 14. a) GCSE – A8 for children with identified SEND – EHCPs: 14.6 b) GCSE – A8 for children with identified SEND - SEN Support: 33.9 c) GCSE – P8 for children with identified SEND – EHCPs: -0.95	

20. Total High needs block spend per child or young person with an EHCP.	d) GCSE – P8 for children with identified SEND - SEN Support: - 0.5 15. a) Achievement @ 19 – level 2– for young people with identified SEND at the end of their school career - EHCPs 34% b) Achievement @ 19 – level 2– for young people with identified SEND at the end of their school career – SEN Support : 72% c) Achievement @ 19 – level 3 – for young people with identified SEND at the end of their school career – EHCPs:21% d) Achievement @ 19 – level 3 – for young people with identified SEND at the end of their school career - SEN Support:40% *Value for Money* 16. Number of EHCPs maintained per 1,000 4 to 19 year olds: 79 17. Number of children and young people with EHCPs educated in independent and non-maintained special schools and colleges: 210 18. Percentage of children with EHCPs aged 5 to 18 yrs of age educated in a mainstream school or college: 61% 19. Total High Needs block spend per head of	

	population (4 to 19 years old): £1,417 20. Total High needs block spend per child or young person with an EHCP: £17,964	

3. What is the local area partnership's strategy for delivering on the above?

A brief summary of your local system's theory of change or reform strategy. Reflect on the output of your **Local Partnership Maturity Assessment Tool**, particularly your *Local System 'change story.'*

250 words

Bury's SEND partnership has delivered substantial change over the past 2 years. This has been achieved through focusing on the child and taking tangible, concrete actions to improve services and change the culture within Bury away from one that led to escalation towards one focused on the support available to children in mainstream schools.

Our Improvement and Assurance Board has tracked progress at a granular level and provided a forum for robust, constructive dialogue. After our recent positive inspection, we feel well equipped and well placed for the next stage of our journey: implementing an ambitious national reform programme that is highly congruent with our Education and Inclusion strategy.

Our strategy for delivery will focus on:

1. delivery of the full **Expert at Hand** model locally in Bury, nested in a wider linked officer model designed to simplify the seeking and provision of support to schools; and
2. development of local targeted plus **(inclusion bases)** within mainstream schools; and specialist school-based support in Bury.

We will also continue to embed consistent inclusive practice through our OAIP work and our Inclusion Charter. Workforce capability will be further strengthened by joining specialist Outreach support teams with the expertise within local Special Schools and Alternative provision and the wider Expert at Hand offer.

Governance will sit with the SEND Partnership Board, with a **Senior Responsible Officer (SRO**) responsible for overall delivery of the programme. The work of the Board will be supported by a Data and Performance subgroup and a Joint Commissioning Group.

4. **Please upload a completed copy of the Local Partnership Maturity Assessment Tool.**

INSERT DOCUMENT UPLOAD LINK

5. **What is the local area partnership roadmap for the next 3 years?**

Reflecting on the broad timescales and expectation for deliverables set out in the Schools White Paper, key documents and core minimum requirements set out in this document, please provide a high-level roadmap for the next 3 years. Please highlight key milestones and a trajectory to the target metrics identified above, including leading indicators.

In the 2026-27 column, in particular, please reference how you plan to meet the core minimum requirements in your narrative, including details and evidence in supporting documents.

You can insert or upload supporting documents including graphics/visuals that illustrate your data trajectory.

Local roadmap for the next 3 years	**2026-27: Building Foundations for SEND Reform** *Establish strong partnership foundations, governance, and shared priorities whilst identifying and designing opportunities based on what is working well to enable sustainable SEND reform.*	**2027-28: Embedding and Scaling** *Embed reforms consistently across the system and scale effective practice to improve experiences and outcomes.*	**2028-29: Maturity, Impact and Sustainability** *Deliver sustained improvements, in inclusion, wellbeing and attainment and preparation for adulthood through a stable, high quality and financially sustainable SEND system.*
Building block 1: Strengthening inclusion across education settings	**Sharing understanding of inclusion across the borough** Establish a consistent borough-wide engagement programme to gather views on what inclusion 'looks like and feels like' from: • Children and young people • Parents and carers • Schools, early years, post-16 and alternative provision	**Embedding shared expectations of inclusion** Embed the Inclusion Charter and agreed principles of inclusive practice across all educational settings through leadership and governance arrangements, aligned support and challenge and integration into improvement, oversight and workforce development activity and agree high-level indicators for how improved inclusion will be measured over Years 2 and 3.	**Consistent inclusive practice across the borough** The SEND system operates as a fully integrated high-performing partnership delivering consistently improved outcomes, experiences, with financial sustainability embedded. High quality inclusive practice is demonstrated consistently across settings, underpinned by a shared and embedded

	• Health, social care and VCSE partners Local Area partners formally agree a definition of inclusion, including; • Core principles and values • Expectations for all education settings • Shared responsibilities across education, health and care Co-produce and launch a Local Area partnership Inclusion Charter, setting out shared values, shared responsibilities and ambitions.		understanding of inclusion and feedback mechanisms established for Children, young people and families will evidence whether inclusion feels different over time.
	Inclusive practice embedded across educational settings Further embed our coproduced Ordinarily Available Inclusive Provision (OAIP), aligned with Greater Manchester principles, and as the baseline expectation for all mainstream settings. Clear, shared messaging agreed, to ensure that OAIP is 'what good inclusion looks like every day' moving from pockets of practice to wider system adoption. Targeted borough-wide programme delivered to strengthen: • Targeted borough-wide programme delivered to strengthen: • Leader and practitioner confidence in applying OAIP • Consistent interpretation across phases and settings • Common language and thresholds agreed, reducing variation in	**Inclusive practice embedded across educational settings** OAIP moves from early adoption and supported to embed OAIP within: • Whole-school inclusion strategies • Classroom practice and reasonable adjustments • SEN support decision-making • OAIP expectations reflected in conversations between schools, LA, health and partners. Strengthen the implementation of the graduated approach and supporting tool kit, ensuring it is well understood and consistency applied and used effectively to identify, assess, plan, implement and review and is demonstrated consistently within requests for EHCNA.	**Inclusive practice embedded across educational settings** OAIP is increasingly referenced in SEN support planning and professional dialogue, with reduced variation in what families can expect from mainstream inclusion. Exemplars of strong inclusive practice identified and shared across the borough and supported through peer learning, evident through a reduced reliance on individual settings or champions driving inclusion alone. OAIP is clearly aligned with: • SEN support and processes • Early Help and graduated approach • Expectations prior to statutory assessment • Improved clarity for families about what should ordinarily be available through mainstream provision.

	expectations between schools and services.		Schools show greater confidence in meeting need without immediate escalation to statutory assessment. Statutory assessment requests increasingly demonstrate clear, proportionate evidence of graduated support at SEN Support stage.
	Establish expert support through a connected local model Develop the Experts at Hand (EaH) model, building on Bury's established locality-based education Communities of Practice and extending them to include wider council services and health partners. The model creates a connected, neighbourhood-based approach aligned to Council and ICB place areas, strengthening the existing education offer and establishing a consistent Team Around the School as the primary route to trusted expertise, early support and shared problem-solving across all educational settings to ensure that **schools experience clearer, more coordinated access to local expertise**, with increasing confidence that education, council and health partners are working together through a consistent, neighbourhood-based Team Around the School approach.	**Establish expert support through a connected local model** Strengthen connectivity between schools and wider partners to support joined up responses to '*commonly occurring*' needs. Experts at Hand operating consistently across all localities, with education, council and health partners working routinely together to support schools, strengthening inclusive practice and reducing the need for escalation to specialist and statutory services. Scale the EaH offer across neighbourhoods building on learning from early implementation and any forthcoming guidance, after year one. Including enhancing collaborative working between outreach teams and specialist schools and Alternative Provision (AP).	**Establish expert support through a connected local model** EaH is a trusted part of the SEND system, with evidence of impact and inclusion, targeted support and inclusion.
	A Skilled, trained local area workforce Build on the established Local Area Partnership Workforce Strategy, ensuring delivery aligns with the SEND reform priorities. Use the completed partnership-wide CPD mapping to identify strengths, gaps and	**A Skilled, trained local area workforce** Use learning from the partnership-wide CPD mapping to align and coordinate workforce development activity. Scale opportunities for joined up and co-delivered CPD, across education, health and care.	

	duplication across education, health and care. Identify and scope opportunities for more joined-up and co-delivered CPD across partners, including joint education and health training offers. Strengthen shared understanding of inclusive practice and early support, laying foundations for improved workforce confidence and capability.	Embed delivery of the Local Area Workforce Strategy, ensuring SEND reform priorities are reflected consistently across education, health and care. Build workforce confidence through consistent high-quality learning, peer support and EaH development to support inclusive practice.	
	Use data and intelligence to support inclusive practice Build on the established Schools Oversight Tracker, an existing data tool that brings together key inclusion measures, including inspection outcomes, SEND and EHCP data, engagement with partnership activity, attendance and exclusions – to strengthen system understanding of practice, consistency and impact across schools. Explore opportunities to align and enhance oversight measures across education, health and care to support a shared understanding of inclusive practice. Use insight data to inform governance, support and improvement conversations, shaping priorities, for embedding and scaling later phases.	**Use data and intelligence to support inclusive practice** Embed consistent use of the schools, oversight tracker across the system, ensuring agreed inclusion measures are routinely understood and used by leaders and partners. Use data to identify variation target support and scale effective inclusive practice, to reduce inconsistencies.	Use agreed data and intelligence, including oversight measures to evidence sustained improvements in inclusive practice, early support and outcomes and which is evidenced through Quality Assurance outcomes.
Building block 2: Improving access to specialist support and local placements	**Understanding need, capacity and pathways** Build on the established SEND Sufficiency Dashboard, completing and strengthening the data required to provide a robust, up-	**Timely access to specialist support and local provision** Use sufficiency intelligence to prioritise and implement development of local specialist provision and services, addressing identified gaps and risks.	**A sustainable specialist system with timely and equitable access** A sufficient and sustainable range of local specialist provision and support is in place, informed by robust sufficiency

	to-date overview of need, capacity and demand across specialist provision. Finalise the SEND Sufficiency Strategy, including sufficiency plans already developed through the Project safety Valve (PSV), to establish a shared system understanding of current and future placement needs, ensuring alignment with inclusion, early intervention and sustainability ambitions. Develop a simple accessible visual delivery roadmap to help families understand the sufficiency programme, what is changing and when. Finalise our 'child pathways' on a page, including post 16pathway, to support informed decision making and smoother transitions. Mobilise the next phase of the SEND capital programme, identifying priority sites for inclusion bases and mainstream adaptations, together with rigorous quality assurance mechanisms. Strengthen joint commissioning arrangements to ensure SEND commissioning is aligned with inclusion, early intervention and SEND sufficiency priorities, building on sufficiency data and plans developed through PSV. Build on the existing targeted education offer, mapping how access routes and thresholds align (or differ) across education, health and care.	Demonstrate year-on-year measurable reduce reliance on out-of-area, independent placements and high-cost placements, where appropriate, improving local placement availability and stability. Use sufficiency data to monitor progress, manage risk and inform system leadership decision-making. Embed a shared, clear understanding of access routes, thresholds and pathways into specialist support across education, health and care. Implement improvements informed by family and young people's feedback, addressing barriers to timely access.	intelligence and sustained delivery of the SEND Sufficiency Strategy. Children and young people experience timely, consistent and equitable access to specialist support through clear, well-understood pathways across education, health and care. Reliance on out-of-area and independent placements is reduced and well-managed, with improved placement stability and stronger local options wherever appropriate. Specialist support is fully aligned with inclusive practice, OAIP, the graduated approach and Experts at Hand, ensuring the right level of support is available at the right time. System-wide data and insight demonstrate sustained improvement in access, outcomes and experience for children, young people and families, supporting long-term financial and operational sustainability.

	Use insight from Communities of Practice to test how access works in practice and where clarity or confidence varies. Engage children, young people and families to understand barriers to accessing the right specialist support at the right time, using feedback to inform pathway clarity and improvement. Use this learning to agree clearer, shared expectations for access to specialist support across the local area.		
Building block 3: System leadership, local partnership collaboration and co-production	**Strengthening governance and partnership leadership** Further embed the SEND Partnership Board as the strategic oversight body for SEND reforms, providing clear leadership, accountability and direction, with named SRO oversight. Strengthen cross-phase and cross-sector representation, ensuring education, health, care, early years, post-16 and the voluntary sector are fully engaged in system leadership. Clarify roles, responsibilities and decision-making pathways to support effective delivery of the SEND reform programme.	**Embedding system leadership, governance and confidence** Embed the SEND Partnership Board as the primary vehicle for driving and assuring delivery of SEND reforms, with clear oversight of progress, impact and risk. Strengthen cross-phase and cross-sector system leadership, ensuring consistent engagement and shared ownership across education, health, social care and the voluntary sector. Use governance arrangements to support challenge, learning and improvement, ensuring reforms are implemented consistently across the local area.	**Confident system leadership, strong governance and trusted partnerships** The SEND Partnership Board operates as a mature, highly effective system leadership forum, providing clear strategic direction, accountability and assurance of impact across the SEND system. Cross-phase and cross-sector collaboration is embedded as business as usual, with education, health, care and the voluntary sector working together consistently to deliver improved outcomes.
	Embedding co-production and shared values Finalise and embed the SEND Co-production Charter across the partnership, strengthening shared expectations for how children, young people and families are involved in shaping SEND services.	**Embedding co-production and clear consistent communication as business as usual** Embed the principles of the Co-production Charter across SEND governance and improvement activity, ensuring co-production is routine rather than exceptional.	Co-production is fully embedded, with children, young people and families playing an active and meaningful role in shaping, reviewing and improving SEND services and pathways. Communication with children, families and communities is clear, accessible and

	Further develop our interim SEND Communications Approach into a Strategy, strengthening clear, consistent and accessible communication with system partners, children, families and communities. Develop a SEND Reforms Plan on a Page to provide a clear, simple overview of priorities, progress and future direction. Clearly articulate the cross-cutting strategies, values and vision that underpin SEND reforms, bringing together inclusion, early intervention, sufficiency and sustainability. Begin to understand parent and family confidence in mainstream inclusion through existing engagement, co-production and feedback mechanisms, including SENDIASS and mediation as relationship, building tools, not just dispute resolution. Use insight from families and young people to inform leadership priorities, communication and system improvement planning.	Scale meaningful involvement of children, young people and families in shaping, reviewing and improving SEND services and pathways. Use insight from engagement, feedback and complaints to address inconsistencies and build confidence in mainstream inclusion and SEND pathways.	trusted, supported by well-embedded tools such as the SEND Reforms Plan on a Page and Child Pathways on a Page, including post-16 pathways. Parent and family confidence in mainstream inclusion and SEND pathways is demonstrably improved, with insight from engagement, feedback and complaints routinely used to strengthen consistency, transparency and responsiveness.
Building block 4: Encouraging inclusive culture & behaviours	**Inclusion – Belonging, trust and engagement** Establish a shared understanding that relational inclusion underpins all effective inclusive practice, recognising the importance of trust, safety, belonging and emotional wellbeing. Co-produce a relational 'Barriers to Education' Pathway with children, young people, families and schools, testing the	**Strengthening leadership confidence to make inclusive decisions that prioritise relationships, trust and belonging alongside academic progress** Embed the co-produced Barriers to Education Pathway across education, health and care, using learning from testing with schools, children and families.	**Inclusion in Bury is grounded in relationships. Strong, trusting relationships between children, families and professionals are the foundation for engagement, learning, wellbeing and positive outcomes.** Relational inclusion is embedded as business as usual, shaping leadership behaviour and everyday practice across education, health and care.

	Co-production Charter in practice and using real-world learning to shape inclusive, trust-based system responses. Embed Reasonable Adjustment training for school leaders, delivered through the Changemakers group, building on a young person-led, co-produced programme currently being piloted with selected schools, grounding leadership decision-making in lived experience. Align relational inclusion approaches with Communities of Practice, Experts at Hand and neighbourhood working to support early, trust-based responses.	Scale relational responses to EBSA, recognising barriers to education as indicators of unmet need and supporting earlier, more compassionate intervention. Embed Reasonable Adjustment leadership practice, building on the young person-led training piloted through the Changemakers group. Strengthen multi-agency, trust-based working so children and families experience a consistent, relational response rather than fragmented services. Use lived experience, feedback and learning to improve consistency, confidence and belonging across settings.	Barriers to education, including EBSA, are recognised and responded to early as indicators of unmet need, reducing escalation and prolonged disengagement. Schools are confident to sustain engagement through reasonable adjustments, trust-based relationships and inclusive leadership. Children, young people and families experience a stronger sense of belonging, trust and emotional safety in education settings. Relational approaches support long-term inclusion, wellbeing and sustainable outcomes across the SEND system.
ENABLERS	Robust SEND Reform Programme architecture, aligning delivery planning, milestones, governance, risk and benefits tracking with Inclusion, Sufficiency, Improvement, Workforce and Safety Valve priorities with clear financial accountability and oversight. Effective risk management arrangements, identifying delivery risks early and implement system-wide mitigation plans. Well established multi-agency partnerships across education, health and social care, to support integrated planning, shared ownership and collective accountability for SEND outcomes. Meaningful engagement with parents, carers, children and young people, ensuring	A mature and embedded SEND Reform Programme architecture, driving consistent delivery, performance, and benefits realisation across Inclusion, Sufficiency, Improvement, Workforce and Safety Valve priorities, with strengthened financial grip and accountability. Proactive and intelligence-led risk management, with system partners routinely identifying, monitoring and mitigating risks, and adapting delivery in response to emerging pressures and performance insights. Highly effective multi-agency partnership working across education, health and social care, enabling fully integrated planning, joint commissioning and shared accountability for outcomes and resource use.	Highly integrated and mature multi-agency partnership working across education, health and social care, delivering seamless system leadership, aligned commissioning and collective accountability for outcomes, experience and resource use. Fully embedded and influential engagement with parents, carers, children and young people, with clear and consistent evidence that lived experience shapes strategic direction, service delivery and system-wide improvement. Co-production established as standard practice across services and programmes, with families and stakeholders acting as equal partners in design, delivery, evaluation and continuous improvement of SEND provision.

	their views inform decision-making and service development. Co-production as a core principle, working in partnership with families and stakeholders to design, deliver and review services.	Embedded and systematic engagement with parents, carers, children and young people, with clear evidence that lived experience is shaping service design, delivery and continuous improvement. Co-production is consistently applied in practice across services and programmes, with families and stakeholders actively influencing decision-making, evaluation and redesign of SEND provision.	
Capital	Co-produce with schools a Capital Plan, which will: • Finalise and mobilise priority SEND capital schemes (including inclusion bases and mainstream adaptations). • Align capital investment with SEND Sufficiency Strategy and demand forecasting. Establish robust capital governance, QA and value-for-money processes. Develop a forward pipeline of capital projects based on projected need and gaps in provision.	Delivery of SEND capital schemes aligned to Year 1 sufficiency priorities, ensuring planned provision is implemented in line with identified need. Capital investment informed by the next phase of the SEND Sufficiency Strategy, incorporating updated demand forecasting, placement trends and emerging gaps, particularly linked to secondary phase planning. Embedded capital governance, quality assurance and value-for-money processes, ensuring consistent oversight of scheme delivery, cost control and risk management across all projects.	A strategically planned and sustainable SEND provision, supporting inclusion, enabling more children and young people to access provision locally, and underpinning long-term system stability and financial sustainability.
Workforce	Workforce Strategy Delivery Plan is agreed by the local partnership, reflects SEND reform priorities and is aligned to CPD mapping. This will include joint cross-partnership training (education, health, care) on: • OAIP • Graduated approach • Inclusion and relational practice	Delivery of the Workforce Strategy across the partnership, with joint training embedded in practice across education, health and care, demonstrating increased confidence and consistency in the application of OAIP, the graduated approach, and inclusive and relational practice. A more integrated and clearly defined universal and targeted offer, with improved	A fully embedded and mature workforce, delivering sustained impact across the partnership, consistently applying OAIP, the graduated approach and inclusive, relational practice across education, health and care. A highly effective and embedded 'Experts at Hand' model, providing consistent, coordinated and impactful multi-agency support, with clear evidence of improved

	Strengthen and evolve the existing Team Around the School model, bringing together current education, health and care universal and targeted offers, and identifying where additional capacity or capability is required (including development of Experts at Hand). Start to address key pressure points (e.g. EP capacity, specialist roles).	alignment across education, health and care services, and clearer pathways for accessing support, including the development and utilisation of Experts at Hand. A clearer, intelligence-led understanding of workforce gaps, enabling targeted commissioning and strengthening of the workforce offer to better meet the needs of children and young people with SEND.	outcomes, earlier intervention and reduced escalation of need. An intelligence-led understanding of workforce supply and demand, enabling strategic commissioning, workforce planning and ongoing development of capacity and capability to meet the needs of children and young people with SEND.
Data/digital systems	Strengthen and align core datasets across education, health and care to create a shared system view of need and inclusion. Strengthened Data and Assurance Sub-group of the SEND partnership reviews both quantitative and qualitative data to inform plan progress and priorities. The sub-group will complement existing mechanisms such as Schools Oversight Tracker and SEND Sufficiency Dashboard.	More integrated and aligned datasets across education, health and care, providing a clearer more consistent system-wide view of need, inclusion and service performance. The Data and Assurance Sub-group operating effectively to provide regular intelligence –led insight, drawing on both quantitative and qualitative data to track performance identify trends, risks, and shape programme priorities.	
Success measures ***Drawing on metrics from the accompanying data template*** *E.g.* *Improve attendance of pupils in all maintained schools (mainstream and special) with SEN* *Reduce spend on ISS places* *Increase # children and young people supported by Education Psychologists/SALT/OT in maintained provision*	**To be considered further following data group modelling workshops 20th & 27th May – likely to be mainly based on the success measures in the table in section 3**		

Improve overall effectiveness of provision NEET data *Leading indicators*			

Data Template:

*****INSERT DOCUMENT UPLOAD LINK*****

6. **What will the local area partnership deliver in the first year?**

Please outline the key workstreams, milestones and trajectory your local area partnership will deliver and achieve in 2026-27 as well as how you plan to spend the investment allocation that will help fund this year's delivery. Please share key milestones and anticipated dates, success measures, cost breakdown and category. These should incorporate the core minimum requirements, be mapped to the building blocks above and should reflect a more detailed trajectory to the narrative, milestones and target metrics outlined in the 202627 column above.

2026-27 Local delivery plan		**2**		**3**		**4**	
Workstream outline – mapped to building block ***Outcome -*** *what you want to achieve with this workstream* ***Success measures –*** *how you measure progress drawing on metrics from the accompanying data template*	***Responsible lead per workstream –*** *accountable for the delivery of the workstream and the identified outcome.*	***Milestones per workstream*** *What key milestones will enable you achieve your targeted trajectory*	*Target trajectory per workstream Where do you expect your data to be?*	***Milestones per workstream*** *What key milestones will enable you achieve your targeted trajectory*	***Target trajectory per workstream*** *Where do you expect your data to be?*	***Milestones per workstream*** *What key milestones will enable you achieve your targeted trajectory*	***Target trajectory per workstream*** *Where do you expect your data to be?*
Building block – Strengthening Inclusion across education settings							
A clearly articulated, co-produced and consistently understood definition of inclusion is agreed and adopted across all local area partners, informing practice and decision making.	*Director of Early Years, Education & Skills / Head of Service, SEND & Inclusion*	*Named leads and OAIP (Inclusion Champions) identified across education, health and social care*		*Draft definition of inclusion developed, informed by existing feedback, national guidance*		*Full stakeholder engagement undertaken* *Final definition of inclusion co-*	

Success measure • *inclusion charter formal sign off by all local are partners* • *Evidence of consistent understanding of inclusion across partners (e.g.: audit/alignment in practice, language, culture)* • *Increased stakeholder confidence in how inclusion is understood locally* • *% of education settings and partner organisations signed up to the charter* • *(These should also link to the data template*		*Scoped engagement plan developed for Education settings, CYP and parent/carer engagement, with methods agreed that maximise participation (timed for autumn term)* *Reporting and oversight arrangements agreed*		*and local intelligence.* *Core principles, values and structure drafted*		*produced and agreed* *Communication and launch plan developed* *Shared messaging embedded across partners*	
Ordinarily Available Inclusive Provision (OAIP) is consistently understood and implemented as the baseline for inclusive practice across all settings, reducing variability and outcomes for children and young people with SEND *Success measure* • *Evidence of charter principles reflected in school inclusion strategies and other policies (Quality Assurance desktop review)* • *% of schools/settings implementing OAIP* • *Reduction in refusal to assess (statutory assessment) /* • *Reduced exclusion and suspension rates,* • *Improved attendance* • *Improved attainment at the end of Key Stage 2 and GCSE* • *Increasing evidence of high-quality inclusive practice through*	*Head of Service SEND & Inclusion*	*Baseline position established, % of schools currently implementing OAIP Mapping of current inclusion practice and OAIP awareness across the borough, including OAIP implementation, exclusions, attendance to identify strengths and gaps, variations between settings* *Quality Assurance approach designed and agreed, which supports a method of evidencing inclusive practice*		*OAIP expectations refreshed and reinforced across all settings* *Targeted support delivered to schools & settings, focused on application not awareness* *Quality assurance cycle underway, including moderation, peer review across a representative sample of schools* *Early performance movement tracked to demonstrate increasing % of schools*		*High percentage of schools evidencing implementation of OAIP* *Quality Assurance demonstrates early signs of inclusive practice, including peer review (where available)* *Chat Health offer supporting Autism and ADHD queries established for families, supporting with reasonable adjustments*	

Ofsted inspection reports and feeedback.				*demonstrating OAIP in practice.*				
Staff and practitioners can access timely coordinated expert support through a well-connected local system, enabling needs to be met earlier reducing escalation and improving outcomes for children and young people with SEND. *Success measure* • *Increased % of schools reporting they know how to access specialist advice and support quickly and easily (survey)* • *Stabilisation in statutory assessment requests (number per 12-month period)* • *Increased practitioner confidence in understanding pathways, accessing support and partnership working (survey and service use/activity)*	*Head of Service, SEND & Inclusion*	*Current expert support model mapped across the local area to clearly identify duplication, gaps and co-delivery opportunities* *Single, clear access model designed, including agreed pathways for schools, e.g. team around the school (EaH) locality model approach, with roles and responsibilities across the partnership clearly defined, including agreed model for health integration* *Data tracking mechanisms agreed and established* *Communication and guidance prepared*		*Pilot locality based universal delivery model in place, which expands the current education 'Team around' the school approach with an extended health focus, to include link Speech & Language Therapists (SaLT) and Mental Health in schools Team (MHST)*		*Connected model embedded and scaled, including pilot approaches* *Increased % of schools regularly using expert consultation routes and locality-based activity to support C/YP with SEND.* *Improved multi-agency working with emerging evidence of joint planning and coordinated support*		
The Local Area Workforce is increasingly skilled and confident in delivering inclusive practice, with structured and sustainable workforce development model in place. *Success measure*	*Executive Director Health & Adult Care / Head of Service, SEND & Inclusion*	*Existing mapping reviewed an updated, using latest intelligence and data* *Key workforce development needs clearly identified,*		*Workforce development delivery plan drafted, based on updated needs analysis and identified priority areas and agreed*		*Workforce development delivery plan finalised, including timeframes for delivery, review*		

• *High engagement in workforce development across education, health and care* • *Evidence of improved practice across QA and case studies* • *Increased practitioner confidence*		*alignment confirmed with OAIP / team around the school model* *HAVEN training offered to all schools and MHST teams in Bury* *All MHST teams in Bury Trained*		*with local area partners* *Multi agency delivery established* *HAVEN offer stood up in % of Bury MHST schools* *PINS training offer into schools*			
The local area is increasingly using data and intelligence to inform inclusive practice, with improved access to and understanding of key information across partners *Success measure* • *Core SEND dataset agreed and accessible across partners* • *Evidence of data used in decision making forums, to identify variation and set priorities*	*Data Subgroup members*	*Existing dataset reviewed against SEND priorities* *Gap analysis completed, wit duplication and inconsistencies across partners identified* *Core SEND dataset refined and agreed, with baseline position confirmed*		*Refined dataset shared across partners* *Data embedded in key forms, including SEND Governance and Partnership Boards, locality planning meetings*		*Improved consistency and quality of SEND data, which is used to identify variation and priorities. And actions taken in response to data analysis*	
Building block 2: Improving access to specialist support and local placements							
The Local Area is strengthening and aligning its understanding of need, capacity and pathways with improved visibility and consistently across partners to support planning and decision-making. *Success measure* • *SEND sufficiency dashboard regularly reviewed and actively used to inform planning* • *Improved shared understanding of need across the borough*	*SEND Sufficiency Lead*	*SEND sufficiency Dashboard developed, with core data agreed and use established within SEND governance and planning forums* *Engagement activity determined on sufficiency plans*		*Accessible and visual delivery roadmap is available for families, including child pathways on a page* *SEND Sufficiency Strategy finalised and agreed, informed by*		*Engage children, young people and families to understand barriers to accessing the right specialist support at the right time, using feedback to inform pathway clarity and improvement.*	

• *Key pathways clearly mapped and accessible, with increased practitioner confidence in navigating these*		*with relevant stakeholders, including parent/carer groups.* *Initial pathway development underway* *Mobilise the delivery aligned to Year 1 priorities aligned within the delivery plan and across Q3 and Q4*		*sufficiency data and needs analysis and draft 'on a page' format in development* *Joint commissioning approach reviewed and strengthened, via the established Joint Commissiong Group .* *Service user feedback mechanisms from the early support offers (ND Hub / MHST/ Digital offers and Advice and guidance) will enable the system to better understand what works and highlight commissioning/ pathway needs*		*Commissiong discussions informed by, sufficiency intelligence, gaps in provision*	
Building block 3: System leadership, local partnership collaboration and co-production							
Governance and partnership leadership across the Local Area is further strengthened, with clear accountability, effective oversight and robust joint decision making across education, health and social care. *Success measure* • *SEND governance structure and roles in place, with strong partnership engagement and attendance* • *Regular oversight of priorities with clear tracking of progress and risk* • *Evidence of joint decision-making, with clear accountability,*	*Director of Early Years, Education & Skills / Head of Service, SEND & Inclusion*	*Refresh governance arrangements to oversee the SEND reforms and wider SEND transformation and improvement, ensuring wider system engagement* *Governance forums aligned to SEND priorities and delivery plans*		*Refreshed governance arrangements embedded and operating effectively* *Consistent multi-agency attendance and engagement established* *Clear oversight of delivery established, with action owners and timescales consistently*		*Governance demonstrates strong oversight and challenge of SEND priorities, with joint decision making embedded and shared ownership across education, health and care*	

challenge and follow-up through governance				*recorded and tracked*			
Co-production is increasingly embedded across the local area, with children, young people and families actively involved in shaping services, priorities and decision making. *Success measure* • *Increased and inclusive participation form CYP and families* • *Co-production embedded across SEND priorities* • *Increased consistency and confidence in co-production*	*All stakeholders*	*Revisit our Communications Approach and agree Communications Strategy* *Draft co-production charter pilot activity underway, with CYP and families actively involved in testing approaches and feedback gathered to inform further development and refinement*		*Learning from co-production pilot activity reviewed and analysed* *Finalise and launch the SEND Co-Production Charter* *Develop SEND Reforms Plan on a Page that clearly articulates cross cutting strategies* *Engage with families in relation to their confidence in mainstream inclusion through existing engagement, co-production and feedback mechanisms*		*Embed and consistently apply co-production approaches across key SEND workstreams with strengthened involvement from education, health and care partners, including ICB and commissioned health services.* *Identify and address variation in co-production practice across the partnership, taking steps to improve inconsistency across services.*	
Building Block 4: Encouraging Inclusive Culture & Behaviours							
Children, young people and their families increasingly feel listened to, included and valued, with growing trust and confidence in the SEND services across education, health and care. *Success measure* • *Increased positive feedback from CYP and families on feeling listened to and included* • *Increase in the number of CYP and families participating in engagement and co-production activity, including under-represented groups* • *Examples of changes in school practice, e.g. adjustments to support, communication and inclusion approaches.*	*Director of Early Years, Education & Skills / Head of Service, SEND & Inclusion*	*Continue development of the Barriers to Education Pathway, with co-production activity underway and input from stakeholder, to shape its design.* *Capture early examples of practice that reflect more relational and inclusive approaches, with schools and across services.*		*Introduce and build a shared understanding of relational inclusion through existing forums, such as SENCo networks / annual inclusion event to influence culture, language and practice in schools and across services.* *Embed Reasonable Adjustment training for school leaders, delivered through the Changemakers group*		*Evidence emerging impact of relational inclusion through an increased use of a graduated supported approaches before escalation* *Professionals reference understanding need and context, not just thresholds through more joint problem-solving conversations, such as through locality based multi-*	

• *Documented examples of changes made to services based on CYP and family input,*		*Pilot CYP-led training for schools, capturing feedback and learning to inform further roll out.*		*Align relational inclusion approaches with 'Team around the School / EaH model* *Learning from CYP-led training pilot, to inform refinement and next steps.*		*agency solution circles* *Expand and embed CYP-led training for schools, to inform and influence inclusive practice and culture.* *Early identification and response to Barriers to education pathway increasingly reflected in practice across schools.*	
Projected Investment Spend per quarter **Pending data group workshops 20th & 27th May** *Please specify funding source for each category* *Example categories*: Programme oversight/additional leadership capacity. Workforce Recruitment Workforce training and development Data/Digital **Total Spend**							

7. How will the local area partnership deliver the first-year plan?

Please set out how you will ensure the required capacity and capability is in place from organisational corporate functions to support implementation of the plan. This could include reference to how you plan to build or bring in project delivery capability to manage delivery against the plan, support prioritisation, and effective use of resources; and how you plan to build the capacity and capability in data and analytics to support effective tracking against the measures in the plan and reporting that informs decision making.

250 words

Delivery of the first-year SEND Reform Plan will be underpinned by strengthened system capacity, clear accountability and robust use of data, building on the progress made through Bury's SEND improvement journey and the findings of the March 2026 Area SEND monitoring inspection.

The Local Authority, as system convener, will establish named workstream leads, access to central project management expertise, and a clear prioritisation framework to ensure resources are directed to the highest-impact activity, particularly around inclusive mainstream practice, timely support and statutory SEND processes. The SEND Improvement and Assurance Board (SIAB), with independent chairing, will be supporting the establishment of Bury's SEND Partnership Board. The governance arrangements will include three sub-groups to secure strong SEND Sufficiency, deliver the Experts at Hand (EAH) model and provide robust risk assurance. This will continue to provide system-wide oversight, pace and challenge, supported by regular, standardised reporting against agreed milestones and risks.

Capacity and capability in data and analytics will be strengthened through closer integration of education, health and care intelligence. Building on existing SEND scorecards and dashboards already scrutinised by SIAB, the partnership will enhance analytical capacity to track demand, timeliness, outcomes and spend across the system. Dedicated analytical support will enable more granular tracking of EHCP processes, early intervention activity, inclusion indicators and preparation for adulthood measures, informing operational decision making and strategic commissioning.

Corporate functions, including finance, commissioning, workforce and digital teams, will be aligned to SEND priorities to support sustainable delivery, workforce planning and value for money. This approach ensures the reform programme is embedded as "business as usual", supporting consistent improvement and readiness for future phases of national SEND reform.

(273 words)

8. Other funding Local Authorities.

Block Transfers: If you have made a block transfer (Schools Block to High Needs Block) for 26-27, please set out how your plans for this funding align with the activities outlined above.

250 words

Capital: We have announced at least £3 billion in high needs capital between 2026-27 and 2029-30 to support children and young people (CYP) with SEND, or those requiring alternative provision (AP). This funding is intended to support place delivery across the full 0-25 age range, including early years and post-16. We expect funding to support the following outcomes:

a. Inclusion at the core of high needs sufficiency strategy, resulting in more children and young people with SEND accessing suitable places in mainstream settings, across all phases of education
b. Every child or young person who needs a place in an inclusion base can access one
c. Fewer children and young people with SEND needing to travel a long way to access a suitable placement
d. Improved suitability of the mainstream estate to support children and young people with SEND, with adaptations to improve inclusivity and accessibility of the physical environment

We also welcome innovative uses of high needs capital to drive inclusion, for example, investment in assistive technology for use in mainstream settings.

Please outline your strategy for how this funding will meet the outcomes above, with reference to the core minimum requirements and other workstreams in this reform plan where appropriate. We would like to see detail around your plans to increase capacity for inclusion bases (formerly known as SEN units, resourced provision and pupil support units – SU/RP/PSUs), such as schools, colleges or early years providers identified, engagement with relevant settings and trusts, and target cohort of needs.

If your plans include increases to places in special schools or specialist post-16 institutions, please include a clear rationale, showing the need that is being met, and why it cannot be met through other types of provision, such as inclusion bases.

If you are receiving additional capital funding to replace one or more planned special or AP free schools, please set out how this funding will meet need in your area, and plans for engaging relevant trusts in your sufficiency planning.

500 words

Section needs further review and specificity, pulling through the PSV programmes.

Bury's strategy for 2026–2030 places inclusion at the core of sufficiency planning, ensuring children and young people with SEND can access the right provision locally, at the right time and across the full 0–25 age range. Capital investment will support a coherent continuum of inclusive mainstream provision, targeted inclusion bases, specialist provision where necessary, and improved suitability of the education estate.

Inclusive mainstream capacity and estate adaptation

Capital funding will be used to strengthen mainstream inclusion across early years settings, primary and secondary schools and our post-16 settings. This includes targeted adaptations to the physical environment—such as sensory-friendly spaces, accessibility improvements, quiet regulation areas and assistive technology—to enable these settings to better meet a wider range of need. This approach supports the strengthened universal offer and Experts at Hand model, reducing escalation to specialist provision and improving placement stability.

Expansion of inclusion bases (resourced provision and SEN units)

A central priority is the expansion of inclusion bases within mainstream settings, particularly to meet growing demand for autism (ASC), social, emotional and mental health (SEMH) and communication needs. Capital investment will support expansion of current specialist resourced provision at Peel Brow Primary Academy and establishment of new provision at Radcliffe Primary Academy, developed in partnership with trusts. Further development of inclusion bases identified through the SEND Sufficiency Strategy will ensure equitable access across planning areas and phases. Engagement with early years providers and post-16 settings will explore specialist inclusion models that enable earlier intervention and smoother transitions.

Special school and specialist post-16 provision

Where needs cannot be met through inclusion bases, targeted expansion of special school or specialist post-16 provision will be pursued. This includes completion of the Millwood Primary Special School expansion to address primary-phase specialist demand, delivery of a new SEMH secondary special school at Redvales to respond to sustained secondary demand that cannot be met within mainstream inclusion, and development of a permanent post-16 specialist facility for Elms Bank, replacing temporary arrangements and improving progression into adulthood. These investments are justified by the complexity of need and persistent gaps in post-16 and SEMH pathways, where mainstream inclusion alone is insufficient.

Reducing travel and out-of-borough placements

Capital decisions will prioritise provision close to where children and young people live, explicitly considering travel distance, journey times and transport costs. Expanding local capacity for ASC, SEMH and post-16 provision will reduce reliance on independent non-maintained and out-of-borough placements, improving outcomes and value for money.

Alternative provision and AP free school replacements

Where additional capital funding is received to replace planned special or alternative provision free schools, this will be aligned with Bury's Alternative Provision Strategy and SEND sufficiency priorities. Engagement with sponsoring trusts will ensure provision meets local need, supports reintegration where appropriate, and strengthens the local continuum rather than creating isolated capacity.

Governance, alignment and delivery

All capital investment will be aligned to the SEND Sufficiency Strategy, Education and Inclusion Strategy and SEND Reform delivery plan, with oversight through established SEND and corporate capital governance, and long-term system sustainability.
(518 words)

9. System partner and stakeholder engagement, and co-production.

Please outline how the local area partnership plans to engage system partners and stakeholders to develop and implement the plan – include planned engagement with schools and early years settings, alternative providers, FE and post-16 providers (including those your young people attend that are not within your local area), Parents and Carers and children and young people with SEND, with reference to the core minimum requirements. Consider changing roles and responsibilities in the context of the Schools White Paper and how you work collaboratively to manage the transition. Please indicate where additional support is required to engage partners or stakeholders - senior officials at the Department for Education will be available to contribute to summer term events with education leaders and parent carer forum leaders.

500 words

Effective engagement and genuine co-production are critical to the successful delivery of Bury's Local SEND Reform Plan. The Local Area Partnership will build on strengthened governance, improved relationships and learning from inspection to ensure reform is developed and implemented collaboratively, with shared ownership across education, health, social care, children, young people and families.

System leadership and shared accountability

The Local Authority will continue to act as system convener, providing clear leadership and coordination. Engagement will be anchored through the independently chaired SEND Improvement and Assurance Board (SIAB), and in time a more stakeholder focused SEND Partnership Board (develop this) which brings together senior leaders from education, health, social care and the Bury2Gether Parent Carer

Forum (PCF). SIAB and the new SEND Partnership Board will continue to provide shared accountability, strategic oversight and assurance, supported by transparent reporting, agreed escalation routes and collective problem-solving to maintain pace and focus.

Engagement with education settings and providers

Early years settings, schools, alternative provision (AP) and post-16 providers will be central partners in delivery. Engagement will be structured through existing and strengthened forums, including early years networks, headteacher, senior leaders and SENCO forums, AP provider groups and post-16 strategic meetings. These will provide the foundations on which strong partnership working will support co-development and consistent implementation of the strengthened universal offer, the Graduated Approach and the Experts at Hand model, clarifying expectations for inclusive mainstream practice in line with the Schools White Paper.

Post-16 engagement will explicitly include further education colleges, sixth forms and independent training providers attended by Bury young people, including those outside the local area. This reflects the partnership's responsibility for children and young people educated beyond borough boundaries and will focus on transitions, preparation for adulthood, clarity of pathways and effective information sharing.

Health and care partners

Health and care partners will be engaged through joint commissioning arrangements, neighbourhood-based working and practitioner forums. The Integrated Care Board and provider organisations will contribute to shaping delivery models, workforce deployment and "support while waiting" arrangements, ensuring reform is operationally deliverable and improves lived experience.

Parents, carers, children and young people

Co-production with parents, carers, children and young people will be strengthened further in year one. The partnership will continue close working with Bury2gether, Burys PCF, ensuring early and meaningful involvement in design, delivery and review of reforms. Learning from inspection has highlighted the need for clearer communication; therefore, engagement will include accessible updates, targeted events and clear feedback on how views have influenced decisions.

The voice of children and young people will be captured directly through Bury's Changemaker group and distinctly through Bury's education setting participation activity and targeted engagement, particularly around transitions and preparation for adulthood. Specific action will be taken to reach under-represented groups and ensure inclusive participation.

Managing change and transition

As roles and responsibilities evolve under the Schools White Paper—particularly for schools, trusts and health partners—the partnership will support transition through clear communication, practical guidance and collaborative planning. This will help partners adapt confidently while maintaining a shared ambition for inclusion and early intervention.

Additional support

The partnership would welcome additional support from the Department for Education and NHS England, including senior official participation in summer term engagement events with education leaders and the PCF, facilitation of peer learning across areas and practical tools to support sustained co-production and system change.

(564 words)

10. Risks and Mitigations

What are the key risks that could affect the successful implementation of your Local SEND Reform Plan, and what mitigation strategies are in place to manage these risks? Please include a maximum of 5 risks with impact and likelihood RAG for each risk. See Annex C for suggested risk matrix.

Risk	Impact	Likelihood	RAG	Mitigation	Residual RAG
Continued rise in number of EHCPs for children requiring specialist provision, exceeding maintained special school capacity and leading to substantial cost growth because of increasing dependence upon Independence Non-	High	Likely			

Maintained Schools (INMNS)					
Lack of parental confidence in system change results in continued escalation	High	Likely			
	High	Likely			
Ensuring parity of service across GM – different starting points, and a single commissioning body Eg SALT, HV					
Unable to deliver an EAH due to recruitment challenges in key professional roles	High	Likely			
Alignment of the different change programmes in the local area	Medium	High			

11. **Dependencies**

Please detail the key areas of the local area partnership's proposed SEND future state and roadmap that may be impacted by wider reforms nationally and locally and outline how you will manage these. We expect these will include but not be limited to:

- NHS reforms
- Local Government Re-organisation
- Reforms to Children's Social Care
- Best Start in Life, including Family Hubs
- Best Start In Life Strategy

- Curriculum and Assessment Review

500 words

Delivery of Bury's SEND future state and three-year reform roadmap is dependent on several wider national and local reforms progressing in a timely and coordinated way. The Local Area Partnership recognises these dependencies and will actively manage their impact through strong system leadership, programme alignment and robust governance, building on the progress achieved through Bury's SEND improvement journey.

NHS reforms

Ongoing NHS reforms, including further development of neighbourhood models and changes to commissioning and provider arrangements, are a critical dependency for SEND reform. These changes directly affect access to health professionals, delivery of early intervention, "support while waiting" and implementation of the Experts at Hand offer. Risks include workforce availability, changing financial flows and transitional disruption. These will be managed through close joint working between the Local Authority and Integrated Care Board, shared commissioning intentions and collective oversight through the SEND Improvement and Advisory Board (SIAB), ensuring continuity of service delivery during periods of change.

Reforms to Children's Social Care

National reforms to children's social care, including the introduction of Family Help models and strengthened early intervention, are closely aligned to SEND reform ambitions. Dependencies include workforce capacity, threshold alignment and clarity of pathways across early help, safeguarding and SEND. In Bury, these reforms are being managed through integrated programme oversight, shared governance and neighbourhood-based working, ensuring children and families experience a coherent system rather than fragmented services.

Best Start in Life and Family Hubs

Expansion of Best Start in Life and Family Hubs is a key dependency for early identification of need, parental engagement and prevention of escalation. Alignment between SEND pathways, health visiting, early years provision and Family Hub delivery is essential. The partnership will ensure SEND reform activity is embedded within Best Start governance and delivery structures, supporting consistent communication, shared data and smooth transitions from early years into school.

Best Start in Life Strategy

National and local developments within the Best Start in Life Strategy, particularly expectations for outcomes in the first 1,001 days, directly influence Bury's SEND roadmap. The partnership will manage this dependency through aligned milestones, shared workforce development and consistent use of evidence-based practice, ensuring coherence across early years, health and SEND reform programmes.

Curriculum and Assessment Review

The ongoing national Curriculum and Assessment Review presents dependencies for inclusive practice, preparation for adulthood and outcome measurement. Changes to curriculum content, assessment or accountability may affect how progress for children and young people with SEND is defined. The partnership will mitigate this by maintaining close engagement with education leaders, aligning local inclusion priorities with emerging national expectations, and retaining flexibility within the SEND reform roadmap.

Across all dependencies, SIAB provides strategic oversight to monitor impact, manage risk and adjust delivery sequencing where required, enabling Bury to sustain momentum, protect recent improvement and deliver a resilient, inclusive and sustainable SEND system.

(540 words)

Section 3 – Monitoring and Evaluation

12. **How will the local area partnership know delivery is on track?**

Please set out how you will monitor and track progress referencing:

- ***Monitoring tools and processes*** - the specific tools, systems, and data you will use to track delivery milestones and measure the impact on outcomes.

Some Local Area Partnerships hold data in a central SEND operational dashboard. This is used by teams on a weekly basis to identify trends in demand or inform conversations with local school or setting leaders.
In some Local Area Partnerships, a view of the Key Performance Indicators (KPIs) is reviewed monthly by a SEND Board to take decisions on prioritisation, resourcing and delivery of services informed by regular data.

Please set out how you will use data to track demand (e.g., EHCP applications for assessment), Service delivery (e.g., Speech and Language Specialists deployment; places created), Service quality (e.g., parental satisfaction) and outputs (e.g., pupil attendance; pupil exclusions)

- ***Feedback and adaptation mechanisms*** - what feedback loops and stakeholder input you will use to review progress and adjust your approach.

500 words

Oversight of delivery will be provided through the SEND Improvement and Assurance Board, which meets bi-monthly and brings together senior leaders from education (MATs, schools and LA), health, care, finance, the voluntary sector, in addition to the local parent carer forum. Every meeting will receive up to date reports against an agreed set of Key Performance Indicators (KPIs) covering demand, service delivery, quality and outcomes, which will drive collective ownership and decision-making around relative priority, resourcing and delivery. We intend that this information will be accessible to all Board members using a Power BI dashboard.

Sitting under the partnership board, will be three sub-groups: Data and Assurance, Expert at Hand; and SEND sufficiency. Each of these sub-groups will have a senior lead. The sub-groups will track progress against milestones and delivery against the plan, highlighting progress and critical issues in reports to the wider Board. The SEND Partnership Board will itself report to a broader Education and Inclusion Board, chaired by the Executive Director for Children's Services. This architecture will be supported by dedicated programme management resource and data support.

To complement this ongoing monitoring of progress against the agreed plan, we will provide an annual position statement and analysis of the local area SEND system (in the autumn of each year) to the SEND Partnership Board and the Education & Inclusion Board, which will bring together a wider range of information and particularly draw on regional and national comparative data, as well as taking a broader view of how well the local system functions and its sufficiency. This annual process will inform strategic planning of provision and investment and will sit alongside what has already existed during our improvement journey: regular quality assurance, parental engagement and wider stakeholder input, especially feedback from children, parents, schools and settings.

The Data and Assurance sub-group will have responsibility for the completion of the DfE quarterly data return, which will be shared for discussion with the SEND Improvement and Assurance Board and will provide a consistent reporting framework to inform assessments of progress on delivery early identification of emerging risks and support timely adjustment of delivery plans.

13. **Reporting to DfE**

Using the attached data template, the local area partnership is required to provide quarterly data returns to DfE against selected key metrics. DfE will, in turn, provide quarterly data reports with visualised analysis and benchmarking that will support your local delivery, monitoring and evaluation. This will include data the department holds on **Attendance**, **Exclusions**, and **Unauthorised absence**. Please use the attached data template to upload your initial data return to DfE.

INSERT DOCUMENT UPLOAD LINK

Section 4 – Governance

14. **How will the local area partnership ensure delivery of plans remain on track?**

Please outline the governance structures in place to oversee delivery. Clearly set out who is responsible for overseeing reform delivery, what each governance group or individual is accountable for, and how these arrangements ensure progress is monitored and decisions are made transparently. Please identify where the named SRO for the Local SEND Reform Plan sits within the governance structure and ensure your response incorporates the core minimum requirements.

Governance Mechanism *This may be a governance group, or an individual (e.g. SRO).*	**Purpose/ Responsibilities** *What is the function of this governance mechanism? What are they accountable for overseeing? What information is reported to this governance mechanism?*	**Membership** *Who does this governance mechanism comprise of? [should include health and PCF representation] What stakeholders are represented at this governance mechanism? Please indicate who chairs this.* *(Include n/a if an individual).*	**Cadence** *How regularly does this governance mechanism meet?*	**Decision Rights** *What decisions can this governance mechanism make?*	**Escalation Route** *Where can this governance mechanism escalate issues or decision to?*
SEND Improvement & Assurance Board (SIAB)	Our SEND Improvement & Assurance Board has overseen the improvement	• MAT Chief Executive (Chair) • Executive Director CYP	Bi-monthly	The Board will use its authority to agree the	Education & Inclusion Board

	in Bury over the last 2 years, and for the next phase of transformation under the SEND reforms will be chaired by a Chief Executive from one of our Multi-Academy Trusts. The Board provides strategic system and partnership leadership, oversight and assurance in relation to the experiences of children with SEND, and their families and includes leaders from across the local area, including our Parent Carer Forum and young people themselves, ensuring that their experiences directly impact the decisions taken.	• Executive Director of Strategy & Transformation • Director of Early Years, Education & Skills • Lead Member for CYP • Lead Member for Health • Shadow Cabinet Member for CYP • Early Years Service Manager • Exec Director, Health & Adult Care & Deputy Placed Based Lead • Head of SEND & Inclusion • Head of Communications • Head of Strategy, Assurance & Reform • Director of Childrens Social Care & Early Help • SEND Youth Ambassador • Director for Adult Social Care • Designated Social Care Officer • Designated Clinical Officer for SEND • Associate Director of Nursing, Quality & Safeguarding		necessary actions that are needed at a Partnership and system-wide level on improvement priorities. The Board Members have sufficient delegated authority to agree actions in principle on behalf of their organisation or partnership body, in order make swift and decisive progress. Where necessary, decisions will be taken through appropriate organisational governance arrangements (for example Executive key decision by the Local Authorities Cabinet Member, or NHS decisions through the Integrated Care Board and The NHS Trust Board).	

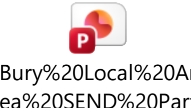
		• NHS GM Programme Manager • Medical Director • Programme Director for CYP • Virtual School Headteacher • Headteachers from Nursery, Primary, Secondary & College • Bury2Gether (Parent Carer Forum)			
Education & Inclusion Board	Our Education & Inclusion Board is chaired by the Executive Director for Children & Young People				Chief Executive
Locality Board (Bury)	The board sets the strategic direction and implements the health, care and well-being system across Bury.	• Leader of Bury Council • Senior Clinical Lead in the Borough • Executive Member of the Council for Adult Care and Health • Executive Member of the Council for Children and Young People • Executive Lead of ICB • Place Based Lead for Bury • Deputy Place Based Lead for Bury • Associate Director of Nursing • Associate Director of Finance	Monthly		GM ICB

		• Executive Director of Health and Care • Executive Director of Children and Young People • Director of Public Health • Director of Adult Social Services and Community Commissioning • Senior Officers from trusts • Representatives from Bury VCFA • Divisional Managing Director Bury Community Services Division			
Bury Health & Wellbeing Board	Statutory Board to promote integration and partnership across health and care; provide a forum for system leaders to improve health and wellbeing outcomes; and lead development of Joint Strategic Needs Assessment and Joint Local Health and Wellbeing Strategy	Statutory membership: • Elected member(s) • Director of Adult Social Services • Director of Children's Services • Director of Public Health • ICB representative • Healthwatch representative Additional members: • Voluntary sector representative • NHSE representative	Quarterly		

Data & Assurance Sub-group	Chaired by a Senior Officer, the sub-group will ensure that quantitative and qualitative data is routinely collated, analysed and reported to the SIAB to inform analysis around progress and impact.		Monthly	Recommendations to SIAB; delegated decision making within their Terms of Reference.	SIAB
Experts At Hand Sub-group	Chaired by a Senior Officer, the sub-group will oversee expansion of our existing Team Around the School & Communities of Practice approach into an Expands at Hand model.		Monthly	Recommendations to SIAB; delegated decision making within their Terms of Reference.	SIAB
SEND Sufficiency Sub-Group	Chaired by a Senior Officer, the-group will analyse local SEND sufficiency and make recommendations		Monthly	Recommendations to SIAB; delegated decision making within their Terms of Reference.	SIAB

If you have a diagram to show the relationship between these governance mechanisms, please upload this here.

Bury Local Area SEND Governance diagram:



Bury%20Local%20Area%20SEND%20Part

Section 5 – Central Government Support

15. **How can we help you?**

Please outline any practical support you need from central government to implement your plan effectively.

This may include:

- Access to specialist expertise or advisory support
- Help with workforce development or recruitment challenges
- Tools or templates to support data collection, reporting, or evaluation
- Facilitation of peer learning or regional collaboration
- Support with system-level coordination across education, health, and care
- Guidance on navigating regulatory or policy barriers

250 words

SEND & AP PARTNERSHIP SELF-ASSESSMENT

ASSESSMENT CONTEXT - *please add any relevant information about how you have completed the tool, including any limiting factors in arriving at a shared assessment.*	Workshop session with Jeanette Richards, Ben Dunne, Wendy Young, Will Blandamer, Robert Arrowsmith, Beth Speak, Kevin Burns (DfE Adviser); adjustment made based on feedback from SIAB members and through consultation workshops delivered in May/early June.	**STATUS** - *use this box for version control (e.g. DATE, v1.0) and to record any formal decisions/agreements about the assessment.*	Version 3, 26/5/2026

Pillar 1: Co-production with parents and carers and children and young people

0 - NOT YET EMERGING	1 - EMERGING	2 - DEVELOPING	3 - MATURING	ASSESSMENT	DATE COMPLETED	STRENGTHS/SUCCESSES/IN PROGRESS	GAPS/ISSUES TO ADDRESS	FOCUS AREAS FOR IMPROVEMENT
Parental representatives are not involved in SEND and AP partnership meetings. The Parent Carer Forum (PCF) is not formalised or in early stages, without wider parental representation evident. PCF Chair is not involved in SEND strategic partnership board meetings. Views of CYP and parents/carers not gathered. Very little evidence of the partnership engaging with parents/carers in co-production.	There is limited parental engagement in the SEND and AP partnership meetings. The area has a PCF that has a formalised structure but is not always supported to actively engage with local partners or is a recent newly formed forum. The PCF strategic leads of the local PCF do not regularly attend partnership board meetings and there is limited engagement. There is an awareness of the principles of co-production and parents, carers and children and young people are beginning to be involved in discussions about services. The partnership is beginning to engage with parents/carers but a clear approach of co-production has not yet been fully embedded as best practice. Relations with families / PCF are not entirely positive and key groups of parents are vocal in their concerns.	The area has an active, effective, and sustainable PCF. Local SEND and AP youth forums or user groups are engaged with throughout planning and delivery. The partnership is developing practice to co-produce with parents and children and young people. Some aspects of service planning and review cycles actively seek input, but participation is not yet universal or embedded.	The area has an active PCF which meets regularly with the system partners. Strong feedback mechanisms ensure that children, young people and families know how their views influence decisions. There is strong evidence that their views shape services and outcomes. Co-production is a core feature of planning, delivery and review. Parents, carers and children and young people are equal partners, with clear and regular opportunities to influence strategic priorities, service design and quality assurance. The partnership has embedded practices to co-produce with parents and children and young people.	**1 – EMERGING**	26/05/2026	Active PCF which meets regularly. Clear evidence of PCF engagement and significant contribution to strategic partnership. We have growing evidence of strong co-production (eg EOTAS, Short Breaks) although this is not yet good by habit, but parents and carers are part of assessing local need and strategic planning documents are firmly co-produced by the partnership. We engage well with CYP at a strategic level, with strong feedback mechanisms in place and views and experiences of parents and carers routinely considered. Strategic planning documents are co-produced and reviewed, shaped by children and young people's voices.	Differing views of co-production vs co-design - work underway eg Co-Production Charter. This will also need to set out agreed definition of what good co-production looks like. Not clear how well we hear from parents, carers and young people in relation to AP, EOTAS and EHE. We need to increase the number of platforms through which we engage with our families to ensure a wider reach. Parent carer drop-ins to be aligned to neighbourhoods.	Strengthen relationships with a wider range of parents/carers, eg EOTAS, AP, EHE. This will be driven through involvement of EOTAS in Communities of Practice (COP), Parent Engagement sessions through COP, expansion of COP into an Expert At Hands (EAH) offer, review of AP, member of Youth Cabinet being EHE, use of assembly forums and School Forum Groups. Ensure involvement with PCF at the start of transformation and improvement plans to ensure timescales support co-production and we can maximise parental involvement. Work with schools around consistent co-production (Primary stronger than Secondary) and involvement of families in decision making, and that children and young people understand how their views influence school policies and practices.

Pillar 2: Effective system leadership and governance

0 - NOT YET EMERGING	1 - EMERGING	2 - DEVELOPING	3 - MATURING	ASSESSMENT	DATE COMPLETED	STRENGTHS/SUCCESSES/IN PROGRESS	GAPS/ISSUES TO ADDRESS	PRIORITIES & SUPPORT NEEDS
Key leaders lack requisite knowledge and skills, either with vacant posts or with interim staff, resulting in ineffective practice. Local governance structures are not fully established and local partners are unclear where and how decisions are made about SEND and AP provision and services. No clear communication strategy and limited sharing of data performance measures.	Leaders are in place and starting to influence strategic direction and build partnerships. Partners are working with initial governance structures and developing clarity on where strategic decisions are made. Opportunities exist to further engage stakeholders in operational and strategic planning. Communication is identified as an area for improvement. Accountability is supported by existing processes and compliance measures. The partnership is focused on strengthening outcome measures and building shared understanding of system performance.	Leaders have developed structures and forums for decision-making which are established and increasingly understood, with partners contributing meaningfully to discussions. Feedback pathways between operational and strategic levels are being implemented. Communication channels exist but need strengthening in parts of the system. An outcomes-based approach is developing, with agreed shared outcomes and initial steps to use data for evaluation. Partners are starting to communicate openly about progress, and feedback is more routinely discussed.	Leadership is effective, and well-defined and embedded governance ensures decisions are collectively made at appropriate levels. All partners have clarity on their roles and can easily influence both operational and strategic planning. Processes are continually reviewed for improvement. Commissioning is well understood and integrated across the partnership. Robust, transparent systems for measuring and reporting outcomes are fully embedded. Success is judged by impact on CYP and families, and services are continually improved in response to honest evaluations involving all partners. Decision-making is both aspirational and innovative.	**2 – DEVELOPING**	26/05/2026	Structured systems and governance arrangements are in place and have strengthened partnership working, across services and with education partners at both an operational and strategic level. This has enabled transparency, collaboration and positive challenge and is enabling progressive meaningful change across our systems. There is stable and knowledgeable leadership across the partnership and clear delegation of roles and responsibilities. Strategic planning documents have been developed and a data pack is in place to monitor the impact and effectiveness of our improvement activity. This is routinely shared and discussed, operationally and strategically. Communication channels exist and have improved, this is particularly the case with our schools, children and young people, such as their close regular involvement in the work of our improvement board.	Due to regional arrangements some decisions are taken outside of the partnership - need to ensure these are shared in a timely way. Council and Health Leaders understand how to effect change but more to do with schools to ensure they understand this. We also need to understand what can be refined locally and how we adopt regional models. We need to ensure that schools better understand their strategic role in the system/regarding system wide decisions including Schools Forum. Commissioning is not well understood or consistently integrated across the partnership. Roles, responsibilities and accountability within commissioning arrangements lack clarity for some partners and not always sufficiently aligned with strategic priorities, needs analysis or lived experience. There is sometimes a disconnect between strategic intent and translation into front line services.	There is a need to ensure the SEND Strategy continues to be implemented to improve the lived experience of children, young people with SEND and to ensure that the pace of improvement is sustained. There is a need to establish clearer, open communication and feedback mechanisms, particularly with children, young people and families, to ensure their experiences meaningfully inform decision-making. There is a need to enhance "You Said, We Did". Improve communication channels to all parts of the SEND system. The joint commissioning strategy and governance arrangements require finalisation and implementation.

Pillar 3: Accurate understanding of needs and experiences of children and young people through effective use of quantitative and qualitative data

0 - NOT YET EMERGING	1 - EMERGING	2 - DEVELOPING	3 - MATURING	ASSESSMENT	DATE COMPLETED	STRENGTHS/SUCCESSES/IN PROGRESS	GAPS/ISSUES TO ADDRESS	PRIORITIES & SUPPORT NEEDS
There is limited evidence of using data effectively to inform commissioning of services based on the needs profile of children in the local area. Data analysis is simple and descriptive. Qualitative data is not collected. The LA Self Evaluation does not accurately reflect provision and / or is incomplete, or has not been shared.	Data gathering methods are being established or updated and provide an initial understanding of needs and gaps. Planning is supported by available quantitative data, with opportunities to develop more comprehensive use of family and CYP perspectives. Commissioning is underway within each sector, with some early cross-agency conversations. Providers are engaged with current sufficiency, and there is scope for increasing dialogue and alignment to proactively meet future needs.	Partners collaborate to gather both quantitative and qualitative evidence of needs. There is a growing sophistication in analysing current provision against future demand, and plans are underway to address identified weaknesses and gaps. Partners are working together more actively, consulting providers and starting to coordinate commissioning processes. Efforts are made to co-produce solutions and align plans across agencies, with some shared ownership and responsibility.	A robust and comprehensive evidence base underpins strategic planning. Rich quantitative and qualitative data is routinely collected, shared, and used to monitor trends and inform sufficiency planning. Joint commissioning across the partnership ensures that services are in place to meet the range of needs and achieve positive outcomes for CYP with SEND.	**2 – DEVELOPING**	26/05/2026	PSV supported an in-depth understanding of data and underlying trends and patterns over the last decade to help understand future trajectories' There are also other examples across NHS GM. Quantitative and qualitative data is collected. Data sharing at Board level is well established (eg SIAB, GM Board). A Sufficiency Dashboard has been created and a draft Sufficiency Strategy (2026-30) complete. This is beginning to inform sufficiency planning and commissioning.	JSNA does not have a SEND specific section, although we do have examples of other analysis where there is crossover with other vulnerable groups and waiting lists. We are seeking to improve the systematic gathering of parent/carer feedback on their lived experience to complement our other data and analysis. There is more work to do to understand the quality of specialist provision particularly around INMS & AP. Don't consistently bring together qualitative and quantitative data for analysis - where we have done this, has supported effective decisions to be taken.	Shared commitment across all education settings to share data that informs a borough-wide approach to meeting the challenges at local level and building on strengths and providing support where needed. Establish and embed sufficient infrastructure that captures live trends and accurate reporting across all settings. Explore necessary resource to secure an Early Years, Education and Skill data lead within the School Engagement and Skills Service area. Further develop MIS systems internally (Power BI) that provide live data from all education settings with a focus on attendance, PA, SA exclusion and suspension data. This will provide a more analytical approach to understanding effectiveness of the system partnership. Greater use of 'you said, we did' in our communications to demonstrate that we are listening, to encourage more parents and carers to provide soft data through surveys and other feedback routes.

Pillar 4: High quality service delivery at universal, targeted and specialist levels to promote inclusion

0 - NOT YET EMERGING	1 - EMERGING	2 - DEVELOPING	3 - MATURING	ASSESSMENT	DATE COMPLETED	STRENGTHS/SUCCESSES/IN PROGRESS	GAPS/ISSUES TO ADDRESS	PRIORITIES & SUPPORT NEEDS
No consistent guidance or support for schools to identify needs; inclusive practices are minimal and fragmented. Limited or no targeted interventions in place; AP is poorly integrated and rarely considered as part of the continuum of support. Statutory decision-making is inconsistent and delayed; quality assurance processes are absent or ineffective; specialist provision planning is reactive rather than strategic.	There is some guidance and support in place to support schools in identifying needs, but provision is inconsistent and AP is not well integrated. Schools and settings are beginning to expand their offer for CYP with SEND, but it remains largely focused on statutory responsibilities. Statutory decision-making is inconsistent and often delayed, with limited evidence of effective quality assurance processes and partnership engagement. SEND sufficiency planning is in development and looking at future projections but provision not able to meet demand.	Support services are developing; schools and settings are improving in identifying needs and accessing provision, including AP, evidenced in improving outcomes for CYP with SEND. Schools and settings are broadening their provision and starting to embed inclusive practices, with growing use of AP, and reducing requests for specialist provision. Processes are becoming more consistent and timely, with evidence of quality assurance and improvement. There is a strategic SEND sufficiency plan in place but recognition of some challenges in implementation.	There are effective arrangements and services in place to support schools and settings to identify needs and put in place appropriate provision, including Alternative Provision, evidenced in positive outcomes for CYP with SEND. Schools and settings are delivering a broad offer for all children and young people with SEND (beyond solely statutory responsibilities) that enables inclusive practice across the system, including Alternative Provision, and a higher% of CYP with EHCPs in mainstream. Decision-making and practice relating to statutory decisions is consistent and timely. SEND sufficiency planning is strategic and partners have confidence in the system's capacity to meet needs for the majority of children.	**1 – EMERGING**	26/05/2026	The local area has developed a comprehensive graduated approach offer to improve early identification of need. We have adopted the Greater Manchester model for Ordinarily Available Inclusive Provision (OAIP) which schools are increasingly adopting, and a graduated approach offer supported by a toolkit (early years to Preparation for Adulthood). An Alternative Provision Strategy and approved supplier list has been developed and promoted. Our Communities of Practice (CoP) offers a universal offer to all mainstream settings to create opportunities for professionals and families to come together locally, share practice, problem-solve and build confidence and support schools through discussion, advice and reflection, with a focus on inclusion and emotionally friendly practice. This has been welcomed by our schools and had positive feedback, including from our families who have engaged in the parental drop-in sessions. CoP provides the foundations to develop our EaH offer, majority of primaries and all secondaries have engaged as part of this early help model, already aligned with our 5 ICB areas. The model is also aligned to the Integrated Care Board place areas. We have also increased the SEND Health visiting team and embedded the Speech, language and communication pathways. Early years SENCo networks are established and SENCo networks have been relaunched and are working well with positive feedback from settings. There is analysis of attendance, informed by a Schools Oversight Group.	There is an over-reliance on specialist settings for children and young people and for statutory support through an EHCP. Parents lack confidence in the mainstream offer and in navigating the support system. We still have a diagnostic led system - early stages of our Graduated Approach implementation and understanding impact of early support offer, in moving towards a needs led system. SEND services are not integrated within our early help/family and health support offer. Outreach offer does not expand to specialist Resource Bases/SEND units or specialist settings. Some CYP fall between existing provision - having needs that are not complex enough for specialist settings yet requiring more support than mainstream education settings can currently offer.	Ordinarily Available Inclusive Provision (OAIP) outlines our principles for mainstream inclusion, further embedding across all settings is required. CoP activities need to be data and intelligence led to ensure strategic priorities and local area challenges are supported - greater alignment from health partners is also a key focus. Increase parental engagement and feedback to promote confidence in mainstream inclusion, particularly at transition points. Enhance the Local Offer website through launch of AI Beebot to improve parents' experience of navigating the available information. Increase outreach and specialist support offer to include AP's / specialist bases/schools. Strengthen family hubs offer.

Pillar 5: Effective partnerships working across education, health and social care

0 - NOT YET EMERGING	1 - EMERGING	2 - DEVELOPING	3 - MATURING	ASSESSMENT	DATE COMPLETED	STRENGTHS/SUCCESSES/IN PROGRESS	GAPS/ISSUES TO ADDRESS	PRIORITIES & SUPPORT NEEDS

Education Providers: Limited evidence of joint planning or collaboration. Schools generally operate in isolation with no shared inclusion strategies. Engagement with local authority is minimal.	**Education Providers:** All school types are involved in some way and contribute to the local offer, with engagement variable but developing across providers. Collaborative planning processes and networks are being strengthened, and schools are starting to partner with the LA on inclusion strategies.	**Education Providers:** All settings, including AP, post-16, and early years settings, are represented and most take part in partnership work, with regular consultation on inclusion. Joint processes for planning and provision are developing. Fair access protocols show improving outcomes and growing confidence. SENCO and leader networks are forming, and shared responsibility for inclusion is growing.	**Education Providers:** All providers are fully represented and actively engage in strategic planning, sharing updates with their settings. Evidence shows collaborative work improves planning, transitions, and inclusion. Fair access protocols are trusted and effective. Strong networks enable clusters of schools to commission, support, and respond to needs.	**1 – EMERGING**	26/05/2026	Early years, primary, secondary, post-16 and specialist settings represented at SEND Board. Termly meetings with all CEOs and Trust Leaders, established, well attended and received, led by exec. team. SENCo and DSL networks well developed with over 90% engagement. All stakeholders receive a weekly Leadership Matters bulletin. Termly Bury Leaders Conference. Increasing awareness of shared responsibility for inclusion is evident through engagement to date. This is helping to strengthen inclusice practice across the local area.	Not all education settings are represented consistently, in particular Alternative Providers to effectively take part in partnership work on inclusion The LA does not have a fully realised inclusive ambition to inform teaching/learning and cultural change. Local offer migration is underway but all schools need to contribute to its development. There is a need for more targeted enagement and support for non-maintained Early Years settings and providers to ensure consistency of practice and wider participation across the sector.	Establish Senior Leader Networks across Early Years settings, Primary settings and Secondary Pastoral and Secondary Curriculum. Improve understanding of the Education and Inclusion Strategy outcomes, in accordance with the Delivery Plan. This will require engagement with leadership at all operational and strategic levels to better support communication channels and feedback. Further develop networks/engagement to include AP representation and Post-16 leaders and to ensure effective partnership work on Inclusion. Co-produce local area partnership Inclusion Charter. Further develop strong partnership-working to better support communication and feedback that informs strategic delivery. This will support improved outcomes as measured against Delivery Plan KPI milestones. Local offer migration needs to be completed and strengthened further and ensure involvement from education leaders
Health Services: No established communication or referral pathways between education and health. Health partners are not providing evidence of awareness of SEND responsibilities or participating in planning. There is very little data sharing to inform commissioning.	**Health Services:** Education providers are aware of relevant NHS services and how to signpost or refer to them, with at least limited contact between education and health partners. Understanding of ICB SEND roles is developing, setting the stage for stronger partnerships and health is seeking to understand more about needs from education.	**Health Services:** Positive working relationships with NHS and hospital AP are developing, and strategic engagement is increasing. Health providers are aware of designated ICB leads and the executive SEND lead, but board engagement is still limited. Inspections highlight need for further improvement.	**Health Services:** Partnerships with health are strong and joint commissioning is routine, with clear feedback and resource sharing. Lines of communication with ICB and NHS including health providers are well-established. Inspection reports confirm effective collaboration.	**2 – DEVELOPING**	26/05/2026	Positive feedback in recent CQC & Ofsted inspections in relation to partnership working and the contribution of NHS providers to the local area's SEND transformation programme, and the steps that have been taken to improve services. ICB leadership is evident through a programme of transformation, including Mental Health in School (MHIS), ND Pathway reform, speech and language therapy balance scorecard implementation and also recognition for new service development such as dedicated SEND HV capacity. Early Years settings have strong working relationships with the SEND Health Visiting Team who are increasingly sharing concerns with settings before making referrals allowing settings to discuss the same concerns are seen within the school environment or from a learning perspective. This joined-up appraoch is helping to develop a better understanding of children's needs across services.	Joint commissiong is under-developed and this is a priority for the partnership. There is a recgonised need for more engagement with schools and clarity of communication about pathways and access to support (including referral processes and expected timelines), building on some good practice of MHIS and social and emotional health such as MyHappyMind.	Refresh of Joint Commissioning Strategy and Group. Improved communication and engagement with schools around health pathways.
Social Care/Local Authority: No evidence of strategic collaboration with education or health. Providers do not access local care offers. Early intervention models are not in place. There is very little data sharing to inform commissioning.	**Social Care / Local Authority:** Providers access the local care offer and engage with care teams for individual CYP needs. Strategic collaboration is starting, and the LA is initiating work on early intervention models, such as Families First reforms.	**Social Care / Local Authority:** Positive working relationships with LA care teams and managers are emerging. Designated social care officer helps embed care priorities. The LA is embedding Family Help and child protection reforms, and strategic coordination is improving.	**Social Care / Local Authority:** Strong, embedded relationships between education, health and care ensure joint planning and resource sharing. FFP and multi-agency reforms are routine. Children and families receive early support, and joint commissioning is mature.	**2 – DEVELOPING**	26/05/2026	A DSCO in post and is strengthening practice within Children's Social Care and also links between Social Care and the local area SEND partnership. Ofsted have recognised that the quality of social advice is typically strong (although not not always transfer into EHC plans when it should). There are more effective transition pathways into adulthood, with transition planning beginning earlier. Our FFPP implementation is underway and we are considering opportunties to strengthen our response to children with SEND as part of the implementation. The governance of the two key reform agendas - FFP & SEND - are linked through strategic governance structures with clear links to the Bury Safeguarding Children Partnership. Parents report that there is stronger engagement with social care. Educational settings report that they are able to access training opportunities, with forums available for DSLs and DDSLs to provide useful guidance and opportunities for discussion around safeguarding and supporting vulnerable families.	We have positive examples of good relationships between family help and education settings and we will continue to build on these. We know there is more to do to build a shared understanding about the support available including the different roles within the children's social care service, and including our Family Safeguarding model of practice and our implementation of the Families First Partnership.	Ensure professionals understand social care pathways and thresholds for assessments to support families. Strengthen communications across the partnership with a clear communications strategy.

Pillar 6: Skilled and organised workforce across local authority, education settings, health and social care

0 - NOT YET EMERGING	1 - EMERGING	2 - DEVELOPING	3 - MATURING	ASSESSMENT	DATE COMPLETED	STRENGTHS/SUCCESSES/IN PROGRESS	GAPS/ISSUES TO ADDRESS	PRIORITIES & SUPPORT NEEDS
No structured training or development plan for SEND across education, health, and social care. Many staff lack confidence and skills to effectively deliver support for CYP with SEND. No recognition of the need for coordinated training to share best practice.	The LA workforce is beginning to access training and support as a means to building capacity and consistency into supervision, decision-making, casework and managing difficult conversations. Some education settings are beginning to build awareness and skills to support children with SEND, with early-stage training and resource development underway. There is initial recognition of the need for coordinated training across health, education, and social care. Early efforts are being made to identify best practices and include lived experiences.	The LA workforce accesses structured training and support. Supervision practices are being strengthened, leading to improved consistency in decision-making and casework quality. Education settings are developing the skills and confidence to meet the needs of children with SEND, supported by more coordinated training and guidance. Training and development across the SEND system is becoming more proactive and collaborative, with increasing integration of best practice and lived experience into professional learning.	The LA workforce is well-trained, regularly updated, and appropriately supported, managed and supervised. Wider workforce across education settings is skilled in meeting the needs of children with SEND. There is pro-active shaping of training and development of all practitioners in the local SEND system, including health and social care, to ensure there is a broad understanding of best practice, incorporating lived experiences into practitioners' professional development.	**2 – DEVELOPING**	26/05/2026	Workforce Strategy has been developed which will support consistency across the partnership. Children & Young People have produced a School Survival kit to incorporate lived experience into schools staff training. Community of Practices have established a 'team around the school' approach and incorporates a CPD offer, which is aligned to our strategic priorities and local area challenges. SENCo networks are re-established and health input is being embedded such as to ensure a robust knowledge of therapy pathways/services . The LA workforce embeds regular supervision activity and annual performance reviews. Schools are continuing to grow in confidence when supporting children with a wide range of additional SEND needs, and there has been a noticeable improvement in practitioners' knowledge, understanding and inclusive practice. The Communities of Practice, Solution Circles and wider SEND support offer are helping schools to feel more confident and better equipped to meeting children's needs withing their settings.	Capacity is required to complete the Workforce Strategy Delivery Plan. Impact of health and social care pathways are not yet fully understood at a local level or embedded into universal and targeted multi-agency support. Need for strengthened multi-agency support and training across all educational settings to upskill and enable the wider workforce across settings to better identify and meet the needs of children with SEND. Some gaps in the support available for the non-maintained Early Years sector.	Finalise the Workforce Delivery Plan (WDP). Strengthen tiered support offer to all educational settings, incorporating education, health and social care which is well understood and accessible by leaders at all levels. Determine qualitative and quantitative data measures to understand the effectiveness of the partnership and system effectiveness. Strengthen inclusive practice across Early Years settings by improving consistency in access to training, specialist advice and targeted support for Early Years providers.

Pillar 7: Targeted and judicious use of resources including place planning, sufficiency and use of capital

]#	1 - EMERGING	2 - DEVELOPING	3 - MATURING	ASSESSMENT	DATE COMPLETED	STRENGTHS/SUCCESSES/IN PROGRESS	GAPS/ISSUES TO ADDRESS	PRIORITIES & SUPPORT NEEDS
No clear strategy for sufficiency or place planning and capital projects lack alignment with needs. Review and evaluation processes are absent or extremely limited and stakeholder input is not systematically gathered. The Local SEND Reform Plan is incomplete or missing and there are no clear mitigating actions to ensure efficient use of resources or value for money.	Review and evaluation processes are being used periodically, and stakeholder input informs some service adjustments. Processes for regular monitoring and service improvement are taking shape. The Local SEND Reform Plan provides limited information on mitigating actions to improve the efficient use of resources and secure value for money.	Regular reviews are taking place, drawing on broader stakeholder input including schools, families, and young people. Performance is benchmarked against other areas and findings inform targeted improvement plans. The Local SEND Reform Plan provides evidence of efficient use of resources and value for money.	Comprehensive, ongoing monitoring using multiple sources of data and qualitative insights drives continuous improvement. Deep dives into specific issues lead to strategic changes, and effective benchmarking ensures consistent progress toward the best outcomes. There is clear evidence of efficient use of resources and a focus on value for money.	**2 – DEVELOPING**	26/05/2026	Through the Project Safety Valve (PSV) programme there has been focus on strategic priorities and value for money. There is a clear understanding of performance data A Sufficiency dashboard has been completed and a Sufficiency Strategy drafted, current capital projects are aligned with identified needs The current local area partnership priority impact plan includes mitigating plans to ensure early identification of need and support, to reduce escalation and where possible statutory support	Need a strong early years landscape to manage demand. Performance data analysis needs to include projections on future demand more consistently.	Revisit the JSNA in relation to SEND, to support discussions and decisions around pooled budgets/cost sharing agreements. Finalise SEND Sufficiency Strategy and ensure this effectively communicated, to ensure transparency in decision making. Ensure data supports robust analysis and is used to inform strategic review and forward planning. Continued development is needed to ensure there are sufficient specialist and targeted Early Years places available, alongside consistent access to support across all settings.

EXECUTIVE SUMMARY: LOCAL SYSTEM "CHANGE STORY"

LOCAL AREA	OUR CONTEXT	WHERE ARE WE NOW?	WHERE HAVE WE COME FROM?	WHERE DO WE WANT TO GO NEXT?	WHAT WILL IT TAKE TO GET THERE?
Which area are you completing this narrative for?	*What are the most distinctive features of our local area that shape how we respond to the needs of children and young people?* *What unique challenges or opportunities do we have here that will affect our journey toward a more inclusive and sustainable education system?*	*What are the defining strengths and challenges of our current situation? Consider available data e.g.* *No. of children awaiting EHCP assessment* *Provision mix – No. and % of children by need by setting type (ISS, maintained special, mainstream)* *Spend on Independent Special School provision [per place, overall]* *Supply of Education Psychologists working with CYP* *Supply of SALTs working with CYP* *In what ways are we inclusive? Where do we fall short?* *How do different stakeholders currently experience our system?*	*What big changes or events have shaped us?* *Have there been turning points, either positive or negative?*	*What would true inclusion and sustainability look like here?* *How will stakeholders know things are better?* *Please ground your aspiration in measurable data e.g.* *By the end of FY27-28 we aim to:* *Improve attendance of pupils in all maintained schools (mainstream and special) with SEN from X to Y* *Reduce spend on ISS places from X to Y* *Increase no. of children supported by Education Psychologists in maintained provision from X to Y* *Improve overall effectiveness of provision from X to Y with particular attention to a, b and c [see recent Ofsted inspection report]*	*What are our priority shifts/changes?* *What help do we need—local and national?* *What is our theory of change/reform strategy?* *What will success look like in 1 year, 3 years, 5 years?*

Meeting: Locality Board			
Meeting Date	01 June 2026	Action	Receive
Item No.	9	Confidential	No
Title	Chief Officer's 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

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 priorities	
Scale our work on Population Health Management - Improve population health and reduce health inequality of those in the most disadvantaged areas	☒
Drive prevention, reducing prevalence and proactive care – supporting Demand Reduction through primary intervention, secondary preventions and tertiary prevention	☒
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	☒
Optimise Care in institutional settings and prioritising the key characteristics of reform.	☒

Implications						
Are the risks already included on the Locality Risk Register?	Yes	☒	No	☐	N/A	☐

Implications						
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 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. Programme Delivery

- The majority of the new ICB Place Based Partnership Team are now in post. We are working to define roles and responsibilities across the totality of the resource we have in Place.

- The new neighbourhood planning guidance was released on the 18th March. We have agreed timescales for the development of the plan (see attached) to strengthen and deepen the work we are already doing. This is covered within a separate agenda item. Some of this is still reliant on GM programmes outlining expectations of Place.

- We are in the process of reviewing our delivery arrangements for our Integrated Neighbourhood Teams. Given the CLM changes at the NCA and statutory requirements of the council, we are needing to relook at the single line management arrangements that are in Place. However the principle of neighbourhood approach will remain at the heart of everything we do.

- The new BECCOR asks are now clear from Greater Manchester. Our neighbourhood leads are currently working on our local delivery plans with our practices.

- An engagement event was held at NMGH in March with more than 50 people in attendance to consider how we can strengthen relationships across our programmes of care, with a particular focus on urgent care. We are starting to strengthen relationships across all programmes of work with MFT . It is proposed that MFT are invited as members to the IDC Board given the importance of this relationship to deliver the neighbourhood framework ambitions.

- An outline of the 4LP programme of work with the NCA has now been agreed. We are in the process of scoping the content of these programmes. The outline areas are included in the planning slide deck.

- We ended the year of 25/26 in a strong position with regard to urgent care.

- We are making good progress with the roll out of advice and guidance with utilisation being up by 23%. We are now focusing on inter-practice variation.

- The neighbourhood video is now finalised which outlines our vision for neighbourhood working for the health and care aspect of neighbourhoods

- We have been invited to an event in Cheshire and Mersey on the 5th June to share the work we have done in the locality on frailty. Our progress in this area is covered in a separate agenda item.

- We have continued to work with VCSE partners to explore opportunities for greater collaboration. The outputs from the development session in April 2026 between the IDC Board and the VCSE leadership team are shared with these papers.

- The new CLM model is now in place at the NCA. Representatives have been identified from the Corporate Team and the UEC and Community Group to support Place based arrangements.

- Working with GP Board members to reposition the Board role in the context of ICB governance changes and the neighbourhood plan requirements.

3. IDC Programme Highlights:

3.1 CVD / Diabetes

- 2x community events have been co-designed and delivered in partnership with local community organisations which were supported by the VCFA, Live Well Service, GP Fed, NCA Community Diabetes Team & the Diabetic Eye Screening Programme. The events focussed on diabetes prevention and awareness messaging in the South-Asian community and were attended by over 200 people. The Live Well Service undertook opportunistic BP/ BMI/lifestyle advice and there is a de-brief session planned and learning will be used to shape future engagement and to identify "health champions" to ensure longevity of the work.

- A Hybrid Closed Loop (HCL) engagement event was successfully delivered in Bury, with collaborative working and engagement across system partners. This first-of-its-kind event in Bury aimed to raise awareness and improve understanding of the technology, on a larger scale than had previously been delivered, which is available to patients transitioning to HCL systems. The event was well supported by GP practices across Bury, who invited their Type 1 diabetes patients to attend, helping to increase engagement

3.2 Cancer

- GM Cancer published a patient story about a Bury patient who had a life-saving diagnosis of early-stage lung cancer through the lung cancer screening programme –

https://gmcancer.org.uk/gmcancernews/woman-urges-public-to-attend-nhs-lung-cancer-screening-after-shock-diagnosis/

3.3 LD and Autism

- Engagement/consultation events held with Bury People First, our coproduction network and Care Partners for supported living proposals, enabling their views to influence the design and raise issues
- Persona launch of mini 'social enterprise', at Elton centre, enabling people to learn new skills
- NHS teams are making sure people with learning disabilities have screening services and checks for their health – we are currently performing well in this area

3.4 Community and Elective

- We are currently mobilising a new provider About Health for Dermatology
- Implementation of a GM wide A&G initiative provided through Consult Connect (CC) is now complete with all GP practices having access to A&G. This ties into improvement plans for BeCCoR for primary care . Plans from the GM team to engage individual practices in their CC

usage is expected from April. 12-month contract extension has been confirmed for Consultant Connect. The A&G £20 payment is now incorporated in the GP core contracts from 01/04/2026.

- A&G utilisation in Bury is strong and shows sustained growth (up 23%) with increasing integration into routine primary care, delivering clear clinical impact, evidenced by 44% referral avoidance for Consultant Connect. For eRS, Trust responsiveness is down to 4.9 days. Although adopted as daily practice, to maximise impact, focus is needed on improving outcome recording (currently 30% unrecorded) and addressing variation in uptake across practices and PCNs by supporting lower-use areas.
- The Anticoagulation Services Service review has now been completed we have now re-negotiated the services contract with the provider (placed on an IAP contract reduction in tariff resulting in a £120k saving).
- GM MSK Model of Care review: Bury place and Bury NCA colleagues are part of a GM wider working group to develop a single GM MSK pathway. The first workshop meeting was on the 28/04 to start to scope what the pathway should look like from start to finish.
- The NCA Patient Community Spinal Assessment Day: was a great success. Outcomes from the day will be shared in a Bury report. First initial feedback suggests a great patient experience in accessing multiple services/offers in one place, prior to being seen by their clinician.
- Mandatory Elective SPOA is being rolled out, with NCA Transformation Team agreeing to test in Cardiology specialty. NHS England Technical guidance has been released, with all Trusts working up plans using the guidance, with support from GM Elective team on their implementation. Bury's RBMS team is currently working towards amalgamating with the Manchester team creating one GM team.

3.5 Palliative and End of Life

- Ongoing work is taking place with GP practices in Whitefield, Prestwich and North Neighbourhoods to enable implementation of EPaCCS in line with Locally Commissioned Services framework contract .The LCS funding for 2025/26 have now concluded, and we are now looking at how we sustain and spread the model.
- The number of EPaCCs already created in the 3-month period of 2026, has almost superseded the number of total EPaCCs created in 2025. Total 2025 = 112. 2026 to March = 102
- Discussions are taking place to review the SOI's (Statement of Intent) feasibility to determine its future alignment with EPaCCs
- EPaCCs awareness and training delivered at the Frailty Training Day held on the 29-04-26 at FGH Education Centre to Secondary Care, Community, and wider system colleagues.

3.6 Mental Health

- The Bury Mental Health Strategy completed which is going to Bury MH Programme Board in May.
- Directory of Adult MH Services for GPs completed and circulated.
- ASC Mental Health Huddles have recommenced with focus on residential settings.
- Section 117 work progressing for Bury with LA/ICB/PCFT colleagues undertaking a data cleanse of all patients in receipt of section 117 aftercare.
- The Bury Neuro Development Hub [Neuro Hub] was fully mobilised in April providing two drop-in days per week with no referral required. Children and families can access a wide range of support and evidence-based interventions in response to needs relating to neurodevelopment.
- Pilot multi-agency triage of new referrals for CYP autism and ADHD assessments involving Education, Children's Social Care, Community Paediatrics, CAMHS and SEND Health Visiting Team commenced on 20th May following 3 multi-agency planning workshops.

3.6 Neighbourhood working

- Most practices in most Neighbourhoods met the targets associated with the Neighbourhood priorities in the LCS contract in relation to Frailty and COPD.
- Commencement of initial planning work to support the development of Neighbourhood health action plans to support the delivery of BeCCoR section 3 – prevention and population health.
- Completion of video on INTs: https://vimeo.com/1192181988?share=copy&fl=sv&fe=ci

3.7 Primary Care

GOAL 1IMPROVE HEALTH OUTCOMES (high-priority cohorts)

- Respiratory Diagnostic Hub 26/27 : Funding confirmation received, service commence date to be agreed
- Paediatric Phlebotomy : Funding confirmation received, service to commence 11th May
- BeCCoR Scheme 25/26
  - Year-end achievements have been calculated and shared with practices. A small number of indicator payments will not be made till June due to a data lag. Largely positive results with full details in Q4 paper going to GP Board May 26.
  - MO – AMS indicator, where achievement is based on national prescribing data, this is anticipated June 26. Improvements made across all three MO indicators.
- BeCCoR Scheme 26/27
  - All materials including launch recordings/dashboards are available through the GM Intelligence Hub
  - Internal discussions regarding amendments to local searches and dashboard have taken place
  - Discussions held with Neighbourhood leads to reiterate requirements and timelines for neighbourhood action plans
- **25/26 Unwarranted variation**
  - Q4 data has been analysed with results being included in the Q4 Contract paper

GOAL 2 IMPROVE ACCESS TO GENERAL PRACTICE

- Winter schemes 25/26 : end of service review completed to inform future commissioning intensions. Paper for May GP Board
- Community Services - Self-referrals: Proposed services to prioritise and then progress further
- Capacity and Access Improvement Plans 25/26 - all PCNs submitted self-declarations with Prestwich PCN subsequently chosen for the PPV exercise
- Patient Led Ordering
  - Whitefield practices went live 1st April
  - Knowsley & Rock preparation underway.
  - Engagement with Radcliffe neighbourhood planned in May.
  - Jinnah centre for outreach on access to NHS App and PLO with INT lead, digital facilitator & social prescribers.
  - Two further sessions planned in other neighbourhoods.
- PCN DES:
  - Horizon PCN Q4 assurance template received
  - ARRS 24/25 Bury PCN:
    - Q1-Q3 paid £752k in full, despite gaps in supporting documents
  - ARRS 25/26
    - HPW PCN Claims paid
  - ARRS 26/27

        - Work to be undertaken on GM footprint. Standardisation of validation process to be made
    - Enhanced Access
        - Data received up to February for Bury and March for HPW
        - Model changes for HPW supported by locality PCCC and GM PCCC

GOAL 5 IMPROVE PATIENT AND STAFF SATISFACTION

- GM Portal – Practice uptake continues to be pushed (at least one member per practice now signed up to portal)
- Workforce Strategy (including training and education)
    - Our local April Nurse forum covering Lower Limb Vascular Assessment was attended by our local general practice nurses and also district nurses

OTHER PROGRAMMES

Note local minor ailment scheme is now a GM scheme . There are no changes to patient & practice facing criteria/process, however this is now managed by the GM team. Similar work is planned for the palliative care medicines service.

3.8 Adult Social Care

- Waiting lists remain high and persistent, especially for annual reviews and Care Act assessments.
- There has been some improvement in median waiting times, but maximum waits have escalated due to cases re-entering queues.
- Benchmarking shows Bury remains high in review backlogs compared with GM peers.
- Data quality improvements (assessment vs review logic, EDI completion) are ongoing and essential for reliability.

4. Recommendations

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

Kath Wynne-Jones
Chief Officer – Bury Integrated Delivery Collaborative
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May 2026

Development of the Bury neighbourhood plan

Part of Greater Manchester
Integrated Care Partnership

Defining the programmes of work to deliver the neighbourhood framework

Locality strategy including:
- Live Well
- Public Service Leadership Teams

Neighbourhood Health Framework

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

Reform agenda 2: improve proactive care for people

Reform agenda 3: deliver better alternatives to hospital care

Goal 1: Improve health outcomes

Goal 2: Improve access to Primary Care

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

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

Goal 4: improve patient and staff satisfaction with NHS services

Locality Programmes of Care not requiring multi- provider input : Primary Care / ASC /Major conditions

Locality Programmes of Care requiring multi-provider input: neighbourhood delivery / UEC and out of hospital expansion (including H@H and EOL) / Estates/ Finance . There is opportunity for consistency / standards across Localities here

NCA / MFT across multiple Localities: Community services waiting times, OP transformation, cancer, red tape and digital,

Products

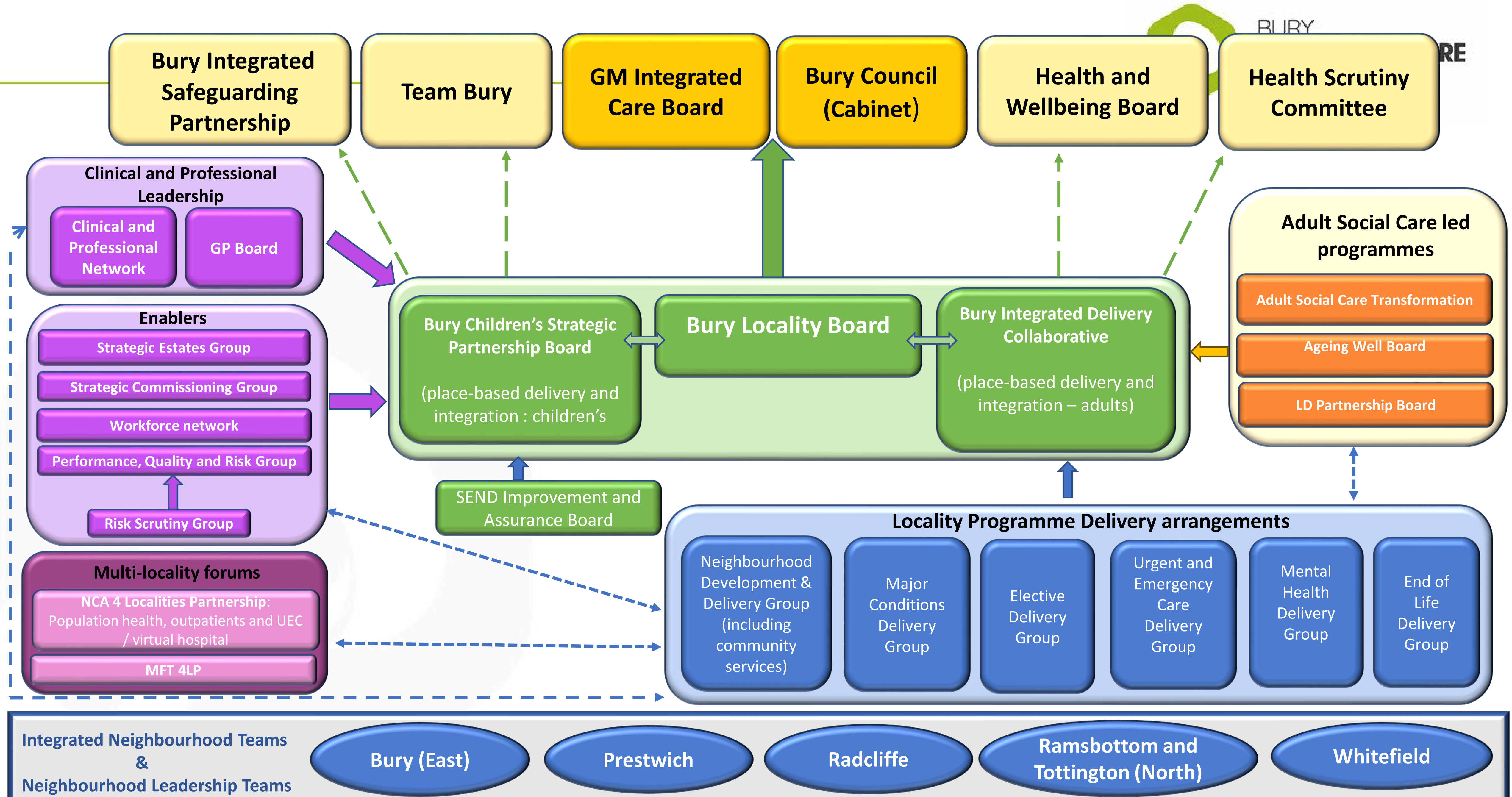
- BCF
- Narrative document based on Initial GM submission
- Confirm ownership of goals and reform objectives by Board: Programme Boards
- Excel template of priorities
- BECORR neighbourhood plans
- Neighbourhood slide deck as the refreshed Locality Plan
- IDC Board in August and LB in September

List of definitional questions produced to be asked to ICB and query regarding baseline data: via DPL'

Review of data packs to see if they give us any new insights

.

Bury Integrated Care Partnership – Governance arrangements - April 2026



Governance for delivery through IDC Board

Goals	Key tasks	Lead	Governance	Date
Goal 1: Improve health outcomes	1. Baseline data for priority cohorts , clinical outcomes, processes of care and children's OP activity and WT 2. Identify interventions and delivery plan for priority areas now to March 2029	Ian Trafford	Major conditions Board ,Neighbourhood Delivery Group, Elective Delivery and GP Board	July
Goal 2: Improve access to General Practice (Primary Care)	1. Baseline data 2. Agree improvement plan	Zoe Alderson	GP Board	Q1
Goal 3: Improve experiences of planned care and cancer care, and support delivery of the referral to treatment (RTT) standard	1. Understand baseline data 2. Agree diversion rate strategies for 25% reduction by March 27 3. Agree SPOA model approach 4. Agree plan for better coordination of care for priority cohorts 5. Agree trajectory and plan for reducing FU apps by 10% by March 2027 6. Confirm requirements of cancer plan for 27	Karen Richardson/ Damien Aston	Elective Delivery Group and GP Board	Q1
Goal 4: better urgent and emergency care (UEC) performance in line with agreed standards	1. Understand baseline data 2. Agree avoidance strategies for cohorts to meet 2929 3. Agree investment plan to support bed reductio and increasing community capacity 4. Agree plan for better coordination of discharge coordination and reducing delays	David Latham/Clare Hunter	UEC Board	July
Goal 5:improve patient and staff satisfaction with NHS services.	1. Confirm definition of 95% of people with complex needs will have an agreed care plan 2. Agree improvement plan 3. Aim to improve staff experience	TBC once definition clearer	TBC	Q1

Priorities

- Reviewing the scope of our programmes for 2026/2027 thinking towards 2029 ambitions
  - UEC (locality and providers)
  - Neighbourhood delivery (locality and providers)
  - Mental Health (locality and providers)
  - Elective and Community (locality only)
  - Major conditions (locality only)
  - End of Life programme board (locality and providers)
  - GP Board (locality and providers)
- Reviewing the approach to neighbourhood working : role changes and aligning ambitions of MDT processes eg ACM/ frailty/ MH MDT's
- Connections between adults and children's: workshop in June
- Agreement of 4LP programme of work with NCA: draft proposed
- Agreement of 4LP programme of work with MFT
- Connection across our Bury team

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NCA priority Areas 2026/27 - Draft

<table>
<tr><th></th><th>Focus in 2026/27</th><th>Neighbourhood Health Framework Goals</th></tr>
<tr><td>Neighbourhood Led Community Services</td><td>Community services transformation programme
• Develop community services capacity & service offer
Frailty & End of Life Care
• Support development of neighbourhood health approaches to frailty and EoL (including NNHIP outputs & learning)
• NCA Frailty Strategy implementation – connected to neighbourhood development</td><td>• Reduce non-elective admissions and bed days of one day or over by 10% in high priority cohorts
• Reduction of community waits</td></tr>
<tr><td>A New Outpatients Model</td><td>Outpatients Transformation Programme
• Single Point of Access (inc A & G offer)
• Reducing Follow Ups
• Identify 3 specialities for a more radical transformation focus</td><td>• A diversion rate of at least 25% by March 2027 for at least 10 high volume specialties
• An overall reduction in secondary care follow-up appointments by at least 10% by March 2027.</td></tr>
<tr><td>Hospital at Home</td><td>Hospital At Home
• Review capacity and understand variation across localities
• Identify scope for new pathways</td><td rowspan="2">• An overall reduction in type 1 ED attendances for high priority cohorts,
• An improvement in average length of discharge delay for all acute adult patients</td></tr>
<tr><td>Integrated Urgent and Emergency Care</td><td>Safer Sooner Collaborative
Eliminating Corridor Care</td></tr>
<tr><td>Prevention and Population Health</td><td>Population Health and Health Inequalities Programme
• Identify a small number of delivery priorities from NCA PHHI objectives for FLP focus</td><td>• improvement of at least 10% in evidence-based clinical outcomes, for CVD, diabetes, COPD</td></tr>
</table>

Minimum requirements 26/27: Assessing our progress

	Bury Status	Responsible
Agree an initial plan to reduce non-elective admissions and bed days by increasing the capacity of urgent, rehabilitation and reablement services at neighbourhood level, based on patient risk register analysis:	In progress as part of BCF plan. Need to do more work on cohort interventions	Working group to be formed across UEC, NDDG, EOL and MH: KWJ
Agree plans to establish INTs focused on high priority cohorts, including how devolving care budgets could work in their area	To be undertaken	NDDG: IT
Agree neighbourhood footprints around natural communities for the future development of INTs	Complete	Complete
Start to plan for a new neighbourhood approach for elective pathways with detail on how they can contribute to meeting the RTT standard and how they would use a devolved commissioning budget for outpatients for their population	Discuss with NCA and MFT	Elective Group : KR/DA FU meeting with MFT NCA plan in development
Agree a plan for tackling unwarranted variation and improving access to general practice, ensuring core hours requirements as defined in the national GMS contract are met, including the newly introduced urgent access requirements	In progress – GP Board	GP Board: ZA

Minimum requirements 26/27: Assessing our progress

	Bury Status	Responsible
Confirm plans to meet 18-week community waits and eliminate 52-week waits.	Discuss with NCA and MFT	Elective Group : KR/DA FU meeting with MFT NCA plan in development
Confirm how ICBs and local authorities intend to use pooled funding under the Better Care Fund (BCF) in line with BCF guidance (noting that any funding decisions must also be consistent with the national conditions for the fund, including the required increases in ICBs' minimum contributions to adult social care over the next 3 years)	In progress –BCF complete	To confirm to local actions required here: HD
Continue to improve the primary and secondary care interface in line with the red tape challenge	Discuss with NCA, MFT and PCFT	Elective Group : Confirm approach with MFT Agreeing approach with NCA
Confirm organisational ownership of planned deliverables	To be confirmed with IDC Board members - also to consider new archetypes	To be considered at June IDC workshop
Confirm plans for having the appropriate data-sharing arrangements in place to do robust patient identification and evaluation	In place – need to check covers all providers	NDDG: Confirm arrangements in place for required data sharing

Risks

- Lack of shared ambition of the neighbourhood model and left shift approach by all partners
- Capacity to implement the model, especially in the midst of organisational change in a number of key partner organisations
- Lack of resource to invest in preventative services , and lack of financial strategies to support
- Limitations of estates and digital capability to support neighbourhood development: OP focus is key
- Communication and engagement capacity and capability

Appendix: national goals and reform ambitions

Part of Greater Manchester
Integrated Care Partnership

Goal 1: Improve health outcomes

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

Goal 1: Improve health outcomes

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

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

Comparing 2025 to 2026 baseline we will:

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

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

BURY
INTEGRATED CARE
PARTNERSHIP

Compared with 2025 to 2026 baseline we will:

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

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

BURY
INTEGRATED CARE
PARTNERSHIP

Compared with 2025 to 2026 baseline we will:

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

Goal 5:improve patient and staff satisfaction with NHS services

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

In the interim,

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

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

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

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

BURY
INTEGRATED CARE
PARTNERSHIP

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

Reform agenda 2: improve proactive care for people

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

Reform agenda 2: improve proactive care for people

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

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

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

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

Reform agenda 2: improve proactive care for people

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

Reform agenda 3: deliver better alternatives to hospital care

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

Meeting:			
Meeting Date	01 June 2026	Action	Receive
Item No.	10	Confidential	No
Title	Frailty and Falls Programme Update		
Presented By	Clare Hunter/Katy Alcock		
Author	Clare Hunter/Katy Alcock		
Clinical Lead	-		

Executive Summary

Before 2018, Bury lacked the integrated approach seen in other Greater Manchester boroughs, with health and social care often working separately. This began to change in 2019 with the support of the new Council Chief Executive and the creation of the Bury Local Care Organisation (LCO).

The LCO focused on establishing five neighbourhood teams across health, social care and the voluntary sector, and on strengthening intermediate tier services to better support people in crisis and enable safe discharge home. Prior to this, Bury had no neighbourhood teams, no clinical rapid response service and a fragmented set of intermediate services delivered by multiple providers. Investment through the Greater Manchester Transformation Fund enabled us to build these teams, embed clinical support and bring services under unified leadership (single line management). These foundations have since underpinned transformation across the Borough.

Recommendations

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 priorities	
Scale our work on Population Health Management - Improve population health and reduce health inequality of those in the most disadvantaged areas	☐
Drive prevention, reducing prevalence and proactive care – supporting Demand Reduction through primary intervention, secondary preventions and tertiary prevention	☐

Links to Locality Plan priorities	
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	☐
Optimise Care in institutional settings and prioritising the key characteristics of reform.	☐

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		

Frailty and Falls Programme Update

Part of Greater Manchester
Integrated Care Partnership

Presentation by:

Clare Hunter – Project Manager, Bury IDC

Katy Alock - Deputy Director of Nursing and AHPs, Community

-

Introduction

Before 2018, Bury lacked the integrated approach seen in other Greater Manchester boroughs, with health and social care often working separately. This began to change in 2019 with the support of the new Council Chief Executive and the creation of the Bury Local Care Organisation (LCO).

The LCO focused on establishing five neighbourhood teams across health, social care and the voluntary sector, and on strengthening intermediate tier services to better support people in crisis and enable safe discharge home. Prior to this, Bury had no neighbourhood teams, no clinical rapid response service and a fragmented set of intermediate services delivered by multiple providers. Investment through the Greater Manchester Transformation Fund enabled us to build these teams, embed clinical support and bring services under unified leadership (single line management). These foundations have since underpinned transformation across the Borough.

Where We Are Now

Building on these foundations, we have continued to strengthen integration and redesign services to better support our older population. Our focus has been on promoting independence through self-care and community initiatives, identifying and preventing frailty and falls earlier, and working collectively as a system to ensure older people receive the right care in the right place, with their needs and wishes at the centre.

These building blocks have been critical in reducing demand at the front door of secondary care services and shifting care closer to home.

This has enabled….

CQC Rated Outstanding

📍 Choices for Living Well (Killelea)

🛏 36-bed Intermediate Care Rehabilitation Facility

CQC rating repeatedly highlighted Killelea as an exemplary model of integrated intermediate care CQC explicitly states that the service is:

"A shining example of how the integration of adult social care and NHS professionals, co-located and working as one, can deliver exceptional evidence-based care, support and rehabilitation."

Care Quality Commission (CQC)

Integrated working is delivering measurable excellence for residents through co-located multidisciplinary rehabilitation and recovery support.

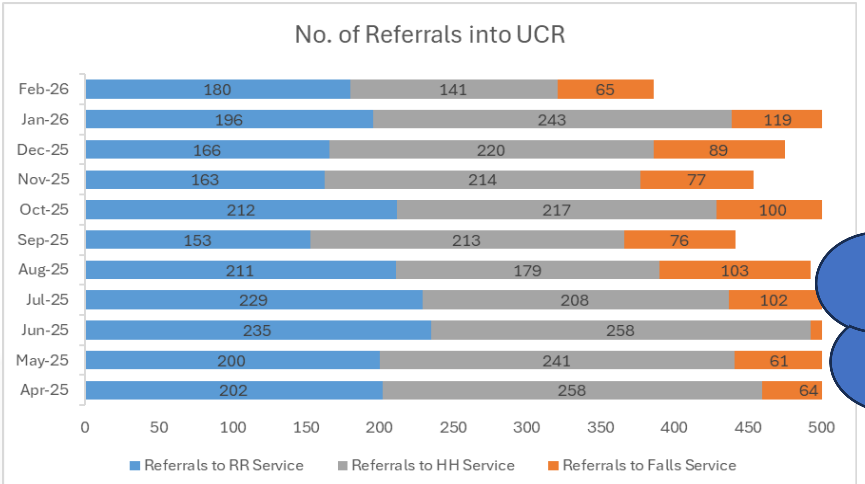
LA Peer Review

The Local Government Association (LGA) Adult Social Care Peer Review was undertaken to assess Bury's readiness for the new CQC assurance framework and to provide an independent evaluation of the quality, leadership and effectiveness of Adult Social Care services.

The review highlighted Bury's integrated approach as a major strength, stating that "integration with health at operational and strategic levels is enviable and exemplary." Peer reviewers recognised the positive impact of partnership working across health and social care, noting that staff could clearly demonstrate the difference integration has made to residents and to adult social care outcomes.

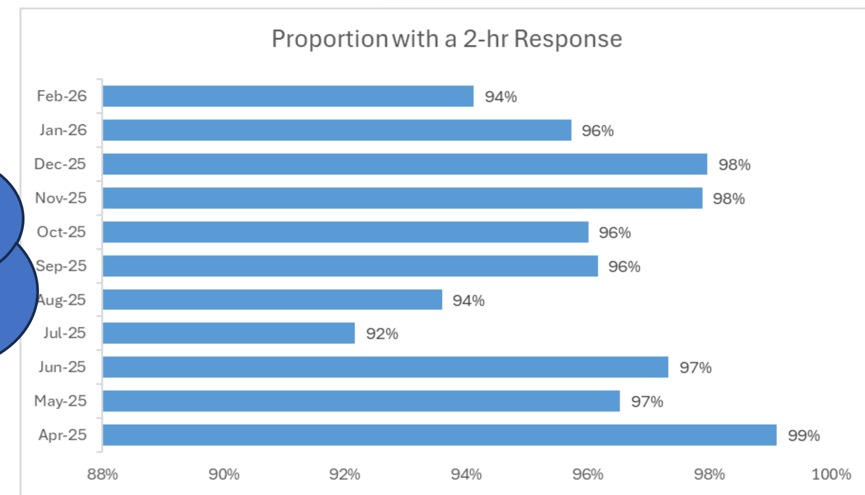
This represents one of the strongest endorsements of integrated working seen in any LGA peer review nationally.

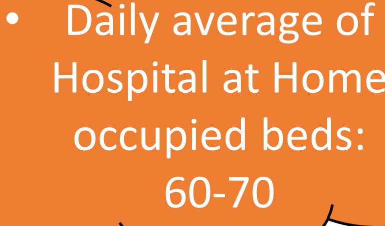
Achievements



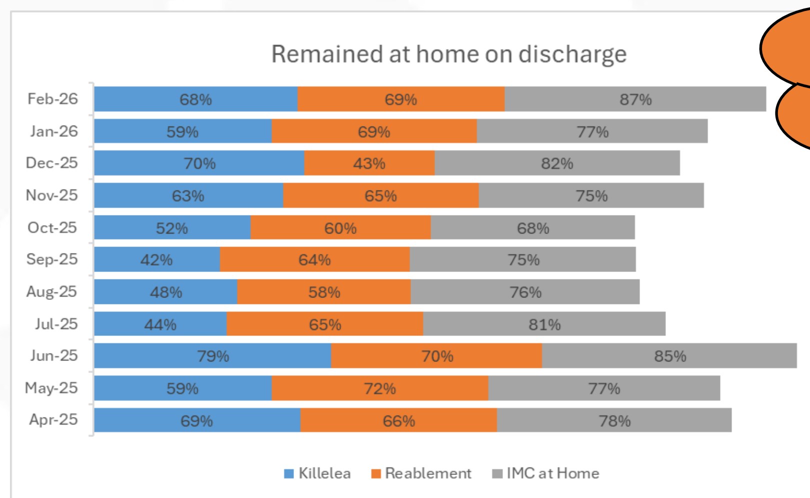
Number of IMC Beds: 49

80% of Hospital at Home patients are supported through the Frailty pathway

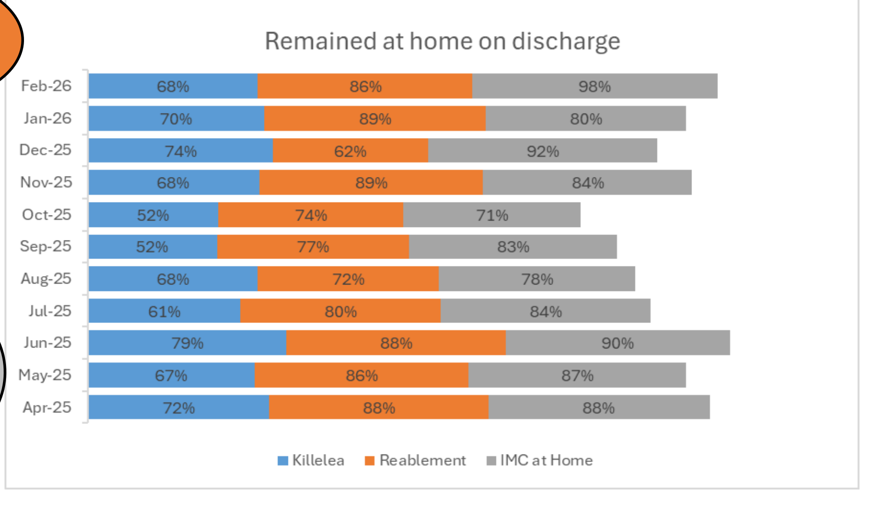




- Daily average of Hospital at Home occupied beds: 60-70



Average number of falls safely lifted in the community per month: 70



This includes those remaining at home with domiciliary care

Integrated Care: Our Success Story

To learn more about our Urgent Community Response and Neighbourhood Teams, please use the video links below:

Urgent Community Response Video Link: https://vimeo.com/1146529636?share=copy&fl=sv&fe=ci

Neighbourhood Team Video Link: https://vimeo.com/1192181988?share=copy&fl=sv&fe=ci

Bury Frailty Programme: Strategic Overview

The Bury Frailty Programme has been aligned to the Neighbourhood Health Framework, supporting a coordinated system-wide approach to improving outcomes for people living with frailty across Bury.

In summary, the strategic priorities established to guide delivery and transformation are:

- Prevention & Early Intervention
- Care Closer to Home
- Integrated Frailty Care
- Personalised & Planned Care
- Workforce & System Capability

This work is aligned with the:

✓ **NHS England three shifts:**
  - Move Care from hospital to community
  - Better use of technology
  - Move from reactive treatment to proactive prevention

✓ **GM Frailty and Healthy Ageing Draft Improvement Plan 2026-29** (This encompasses national ambitions and local priorities for Live Well in Later Life)

✓ **Bury Let's Do It Strategy 2030** (Promoting healthy communities, enabling independence, focus on prevention and early intervention and emphasising a strengths-based approach)

✓ **NCA Frailty Strategy 2025-2030**

Over the past year, partners across the system have worked collaboratively to strengthen community-based frailty support, improve integrated working across neighbourhoods and care settings, expand alternatives to hospital attendance, and enhance personalised care planning for residents living with frailty.

Frailty Aligned to the Neighbourhood Health Framework

Reform Agenda 1:
Improve Services for people who need routine healthcare, so neighbourhood benefits everyone

The NHS will empower GPs to deliver better care to better manage the health of their population by incentivising proactive population health management. This will take place through risk stratification, long-term condition management, secondary prevention and better continuity of care, backed up by improved access to specialist opinion.

Reform Agenda 2:
Improve proactive care for people

NHSE will produce a best practice guide for NHS **Frailty pathways**. This will set out essential actions for ICBs and providers to improve the entire frailty

ICBs will prioritise reducing community service waits for people living with **frailty**, recognising that long delays can quickly worsen their health, independence and quality of life. By expanding capacity to meet rising demand and actively managing long waits

The NHS will reduce unnecessary hospital visits by strengthening GP specialist collaboration, helping people with **frailty** receive more care closer to home. By giving GPs greater control and expanding rapid specialist advice through single points of access across at least 10 specialties by 2026–27, frail patients can avoid avoidable travel and get timely support in their community.

Reform Agenda 3:
Deliver better alternatives to hospital care

The NHS will expand urgent community response services to better support people living with **frailty**, helping prevent avoidable attendances linked to frailty and falls. By increasing capacity and delivering care through new community integrated neighbourhood teams, more people will receive timely help at

Goal 1:
Improve Health Outcomes

Reduce none elective admissions and bed days of one day or over by 10% for people living with mild to severe frailty in care homes or housebound by March 2029

Goal 2:
Improve access to Primary Care

Goal 3:
Improve experiences of planned care and cancer care, and support delivery of RTT standard

Make sure there is better coordination of outpatient activity across multiple specialities for patients in high priority cohorts

Goal 4:
Better urgent and emergency care performance in line with agreed standards

Reduce category 3 and 4 ambulance conveyances in high priority cohorts in a care home, house bound and EOL by March 2029

Keep growth flat and work towards an overall reduction in non-elective admissions for high priority cohorts by March 2029. [Better coordination of re-active care for high priority cohorts - Those with mid-severe frailty in a care home, housebound one EOL, increasing urgent

Contribute to an increase in type 1 ED or A&E admitted and non admitted performance supporting overall 4-hour trajectories of 85%. Aiming for a trajectory of 82% by March 2027 and 85% by March 2029 [Better coordination of re-active care for high priority cohorts - Those with mid-severe frailty in a care home, housebound one EOL, increasing urgent care provision]

Contribute to an overall reduction in type 1 ED attendances for high priority cohorts. [Better coordination of re-active care for high priority cohorts - Those with mid-severe frailty in a care home, housebound one EOL, increasing urgent care provision]

Goal 5:
Improve patient and staff satisfaction with NHS services

By 2027, 95% of people with complex needs will have an agreed care plan

What We Have – Local Infrastructure

GM Falls Collaborative

GM Frailty Care Reference Group (Soon to be re-established)

Bury Locality Board

Bury IDC Board

Bury Aging Well Board

Bury Major Conditions Board

NCA Frailty Strategy Delivery Group

Bury Frailty Steering Group

Our Pathways

GP Surgery

Pharmacy

Ward 24

Ward 9 / SDEC

Hospital at Home

Rapid Response / Urgent Response

INT (Integrated Neighbourhood Team)

One person.
Many pathways.
Better decisions.
Better outcomes.

Reablement

Killelea IMC

Live Well

Social Prescribing

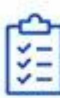
Age UK Home from Hospital

Volunteer & Community Centre

Right support, right time, better outcomes

The shift “Re-active verse Pro-active” - Frailty Care

PROACTIVE, COMMUNITY-FOCUSED CARE
Early thinking. More options.



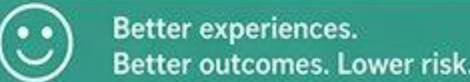
Earlier identification
Frailty recognised sooner through proactive case finding

Community-first response
UCR, Falls Response, Virtual Ward and home-based support

Rapid frailty assessment
Early CGA, therapy input and discharge planning

Earlier supported discharge
D2A and home-first planning begin from the start

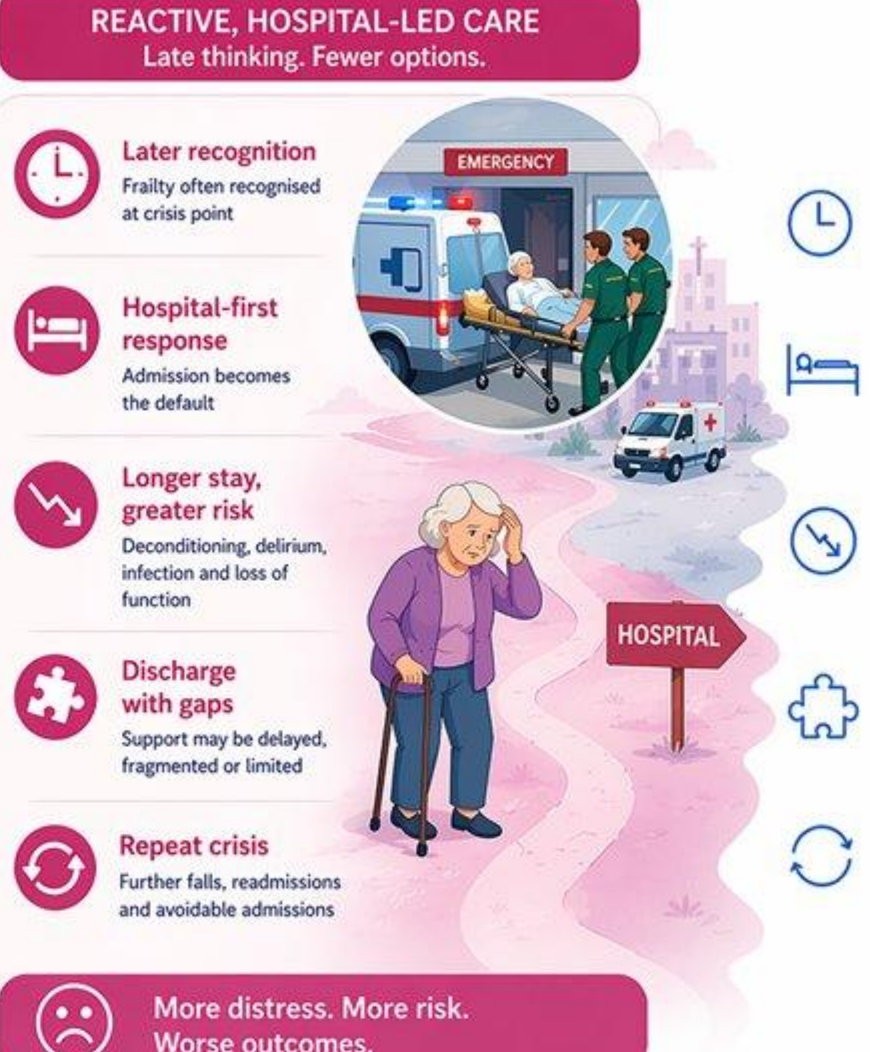
Prevention and MDT support
Neighbourhood teams help reduce repeat crisis and maintain independence



Better experiences.
Better outcomes. Lower risk.

Shift to the left

REACTIVE, HOSPITAL-LED CARE
Late thinking. Fewer options.



Later recognition
Frailty often recognised at crisis point

Hospital-first response
Admission becomes the default

Longer stay, greater risk
Deconditioning, delirium, infection and loss of function

Discharge with gaps
Support may be delayed, fragmented or limited

Repeat crisis
Further falls, readmissions and avoidable admissions

More distress. More risk.
Worse outcomes.

Frailty Key Achievements in Delivery 2025/26

Prevention & Early Intervention

Expanded frailty identification, falls prevention and proactive community support pathways.

Care Closer to Home

Strengthened UCR, Hospital at Home and Frailty SDEC to reduce avoidable admissions.

Integrated Frailty Care

Improved MDT collaboration, geriatrician in-reach and care home support.

Personalised & Planned Care

Advanced EPaCCS rollout and strengthened advance care planning.

Workforce & System Capability

Delivered frailty training and strengthened system-wide collaboration.

Neighbourhood Delivery Collaborative Workshop

Frailty Training Day

Falls Workshop

Community Cafe

Alignment to the NCA Frailty Strategy – Yr 1 achievements 2025/26

Some of the work locally undertaken to support this

- ✓ 91.07% CFS Completed at FGH between 01-04-25 – 31-03-26, nearing the 95% target
- ✓ Frailty Training and Awareness Day delivered at FGH Education Centre to NCA and Community staff with 53 colleagues in attendance.
- ✓ Promotion of Frailty Training via ESR through comms publications shared with Hospital and Community Staff to supplement the Frailty Training Day.
- ✓ The NCA Geriatricians are in-reaching into Care Homes alongside the GPs to support with Advanced Care Planning [ACPs], De-prescribing and Complex decision making.
- ✓ Trying to improve awareness and uptake of utilizing GMCR through GMCR hospital champions and the implementation of EPaCCs [Electronic Palliative Care Coordination Systems]
- ✓ Hospital at Home capacity averaging at 80% per month, specifically via the Frailty pathway.

NCA Frailty Strategy Delivery Group

NHS
Northern Care Alliance
NHS Foundation Trust

AIM

The NCA Frailty strategy 2025-2030 outlines 10 NCA frailty principles; in delivering these principles we align to the 3 NHS shifts described by the government and NHS England, these being:

- Move care from hospital to the community.
- Better use of technology.
- Move from reactive treatment to proactive prevention.

OBJECTIVES

- Patients 65+ consistently have a Clinical Frailty score established when admitted to hospital.
- 4AT delirium assessment tool for all those 65 years and above.
- Structured medication reviews and Comprehensive Geriatric Assessment (CGA) for all those with a CFS score of 6 or above.
- Reduced Falls for patients with delirium.
- Increased number of staff completing all frailty modules.
- Utilise digital recording systems.

ACTIVITIES TO DELIVER THE STRATEGY

Frailty Identification:

- Improve Clinical Frailty Score %.
- Improve recording of 4AT delirium assessment tool.
- Structured medication reviews and Comprehensive Geriatric Assessment (CGA) for all those with a CFS score of 6 or above.
- Reduced falls for patients with delirium.
- ToC for 65+ with multi-morbidity.
- Targeted improvements in access to frailty assessment and interventions in one group of people experiencing inequalities i.e. ethnicity, LGBTQ.
- NCA action plan against the National Audit of Dementia, aligning with Dementia Front Runner Programme.
- Reduce conveyances of severely frail care home residents, who are nearing end of life, to hospital through supporting care home staff and community teams in decision making and delivery of palliative care where appropriate.

Digital & Technology:

- Development of frailty information for recording and monitoring built into the trust Electronic Patient Record.
- Utilise regional clinical data systems effectively.
- GM Care Record.

Staff Training:

Increase numbers completing the following training:

- Health Education England tiered frailty training.
- GM Care Record in relation to modules for Frailty, Dementia and EPaCCS.
- Clinical Frailty Scale Digital Learning.
- Staff trained in Strengths Based approach.

Communications:

- Communicate Frailty Strategy and training offer via NCA com's channels to internal and external partners.
- Share and engage locality stakeholders in the Frailty Strategy implementation across the year at key forums.
- Refresh NCA Frailty Web Pages.

Localities:

- Dementia friendly wards at all localities.
- Embed Discharge Integration Frontrunner programme.
- Achieve 80% Hospital at Home capacity.

IMPROVEMENT MEASURES

- % beds occupied by stays over 21 days (target 9% - NCA June Average 23.5%).
- Percentage returning to usual residence 65+ (target 95% - NCA June Average 86.5%).
- Clinical frailty score (CFS) completion for all those 65 years and above (target 95% - NCA June Average 86.6%).
- Reduce falls for patients with delirium.
- Increase staff training numbers for all frailty modules.

CONTACT DETAILS

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Programme Director
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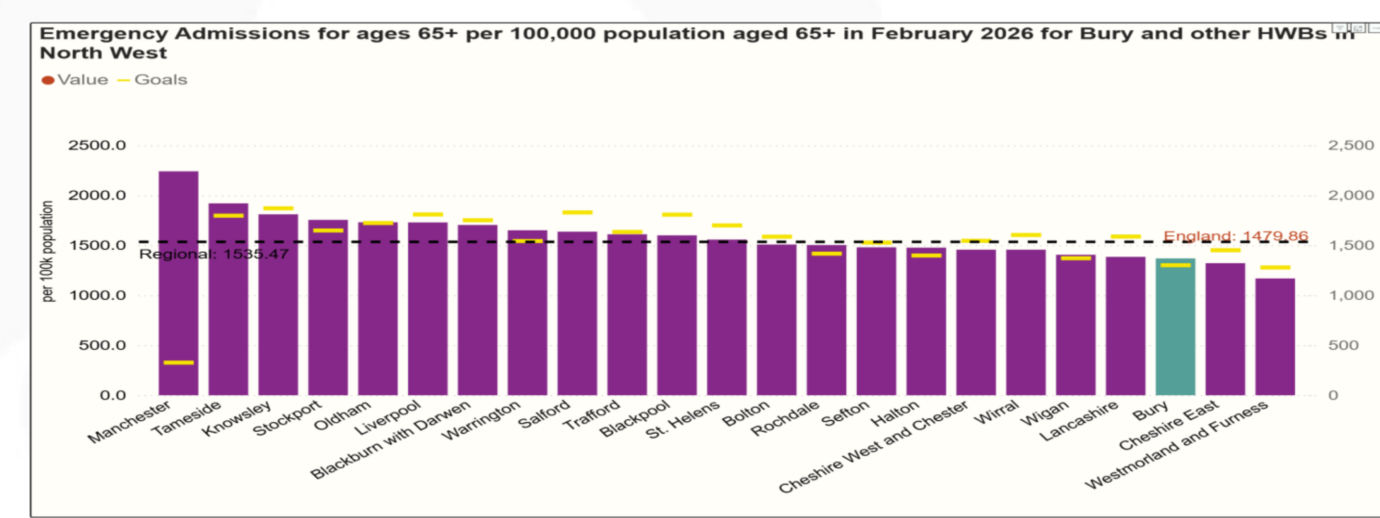
CARE APPRECIATE INSPIRE

PLAN ON A PAGE

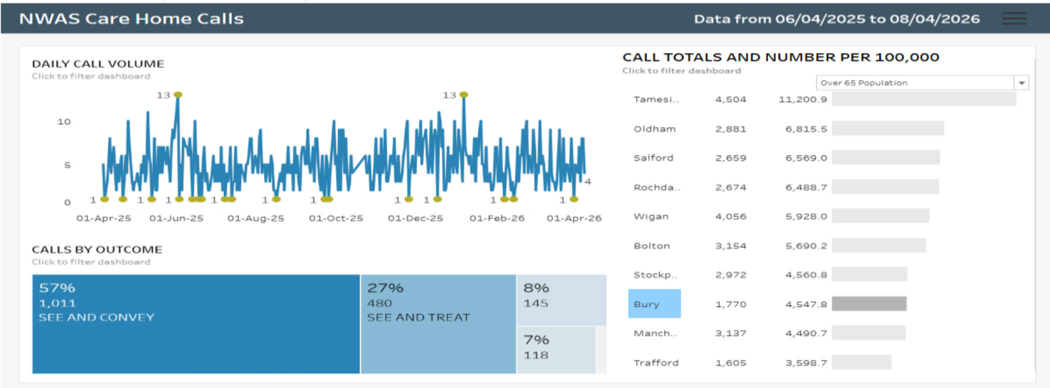
Data

GM Locality	# 65+	# No assessment	% no assessment	# assessment	% assessment	Rate per 1,000 had assessment
Wigan	62,961	26,792	42.6%	36,169	57.4%	574.5
Heywood, Middleton and Rochdale	37,707	15,703	41.6%	22,004	58.4%	583.6
Stockport	59,286	24,364	41.1%	34,922	58.9%	589.0
Tameside	30,541	11,328	37.1%	19,213	62.9%	629.1
Manchester	63,142	18,030	28.6%	45,112	71.4%	714.5
Trafford	40,251	10,212	25.4%	30,039	74.6%	746.3
Bolton	48,223	9,776	20.3%	38,447	79.7%	797.3
Oldham	33,987	2,613	7.7%	31,374	92.3%	923.1
Bury	**35,921**	**2,669**	**7.4%**	**33,252**	**92.6%**	**925.7**
Salford	37,098	285	0.8%	36,813	99.2%	992.3

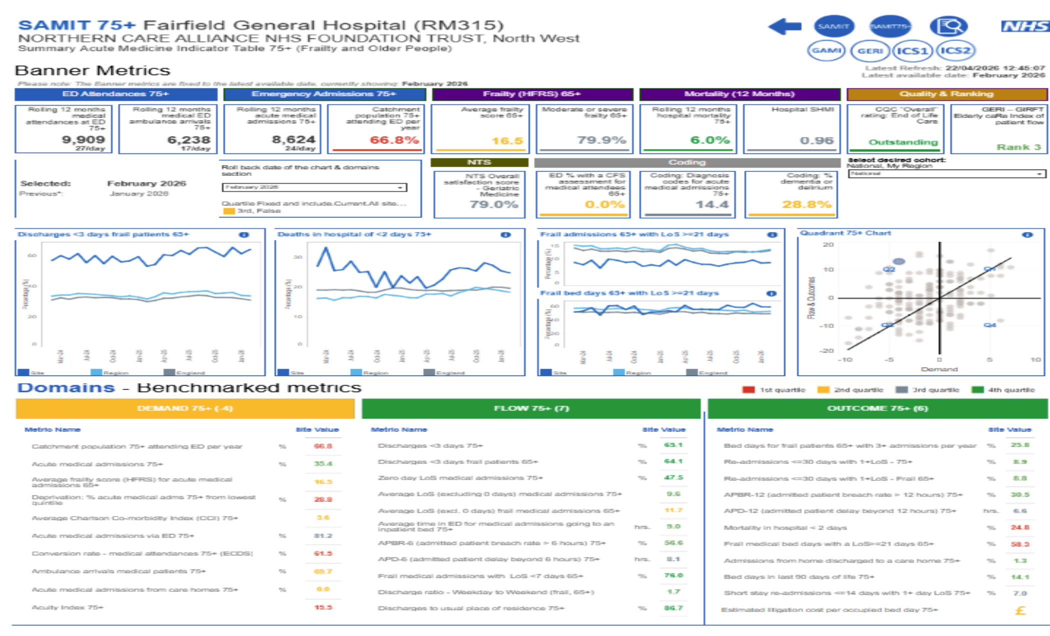
We are proud to recognise the remarkable progress made in Frailty identification and assessment across our locality. In 2021, Bury stood out as an outlier within Greater Manchester for Frailty assessment completion, but through collective action and system-wide integration, we've turned that challenge into a success story.



DHSC data on unplanned hospital admissions per 100,000 residents aged 65 and over, **places Bury third within the lower-performing category.**



The data presents NWAS activity for care home call-outs across Greater Manchester from 06-04-25 to 08-04-26, covering see-and-convey, see-and-treat, and hear-and-treat responses. When adjusted per 100,000 residents aged 65+, **Bury ranks third lowest in overall NWAS activity for care homes**.



Fairfield Hospital was ranked **3rd in the country for Geriatric Medicine out of 127 hospitals** in the SAMIT 75+ Model Hospital dataset.

Primary Care Success:
Frailty LCS Targets Delivered for 2025–26

				EAST Neighbourhood							WEST Neighbourhood				
Number	Description	Huntley Mount MC	Knowsley Street MC	Knowsley Street MC	Peel GPs	Ribblesdale Surgery	Rock Healthcare	Tower - Minden	Townside Surgery	Walmersley Rd Surgery	Mile Lane HC	Monarch MC	Radcliffe MP	Redbank GP	Tower - Spring Lane
FRA00 I xNEG	FRA00 I xNEG I Requires Frailty Assessment	217	295	295	1003	1031	336	2080	405	284	648	211	1195	1368	509
FRA01 I DEN	FRA01 I DEN I >=65y with Rockwood 5 or 6 (Rockwood Score of 5/6)	214	121	121	423	336	151	674	615	53	550	221	311	620	496
	Target Number	55	82	82	188	199	67	411	132	44	163	73	195	268	157
A minimum of 12% of patients ≥65 identified as having frailty as determined by a recording of Rockwood score 5 or 6		46.52%	17.61%	17.61%	26.96%	20.28%	27.01%	19.68%	55.76%	14.44%	40.41%	36.23%	19.17%	27.77%	38.01%
FRA08 I NUM	FRA08 I NUM I Rockwood 5 or 6 with Med Review & VitD/Calcium I this fy	74	77	77	165	235	79	345	164	41	156	67	172	227	143
	Lower threshold: 50% achievement = 50% payment	28	41	41	94	99	34	205	66	22	82	37	97	134	78
	Sliding threshold from 51% - 79% achievement = +50% payment (so 51% = 51% payment)	28	42	42	96	101	34	210	68	22	83	37	99	137	80
	Upper threshold: 80% or greater achievement = 100% of payment	44	66	66	151	159	54	329	106	35	131	59	156	214	125
An annual review of these patients which includes both: 1.A review of the patient's medication; and 2.Calcium/Vitamin D preparation as per GMMMG Formulary except where patient declines or it is not clinically appropriate to prescribe		134.06%	93.40%	93.40%	87.64%	118.19%	117.77%	83.97%	123.90%	93.10%	95.52%	91.53%	88.37%	84.71%	91.32%

Strategic Ambitions for Frailty in 2026/27

Further strengthening proactive prevention and earlier identification of frailty across communities	Expanding seven-day, rapid access frailty pathways and to reduce avoidable hospital attendance and admission	Developing a more fully integrated neighbourhood frailty model across health and care partners	Embedding consistent personalised care planning, including wider adoption of EPaCCs and advance care planning	Building workforce capability and confidence in frailty management across all settings, supported by shared system learning and training
We will continue to collaborate with Primary Care to support ongoing frailty and falls identification, including medication reviews/ de-prescribing. Promote Frailty identification amongst services supported by a GM wide Frailty flag within GMCR. Promote the use of digital enabled independence tools.	Frailty SDEC at FGH will be expanded to operate as a full 7-day service. We will continue to raise awareness of the UCR (Hospital at Home, Rapid Response, Falls Pick-up Service) offer and ensure the service is well understood and accessible across neighbourhoods. promote alternatives to hospital admission by maximising the use of community-based services and offers: Geriatrician A&G line, Call B4 Convey, UCR etc. The GP Federation have recruited a GP with a specialist interest in frailty to lead proactive admission-avoidance within IMT, supported by an interim GP already embedded at Elmhurst to bolster MDT decision-making and early intervention. IMT reablement transformation programme is underway, focused on restoring independence and reducing avoidable hospital use.	NCA Geriatricians at FGH aim to reduce care home admissions by 25% by January 2027 through standardising ACPs, adopting a Frailty SDEC-first approach, assigning a dedicated geriatrician to each care home, and developing a Hospital @ Home care home pathway. We will strengthen geriatrician in-reach into neighbourhoods, including exploring the development of a Frailty MDT model. We will work with NMGH to identify improvement opportunities for enhanced geriatrician in-reach into Bury South care homes and the neighbourhood team. We will strengthen frailty and intermediate care through neighbourhood-based development. We will increase the visibility and profile of neighbourhood teams and the services available to local residents, including delivering frailty awareness events in each neighbourhood to promote self-care and highlight community-based alternatives to hospital and Community offers	In 2026–27, Bury plans to fully roll out EPaCCS across all practices and increase staff awareness and use of the GM Care Record to ensure EPaCCS information is actively checked for patients who are palliative or in the last 12 months of life. NWAS crews in 2026-27 will have visibility of the persons care preferences, not automatically defaulting to hospital. Expand access to CGA or equivalent holistic assessment for people with moderate or severe frailty. Encourage the use of advanced care planning and support its implementation for patients Ensure delivery of national frailty standards, including early CFS and 4AT assessment, timely senior review and access to specialist frailty input. Champion the use of shared care [GMCR]	Provide targeted training in frailty identification and clinical decision making System collaboration through the Bury Frailty and Falls Steering Group Engagement at the NCA Frailty Strategy Group Engagement at the GM Falls Collaborative Community of Practice Improve patient experience

Bury Falls – Our Mission Statement

"To reduce the frequency of falls in Bury, and improve the outcome following a fall, by providing timely access to appropriate assessment, treatment, and management - ultimately preventing harm and promoting independence."

Transforming Falls through Integration and Collaboration

Across our system, we have made significant progress in strengthening our collaborative approach to falls prevention and response. Over the past year, partners have worked together to deliver meaningful improvements in both preventative support and post-fall care. Key achievements include:

- ✓ **Launching the Falls Pick-Up Service**, reducing risk and improving recovery outcomes for individuals experiencing low-level falls.
- ✓ **Embedding proactive prevention**, including the rollout of the SafeSteps Falls Prevention app across care homes to support earlier identification and management of risk, amongst looking at community opportunities via SafeSteps i4i.
- ✓ **Deepening integration with the Falls and Fracture Liaison Service and wider system partners**, creating stronger pathways and more coordinated care.
- ✓ **Building on the comprehensive Falls Services paper for Bury**, using its recommendations to guide improvements in service offers, waiting times and strategic planning.
- ✓ **Supporting workforce and public awareness** through contributions to Falls Prevention Week bitesize learning sessions.
- ✓ **Advancing neighbourhood-level prevention**, working with Live Well, the Staying Well Team, Social Prescribers and voluntary sector partners such as S&B, KOKU and community offer providers.
- ✓ **Initiating a service review with the Falls and Fracture Liaison Service**, leading to tests of change aimed at streamlining processes and reducing waiting times.
- ✓ **Actively engaging in the Greater Manchester Falls Collaborative**, strengthening shared learning and regional alignment.
- ✓ **Participating in the Falls sub-group of the Frailty Steering Group**, ensuring falls prevention remains a core component of wider frailty work.
- ✓ **Mapping local falls provision against NICE guidance**, including a system-wide workshop to ensure alignment with the forthcoming 2025 recommendations.

Achievements

Falls Prevention Awareness Week 2025 – Bury

15–19 September 2025

Purpose & Theme

To spotlight the importance of falls prevention across Bury and Greater Manchester.

"From Awareness to Action" Falls are not inevitable with the right support and timely interventions we can all make a meaningful difference in helping people age well.

Strategic Importance:

- Falls are a key indicator of declining health in later life.
- Timely interventions help people age well.
- Everyone in community, clinical, and care settings plays a role.

Local Approach and Outcomes

Highlights:

Daily 30-minute bitesize sessions via Teams

Open to professionals and individuals with lived experience

Nearly 100 attendees from across the system attended the sessions throughout the week

Posters distributed to GP surgeries and Care Homes

Resources shared from Greater Manchester

Dedicated landing page on the "Bury Directory"

Presenting Services:

- Bury Falls & Fracture Liaison Service
- Neighbourhoods – Active Case Management
- Bury Live Well Service
- Older Peoples Staying Well Team
- Falls Pick-Up Service
- NCA – Equipment Offer & Drop-ins
- First Contact Practitioners
- Podiatry Service
- Community Eye Service
- Social Prescribing
- VCFA – Voluntary Sector

Participant Feedback:

Q1: One word to describe sessions

→ **Informative, engaging, invaluable, brilliant, professional**

Q2: Confidence in signposting services

→ **Majority felt very confident or confident**

Q3: Key takeaways

→ **Integration, huge support available, connectivity**

Q4: Suggestions for improvement

→ **Bitesize format is excellent – keep it!**

Thank you and Next Steps

- Thank you for your support and engagement
- Your efforts help empower safer, healthier ageing
- Let's continue building awareness and improving outcomes together

Social Events:

Social prescribers from the Bury GP Federation generously shared photos capturing the strong community turnout at local falls awareness sessions held in support of Falls Prevention Week.

Contact Details:

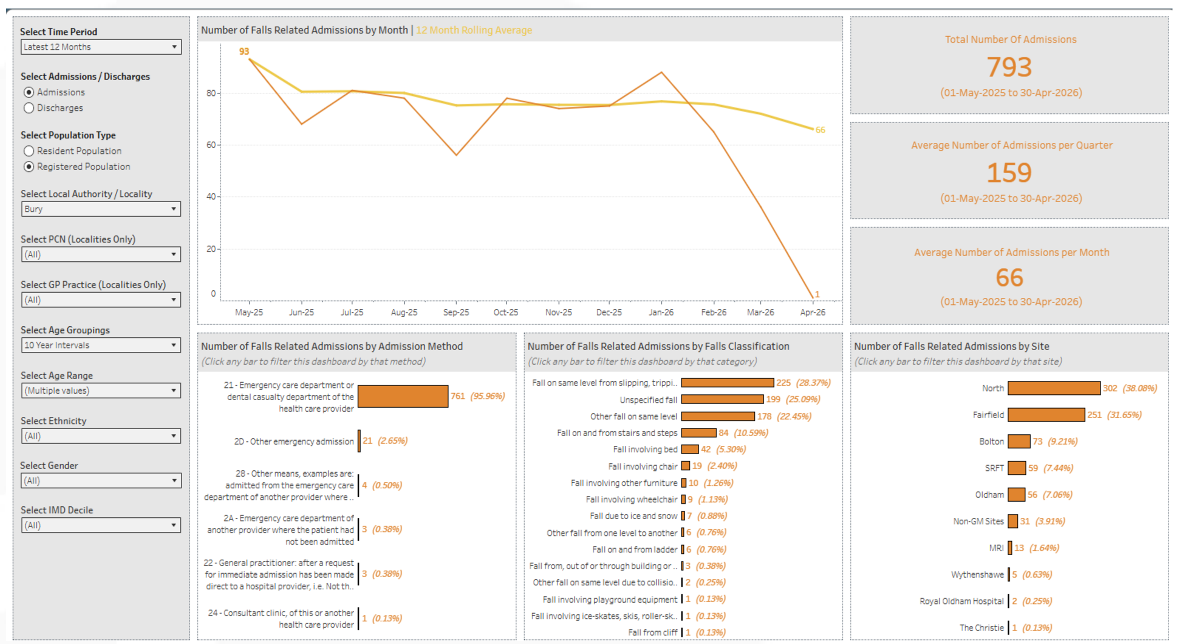
Clare Hunter

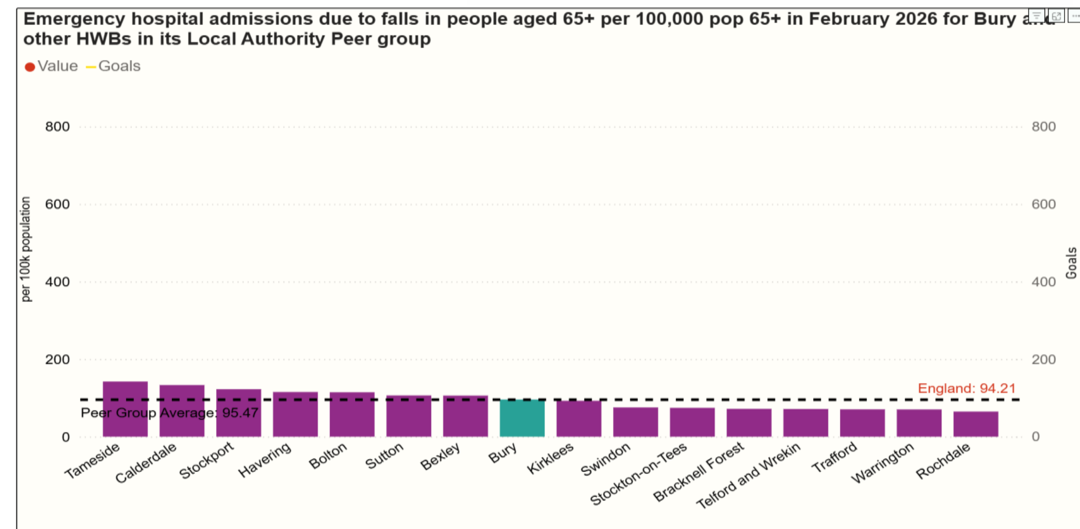
Project Manager – Bury IDC

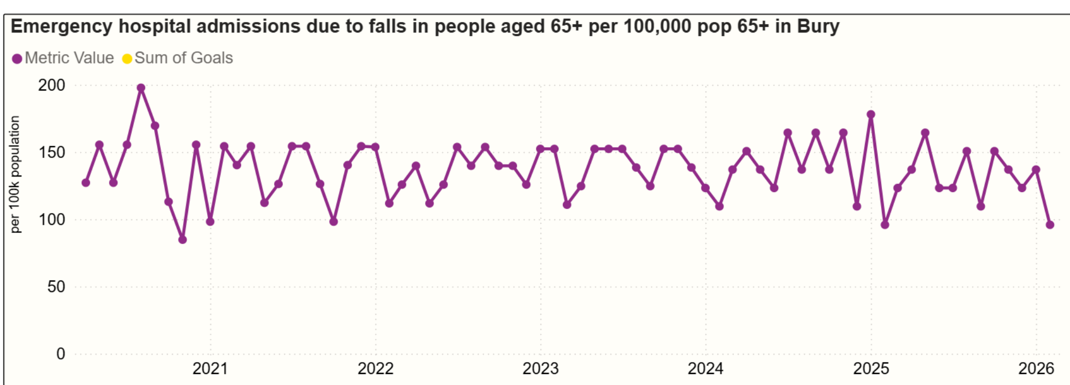
Clare.hunter22@nca.nhs.uk

Falls Admission Data 50+ years

This year, falls-related hospital admissions for Bury residents aged 50+ have dropped below the 12-month rolling average, demonstrating the positive effect of our joint work across the system (see slide 18).







Next Steps: Aligning Our Falls Pathway with NICE Falls Guidance

Consider single point of access
Self-identifying
Frailty
Risk factor identified by professional?
e.g. women approaching menopause (age), health check
Other Entry Routes
e.g. MSK - prevention work when someone has lower mobility -> becomes falls risk
- EFI score (EMIS)
- anything more predictive?

Fall in the last year?
No → Health and Wellbeing Information and advice on physical activity
Yes

additional exercises for falls risk on top of planned service
Lots of services in community avaialble which qualify here (preventing first fall)
Universal offer for this part of the pathway?

Bury Live Well - Excludes Bury and Prestwich PCNs?
PCN Social Prescribers (Local Activities and Community Offers)
Staying Well (KOKU app) - Excludes Bury PCN
Bury Directory

- Living with Frailty?
- Injured and needed medical treatment?
- Lost consciousness?
- Unable to get up independently?

No → Gait and balance assessment
No Gait & Balance Impairment
Assessments for those who haven't fallen?
Is this a frailty assessment in practice?

First Contact Physios
MSK Outpatients
Falls Prevention Service
Community Physio

Is there a specific intervention? Something to add to e.g. FCP and MSK?
Primary care (in guidance) + FCP
Self-referral options -> should be signposted at this stage

Gait & Balance Impaired

Yes
Offer comprehensive falls assessment
First Contact Physios
MSK Outpatients
Falls Prevention Service

Comprehensive Falls Management
Quite vague!
Address risk factors from comprehensive falls assessment
Bury Live Well - Excludes Bury and Prestwich PCNs?
Staying Well (KOKU app)
Vitamin D supplements
Bury Live Well - Excludes Bury and Prestwich PCNs?
Neighbourhood reviews
Consider medication review
Fracture Liaison Service
PCN Pharmacists
GPs
Offer home hazard interventions
Staying Well (Environment Advice and minor adaptations)
Age UK (Home from Hosp.) Handyman service
Community OT
Technology Abled Care
Consider falls prevention exercise programme
Bury Live Well - Excludes Bury and Prestwich PCNs?
Staying Well (KOKU app)
Surgical Interventions
Orthopaedic Services

Offer a falls prevention exercise programme
Bury Live Well - Excludes Bury and Prestwich
Staying Well (KOKU app)
Falls Prevention Service (e.g. ATAGO)
Consider cognitive behavioural interventions if fear of falling not helped by exercise
??

Consider home hazard interventions
Staying Well - Excludes Bury PCN
Age UK (Home from Hosp.) Handyman service
Falls Prevention Service
Community OT

NICE Guidance NG429 Falls in older people: assessing risk and prevention

Population: Bury Residents over 65, or age 50-64 with one or more fall risk factor

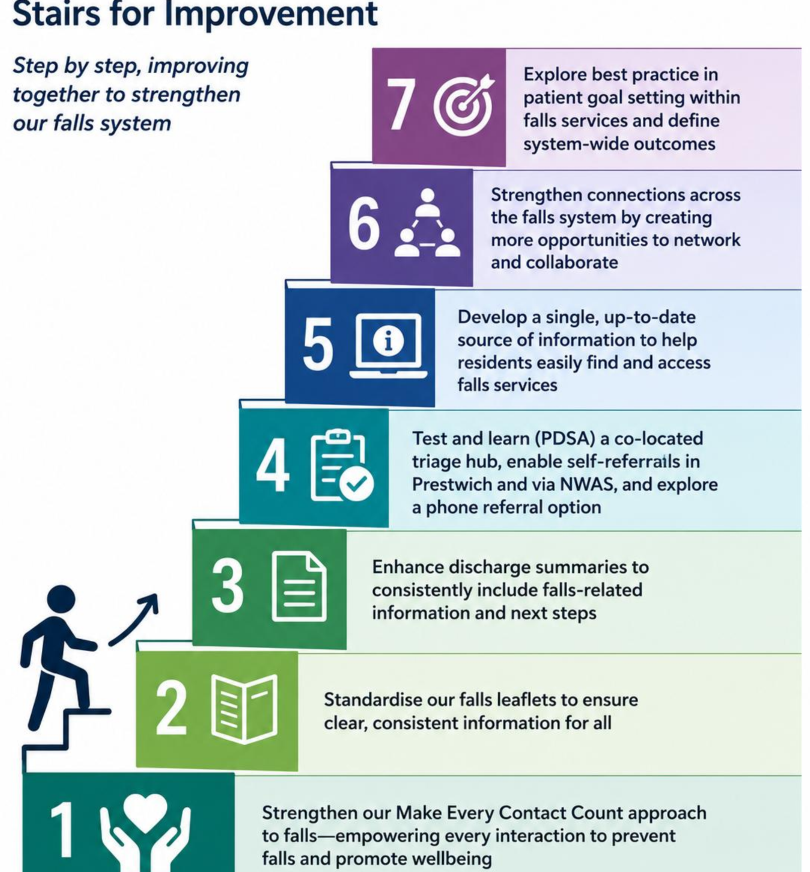
As part of this scoping work, we recognised that many services across the system respond to falls. However, participants highlighted challenges in directing people to the right service at first contact.

This leads to unnecessary re-referrals, duplicated effort, and longer waiting times

Bury Falls Improvement Plan for 2026/27

The "Stairs for Improvement" model has been developed from the recommendations identified during the Falls System Workshop. It reflects a shared commitment to moving away from the current culture of multiple and often duplicated referrals across services, driven by the absence of a clearly defined pathway, towards a more coordinated, person-centred and efficient system.

By strengthening collaboration across the workforce and improving the way services connect, we aim to streamline referrals, reduce duplication, ensure individuals receive the right care at the right time, minimise unwarranted waiting lists, reduce avoidable hospital admissions, and provide better support for people at risk of or affected by falls.



BURY
INTEGRATED CARE
PARTNERSHIP

Thank You...

NHS
Pennine Care
NHS Foundation Trust

NHS
Northern Care Alliance
NHS Group

Bury
COUNCIL

Bury GP
Federation

Persona
We're all about you

VCFA

BARDOC

Meeting:			
Meeting Date	01 June 2026	Action	Receive
Item No.	11	Confidential	No
Title	Better Care Fund Planning 26/27		
Presented By	Will Blandamer - Executive Director Health and Adult Care and Place Based lead Adrian Crook - Director Adult Social Care		
Author	Hannah Dixon – Commissioning Manager		
Clinical Lead	N/A		

Executive Summary
The purpose of this report is to update the Locality Board on the BCF Planning 26/27 which has been co-produced by council and health partners.
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 the progress of the 26/27 plans versus metrics and expenditure.

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 priorities	
Scale our work on Population Health Management - Improve population health and reduce health inequality of those in the most disadvantaged areas	☐
Drive prevention, reducing prevalence and proactive care – supporting Demand Reduction through primary intervention, secondary preventions and tertiary prevention	☒
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	☒
Optimise Care in institutional settings and prioritising the key characteristics of reform.	☐

Links to Locality Plan priorities	

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		

Better Care Fund (BCF) Planning 2026/27

1. Introduction

1.1 The aim of the BCF is to support ICBs and local authorities in designing and delivering more integrated and preventative care, particularly for people with more complex health and social care needs, helping people stay independent for longer.

1.2 The **Better Care Fund framework 2026 to 2027** sets out the first phase of national reforms to strengthen the integration of health and social care, aligned to the government's 10-Year Health Plan and the development of neighbourhood health services. The framework asks health and care systems to identify progress in the following areas:

- improve joint commissioning of integrated neighbourhood teams and bring together urgent community response, intermediate care and other community services at a multi-neighbourhood level
- ensure that services funded from the BCF are part of wider plans to support people living with frailty and others with more complex health and social care needs
- improve shared understanding and transparency about the outcomes and impact of the current BCF locally
- lay a strong shared foundation for future reform of the BCF and begin alignment with neighbourhood health service

1.3 The Bury BCF plan was submitted to the national team before or on the 19th May and comprised of the following documents:
- Narrative Plan
- Numerical Template

1.4 It was a requirement that Health and Wellbeing Board (HWBB chairs and the Chief Executives of Local Authorities and ICBs agree the plan prior to submission, which reflects previous years requirements. It was agreed with the North West Regional BCF Lead that, due to the scheduled dates of the HWBB, the plan could be approved retrospectively at the next HWBB meeting on 11 June 2026.

2. 2026/27 BCF Planning Requirements

2.1. **National condition 1: effectively support the delivery of integrated and preventative care**
ICBs and local authorities must develop joint plans, agreed by health and wellbeing boards, outlining how ICBs and local authorities intend to use BCF funding to deliver more integrated and preventative care, linked to the relevant areas of neighbourhood health and social care services.

2.2. **National condition 2: comply with expenditure and grant conditions**
ICBs and local authorities must comply with all national grant and funding conditions and deliver in accordance with their approved return. ICBs must maintain the NHS minimum contribution to adult social care and pool NHS BCF contributions into a section 75 (of the NHS Act 2006) pooled fund.

2.3 **National condition 3: effective governance, reporting and engagement**
ICBs and local authorities must comply and engage with BCF planning, governance and reporting requirements, including adherence to any assurance and oversight processes.

2.4 All national conditions in 2026/27 BCF plan have been met.

3. National Metrics

3.1 In 2026/27 there are three national metrics, which were also in place in 2025/26. The metrics are:

- Non-elective hospital admissions for people aged 65 and over
- Average length of discharge delay for all acute patients
- Long-term admissions to residential care homes and nursing homes for people aged 65 and over

3.2 The requirements for 2026/27 are to show “reasonable progress” with these metrics. There is also a requirement for HWBBs to monitor and drive improvements on the proportion of people aged 65 and over discharged from hospital, with reablement provided partly or solely by local authorities, who remained in the community within 12 weeks of discharge. It is likely this will become a national BCF metric in 27/28.

3.3 The goals for the 2026/27 plan have been set, as in previous years, to be reasonable and achievable. The full BCF plan can be viewed in the appendix 1.0 and 2.0.

4 Finance

4.1 Table 1.0 shows a comparison in the BCF income streams in 2025/26 and 2026/27.

Table 1.0: BCF income for 2025/6 and 2026/27

	2025-26	2026-27
Source of Funding	Income	Income
DFG (including top-up)	£2,757,942	£2,669,235
Minimum NHS Contribution	£19,577,112	£20,235,159
Local Authority Better Care Grant	£9,410,943	£9,410,943
Additional LA Contribution	£0	£0

Additional NHS Contribution	£2,136,317	£9,303,814
Total	**£33,882,314**	**£41,619,152**

4.2 The government has signalled its intent to next year standardise some of the contents of the BCF across localities to ensure they are all aligned to integrated services and intermediate care. Greater Manchester NHS and the council have started this process in the BCF 26-27, so some movement of services both in and out can be seen. The overall amounts in the pooled budget have not changed. A full list of removals and additions from expenditure are outlined below and GM ICB Finance have confirmed those schemes removed will continue to be funded outside of BCF funding.

4.3 Table 2.0 demonstrates the following expenditure funding lines for 2025/26 have been removed from the BCF in 2026/27 and will be funded centrally by NHS GM ICB. An appendix for these schemes has been requested from NHS GM Finance, to ensure these schemes can be monitored locally.

Table 2.0: BCF Expenditure Lines Removed from BCF 2026/27

Schemes Removed	**Value**
Core 24 Liaison	£711,109
Alzheimers Society	£82,765
Nursing Home Training x2	£69,168
Falls	£226,272
LCO Costs	£551,530
Project Management Support for Bury IDC	£138,332
INT Transformation	£186,606
Primary Care Additional Support	£404,029
EOL Palliative Care Consultant	£134,606
Stroke Association	£70,000
Total	**£2,574,417**

4.4 Table 3.0 demonstrates the additional BCF expenditure lines in 2026/27:

Table 3.0: BCF Expenditure Additions to BCF 2026/27

Scheme Additions	**Value**
Assistive Technology and Equipment	£925,019
Hospice	£617,645
Community Nursing	£7,228,565
Integrated Neighbourhood Teams	£1,127,682
Total	**£9,898,911**

4.5 A full list of BCF expenditure schemes is available in appendix 1.0.

5 Recommendations

5.1 Locality Board members are asked to

- Note the contents of the paper and the attachments regarding the detail of the BCF
- Note that they will receive quarterly updates on the progress of the 2026/27 plans versus metrics and expenditure.

6 Actions Required

6.1 The Bury Locality Board is required to:

- receive information

Hannah Dixon
Commissioning Manager
Hannah.dixon27@nhs.net
June 2026

Appendices

1.0 BCF Narrative Return 2026-27

Bury BCF 2026-27
Narrative Return FINA

2.0 BCF Numerical Return 2026-27

Bury BCF 2026-27
Numerical Template

Choose an item.

Better Care Fund 2026-27 Narrative return

Introduction and guidance

This return has been designed to enable ICBs and local authorities, working with Health and Wellbeing Boards (HWBs), to submit information which demonstrates how their plans for the Better Care Fund (BCF) meet the national conditions and planning requirements for 2026-27. Completing and submitting the BCF narrative return is a required part of the overall BCF submission process. Planning leads should ensure that all questions within this narrative return are fully addressed.

This year, the length of the narrative return has been reduced. This reflects feedback on the benefits of a more focused BCF assurance process. In completing the return, HWBs, ICBs and local authorities may wish to develop more detailed joint plans for BCF expenditure for their own use and/or draw on other joint plans.

Each question in the return has a suggested length of around a page (around 500 words) and we would generally expect the overall submission to be around 2500 words. These act as a guide to support a more focused assurance process rather than strict limits.

The narrative provided in this return should align with the expenditure plans and the ambitions for the national metrics set out in your BCF excel numerical return.

When completing the narrative return, please use the following documents for guidance and support, these can be found on the BCF Exchange:

- **Planning Principles:** outlines what good practice looks like in relation to each narrative question and aligns with the relevant national conditions.
- **Metrics Handbook:** provides the formal technical specifications for the national metrics within the framework, including the rationale, methodology, required data inputs and worked examples.

Submission Requirements:

- Each HWB area must have its own BCF excel numerical return, but a single narrative BCF return covering multiple HWBs may be submitted where this reflects local integrated working arrangements.
- Each HWB area included in a combined narrative return should provide clarity and state any specific details relevant to the separate HWBs within the narrative questions (and more words may be required for this than a single HWB return). Local authorities, ICBs and HWBs for each area should formally sign off the shared narrative return and their individual numerical excel BCF return.

- The deadline for completing this narrative return is **19 May 2026.**
- Please submit this return to both: england.bettercarefundteam@nhs.net and your regional better care manager(s).

Submission details

Mandatory to complete, please do not submit a return without completing the details below:

Adapt as necessary	**HWB area 1**
HWB	**Bury**
ICB	**Greater Manchester - Bury**

1. **Please provide a short statement setting out the rationale for using BCF funding to maximise delivery of integrated and preventative care linked to the relevant areas of neighbourhood health and social care services.**

1.1 BCF Introduction and Changes
The Better Care Fund (BCF) is designed to support local areas to integrate health, social care and wider community services in order to improve population outcomes, reduce avoidable pressures on acute care, and enhance independence. Using BCF resources to strengthen integrated and preventative care within Bury's neighbourhood model aligns directly with national BCF policy aims, the National NHS Neighbourhood Health Framework and local strategic priorities, including the Bury Lets Do It! Strategy across the Council and NHS Greater Manchester. The key changes to the expenditure schemes for 26-27 are the removal of the Core 24 Liaison, Programme Costs, Primary Care Additional Support, along with some smaller value schemes due to a GM standardisation process, which ensures consistency across the localities within GM. All schemes that have been removed will be funded in 26-27, but not through the BCF. Some additions to expenditure for 26/27 are Community Nursing, Community Equipment and Hospice schemes that will be funded through the BCF, to support the "left shift" of care.

1.2 Supporting Bury's Neighbourhood Model and Place-Based Integration
Bury has well established neighbourhood teams that have been delivering integrated, proactive and joined up care. BCF funding enables further practical delivery of Bury's integrated neighbourhood teams, which bring together primary care, community health, social care, housing, voluntary sector providers and wider public services. Targeting BCF investment here helps create a single coordinated response around residents, reduces duplication and supports consistent multidisciplinary working. GP practices are integral to Bury's Neighbourhood model of population health management and prevention. In 2026.27 GP practices will be working with our Integrated Neighbourhood Teams and other partners to develop Neighbourhood Health Action Plans. These will be focusing on engagement and prevention work with patients with the highest risk of poor health outcomes and one of the goals is optimising treatment and care in order to reduce the risk of exacerbation leading to emergency admission to hospital. This improves access, promotes person-centred care and ensures earlier identification of risks or unmet needs.

1.3 Shifting the System Towards Prevention and Early Intervention
Bury faces rising demand pressures across adult social care, urgent care and long-term condition management. BCF investment in preventative neighbourhood services, such as reablement, Urgent Community Response (UCR), falls prevention, anticipatory care and targeted early help; helps avoid unnecessary hospital attendances, delays and long-term care admissions. This supports the wider system ambition of "home first", maintaining independence and quality of life for residents.

1.4 Reducing Hospital Demand and Facilitating Timely Discharge
Integrated neighbourhood teams, backed by BCF resources, play a critical role in preventing avoidable hospital admissions and supporting safe, timely discharge. BCF-funded pathways (e.g., community rehabilitation, step-up/step-down beds, home-based recovery support) reduce delayed discharges, free hospital capacity and provide residents with recovery-focused alternatives to institutional care. Bury Hospice provides a specialist care intensive care unit that provides specialist palliative care for Bury patients that supports a reduction in discharge delays for Bury's palliative patients who are nearing end of life or require specialist care.

1.5 Targeting Resources Where Population Need Is Highest

Neighbourhood working allows Bury to focus BCF investment where it will have the greatest impact: specific communities, high-risk groups, or people living with frailty or multiple long-term conditions. This is supported by the Active Case Management (ACM) process which brings together health, social care and voluntary sector partners in neighbourhoods to deliver MDTs. Together the MDT coordinates care for individuals to improve independence, prevent acute exacerbations and reduce hospital/residential care admissions by improving access to the right service(s) at the right time ensuring a person-centred and strength-based approach. This approach strengthens health equity by addressing variation in outcomes and access at a local level.

1.6 Enabling System-Wide Efficiency and Better Use of Collective Resources

Integrated and preventative services are significantly more cost-effective than reactive or crisis-driven care. Using BCF flexibly across neighbourhood services allows the Council and NHS partners to pool resources, reduce fragmentation and generate shared savings through reduced bed days, lower long-term care costs and improved productivity across teams. The Staying well team are a service that support this, 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.

1.7 Strengthening Community Capacity and the VCSE Workforce

Neighbourhood integration supported through BCF funding enables Bury to harness the strengths of its VCSE sector, community groups and prevention-focused programmes. This enhances resilience, widens access to low-level support, and reduces over-reliance on statutory services. Bury has established a considerable programme of work in addition to the current VCSE commissioned services with Age Uk to support the community to reduce social isolation, handyperson schemes, befriending schemes and also Home from Hospital to support the discharge ready date metric to be achieved, as well as admission avoidance.

The Bury carers hub also supports and signposts people to appropriate services and gives advice on meeting needs on a non-statutory and statutory basis by referral to appropriate teams within our locality.

1.8 Assessment of Demand and Capacity for Intermediate Care

Our assessment of demand and capacity for intermediate care has been informed by activity and investment across home-based and bed-based intermediate care schemes, discharge support, UCR, and wider community-based services, as reflected in our BCF programme. Intermediate care continues to be a critical enabler in supporting timely hospital discharge, preventing avoidable admissions, and maintaining independence.

Demand pressures are driven by:

- Increased acuity and complexity of need among older people and adults with long-term conditions.
- Rising hospital discharge volumes and the need for timely Discharge to Assess pathways.
- Prevention of hospital admissions and
- Greater reliance on short-term rehabilitation using home first strengths-based models and reablement to avoid longer-term care placements.
- Move to Home First Models for discharge

These pressures are evident across both home-based intermediate care (rehabilitation, reablement and recovery at home) and bed-based intermediate care, which provide short-term, person-centred interventions to maximise independence and reduce length of hospital stay.

Capacity analysis has considered:

- Availability and responsiveness of home-based reablement and recovery services;

- Access to appropriate bed-based intermediate care for individuals who cannot safely return home immediately.
- Workforce availability across health, social care and community providers;
- Flow and interface with UCR and discharge support functions.

The Bury Locality analysis has identified the importance of maintaining sufficient flexible capacity across both pathways, with particular emphasis on scaling care at home wherever safe and appropriate, in line with the Home First principle.

1.9 How the Assessment Has Informed Planning

The demand and capacity assessment has directly informed BCF planning for 26–27 in the following ways:

- Strengthening home-based intermediate care capacity: Investment priorities continue to focus on short-term home-based rehabilitation, reablement and recovery services, recognising their role in supporting independence, improving outcomes and reducing demand for bed-based provision and long-term care.
- Targeted use of bed-based intermediate care:
  Bed-based intermediate care remains available for people whose needs cannot initially be met at home, ensuring smooth hospital flow and enabling recovery in an appropriate setting. Planning reflects appropriate volume, length of stay and clear pathways back into the community.
- Integration with discharge support and infrastructure: Intermediate care capacity planning is aligned with discharge coordination functions, Discharge to Assess pathways, and multi-disciplinary working, ensuring people experience seamless transitions from hospital to home or community settings.
- Alignment with UCR: Bury UCR teams provide rapid interventions that help avoid hospital admissions and support people to remain at home, reducing downstream pressure on intermediate care capacity. The team also play a critical role at times of severe system pressures, helping to facilitate the step-down of acute hospital and pulling patients from A&E and wards in real-time.
- Workforce and system enablers: Recognising workforce constraints in Bury, planning incorporates system enablers such as joint commissioning, market development and workforce recruitment and retention initiatives, supporting the sustainability of intermediate care services.

1.10 Wider BCF Framework Factors

In line with the BCF Framework 26–27, planning for intermediate care is supported by the following complementary areas:

- Disabled Facilities Grant (DFG): DFG investment supports timely adaptations that enable people to return home following intermediate care, reducing delays, preventing readmission and sustaining independence. Cabinet approval in March 2023 endorsed a more strategic and flexible use of BCF-funded DFG resources through the Council's Housing Assistance Policy. This has enabled the service to move beyond a solely statutory, reactive DFG model towards a broader preventative offer that can respond proportionately and at pace. The service delivers a range of interventions including mandatory and discretionary adaptations, minor adaptations, technology-enabled care (TEC), relocation assistance and housing-related support. These interventions are coordinated with adult social care, occupational therapy, health colleagues and neighbourhood teams to ensure alignment with care pathways.

The Health and Wellbeing Board assessment of demand and capacity identifies rising levels of need associated with ageing, disability, long-term conditions and increasing complexity. Pressure on intermediate care and discharge pathways is often linked to unsafe or inaccessible home environments, where delays in adaptations can lead to extended hospital stays or avoidable admission. Service planning has therefore prioritised the use of Regulatory Reform Order flexibilities to streamline processes, reduce waiting times and deliver earlier, lower-cost interventions where appropriate. Discretionary routes enable faster delivery for straightforward or urgent cases, helping to prevent escalation to more complex and costly solutions.

BCF funding supports integrated delivery across neighbourhood services by enabling targeted investment in preventative housing measures. This includes smaller adaptations that reduce falls risk, innovation funding and TEC solutions that improve safety and independence while reducing reliance on formal care. Where adaptation is not appropriate or cost-effective, relocation assistance supports timely moves to more suitable accommodation. Collectively, these interventions help to reduce delayed discharges, prevent re-admission and ease pressure on intermediate care services.

This approach aligns with the ICB five-year strategic commissioning plan priorities on prevention, place-based working, reducing health inequalities and supporting people to remain independent at home. It also supports unpaid carers by reducing physical risk and care burden within the home. Delivery is underpinned by partnership working across housing, health, adult social care and the VCSE sector, ensuring that housing interventions are fully integrated within neighbourhood health and social care models and deliver measurable system benefits.

- Support for Unpaid Carers: Unpaid carers play a critical role in enabling successful discharge and recovery at home. Investment in carers' services, including information, emotional support and respite, helps mitigate carer breakdown and reduces avoidable escalation into longer-term care.
- Voluntary, Community and Social Enterprise (VCSE) partnerships: VCSE partners contribute to prevention, recovery and support during intermediate care episodes, including practical help, social support and community connections that enhance outcomes and resilience, as well as reducing spend on statutory services by maximising community infrastructure and support.

1.11 The assessment of intermediate care demand and capacity under the BCF demonstrates a system-wide, evidence-based approach to planning for 26–27. By prioritising home-based intermediate care, maintaining appropriate bed-based capacity and aligning with discharge, prevention, carers and VCSE support, our planning supports improved system flow, better outcomes for individuals, and sustainable use of health and social care resources.

2. **Please provide a brief explanation of the rationale for how you have set out goals for the metrics of non-elective admissions (for those 65 years old and over) and delayed discharges. Please also set out how you will monitor and drive progress in preventing avoidable long-term care home admissions and improving outcomes from reablement, including through any locally agreed goals for long term admissions to residential care and nursing homes.**

2.1 25-26 Performance Summary
Performance reporting for 25–26 has informed the 26-27 plan. This has been based on the most complete locality data available at the time of writing. For Emergency admissions and Discharge Ready Date this is based on Admitted Patient Care Dataset submitted via SUS.

Emergency Admissions
The BCF Exchange provides data through December, has been replaced with more timely data from locality for the full year performance. For emergency admissions, confirmed locality data for the whole of 25–26 has been used to set the 26–27 metric, which represents a reduction compared to the 25–26 plan, with the metric achieved for 25–26, as demonstrated in table 1.0.

Table 1.0: Emergency Admissions Performance 25-26

		Plan	Actual		Plan	Actual	
		Q4 Total	Q4 Total	Performance	FY	FY	Performance
Emergency admissions to hospital for people aged 65+ per 100,000 population	Rate	4,488.3	4,014.5	-10.6%	18,036.2	16,808.9	-6.8%
	Number of Admissions 65+	1,620	1,449		6,510	6,067	

Discharge Ready Date (DRD)
For DRD, actual performance data up to January 2026 and plan figures for February and March have informed the 26–27 metric, resulting in a planned improvement in the proportion of patients discharged on their DRD; this metric remains on target for achievement in 25–26, as demonstrated in table 2.0.

Table 2.0: DRD Performance 25-26

	Plan	Actual	
	FY Estimate	FY Estimate	Performance
Average length of discharge delay for all acute adult patients (this calculates the % of patients discharged after their DRD, multiplied by the average number of days)	1.20	0.96	-19.7%
Proportion of adult patients discharged from acute hospitals on their discharge ready date	87.0%	88.5%	1.7%

For those adult patients not discharged on DRD, average number of days from DRD to discharge	9.19	8.36	-9.0%

Residential Admissions

In addition, the residential admissions target for 25–26 has been met. Local data from Liquid Logic has been used to verify performance against the 25-26 target of 248 admissions, which is demonstrated in table 3.0.

Table 3.0: Residential Admissions Performance 25-26

Scenario	Rate per 100,000 (65+)	Number of admissions
Bury's Position 25/26	**591.78**	**≈ 216 people**
England average 24/25	592.5	≈ 216 people
Middle-of-the-pack	600	≈ 219 people
Top-quartile (strong performance)	500	≈ 182 people

2.2 Non-Elective (NEL) Admissions for People Aged 65+ – Rationale for Goals

Goals for NEL admissions for older people are based on Bury's population need, historic activity patterns, actual and projected performance where data is not yet available. This has resulted in a more challenging plan than 25-26 being adopted. The focus is on avoidable admissions linked to frailty, falls, long-term conditions and deterioration that can be prevented or managed effectively in the community. Targets reflect the ambition to shift care "left" towards proactive and anticipatory intervention while remaining realistic given demographic growth, acuity and benchmarking performance against peers for 25-26, where data is available.

2.3 Delayed Discharges – Rationale for Goals

Targets for delayed discharges are set to support flow through hospital, reduce length of stay and ensure timely transitions to home-based or community recovery pathways. The goals reflect the expected capacity of reablement, community therapy, discharge-to-assess (D2A) arrangements and the commissioned homecare and intermediate care market as well as actual performance. This has resulted in a more challenging plan than 25-26 being adopted. They also align with the system's Home First principles that discharge home with support should be the default and with national ambitions to reduce delays caused by availability of social care or community health provision.

2.4 Avoidable Long-Term Care Home Admissions

Bury will monitor avoidable admissions using locally agreed goals which will focus on stabilising or reducing long-term admissions by strengthening community-based alternatives, commissioning short-term recovery pathways and ensuring MDT decision-making before long-term care is agreed.

2.5 Improving Outcomes From Reablement

Progress in reablement will be driven through:

- Performance tracking of key reablement indicators, including the proportion of people still at home 91 days after discharge and conversion rates to long-term care.

- Weekly operational reviews that consider caseloads, throughput, staffing and barriers to progression.
- Case-file sampling to identify strengths, missed opportunities for progression and variation across neighbourhood teams.
- Strengthened pathway alignment, ensuring rapid response, therapy, homecare and equipment services work seamlessly and at pace.
- Active MDT oversight, ensuring goal-setting, step-down plans and independence-focused interventions are applied consistently.
- Planned increase utliisation of IMC Based Services - project is currently underway to support increased capacity in IMC services and a reduction in Long Term Care

Local goals are centred on improving independence, maximising recovery and reducing transitions into long-term care immediately following discharge.

3. Please provide a short explanation of the planned impact of BCF funding on achievement of goals.

3.1 BCF funding is a critical enabler of Bury's approach to integrated, preventative and community-based care. It directly supports the delivery of the system's goals on reducing non-elective admissions, minimising delayed discharges, improving reablement outcomes and preventing avoidable long-term care home admissions, which is demonstrated with Bury's BCF performance against these metrics for 25-26.

3.2 BCF investment strengthens the well-established neighbourhood-based multidisciplinary teams, ensuring coordinated community responses that reduce avoidable emergency activity for older people. By expanding rapid response, falls prevention and proactive frailty management, BCF funding contributes directly to reducing admissions for people aged 65 and over.

3.3 In Bury we have a strong foundation of an urgent neighbourhood service within our intermediate tier of services. Our UCR service incorporates Hospital at Home, Rapid Response and the Falls pick-up service. The team are consistently overachieving the GM and National 2-hour response measure. The team are continuing 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. This work is also supported by the Northern Care Alliance (NCA) Call B4 Convey and single point of access (SPOA).

3.4 Since October 2022, Burys Hospital at Home (H@H) service has supported thousands of patients in their own residences, avoiding an equivalent number of hospital attendances or admissions. Bury is noted as having above required utilisation for H@H. This has been especially valuable for frail patients, who face greater risks from hospitalisation including deconditioning, falls and hospital-acquired infections who without funded services through BCF, are often subject to longer stays or discharge to care settings.

3.5 The fund underpins discharge pathways and flow, including Home First, reablement capacity and intermediate care. This supports timely discharge, reduces delays and ensures that people can return home or recover in community settings with appropriate support. Strengthened community recovery reduces both hospital length of stay and the risk of entering long-term care prematurely.

3.6 BCF resources enable Bury to boost reablement effectiveness, increasing therapy capacity, equipment availability and staffing resilience. This helps more people regain independence following hospital discharge, improving the 91-day measure and reducing conversion to long-term residential care.

3.7 Finally, by supporting a more resilient homecare market, enabling greater VCSE involvement and funding preventative support at neighbourhood level, the BCF helps reduce avoidable long-term care home admissions through earlier intervention, stabilising people at home and preventing escalation to high-cost long-term options.

4. Please outline how ICBs and local authorities have confidence that the services funded through the BCF represent value for money, and how they will seek to raise the productivity of services.

4.1 GM ICB (Bury) and Bury Council have confidence that services funded through the BCF represent value for money. This includes sustained investment in a well-evidenced Intermediate Tier offer that demonstrably improves outcomes, reduces avoidable demand on acute services and supports people to live healthier, more independent lives.

4.2 In Bury, a strong commitment to collaborative, enterprising delivery has resulted in the Council leading the provision of Intermediate Care, Reablement, UCR, Falls Pick Up and H@H services. This integrated model ensures the right support is provided at the right time, preventing escalation of need and reducing long-term dependence on statutory services. As a result of additional investment and expansion of the Intermediate Tier, 85% of people using these services experience a reduction in ongoing support, demonstrating both effectiveness and cost efficiency.

4.3 Value for money is further assured through strong quality oversight and performance. All Intermediate Care services delivered through this integrated model are rated Good or Outstanding by the CQC, reflecting safe, effective and well-managed services. NHS and Council staff operate together under council leadership, reducing duplication, improving coordination and maximising the impact of the funded workforce.
These services support hundreds of residents each month and play a critical role in:

- Avoiding hospital admissions
- Supporting timely discharge
- Preventing unnecessary or premature admission to residential care
- Maximising independence and self-management of health and wellbeing

This system-wide impact provides confidence that BCF investment is mitigating higher-cost demand elsewhere in the system.

4.4 A thorough review of Intermediate Care services has been completed to strengthen productivity and future-proof capacity in line with rising demand. This includes:

- Additional staff focused on maintaining independence for people in hospital
- Expansion of reablement capacity to support safe and timely discharge
- Integration of Reablement with Intermediate Care at Home to improve outcomes

These changes are set out in the Bury Intermediate Care Strategy 2025–2027 and are designed to optimise workforce deployment, improve flow and ensure resources are targeted where they deliver the greatest impact.

4.5 Intermediate Care in Bury is delivered across a range of cost-effective settings:

- Killelea, a council-managed bed-based service with clinical oversight from Northern Care Alliance, provides specialist rehabilitation support. It was recently rated Outstanding by the CQC, offering strong assurance of quality and value.
- Elmhurst, delivered through the council's LATCO, Persona, provides 13 dedicated Intermediate Care beds to support system flow.
- Hospital at Home, embedded within Rapid Response, enables people to receive hospital-level care at home, significantly reducing the need for admission.
- The Community IV Therapy service, working alongside Rapid Response, prevents admissions by delivering treatment safely in people's homes.

4.6 An optimal / single-handed care pilot is currently in the development and testing stage focused on people in receipt of high-cost care packages. This includes targeted review of existing packages and earlier Occupational Therapy (OT) assessment at the point of request to increase support (e.g. from one to two carers), to ensure decisions are clinically appropriate, proportionate and to avoid unnecessary cost escalation. Alongside this, therapists across Intermediate Care and Adult Social Care have recently received optimal handed care training with a view to supporting more consistent decision-making, reduction in unwarranted variation and fewer unnecessary handoffs across pathways. There are plans to strengthen OT presence at key points within pathways which is intended to support trusted assessment, timely functional intervention and improved flow and contributing to admission avoidance, earlier discharge and more sustainable outcomes.

4.7 Use of 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.

4.8 Work is ongoing to improve grip on equipment and adaptations pathways, aimed at reducing delay and duplication and supporting timely, cost-effective solutions. Collectively, these actions support better use of workforce capacity, improved flow and value for money while delivering improved outcomes for residents across the BCF portfolio.

4.9 Productivity is being raised through integration, service redesign and a focus on prevention and early intervention. By shifting care closer to home, reducing length of stay and improving functional outcomes, BCF funded services enable better use of resources across Bury's health and care system while improving residents' experience and independence. This is supported by continued promotion of shared information systems such as Greater Manchester Care Record and the mobilisation of shared care records such as EPaCCS to improve information sharing across different professional teams to improve the efficiency and safety of care.

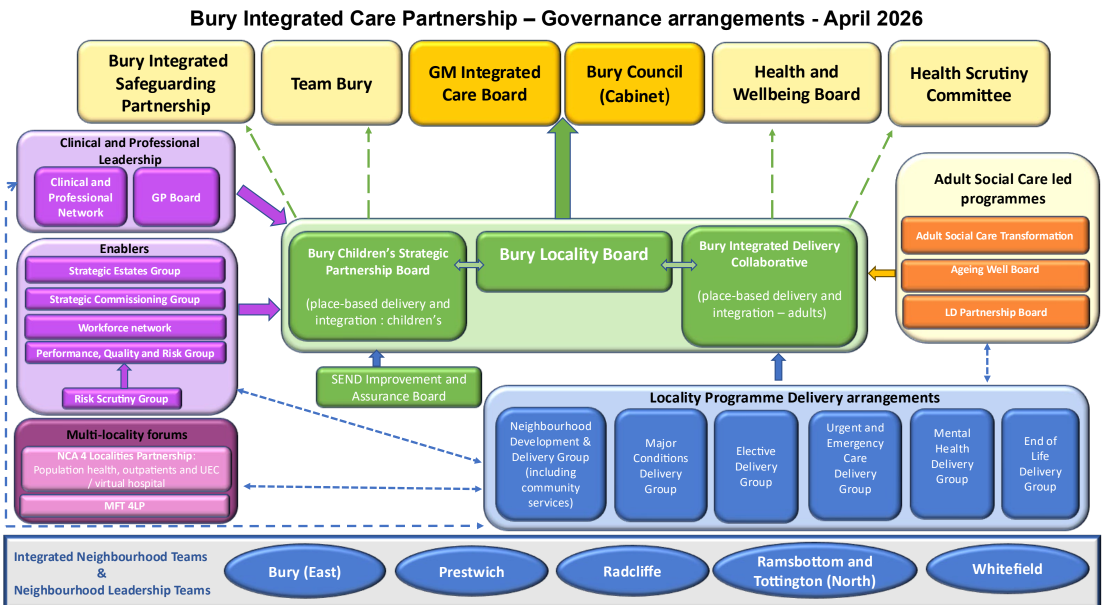
4.10 A benchmarking exercise shows Bury has 24 reablement beds per 100,000 population against a GM average of 17.5. There is an admission rate of 10.4 per 100,000 population, which is similar to the GM average of 11 and considerably above the England average of 7.3. The occupancy rate is 95-98% which is above both the GM average at 90-93% and England at 88-90%. ASCOF measure: The proportion of people aged 65 and over who were discharged from hospital into reablement and who remained in the community in the 12 weeks following discharge shows Bury ranked 44 nationally with a value of 65.5 which is above the region value of 62.2 and the England value of 60.7. ASCOF measure: proportion of people who received short-term services during the year (who previously were not receiving services) where no further request was made for ongoing support shows Bury as ranked 40 nationally with a value of 82.3 which is above both the regional figure of 78.5 and the England value of 77.1. This demonstrates that Bury's reablement service is both effective and efficient in supporting people to regain independence and avoid longer-term care needs.

4.11 Within the BCF the Bury locality identifies a number of schemes as health led and supporting discharge arrangements. These schemes are subject to annual evaluation as part the decision-making process for continuation into the next financial year. To allow for full year data the evaluations are submitted in April/May. The evaluations are reviewed by the Bury Locality UEC Board. Should for any reason a scheme not continue the UEC board may invite locality UEC stakeholders to submit new scheme preproposals for consideration.

5. Please outline your robust joint governance for managing the expenditure of BCF funding, including assessing impact of funding, value for money and continuous improvement.

5.1 Robust joint governance arrangements are in place to ensure that BCF resources are managed transparently, deliver value for money and achieve agreed system outcomes. These arrangements are overseen by GM ICB and led by the Bury Locality Board and the Local Authority, with strategic oversight and sign-off provided through the Health and Wellbeing Board (HWB), ensuring full alignment with local priorities and statutory responsibilities. Bury Locality's Integrated Care Partnership governance structure is demonstrated in Figure 1.

Figure 1: Bury Locality Integrated Care Partnership Governance Structure



5.2 The HWB provides strategic leadership, approves the BCF planning and reporting and receives assurance on delivery against agreed objectives and national BCF conditions.

5.3 Overall accountability for the BCF sits jointly with the ICB and Local Authority, formalised through a Section 75 agreement. The Locality Board (Figure 1) is a delegated sub-committee of the NHS GM board (as well as operating as the apex of senior partnership leadership in the health and care system, jointly chaired by the Leader of the Council and the Senior GP in the borough) and receives budget updates and quarterly reporting.

5.4 The Integrated Delivery Collaborative Board is the vehicle for the delivery of the health and care priorities on behalf of the Locality Board, oversees the localities main health and care transformation programmes and performance, including BCF goals.

5.5 Neighbourhood Development and Delivery Group – oversees the operation of Integrated Neighbourhood (health and care) Teams and Active Case Management and receives INT and Community Health Services performance reports on a monthly basis.

5.6 Palliative and End of Life Delivery Group - oversees the operation of specialist and generalist palliative care services and receives routine performance reports including review of metrics such as proportion of deaths in usual place of residence and emergency attendance and admission rates in the last 12 months of life.

5.7 Major Conditions delivery group leads on the development of improved integration and the delivery of preventative, community-based interventions in disease areas such as frailty, CVD, respiratory disease and cancer and monitors progress through a dashboard of relevant performance metrics

5.8 Operational oversight is provided through a quarterly BCF Governance Meeting, attended by representatives from the ICB, Local Authority finance and commissioning teams as well as relevant providers. This group monitors expenditure, reviews performance and escalates any issues including performance.

5.9 The impact of BCF funding is monitored through national BCF metrics. Performance data is reviewed quarterly alongside qualitative intelligence from operational teams and neighbourhood partnerships. Learning from performance reviews, audits and evaluation activity is used to inform continuous improvement and future commissioning decisions.

5.10 The BCF governance arrangements are fully aligned with other system governance structures, including neighbourhood health and place-based partnership boards, ensuring coherent decision-making and integrated delivery. This layered and collaborative approach provides assurance that BCF funding is used effectively, delivers tangible benefits for residents and supports sustainable system transformation.

Better Care Fund 2026-27 Numerical Template

Data Sharing Statement

Data Sharing Statement

Please see below important information regarding data sharing and how the data provided during this collection will be used. This statement covers how NHS England will use the information provided.

Purpose of data collection

NHS England is collecting data on behalf of Better Care Fund (BCF) partners to fulfil statutory duties, including improving healthcare quality, efficiency, and transparency. The data supports operational and strategic planning, financial management, workforce planning, and system feedback, as mandated by the NHS Act 2006 and relevant regulations.

Type and scope of data

Patient-level data, including identifiable information like NHS numbers, is not required.
Data includes finance, activity, workforce, and planning information as specified in the national guidance documents.
The BCF numerical template is categorised as "Management Information," and aggregated data, including narrative sections, will be published on the NHS England website and gov.uk.

Access, sharing, and publication

The BCF numerical template is categorised as 'Management Information' and data submitted will be published in an aggregated form on the NHS England website and gov.uk. This will include a narrative section. Please also note that all BCF information collected here is subject to Freedom of Information requests.
Internal Access: Data will be accessed by NHS England national and regional teams on a "need-to-know" basis and may be shared internally to support statutory responsibilities.
External Sharing: Data and information from this numerical template and associated narrative return may be shared with partner organisations and Arm's Length Bodies (ALBs) including BCF partners (i.e. Ministry of Housing, Communities and Local Government (MHCLG), Department of Health and Social Care (DHSC) and NHS England) for joint working and policy development.
Publication: Local Health and Wellbeing Boards (HWBs) are encouraged to publish local plans. Until publication, recipients of BCF reporting data (including those accessing the Better Care Exchange) cannot share it publicly or use it for journalism or research without prior consent from the HWB (for single HWB data) or BCF national partners (for aggregated data).

Storage and security

Data will be securely stored on NHS England servers. Shared data will be minimised and handled per confidentiality and security requirements.
The BCF template is password-protected to ensure data integrity and accurate aggregation. Breaches may require resubmission.

Data analysis and use

NHS England will analyse data submissions for feedback, reporting, benchmarking, and system improvement.
Triangulation with other data may be conducted to support deeper analysis and insights and inform decision-making.

Concerns

For any questions about data sharing, please contact your regional Better Care Managers or the national Better Care Fund team england.bettercarefundteam@nhs.net

Better Care Fund (BCF) 2026-27 Numerical Template

1. Guidance

Overview

The numerical return is designed to capture planned BCF spend, goals and assurance statements. Together with the narrative return these will enable local areas to demonstrate how they meet the national funding conditions, in line with the published BCF 2026-27: https://www.gov.uk/government/publications/better-care-fund-framework-2026-to-2027/better-care-fund-framework-2026-to-2027.

Completed numerical returns are due by Tuesday 19 May 2026 (noon)

Submissions should be sent to the national BCF team at england.bettercarefundteam@nhs.net, as well as to regional Better Care Managers.

This guidance provides an overview of how to complete this numerical return. Further guidance is provided in the BCF Planning Principles guidance and and supporting documents which can be found on the Better Care Exchange - https://future.nhs.uk/bettercareexchange/view?objectID=70716560

Functional use of the template

We are using the latest version of Excel in Office 365, an older version may cause an issue.
Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell
Pre-populated cells

This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

2. Cover

The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. To view pre-populated data for your area and begin completing your template, you should select your HWB from the top of the sheet.

Governance and sign-off
National condition one (refer to tab 6) outlines the expectation for the local sign off of plans. Plans must be jointly agreed and be signed off in accordance with organisational governance processes across the relevant ICB and local authorities. Plans must be accompanied by signed confirmation from local authority and ICB chief executives that they have agreed to their BCF plans, including the goals for performance against headline metrics. Please enter date of expected sign off if not yet signed off. **This accountability must not be delegated**.

Data completeness and data quality:
- Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells in this table are green should the template be sent to the BCF team: england.bettercarefundteam@nhs.net (please also copy in your better care manager).
- The checker column, which can be found on each individual sheet, updates automatically as questions are completed. It will appear red and contain the word 'No' if the information has not been completed. Once completed the checker column will change to green and contain the word 'Yes'.
- The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
- Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'. Please ensure that all boxes on the checklist are green before submission. Please contact your regional BCF team if you have any issues.

3. Income

This sheet should be used to specify all funding contributions to the HWBs BCF plan and pooled budget for 2026-27. This section will be pre-populated with the NHS minimum contributions, Disabled Facilities Grant (DFG) and Local Authority Better Care Grant (LABCG). For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your better care manager).

Additional Contributions
This sheet also allows local areas to add in additional contributions from both the NHS and local authority. You will be able to update the value of any additional contributions (local authority and NHS) income types locally. If you need to make an update to any of the funding streams, select 'Yes' in the boxes where this is asked and cells for the income stream below will turn yellow and become editable. Please use the comments boxes to outline reasons for any changes and any other relevant information as this will ensure section is marked as complete.

Unallocated funds
Plans should account for full allocations meaning no unallocated funds should remain once the template is complete.

4. Expenditure

Please see tab '4a. Expenditure guidance' for further information.

5. Metrics

For 2026-27, local authorities, integrated care boards (ICBs) and HWBs will be expected to monitor performance and improvement for the four metrics listed in the Metrics Handbook https://future.nhs.uk/bettercareexchange/view?objectID=277641413, available on the Better Care Exchange:

It is a national requirement for partners to set local goals in relation to the following two metrics:

- Non elective admissions to hospital for people aged 65 and over per 100,000 population
- Average length of discharge delay for all acute adult patients

HWBs are also encouraged to set goals for the metric on long-term admissions to residential and nursing homes for people aged 65 and over per 100, 000 population.

We also expect HWBs to monitor and drive improvements for the metric on the proportion of people aged 65 and over discharged from hospital with reablement provided partly or solely by local authorities who remained in the community within 12 weeks of discharge.

Further details on the metrics, can be found below:

1. Non-elective admissions to hospital for people aged 65 and over per 100,000 population. (monthly)
- This is a count of non-elective inpatient spells at English hospitals with a length of stay of at least 1 day, for specific acute treatment functions and patients aged 65+
- This requires inputting of both the planned count of emergency admissions. The population figure is pre-populated using the latest available mid-year estimates.
- This will then auto populate the rate per 100,000 population for each month
Source statistics: https://digital.nhs.uk/supplementary-information/2026/non-elective-inpatient-spells-at-english-hospitals-occurring-between-1-april-2020-and-30-november-2025-for-patients-aged-18-and-65

2. Average number of days from Discharge Ready Date to discharge (all adult acute patients). (monthly)
- This is calculated as the sum of all bed days between the Discharge Ready Date and discharge (bed days lost) for patients discharged in a given month, divided by the total number of patients discharged in that month.
In completing the table for 2026-27 we ask areas to set out these two components and sheet automatically calculates the average figure:
- In a given month, the total number of patients discharged on the same day as their Discharge Ready Date, divided by the total number of patients discharged in that month.
- The sum of all bed days between the Discharge Ready Date and discharge (bed days lost) for patients discharged in a given month, divided by the total number of patients delayed by at least 1 day and discharged in that month.
Source statistics: https://www.england.nhs.uk/statistics/statistical-work-areas/discharge-delays/discharge-ready-date/

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3. Long term admissions to residential and nursing care homes for people aged 65 and over per 100,000 population
- Admissions data is taken from the Client Level Data (CLD) source published on a quarterly basis and presents admissions as a rolling 12 month total, calculated to the end of each quarter and reported as a rate per 100,000 population.
- Population are based on a calendar year using the latest available mid-year estimates.

Any improvement planned in reablement can be noted in the narrative template but does not need to be included in this numerical template.

For missing pre-populated actuals data from November 2025 to date, please check the BCF dashboard on the DHeXchange which will have more recent data as it becomes available.

6. National conditions

This section requires local authorities, ICBs and HWBs to confirm whether the three BCF national conditions and planning requirements detailed in the published BCF 2026-27 guidance will be met. The assurance statements in this section refer to specific planning requirements, supplementing the information provided in the narrative template and this numerical template.

This sheet requires the local authories, ICBs and HWBs to confirm 'Yes' or 'No' to the assurance statements. Should 'No' be selected, please note the actions in place towards meeting the requirement and outline the timeframe for resolution.
In summary, the national conditions are as below:

- ***National condition 1:*** ICBs and local authorities must develop joint plans, agreed by health and wellbeing boards, outlining how ICBs and local authorities intend to use BCF funding.
to deliver more integrated and preventative care, linked to the wider development of neighbourhood health and social care services.
- ***National condition 2:*** ICBs and local authorities must comply with all national grant and funding conditions and deliver in accordance with their approved return. ICBs must
maintain the NHS minimum contribution to adult social care and pool NHS BCF contributions into a section 75 (of the NHS Act 2006) pooled fund.
- ***National condition 3:*** ICBs and local authorities must comply and engage with BCF planning, governance and reporting requirements including adherence to any assurance and oversight processes.

Better Care Fund 2026-27 Numerical Template

2. Cover

Version 1.0

Please Note:
- The BCF numerical template is categorised as 'Management Information' and data from them will be published in an aggregated form on the NHS England website and gov.uk. This will include any narrative section. Some data may also be published in non-aggregated form on gov.uk. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.
- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the Better Care Exchange) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- All information will be supplied to BCF partners (MHCLG, DHSC, NHS England) to inform policy development.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Governance and Sign off

Health and Wellbeing Board:	Bury
Confirmation that the plan has been signed off by Health and Wellbeing Board ahead of submission - Plans should be signed off ahead of submission.	No
If no indicate the reasons for the delay.	The next H&WB Board is not until June
If no please indicate when the HWB is expected to sign off the plan:	Thu 11/06/2026 << Please enter using the format, DD/MM/YYYY

Submitted by:	Hannah Dixon
Role and organisation:	Commissioning Manager, Bury Council
E-mail:	hannah.dixon27@nhs.net
Contact number:	7919963240
Documents submitted (please select from drop down) In addition to this template the HWB are submitting the following:	Narrative

	Role:	Professional title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:	Organisation
Health and wellbeing board chair(s) sign off	Health and wellbeing board chair	Cllr	Tamoor	Tariq	t.tariq@bury.gov.uk	
	Health and wellbeing board chair					
Named accountable person	Local authority chief executive	Ms	Lynne	Ridsdale	l.ridsdale@bury.gov.uk	
	ICB chief executive 1	Prof	Colin	Scales	colin.scales1@nhs.net	NHS GM ICB
	ICB chief executive 2 (where required)					
	ICB chief executive 3 (where required)					
Finance sign off	LA section 151 officer	Mr	Neil	Kissock	N.Kissock@bury.gov.uk	
	ICB finance director 1	Ms	Kathy	Roe	kathy.roe@nhs.net	NHS GM ICB
	ICB finance director 2 (where required)					
	ICB finance director 3 (where required)					
Area assurance contacts	Local authority director of adult social services	Mr	Adrian	Crook	a.crook@bury.gov.uk	
	DFG lead	Ms	Michelle	Stott	m.d.stott@bury.gov.uk	
	ICB place lead 1	Mr	Will	Blandamer	w.blandamer@bury.gov.uk	Bury Council & NHS GM ICB Bury
Please add any additional key contacts who have been responsible for completing the plan	ICB place lead 2 (where required)					
	ICB place lead 3 (where required)					

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your better care manager(s).

	Complete:
2. Cover	Yes
3. Income	Yes
4. Expenditure	Yes
5. Metrics	Yes
6. National Conditions	Yes

^^ Link back to top

Better Care Fund 2026-27 Numerical Template

3. Income

Selected HWB: Bury

Local authority contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Bury	£2,669,235
DFG breakdown for two-tier areas only (where applicable)	
Total Minimum local authority contribution (exc local authority BCF grant)	**£2,669,235**

Local authority better care grant (LABCG)	Contribution
Bury	£9,410,943
Total Local authority better care grant	**£9,410,943**

Are any additional local authority contributions being made in 2026-27? If yes, please detail below	No

Local authority additional contribution	Contribution	Comments - Please use this box to clarify any specific uses or sources of funding
Total additional local authority contribution	**£0**	

NHS minimum contribution	Contribution
NHS Greater Manchester ICB	£20,235,160
Total NHS minimum contribution	**£20,235,160**

Are any additional NHS contributions being made in 2026-27? If yes, please detail below	Yes

Additional NHS contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
NHS Greater Manchester ICB	£9,281,266	Core recurrent ICB funding
Total additional NHS contribution	**£9,281,266**	
Total NHS contribution	**£29,516,426**	

	2026-27
Total BCF pooled budget	**£41,596,604**

Funding contributions comments For any useful details please use the text box below (for no additional comments, insert 'NA')
NA

Better Care Fund 2026-27 Numerical Template

4. Expenditure

Selected Health and Wellbeing Board: Bury

Running Balances	Income (2026-27)	Expenditure (2026-27)	Balance (2026-27)
DFG	£2,669,235	£2,669,235	£0
NHS Minimum Contribution	£20,235,160	£20,257,707	-£22,547
Local Authority Better Care Grant	£9,410,943	£9,410,943	£0
Additional LA Contribution	£0	£0	£0
Additional NHS Contribution	£9,281,266	£9,281,266	£0
Total	**£41,596,604**	**£41,619,152**	**-£22,548**

Required spend on adult social care from NHS minimum allocations

	2026-27	
	Minimum required spend	Planned Spend
Adult Social Care services spend from the NHS minimum allocations	£11,037,663	£13,602,463

Checklist

Column complete:

	Yes	Yes	Yes	Yes	Yes

Number	Category of scheme	Description of scheme	Source of funding	Adult Social Care Spend	Expenditure for 2026-27 (£)
1	Long-term home-based social care services	Domicillary Care Packages	NHS Minimum Contribution	Yes	£992,606
2	Long-term residential/nursing home care	Residential care packages	NHS Minimum Contribution	Yes	£992,606
3	Long-term residential/nursing home care	Residential care packages	NHS Minimum Contribution	Yes	£38,401
4	Long-term residential/nursing home care	Nursing Home Care Packages	NHS Minimum Contribution	Yes	£1,031,317
5	Long-term home-based social care services	Supported Housing care Packages	NHS Minimum Contribution	Yes	£1,031,317
6	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and	Short Stay Residential Care (i.e following time in hospital or emergency home vacation where there is a need for a period of	NHS Minimum Contribution	Yes	£128,250
7	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and	Staffingt to Support Short Term Residential Care	NHS Minimum Contribution	Yes	£422,009
8	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and	Short Stay Residential Care (i.e following time in hospital or emergency home vacation where there is a need for a period of	NHS Minimum Contribution	Yes	£1,417,010
9	Home-based intermediate care (short-term home-based rehabilitation, reablement and	Short term adult rehabilitation and reablement support	NHS Minimum Contribution	Yes	£3,891,207
10	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,	NHS Minimum Contribution	Yes	£571,270
11	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	NHS Minimum Contribution	Yes	£82,152
12	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	NHS Minimum Contribution	Yes	£985,739
13	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	NHS Minimum Contribution	Yes	£1,922,970
14	Urgent community response	Crisis Response Community (incs rapid response)	NHS Minimum Contribution	No	£1,822,552
15	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and	Intermediate Tier	NHS Minimum Contribution	No	£2,562,098
16	Wider local support to promote prevention and independence	Integrated Neighbourhood Teams	NHS Minimum Contribution	No	£583,595
17	Discharge support and infrastructure	GP Inreach to Intermediate Care	NHS Minimum Contribution	No	£43,387
18	Discharge support and infrastructure	Home From Hospital (Increasing voluntary sector capacity)	NHS Minimum Contribution	No	£107,866
19	End of life care	Hospice Services support	NHS Minimum Contribution	No	£208,876
20	Other	Intermediate Care	NHS Minimum Contribution	No	£283,738
21	Other	SDEC Frailty	NHS Minimum Contribution	No	£296,770
22	Discharge support and infrastructure	Mental health discharge support schemes	NHS Minimum Contribution	No	£128,716
23	Long-term home-based social care services	Staywell	NHS Minimum Contribution	Yes	£95,609
24	Assistive technologies and equipment	Community Equip inc Telehealth	Additional NHS Contribution	No	£925,019
25	End of life care	Hospice	NHS Minimum Contribution	No	£617,645
26	Long-term home-based community health services	Community Nursing	Additional NHS Contribution	No	£7,228,565

27	Bed-based intermediate care (short-term bed-based	Integrated Neighbourhood Teams	Additional NHS Contribution	No	£1,127,682
28	Disabled Facilities Grant related schemes	Meeting the costs of adapting homes to enable people to stay independent in their homes	DFG	Yes	£2,669,235
29	Long-term home-based social care services	Deployment of resourec to enebalem contiued whole system flow	Local Authority Better Care Grant	Yes	£5,781,385
30	Wider local support to promote prevention and independence	Integrated Care Planning & Navigation -MDT case management supporting adults particularly	Local Authority Better Care Grant	Yes	£313,846
31	Wider local support to promote prevention and independence	Risk Stratufication -MDT case management supporting adults particularly at risk of	Local Authority Better Care Grant	Yes	£1,533,217
32	Long-term home-based social care services	Domicillary Care Packages	Local Authority Better Care Grant	Yes	£274,912
33	Long-term residential/nursing home care	Residential care packages	Local Authority Better Care Grant	Yes	£274,912
34	Long-term residential/nursing home care	Nursing Home Care Packages	Local Authority Better Care Grant	Yes	£274,912
35	Long-term home-based social care services	Supported Housing care Packages	Local Authority Better Care Grant	Yes	£274,912
36	Home-based intermediate care (short-term home-based	Short term adult rehabilitation and reablement support	Local Authority Better Care Grant	Yes	£682,847

4a. Expenditure Guidance

Guidance for completing expenditure sheet

1. Please enter spend information in the bottom table starting cell B30 including the category of spend which is a dropdown containing the categories listed in the table below. You must also enter scheme-level detail for the line of spend in 'Description of Scheme' with the appropriate level of information keeping this relatively succint, for example 'Community Health Rehabilitation' or 'MSK services' or 'Integrated Crisis and Rapid Response' would be sufficient. Please also enter source of funding which determines the total spend appearing in the source of funding table at the top. Ensure a 'Number' is entered in the 'Expenditure for 2026-27 (£)' so that the validation boxes can be marked as complete.

2. Please ensure 'Adult Social Care Spend' is marked 'Yes' when the money is spent on Adult Social Care across any funding source.

Scheme Types

Number	Category of scheme	Description
1	Assistive technologies and equipment	Using technology in care processes to support self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Housing related schemes	This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
3	DFG related schemes	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place.
4	Wider support to promote prevention and independence	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and wellbeing.
5	Short-term home-based intermediate care (rehabilitation, reablement and recovery services)	Short-term (up to 6 weeks), therapy-led services in the person's usual residence (home or care home), following the 'Home First' principle. For adults 18+ to regain independence post-illness/injury/discharge (step-down) or prevent admissions/long-term care (step-up). Person-centred, with initial assessment and regular reviews; led by registered therapists (physiotherapists, occupational therapists, speech/language therapists) plus support from unregistered workers and other professionals (nurses, doctors, social workers). Outcomes: better function, confidence, wellbeing; less carer reliance and long-term care demand. Domiciliary social care (personal care, domestic help) included only within a rehab/reablement-focused package.
6	Short-term home-based social care (excluding rehabilitation, reablement and recovery services)	Short-term domiciliary social care (e.g. personal care, help with domestic tasks, voluntary sector support), except where it is provided as part of a package that also includes rehabilitation, reablement and/or recovery services.
7	Long-term home-based social care services	Ongoing social care services (e.g. personal care, help with domestic tasks), helping people continue to live at home and maintain independence.
8	Long-term home-based community health services	Ongoing health services provided in people's own homes or in other non-residential community-based settings.
9	Bed-based intermediate care (short-term bed-based rehabilitation, reablement or recovery)	Short-term (up to 6 weeks), therapy-led services in a community bed-based setting (e.g. community hospital, care home bed or designated facility). For adults 18+ to regain independence post-hospital stay (step-down) or prevent avoidable admission/long-term residential care (step-up from community). Person-centred, with initial assessment and regular reviews; led by registered therapists (physiotherapists, occupational therapists, speech/language therapists) plus multi-disciplinary support (unregistered workers, nurses, doctors, others as needed). Where safe and appropriate, transition to home-based intermediate care is required to continue recovery at usual residence. Outcomes: improved function, confidence, wellbeing; reduced acute admissions, readmissions and long-term social care demand. May include mixed health and social care interventions.
10	Long-term residential or nursing home care	Ongoing care provided in a residential care home or nursing home for people who need more intensive or specialised support than can be provided at home.
11	Discharge support and infrastructure	Services and activity to enable discharge. Examples include multi-disciplinary/multi-agency discharge functions or Home First/ Discharge to Assess process support/ core costs.
12	End of life care	Schemes specifically designed to provide care and support for people nearing the end of life.
13	Support to carers, including unpaid carers	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
14	Evaluation and enabling integration	Schemes that monitor or evaluate the impact of integrated care schemes. Schemes or services that enable integrated care, such as (but not necessarily limited to): - Joint commissioning arrangements - Integrated care planning - Helping people navigate services - Workforce development or recruitment and retention
15	Urgent Community Response	Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
16	Personalised budgeting and commissioning	Various person centred approaches to commissioning and budgeting, including direct payments.
17	Other	This should only be selected where the scheme is not adequately represented by the above scheme types.

Better Care Fund 2026-27 Numerical Template

5. Metrics for 2026-27

Selected Health and Wellbeing Board: Bury

5.1 Non-Elective admissions

		Apr 25 Actual	May 25 Actual	Jun 25 Actual	Jul 25 Actual	Aug 25 Actual	Sep 25 Actual	Oct 25 Actual	Nov 25 Actual	Dec 25 Actual	Jan 26 Actual	Feb 26 Actual	Mar 26 Actual
Non elective admissions to hospital for people aged 65 and over per 100,000 population	Rate	1,384	1,479	1,329	1,370	1,288	1,397	1,425					
	Number of admissions 65+	505	540	485	500	470	510	520					
	Population of 65+*	36,500	36,500	36,500	36,500	36,500	36,500	36,500					
		Apr 26 Plan	May 26 Plan	Jun 26 Plan	Jul 26 Plan	Aug 26 Plan	Sep 26 Plan	Oct 26 Plan	Nov 26 Plan	Dec 26 Plan	Jan 27 Plan	Feb 27 Plan	Mar 27 Plan
	Rate	1,384	1,477	1,329	1,373	1,296	1,433	1,430	1,332	1,600	1,452	1,403	1,115
	Number of admissions 65+	505	539	485	501	473	523	522	486	584	530	512	407
	Population of 65+	36,500	36,500	36,500	36,500	36,500	36,500	36,500	36,500	36,500	36,500	36,500	36,500

Source: https://digital.nhs.uk/supplementary-information/2025/non-elective-inpatient-spells-at-english-hospitals-occurring-between-01-04-2020-and-30-11-2024-for-patients-aged-18-and-65

5.2 Discharge delays

*Dec Actual onwards are not available at time of publication

	Apr 25 Actual	May 25 Actual	Jun 25 Actual	Jul 25 Actual	Aug 25 Actual	Sep 25 Actual	Oct 25 Actual	Nov 25 Actual	Dec 25 Actual	Jan 26 Actual	Feb 26 Actual	Mar 26 Actual
Average length of discharge delay for all acute adult patients (this calculates the % of patients discharged after their DRD, multiplied by the average number of days)	1.07	1.05	0.70	0.90	0.43	1.07	1.14	1.03				
Proportion of adult patients discharged from acute hospitals on their discharge ready date	85.8%	88.4%	89.7%	89.0%	92.0%	88.3%	90.4%	86.7%				
For those adult patients not discharged on DRD, average number of days from DRD to discharge	7.5	9.1	6.8	8.2	5.3	9.1	11.9	7.8				
	Apr 26 Plan	May 26 Plan	Jun 26 Plan	Jul 26 Plan	Aug 26 Plan	Sep 26 Plan	Oct 26 Plan	Nov 26 Plan	Dec 26 Plan	Jan 27 Plan	Feb 27 Plan	Mar 27 Plan
Average length of discharge delay for all acute adult patients	1.07	1.05	0.70	0.90	0.43	1.07	1.14	1.03	1.15	1.10	0.98	0.92
Proportion of adult patients discharged from acute hospitals on their discharge ready date	85.8%	88.4%	89.7%	89.0%	92.0%	88.3%	90.4%	86.7%	89.8%	87.5%	86.0%	88.0%
For those adult patients not discharged on DRD, average number of days from DRD to discharge	7.49	9.06	6.75	8.18	5.32	9.09	11.86	7.76	11.28	8.83	7.00	7.70

Source: https://www.england.nhs.uk/statistics/statistical-work-areas/discharge-delays/discharge-ready-date/

5.3 Admissions to residential and nursing care homes

		Rolling 12 month total until end of quarter date indicated							
		Actual Ending 31-12-2024	Actual Ending 31-03-2025	Actual Ending 30-06-2025	Actual Ending 30-09-2025	2026-27 Plan Ending 30-06-2026	2026-27 Plan Ending 30-09-2026	2026-27 Plan Ending 31-12-2026	2026-27 Plan Ending 31-03-2027
- Long term admissions to residential and nursing care homes for people aged 65 and over per 100,000 population	Rate	904.1	854.8	780.8	778.1	150.7	150.7	150.7	150.7
	Number of admissions	330	312	285	284	55	55	55	55
	Population of 65+*	36,500	36,500	36,500	36,500	36,500	36,500	36,500	36,500

*Population of people aged 65 and above are based on the latest available mid-year estimates from the ONS

Better Care Fund 2026-27 Numerical Template
6: National Condition Planning Requirements

Health and wellbeing board: Bury

National Condition	Planning requirement	Assurance statement	Yes/No to assurance statement	Where the planning requirement or assurance statement is not met, please note the actions in place towards meeting the requirement	Timeframe for resolution	Complete:
National Condition 1: effectively support the delivery of integrated and preventative care ICBs and local authorities must develop joint plans, agreed by health and wellbeing boards, outlining how ICBs and local authorities intend to use BCF funding to deliver more integrated and preventative care, linked to the relevant areas of neighbourhood health and social care services.	ICBs and local authorities must have considered how to use the BCF most effectively to support the delivery of more integrated and preventative services, particularly supporting those with more complex health and social care needs. This must include setting out how the funding will be used to develop the quality, efficiency and outcomes from intermediate care.	Named ICB and local authority chief executives and named HWB chair must confirm that BCF expenditure is agreed and aligned with wider strategic objectives for neighbourhood health and social care.	Yes			Yes
	ICBs and local authorities must set out plans that: - show reasonable progress in the metrics of non-elective admissions (for people aged 65 and over) and delayed discharges - show how they will monitor and drive progress in preventing avoidable long-term care home admissions and improving outcomes from reablement - include the specific contribution of BCF-funded services.					
	ICBs and local authorities must demonstrate that their plans for the use of the BCF represent value for money and improve overall productivity					
National Condition 2: comply with expenditure and grant conditions ICBs and local authorities must comply with all national grant and funding conditions and deliver in accordance with their approved return. ICBs must maintain the NHS minimum contribution to adult social care and pool NHS BCF contributions into a section 75 (of the NHS Act 2006) pooled fund.	ICBs and local authorities must pool their designated minimum contribution (in the case of ICB partners) and the Local Authority Better Care Grant and DFG (in the case of local authority partners). ICBs and local authorities are able to voluntarily pool additional funding through the BCF where they consider this is likely to lead to an improvement in the services being funded.					
	The NHS minimum contribution to adult social care must be met and maintained by the ICB in line with the published BCF allocations. This represents an increase of 4.4% in each health and wellbeing board area.	ICBs and local authorities confirm compliance with BCF national grant and funding conditions, and that they will deliver in accordance with approved spend and BCF numerical return, including maintaining the NHS minimum contribution to adult social care.	Yes			Yes
	Local authorities must comply with the grant conditions of the Local Authority Better Care Grant and the DFG, including the pooling of funding.	ICBs and local authorities confirm they will pool funds through Section 75 agreements by 30th September 2026.	Yes			Yes
National Condition 3: - effective governance, reporting and engagement ICBs and local authorities must comply and engage with BCF planning, governance and reporting requirements including adherence to any assurance and oversight processes.	ICBs and local authorities must have effective joint governance is in place to ensure local accountability for delivery of outcomes, including reviewing performance against plan objectives and local goals, and taking action if necessary to bring delivery back on track.					
	ICBs, local authorities and health and wellbeing boards are required to engage with BCF reporting, oversight and support processes	ICBs and local authorities confirm full compliance with BCF planning and reporting requirements and will adhere to the BCF oversight and support processes.	Yes			Yes

Meeting:			
Meeting Date	01 June 2026	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	☒
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		

Population Health and Wellbeing update

1. Introduction

1.1. This paper sets out recent population health updates from the Bury health and wellbeing board.

2. Bury Health and Wellbeing Board

2.1 Bury health and wellbeing board took place on 17th March 2026. The agenda included discussions on the Better Care Fund, the Healthwatch annual report, an update on physical activity and the locality model.

2.2 Better Care Fund (BCF) Update

- Overall performance is stable, with Bury around the national average; residential admissions remain slightly below historic levels.
- Strong outcomes from intermediate care (e.g. ~82% reduce need), though pressures remain around residential care demand and capacity.
- The Board was assured on governance, use of the pooled budget, and delivery against requirements.

2.2 Healthwatch Annual Report

- Healthwatch highlighted strong community engagement, including work on women's health, youth engagement, and resident voice.
- Widely valued as an independent partner, though awareness varies across communities and needs strengthening.
- Ongoing concern about funding pressures, with static funding over 13 years posing sustainability risks.

2.3 Physical Activity Update

- Focus on increasing activity levels using a whole-system, place-based approach, aligned with GM and national guidance.
- Key challenges include:
    - Falling activity among children and young people
    - Gender inequalities (lower activity in girls)
    - Lower activity in deprived areas
- Emphasis on embedding activity into everyday life (not just sport) and targeting inactive groups.
- Agreed actions include exploring links with primary care, pharmacies, and community champions to promote activity.

2.4 Neighbourhood Working / Locality Model

- Strong emphasis on integrated neighbourhood teams to improve prevention, reduce hospital admissions, and join up services across sectors.
- The model aims to bring together health, social care, schools, housing, and emergency services at neighbourhood level.
- Alignment with Live Well GM and national policy highlighted as key.
- Members stressed:
    - Importance of schools and community engagement

- Avoiding a “building-led” approach to Live Well Centres
- Ensuring neighbourhood working is meaningful and not duplicative

Overall Themes

- Continued focus on integration and prevention across health and care.
- Growing emphasis on place-based and neighbourhood delivery models.
- Recognition of inequalities (e.g. deprivation, gender, awareness) and need for targeted action.
- Financial sustainability concerns, particularly for partner organisations like Healthwatch.

Jon Hobday
Director of Public Health
j.hobday@bury.gov.uk
February 2025

Meeting:			
Meeting Date	01 June 2026	Action	Receive
Item No.	13	Confidential	No
Title	**Report from the Performance & Quality Meeting – including quarterly risk report**		
Presented By	Catherine Jackson		
Author	Kath Wynne-Jones Catherine Jackson		
Clinical Lead	Cathy Fines Kiran Patel Catherine Jackson		

Executive Summary

This paper provides an update to the Locality Board on meetings, activity and discussions in relation to performance, IDCB work and quality.

The risk paper details the locality strategic and programme risks set by the locality Risk and Scrutiny Group as scored 12 and above using the strategic risk descriptors detailed in section 3 of this report. The risks are 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.

The risk register is cross referenced with the ICB risks as presented in the Board Assurance Framework.

Recommendations

The Board is asked to note the report, discuss and consider the risks and make recommendations to the Risk and Scrutiny Group to ensure robust transparency, oversight and mitigation of locality strategic and performance risks.

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 priorities	
Scale our work on Population Health Management – Improve population health and reduce health inequality of those in the most disadvantaged areas	☒
Drive prevention, reducing prevalence and proactive care – supporting Demand Reduction through primary intervention, secondary preventions and tertiary prevention.	☒
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	☒

Links to Locality Plan priorities	
Optimise Care in institutional settings and prioritising the key characteristics of reform.	☒

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		

Performance and Quality Meeting

Summary of Deep Dive into Primary Care

Zoe Alderson and Rachele Schofield presented a range of Primary Care data including a specific focus on access and triangulation of the various entry points across the system which provided assurance that Primary Care data was understood locally.

The key points in relation to CQC inspection ratings, the number of Friends and Family Test responses, the percentage of patients with hypertension - treat to target and cardiovascular disease (CVD) indicators were presented.

CQC Inspections – there were two visits undertaken in the last year to Ribblesdale and Rock Healthcare. Ribblesdale received a full and comprehensive inspection, whereas Rock Healthcare was rated through a desktop exercise. Both practices received a CQC **good** rating.

The Friends and Family Test (FFT) provides an indication of whether patients are appreciative of the support received from practices or believe that there could be improvements. Practices are required to submit data each month with a breach only occurring after three consecutive months of non-submission; no practices have breached this year. Rock Healthcare had the lowest positive responses and highest negative responses, while Huntley Mount also has relatively low positive response rates.

Results are tracked monthly to flag potential issues, but it is noted that the FFT only represents a small snapshot of patient feedback and there is no minimum number of responses needed. Any concerns about FFT results are discussed with the practice.

Additional quality indicators for example hypertension and CVD were discussed - a breakdown was provided at a practice level to support locality reporting; the overall borough position is often affected by variation between practices. The data provided assurance that the Primary Care team understood the data and any variations and picked up any concerns at a practice level through the quality meetings.

National Institute of Clinical Excellence (NICE) guidance – discussions took place on how practices can support treating patients in line with NICE guidance to ensure best patient outcomes including discussions in relation to communication and management of messages in relation to medication. It was agreed to invite the Head of Medicines Optimisation to have a regular GP webinar slot to reinforce key clinical guidance (e.g. hypertension and lipid-lowering) and to highlight key NICE / GMMMG[1] messages to support consistent clinical practice.

The Performance and Quality group agreed the following:

- The Primary Care data would be discussed at the Major Conditions board.
- The committee would review the 8 processes of care related to diabetes by practice, explore prescribing of anti-hypertensive medication and statins, and review admission data related to diabetes at a further meeting.

[1] Greater Manchester Medicines Management Group - Welcome to GMMMG - GMMMG

Bury ICP Strategic Risk Report

Introduction

This report updates the Locality Board on the key strategic risks to the delivery of the Locality Plan and Board priorities.

This report updates the Locality Board on the risks considered 12 or greater by the workstreams of the IDCB.

Risks are managed by the relevant IDCB workstreams and this report providers an overview to inform Locality Board members of high risks but does not contain those judged to be under 12 or all the actions that are ongoing in mitigation.

There is a locality Risk and Scrutiny Group who consider all the borough level risks, seeks assurance from the Transformation/Programme Boards and workstreams to advise on the elements of managing, scoring and escalation processes.

There is currently no electronic system for risk management for the borough whilst an agreement is made across the GM ICP and no locality risk manager.

Risk Descriptors

			Likelihood				
			1	2	3	4	5
			Rare	Unlikely	Possible	Likely	Almost certain
Consequence	5	Catastrophic	5	10	15	20	25
	4	Major	4	8	12	16	20
	3	Moderate	3	6	9	12	15
	2	Minor	2	4	6	8	10
	1	Negligible	1	2	3	4	5

KEY

No	Theme	Risk description	Initial score							Risk movement	Risk target	Key control / assurance
			25-26 – 26/27				26/27 – 27/28					
			Q3	Q4	Q1	Q2	Q3	Q4	Q1			
	Health of GM residents Taken from NHS GM Board Assurance Framework (BAF)	There is a risk that the health of the population will worsen due to wider economic and social conditions deteriorating. This could include societal challenges and structural inequalities that relate to poverty / socio-economic disadvantage, housing and local infrastructure, early years experiences and educational attainment, access to good employment, crime and safety, air quality and transport. This will result in poorer health, unsustainable demand on health and care services and will impede economic growth.	15	15						↔	10	The Greater Manchester Strategy is the main control measure and the deliverability of the strategy including the extent to which the ICB can act as a system influencer and strategic investor is key to mitigating this risk. In the current landscape of NHS reform, it is crucial that the ICB retains the capacity, expertise and ability to act as a collaborative system influencer and co-investor in relation to the building blocks of health which the strategy covers. Alongside the GMS, another key control is the development of a comprehensive strategic approach to NHS 'left shift' which builds upon our GM Population Health Model and comprehensive Prevention and Early Intervention Framework and underpins ICB reform and future transformational operating model. An evidence-based, co-produced and fully costed NHS GM Annual Plan for 2025/26 includes a series of actions relating to reducing the prevalence of poor health and scaling up proactive care. A Fairer Health for All Framework has been agreed by the Integrated Care Board and there are significant

												implementation plans in place for 2025/26 which will seek to embed tacking inequalities as a focus of the system. The GM Housing Tripartite Agreement ensures a collaborative approach to healthy homes across NHS GM, GMCA and Housing Providers.
	<u>Quality of Services</u> Taken from NHS GM BAF	There is a risk that key health and care services become unsafe and unstable due to growing and changing demand, pressures faced by other sectors and workforce, estates and technology gaps. This will result in poorer health outcomes for the GM population and a reduction in quality of care and patient safety and an inability to deliver operational delivery standards.	15	15						↔	10	NHS trust provider oversight (POM) in place and well established with plans to further develop and further strengthen. • Exec to exec meetings now a regular occurrence, with Quality KLOES identified. • ICB Provider Oversight Framework established in line with National Guidance. • Quality Assurance Framework established/aligned to meet the National Quality Board Standards. • Work underway to strengthen quality in contractual mechanisms to align with the strategic commissioner aim. • Quality Impact Assessment processes established • GM System Quality Group currently being reviewed in line with wider governance work underway at the ICB). • Reporting, audits and actions in place for safeguarding assurance (aligns to Safeguarding Policy). • MIAA Audit findings/actions • Annual reports (Quality Accounts / Safeguarding Report). • Assurance meetings with NHSE. • Submission to RSQG with escalations as part of business as

												usual. • External audits. • External inspections by regulators
	<u>Widening inequalities</u> Taken from NHS GM BAF	There is a risk that health inequalities are widened, and health outcomes are reduced to due to a lack of sustained investment in preventive, proactive and evidence-based services. This will result in increased demand and cost of health and care services and impede economic growth.	16	12						↓	8	Development of a comprehensive strategic approach to NHS 'left shift' which underpins ICB reform and future operating model. Inclusion of 'left shift' investments in the annual plan and budget for 2025/26. Strong oversight of the risk and mitigations through the Population Health Committee (chaired by an NHS GM NED) which has a risk register in place which is reviewed as a standing item at every committee meeting. An evidence-based, co-produced and fully costed NHS GM Annual Plan for 2025/26 includes a series of actions relating to reducing the prevalence of poor health and scaling up proactive care. A Fairer Health for All Framework has been agreed by the Integrated Care Board and there are significant implementation plans in place for 2025/26 which will seek to embed tacking inequalities as a focus of the system. The ICP Strategy and NHS GM Sustainability Plan both have a strong emphasis on improving health and reducing inequalities through prevention. NHS GM has agreed a comprehensive, whole system model for improving health and reducing inequalities in the form of the GM Prevention and Early

												Intervention Framework and co-produced GM Population Health Model. Refresh of the GM Strategy which has a significant impact on the wider determinants of health.
	Workforce Taken from NHS GM BAF	There is a risk that existing workforce challenges are exacerbated due to the requirement for financial savings and the impact of NHS reforms. This will result in recruitment challenges to key areas, reduced staff wellbeing, lower morale and inequality of opportunity. This will further impact on service delivery and leadership capacity to manage change.	12	16						↑		Direct reporting to NHS GM Board while Committee is stood down. • P&C Governance and supporting TORs • Committee working groups, focus on workforce efficiency, Transforming People Services, Leadership Culture & EDI • Monthly workforce reports • Operational planning rounds and provider oversight meetings, supporting pay bill reduction to support long term financial sustainability. • Regular review of the P&C risk register • Leadership, Culture and EDI; System-level equality impact assessment (EIA) risks noted at P&C; mitigation through electronic systems to increase visibility and assurance
	NHS Reform Programme disruption of core ICB business service delivery Taken from NHS GM BAF	There is a risk that the NHS Reform Programme could disrupt delivery of core ICB business due to restructure and staffing reductions. This will result in core ICB business being disrupted during the transition. Included in this risk is quality oversight of	16	16						↔	4	GM Transition Programme Team oversees management and updates of the risks for all component programme areas. Transition Operational Delivery Group holds oversight on all the risks within the transition programme and component workstreams. Transition Risk Group to have a grip and oversight over all programme risks. This group will

		commissioned services.										monitor controls, actions and ensure that all work is being done to lower the risk. Chief Officers meeting gives exec level assurance and approval of BAF risks and other high-level risks within the transition needed to be escalated. They will provide periodic updates to ensure progress on mitigations. Executive Committee has exec level assurance and approval of BAF risks and other high-level risks within the transition needed to be escalated. They will provide periodic updates to ensure progress on mitigations. NEDs/Execs Meeting assurance of the high-level risks within the transition programme with monitoring to ensure the risks are correctly being mitigated periodically. NHSE Oversight Meetings report on progress of the reform and any risks that need to be escalated.
	Finance: System Finance Position Taken from NHS GM BAF	There is a risk that the ICS does not achieve in-year and medium-term financial sustainability due to continued growth in demand, inflationary and cost pressures, inability to deliver CIPs in full and other identified causes such that the financial resources do not meet	20	20						↔	12	The enhanced levels of grip and control and financial assurance established during 2024/25 continue across the GM system, including CIP Governance, Provider Oversight. • NHSE has undertaken a review of both ICB and Provider Trusts exit run rate modelling to ensure consistency and robustness as part of planning. ICB plans submitted to NHSE 12/2/26

		system needs. This will result in the inability to deliver on the ICP Strategy, reducing our ability to invest in preventative care which will drive demand, and continued inequalities and variation in health and care.										showing achievement of plan in 2026/7,2027/8 and 2028/29. • The medium-term financial plan and financial strategy will be further developed to identify key principles and robust CIPs to support financial sustainability. • ICB has revised the reporting pack with a focus on run rate to allow identification of potential issues and mitigation plans have been implemented to address the risks on in year delivery. Run rates became a focus within the finance item of LAMs from July and are a key item within monthly monitoring for all ICB areas of expenditure. • Recovery plans have been developed for the 4 key areas of overspend: o CIP o Independent Sector o IPoC o ADHD/Autism Each recovery plan has SMART actions in place which will be monitored through the Financial Recovery Group with Committee and Board scrutiny. The ICB Recovery plan is now being accelerated to evaluate and approve new options to mitigate the current risk level with appropriate Board governance. Further schemes were developed including: o Meds Optimisation stretch target o Additional IS contracts activity plans o Primary Care o Non Pay and Workforce • All CIPs are subject to a quarterly deep dive to ensure they remain on track and

											determine if there is any opportunity for stretch. • Productivity pack - GM to continue with the system developed productivity pack that is now used across the NW. This helps to inform opportunities for improved performance and will become part of POMs.
	Urgent and Emergency Care	BECAUSE of limited flow of patients out of the ED and hospital, the number of patients in ED can be greater than the staff's capacity to manage within targets, 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).	16	16						↔	8	FGH failed the 4-hour target in 2024-25. However, the site is on an improvement trajectory and has seen improved performance month on month since December 2024. This improvement is currently set to continue in May 2025. Further work continues into 2025 -26 including: • Front door streaming review • Re launch of Bury Patient Flow Collaborative • Avoiding needless in patient/emergency care" Deflection from ED • Stroke Rehab -Right Place, Right Time • 7 Day Working More People Home Same Day • Understanding Length of Stay Wards Why not home? why not today? • Increase opening hours on SDEC Staffing review • Consultant Community in reach for Frailty and Dementia • Relaunch Activity rooms on Ward 18 & Ward 8

												• Understand Blockers to be able to Discharge before 10am • Review of services that we can left shift to the community • Implementation booking system to bring patients back the following day for SDEC/UTC June/July 25 • Fall Pilot in the Community • Rochdale Pathways • Weekend SDEC Frailty • Implementation of Hot Clinics • Roll out of Call before your conveyance starting 19th May 25 Review of a 24-hour Assessment area
	<u>Services for Children, including SEND</u> Awaiting inspection outcome letter	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. The increase in requests for ND assessments is being felt nationally and locally.	16	12						↔	8	Children's Improvement Board in place. Work continues on an improvement journey to strengthen the support for children, young people and families in the borough. External support from national team. Independently chairing a SEND improvement board. Committed £300k investment in the HV service delivered by NCA. mobilised in increasing SEND HV team. Investment into Early Years team. Developing - GM Investment (£200k) in the Neurodevelopmental offer, with the progress of a new model of care pathway. Offering early help to families – this should be fully mobilised by October 25. GM ADHD consultation on adult pathway changes is ongoing. Developing (GM) work is ongoing to

												address reduction in CAMHS waiting lists. Locally focus activity continues to address aspects of the pathway that are under significant pressure. Pathway mapping of the first 1001 days, and the potential roll-out of family hubs. Launch parenting strategy and early years proposition with oversight by the Children's Strategic Partnership Board. February 2025 – feedback following monitoring visit, positive improvements evidenced. Awaiting inspection letter confirming feedback.
	Local Implementation of Families First Partnership	There is a risk that the GM ICB will be unable to fulfill the statutory requirements of the Families First Partnership due to a lack of available funds to sustain the health workforce elements of the programme, following the initial allocation of grant monies in year one. Cause - Each of the 10 localities across the GM ICB footprint has a unique starting position both financially from the FFP grant and with the existing workforce within Provider Safeguarding Teams. Impact - This presents risk	16	12							6	FFP board in place. Good engagement from partners across the system. Funding agreed including split between agencies. Bury has the Family Safeguarding Model as its social work operating model. Family Safeguarding social work teams are aligned to neighbourhoods. Partners contributing to the design of the Early Help and MACPT design; on tract with the MACPT test and learn site. The reforms will build on the existing Family Safeguarding Model, align but not duplicate the MASH.

		that the Multi Agency Protection Teams will not have sufficient input from health to be able to ensure a true multi-agency response to child protection concerns.										
	Lack of a Plan for Managing the Dynamic Support Register for LDA Children	Dynamic support registers (DSRs) and Care (Education) and Treatment Reviews (C(E)TRs) are essential elements of the pathway providing people with a learning disability and autistic people with appropriate support and care at the right time. There is a risk due to the GM ICB reforms that the staff member responsible locally (DSO) will no longer carry out this function and there will be a gap in this function.	12	12						↔		Locally the Designated Clinical Officer (DSO) for SEND has responsibility for this function. Reform discussion underway with regard to having a centralised GM DSO team with fewer staff. Discussions with GM ICB on the role and responsibilities of the DSO ongoing. Adult DSR managed in Complex Care - no capacity in the team to pick this work up. Support from Complex Care team member to stream line process. No current identified landing place post ICB reforms for the DSR .
	Safeguarding workforce	There is a risk that the proposed GM ICB Safeguarding Team will be unable to fulfil all of its statutory obligations due to insufficient capacity within the team. Requirements for Named and Designated professionals who have delegated responsibility from the ICB to carry out	12	12						↔		Across GM there are gaps in staff in key safeguarding positions, additionally GM ICB have agreed further VR posts which will create more gaps. Locally the borough has statutory posts filled at the current time. Work on-going with GM ICB on the new proposed model. JDs and responsibilities being developed at GM level without local

		safeguarding duties on behalf of the organisation may not comply with statutory guidance. Impact - Insufficient capacity to deliver the level of assurance and oversight required by the GM delivery model Inability to meet required levels of audit and oversight within the multi-agency strategic safeguarding partnership. Workstreams, support General Practice and provide assurance that learning is adequately embedded across the health economy										input into the design. Mutual aid will be offered where able to as requested.
	Sustainable General Practice	IF: the apportionment of delegated PC monies is not sufficient enough to cover local elements unique to Bury (such as dementia diagnosis, ring pessaries, bloods etc) THEN: services may need to be stopped limiting what general practice support/deliver LEADING TO: Wider provider pathway pressures which cost more and possible poorer outcomes for the patients	12	12						↔	12	Additional investment supported by GM Board for 25/26 and whilst this hasn't fully addressed the variability goes some way to increasing investment and therefore service delivery/improvement over a phased period. Several services including Dementia Diagnosis are funded through LCS investment. Depending on the financial value attributed to further GM standardisation 1st April 2026 these locality specific services may be at risk. This has been flagged through various committees both locally and centrally in GM.

		of Bury										
	The delivery of the Uplands Practice estate solution	BEAUSE 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. The current facility is becoming increasingly difficult to maintain to an acceptable level and is already impacting on patient experience and staff within the practice.	12	12						↔	8	Financial and contractual discussions are progressing well with all parties, and the agreed site has now been in NHS Property Services for a number of months. National approval has been secured for capital to deliver the scheme on the ex-library site – the planning application has now been submitted with a decision expected in the coming months. The contract is currently out to tender with submissions due back towards the end of May 2026 – the financial approval documents will then need to be updated to reflect prices received. As in all complex projects of this type, until a contract has been awarded and works have started on site, careful management of all known risks continues. Current project plans estimate completion on site around May-July 2027.

	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	12	12						↔	8	Risk score reduced due in Q2 due to progress made. Bury has consistently had an average if between 0 and 1 inappropriate out of area placement and Month on month since April 2025 the number of bed days occupied on acute MH wards by Bury Patients who are clinically ready for discharge has been below target. The YTD position in the last reported month (October) was 817 bed days lost against a maximum target of 1113. LOS for adults and older adults have been on a downward trajectory since the start of the financial year and the number of 12 hour breaches has been consistently below the peak in December 2024. GM, PFT and locality level improvement plan in place. Weekly locality and GM MADE meetings to support flow in MH wards. GM crisis programme to increase / improve community-based crisis provision and pathways. Actively monitored through Bury MH Programme Board.

	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.	16	16						↔	8	Expenditure is significantly up on the same period last year with significant overspend projected. Budgets for ADHD / ASD provision are being centralised by GMICB and GMICB has taken the decision to suspend funding for new assessments by so called right to choose providers until at least April 2026 to control costs. Expenditure is being closely monitored. Standard service specifications for ASD assessment and ADHD assessment and treatment have been developed and will be implemented with all contracted and right to choose providers in 2026 which should support greater consistency in terms of quality. Plans to implement a triage gateway for adult ADHD assessments have been approved by the GMICB following a public consultation and this will ultimately limit the number of assessment referrals. There has been in principle agreement with GMICB exec to recommission Optimise Healthcare to provide shared care oversight and ADHD / ASD assessment for in 2026.27. This will provide a commissioned alternative to right to choose for patients requiring an

												ADHD or ASC assessment. The transformation of adult ADHD pathways is overseen by the GM Adult ADHD Steering Group with Bury Commissioner representation.
	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.	16	16						↔	8	Waiting times remain long – further work required to ensure standard routine reporting of waiting times. Progress monitored as part of the SEND improvement programme with regular reporting to SIAB PCFT CAMHS have implemented: - routine check-ins with families on waiting lists. - waiting list initiatives. GM triage / prioritisation criteria for ADHD / ASD assessments due to be implemented within CAMHS and community pediatrics as part of a wider neurodevelopment transformation programme from Jan 2026. CYP with the greatest needs / risks will be prioritised for assessment. The Bury ND Hub has been established to provider early help and needs based support without the need for a diagnosis. This together with other early help initiatives will provide needs led support to children and families and may reduce demand for full assessment in the

												longer term.
	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 (2025.26) there will be complete reliance on the right to choose pathway for new assessments and risk to the continuity of care for patients on medication resulting in: • Inability to implement managed pathways of care e.g., for CYP transition to an adult service. • Potential disruption to prescribing to patients. • Increased potential for GPs to refuse to enter into shared care agreements. • Reliance on right to choose with the associated inequality in access and cost pressures. Ongoing reputational impact.	12	12						↔	8	There has been in principle agreement with GMICB exec to recommission Optimise Healthcare to provide shared care oversight and ADHD / ASD assessment for in 2026.27. The STAR form has been submitted. The Process of seeking approval from the GM procurement team is in process. CAMHS teams have been notified that they can continue to transition young people on ADHD medication to Optimise. GMICB has taken the decision to suspend funding for new assessments by so called right to choose providers until at least April 2026 to control costs. NES commissioners continue to meet fortnightly to monitor the situation and progress commissioning arrangements for 2026.27.

4 Recommendations

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

5 Actions Required

5.1 The Locality Board is asked to note the contents of the report and to raise any issues for the IDCB and Risk, Performance and Scrutiny Group.

Catherine Jackson
Associate Director of Nursing, Quality and Safeguarding
Catherine.jackson2@nhs.net
NHS GM Bury

Meeting: Locality Board			
Meeting Date	01 June 2026	**Action**	Receive
Item No.	14	**Confidential**	No
Title	SEND Improvement and Assurance Board Minutes – 12th May 2026		
Presented By	Will Blandamer, Deputy Place Based Lead		
Author			
Clinical Lead	N/A		

Executive Summary
The minutes from the SEND Improvement and Assurance Board held on the 12th May 2026 are attached for information.
Recommendations
It is recommended that the Locality Board 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** ☐		

Links to Locality Plan priorities	
Scale our work on Population Health Management - Improve population health and reduce health inequality of those in the most disadvantaged areas	☒
Drive prevention, reducing prevalence and proactive care – supporting Demand Reduction through primary intervention, secondary preventions and tertiary prevention	☒
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	☒
Optimise Care in institutional settings and prioritising the key characteristics of reform.	☒

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 Council
Department of Children & Young People

Minutes

SEND Improvement & Assurance Board Meeting
12th May 2026

	ATTENDANCE	ROLE	ORGANISATION
	Deborah Glassbrook	Independent Chair	Optimising Potential Limited
	James Franklin Smith	CEO/Vice-Chair	Oak Learning Partnership
	Lynne Ridsdale	Chief Executive	Bury Council
	Kate Waterhouse	Executive Director of Strategy & Transformation & Vice-Chair	Bury Council
	Jeanette Richards	Executive Director for Children, Young People & Education	Bury Council
	Cllr Mary Walsh	Shadow Cabinet Member for Children & Young People	Bury Council
	Ben Dunne	Director of Early Years, Education and Skills	Bury Council
	Will Blandamer	Executive Director, Health and Adult Care; Deputy Place Lead	Bury Council; NHS GM (Bury)
	Wendy Young	Head of Service, SEND & Inclusion	Bury Council
	Jo McMaster	Designated Children's Officer for SEND (Bury)	NHS GM (Bury)
	Bridget Aherne	Head of Communications	Bury Council
	Robert Arrowsmith	Head of Strategy, Assurance and Reform	Bury Council
	Beth Speak	Children's Transformation & Improvement Manager	Bury Council

	Linda Evans	Director of Children's Social Care & Early Help	Bury Council
	Collette Radcliffe	Early Years Service Manager	Bury Council
	Scout Stirling	SEND Youth Ambassador	Bury Council
	Beth Osbaldeston	SEND Inclusion Ambassador	Bury Council
	Jane Bernhardt	Chair	BURY2GETHER
	Dr Cathy Fines	Medical Director	NHS GM
	Catherine Jackson	Associate Director of Nursing, Quality & Safeguarding (Bury)	NHS GM (Bury)
	Chris Bell	Joint Interim CEO	Vision Trust
	Catherine Hobday	Headteacher	Bury Virtual School
	Sarah Walton	Assistant Principal Personal Development Vocational & Foundation	Bury College
	Catherine Dent	Headteacher	Elmsbank School and College, Bury
	Rachel O'Neil	Headteacher/ SENDCO	Hoyle Nursery School
	Kirsty Jankowski	Designated Social Care Officer	Bury Council
	Additional		
	Kevin Burns	DfE SEND Adviser	DfE
	Gareth Llewellyn	Senior SEND Delivery Case Lead	DfE
	Janet Wray	NHSE Adviser	NHSE
	Helen Corbishley	Head of Performance and Delivery	Bury Council
	Kate Dowthwaite	Data & Intelligence Lead, SEND	Bury Council
	Nick Bell	Secondary Inclusion Lead	Bury Council
	Louisa Yau	Improvement Delivery Officer	Bury Council
	Sebastian Heywood	Minutes taker	Bury Council
	Apologies		
	Ian Trafford	Project Manager	NHS GM
	Adrian Crook	Director for Adult Social Care	Bury Council
	Cllr Lucy Smith	Lead Member for Children & Young People	Bury Council
	Cllr Tamoor Tariq	Lead Member for Health	Bury Council
	Jon Hobday	Director of Public Health	Bury Council
	Kathryn Mort	Headteacher	East Ward Primary School, Bury
	Martin McAndrew	Director	BURY2GETHER

1	**WELCOME & INTRODUCTIONS**
	The Chair welcomed the Board.

2	**MINUTES FROM THE PREVIOUS MEETING**
	The Chair reviewed the previous meetings' minutes. Page 10 – The word 'plan' was written twice, now corrected. Page 12 – Spelling correction, 'Monitoring' not 'Monitory', now corrected. Following the above corrections, the minutes were agreed as an accurate record of the previous meeting.
3	**ACTIONS AND RISKS LOG**
	81/219/221/259/300 – There was an extended discussion about workforce development actions. Will Blandamer suggests revisiting the entire thing as he feels sufficient progress isn't being made. Agrees there is some progress but recommends keeping the action open to be updated on a future Board. It was agreed that Workforce actions should be consolidated into a single action. **110/259 –** Communications related actions were discussed, Kate Waterhouse and Wendy Young updated on work done around updates, including work on more accessible formats and local offer materials. With issues around Beebot and other options being explored which have not progressed further yet, it was agreed that the action would remain open. **128 –** Ben Dunne updated on engagement with Jewish school leaders advising there is now a termly meeting set up with the last in mid-April. There had previously been Police support issues which have since been rectified with Police colleagues with direct contacts agreed. He suggested that Scout Stirling and the Changemakers should meet with the group in the future. **156 –** Participation group. Scout Stirling updated, Beth Osbaldeston has contacted CAMHS but has been told they are not currently looking to set up this group. They have offered to attend the Changemakers in lieu of a new group being created. Jo McMaster agreed to speak with the CAMHS team around this and update again in July. **195 –** Will Blandamer updated on engagement work, much work has been done with more to come, the ND pathway and Hub implementation group are to be reconvened, with the action to remain open with an extended deadline to next month. **276 –** Ben Dunne – non-maintained sectors, meeting with Nick to take place with SEND and AP sufficiency going forward. Nick Bell advised we now have two additional QA officers, which has been a priority. There is now a system and a team in place with work ongoing. Ben Dunne added that a future update could be folded into the SEND AP space in future discussions. Action to remain open for future update. **300/309 –** Workforce recruitment, Scout Stirling and Beth Speak discussed work on SEND student opportunities and workforce experience which is to be drawn together in impact reporting.

	310 – Liaise with Health on work experience, Scout updated work has been done but needs to be completed and added to her report which will be done toward the end of the month. **312 –** Beth Speak updated on must/would/should which links to 313. The Chair advised the action should be left open for future update. **315 –** Project Safety Valve, Jeanette Richards updated that DfE have announced formal closure of project safety valve. There is a good foundation of work in PSV which will be rolled into forward planning to support future workstreams on sufficiency and budget management. There will be regular financial reporting with an ongoing focus on this and linking into the reform plan going forward. **317 –** Full review of risk, The Chair asked if it would be valuable to review this now, Beth Speak updated following review of the SEND reform plan, she suggested this would be a part of the work being done. Lynne Ridsdale added that many of the risks link into the plan and asks how specific the plan will be. Beth noted that any work not directly linked to the reforms would have its own plan. Beth and The Chair agreed that any work is brought to the Board to ensure no work is lost. The Chair noted two risks were high, one on comms and one on health teams. Beth Speak to update on this at a future Board. **156 –** Scout Stirling updated on Schools engagement and CYP, item to remain open for future update. Nick Bell updated on fortnightly sufficiency meetings, the group are to engage with wider stakeholders around year-on-year plans. Roadmaps will be produced that will link into SEND Reforms and improvement. The group are currently mapping specialist pathways across pre and post 16 journeys. He suggests this should remain open constantly as this is a long-term plan. Ben Dunne added that this plan will be presented to Primary and Secondary school leaders in Summer. **Action 323 – Ben Dunne/Scout Stirling –** Scout Stirling and Changemakers to attend Jewish School Leaders Meeting. **Action 324 – Jo McMaster** – To speak with the CAMHS team around the participation group and update again at the July Board. **Action 325 – Will Blandamer –** ND pathway and Hub implementation group are to be reconvened ahead of the June Board.
	Changemakers update
	Scout Stirling and Beth Osbaldeston presented to the Board and offered updates on recent Changemakers activity. Beth Osbaldeston noted the group had contributed to the SEND charter and reviewed the Neuro Hub logo. The group attended a full youth cabinet session which took place on 31st March. The group have been designing a "school

	survival guide" for key stage 3 and key stage 4, with all content and priorities set by the young people themselves. Changemakers have co-produced a video with NHS colleagues to explain changes to the autism and ADHD assessment pathway. The Board watched the video, which featured Changemakers' members speaking about current waiting times, triage and prioritisation, examples of available support, and the principle that "support does not only start at the diagnosis". Board members welcomed the video and suggested adding clear information on how to access support alongside it. Scout Stirling then updated on the upcoming Impact Measuring day, tracking historic responses versus current, she noted that 32 education providers had been contacted with only 5 responding so fare. Ben Dunne and James Franklin-Smith agreed to assist in improving this response rate. Lynne Ridsdale advised corporate comms support for this would also be welcomed. The session will review SEND strategy, diagnostic pathway, statistics and video on assessment wait times. Prioritisation activity, transitions, specifically the 6-7 transition. A round table discussion about EHCPs and review finally with prioritisation activity based on the 6 PIPs. Several board members offered support and Jane Bernhardt asked what would happen with responses from the engagement day, hoping that the Board can make a commitment that young people's responses will be progressed, so that young people see tangible outcomes. Scout Stirling confirmed all responses would be written up and shared with the Board and potentially other young people in schools. It was agreed this would be an agenda item in July with feedback. She continued to explain that on the engagement day there are set times for each update and invited the Board to attend any sections relevant to them. Responses to parent carer feedback will also be picked up in July, Jeanette Richards added that this would be a function of the data sub group, with a suggestion to rename the group as the 'data and assurance sub group', Ben Dunne advised the group will reform and it's remit will shift, with issues raised by Jane Bernhardt to be discussed. The Chair advised that it is important that quality isn't missed in the way of ensuring things are done in a timely manner. Jeanette Richards advised that the subgroup should focus on high level KPIs, and data, but should also work on the assurance framework, reassuring the Board that these are being considered. Linda Evans updated on the engagement day, suggesting Kirsty Jankowksi and Fran Holden, member of the preparing for adulthood team, would link in with Scout Stirling to support on the day. The Chair would be interested to hear young people's thoughts on the transition from nursery to primary as she feels this is often overlooked and is a potential opportunity for early indicators for support.

	Ben Dunne added that as part of the Best Start Board there is a GLD support group which will investigate this to capture the voice of the child. The Chair asked the group to consider any other suggestions and asked that these are given to Scout Stirling. Beth Osbaldeston spoke about the Change Champions pilot, rolling out a Changemakers style group at schools. Elms Bank, Brookhaven and The Derby High School were piloting this model, with primary schools to follow. Scout Stirling provided a short update on voice mapping, listing schools that had responded so far with good uptake reported. But suggested another push, Ben Dunne asked Scout to go to him for support. James Franklin-Smith asked if it could be reported who had not responded yet for a targeted approach. Changemakers actions were then reviewed, including young people's attendance at SIAB and member attendance at Changemakers' meetings. The Chair asked that any Board members who have not yet attended Changemakers make plans to do so. The Chair raised timings for the July SIAB and asked if this could be hosted at a school, with potential to host at Oak LP discussed by James Franklin-Smith, which would allow for children from Elms Bank School to attend on July 14th. The Board revisited an earlier action about establishing a children and young people's participation group with CAMHS. Scout Stirling reported that CAMHS had now said they did not plan to set up this group, although they had offered to visit Changemakers again instead. Several members expressed concern that young people had been led to expect a group that then did not materialise, which risked undermining trust in co-production. Jo McMaster was asked to pick this up with CAMHS, with an update to come back to a future meeting. Scout and Beth indicated they would also cover this in their presentation as an area where they felt "this is a very important group to set up" and wanted stronger health support. **Action 326 – Scout Stirling –** To produce the impact measurement report from the 20th of May session, including comparison with the 2024 consultation, and present findings to the July board. **Action 327 – Ben Dunne –** Responses to parent carer feedback to be picked up in July, data subgroup to be reformed as a 'data and assurance subgroup', and its remit will shift.
4	**SIAB: Next Steps**
	Jeanette Richards discussed changes to SIAB following the Ofsted and CQC monitoring inspection, which focused on revisiting the PIP and the 6 areas identified as priority areas. She noted the inspection was 3 weeks of intensive work, built on two years of work and thanked all who contributed for their hard work. It was advised that the draft report has been supplied but that the wider report could not yet be shared as this was under embargo due to a local election

	postponement and would be published in June alongside the separate CQC adults report. She added that feedback had generally been positive around all areas where action was to be taken but recognised that there is more to be done to deliver consistently strong outcomes for young people and the community. Highlighting that this is a staging post with a need for continued improvement, whilst folding these into our wider transformation plan alongside the SEND reforms. It was noted that a key factor presented to inspectors was our ambition for young people and plans for a sustainable approach to governance going forward. Noting the transition of the independently chaired SIAB to James Franklin-Smith's chairing of a future SEND Board, an example of an incremental approach to arranging local ownership of the improvement. She noted that since the last SIAB, work had been ongoing to plan for the SEND reforms, with the next stage being to update Board members on where we are and how we plan to organise going forward. The Chair underlined that achieving effective action across all six priorities, given Bury's relatively high number of priorities, was a significant achievement. She confirmed that she would support lifting the SEND Improvement Notice in her report to the Department for Education once the inspection report was published, with the final decision sitting with the Minister. Gareth Lewellyn outlined how DfE engagement would change once the Improvement Notice was lifted. Shifting from a formal to an informal based assurance model with himself, Kevin Burns and Janet Wray still attending in a supportive capacity, maintaining informal contact with Leaders in Bury, reviewing emerging pressures and maintaining periodic check-ins with Wendy Young, Jeanette Richards and Ben Dunne, to understand any emerging risks. Without needing to refer to formal escalation processes. Gareth Lewellyn then noted his confidence in the leadership at Bury, highlighting his belief that Bury's internal processes will be able to manage the work, with the DfE acting as a partner throughout this change. Lynne Ridsdale welcomed these changes but advised that she would like to meet regularly with Gareth Lewellyn, ensuring we continue to maintain accountability for the whole department. Ensuring improvement is visible, and that suitable escalation processes remain in place to ensure all areas are together working to do their part. Noting the importance of clarity in these processes. The Chair discussed the transition to a new Chairperson for review in June, suggesting James Franklin-Smith act as Chair for the first time on the July Board meeting, with current Chair Deborah Glassbrook in attendance to support. With James Franklin-Smith assuming the role of Chair in full, from September onwards. The Chair, Deborah Glassbrook, offered to attend a future Board to assure quality following this change if required. The Chair noted that going forward the Local Area Reform Plan (LARP) will need to be reviewed and blended with the Priority impact Plan, with Lynne Ridsdale signing off on this. Will Blandamer added that the ICB will need to sign this off also, reminding the Board that this needs to be considered when discussing sign off.

5	**Local Area SEND Reform Plan Update**
	The Chair advised the Board will be reviewing the associated documents to ensure the full partnership LARP is complete and signed off ahead of deadline of 19th June. She added that for a variety of reasons the window to prepare documents has been reduced and has been a significant strain to progress. It was noted that there has been a shift around co-production to a consultation capacity rather than a full co-productive approach although as much co-production has been implemented as possible. The Chair noted the importance of getting the report signed off at the first time of asking to ensure the optimum timeline can be achieved to ensure timely funding. She outlined challenges, one being Experts at Hand, the new term for wrap-around teams for schools, as there is not yet a full set of criteria. Ben Dunne presented to the Board and spoke to key elements. He outlined the three items to be discussed, the Maturity assessment feedback form the group, the SEND data template and the Bury LARP. He assured the Board that he is confident the timeline will be met and welcomes the huge opportunity. Understanding that the Local Authority working collaboratively with School Settings is a wonderful opportunity which will be welcomed by educational settings. He continued to advise that much of the draft plan has been completed, and acts as an all-encompassing reform plan going forward, and ensures we won't lose sight of some of the more negative feedback received. He noted it is important that the data template speaks to the reform plan. He then presented the Maturity assessment and encouraged the Board to discuss. The Chair spoke highlighted the four categories, not yet emerging, emerging, developing and maturing. Suggesting it is better to be realistic than too optimistic. Noting she believes currently there are two 'emerging' and asked the Board to consider where the evidence for this progress is. Jeanette Richards asked Beth Speak to provide an overview of the process around the maturity tool. She noted that a workshop session with the DfE advisor, Health, Social Care and Education colleagues, had taken place and was a full afternoon spent working through the challenges and that at that point there were no 'Emerging', with future guidance simplifying some of this and work has now been done to speak to this. She added this had become a part of the wider plan, with herself, Wendy Young and Bury2Gether supporting what had been written on the assessment up to that point. Also noting the weekly reference group had been helpful to provide oversight for all involved to encourage regular feedback.

	Robert Arrowsmith noted that this is a best fit grading, and that not all of the characteristics given to all pillars were not necessarily hierarchal. Which is what allowed the workshop to determine which descriptors were more relevant to Bury. He added we need to regard this as a snapshot and that the actual reform plan will be significantly more important to the DfE and should be approached as such. Lynne Ridsdale added that she would welcome Kevin Burns' perspective but noted it may be in our interest not to overpromise. Ben Dunne agreed, adding that we should try not to be overly optimistic. Jeanette Richards added that our inspectors advised we do have a realistic understanding of where we are, noting we may be more critical of ourselves. Kevin Burns noted the maturity assessment is important, specifically in it's triangulation of where we are and next steps. These things will be reviewed together. He added that he has tried to highlight criteria and noted that there will be more criteria to follow. Adding that its accuracy and fairness will be important. He continued to add that number four stands out and he has raised this with Ben Dunne, noting that it comes out as emerging but is written in a very positive form. Suggesting an inconsistency, questioning why this would be considered as emerging rather than developing in that case. Noting that he doesn't disagree with the decision made, but questions continuity throughout the assessment. The Chair challenged number three, and the effective use of qualitative and quantitative data, noting she feels this has not yet been a key feature in thematic research. She added that it isn't clear that data is being used accurately and suggests this is 'emerging' rather than 'developing'. James Franklin-Smith added that self-evaluation requires a solid understanding of the start point, noting the danger of being overly optimistic. Noting pillar seven, highlighting that this is still a plan, but believes this is 'emerging'. Chris Bell noted Pillar five, questioning where the evidence for this is. He noted this was because conversations he had with the HMR were positive. Ben Dunne answered that whether emerging or developing, will it affect the quality of our plan going forward, welcoming the Boards feedback. Jane Bernhardt spoke about pillar one, adding that co-production for this needs to continue as it is not currently solid, suggesting that if this falls behind it will mean other feedback streams will stop. The Chair asked the Board how to take this forward, Robert Arrowsmith noted this was initially done as a self-evaluation tool, noting this perspective needs to be considered when reviewing. Kevin Burns added that there is an upcoming review point which he suggests using as a step back, to review and get some feedback which may highlight any issues which could be brought back for scrutiny.

	Scout Stirling pointed out Pillar six, noting the School Survival Guide is mentioned alongside another piece of work but noted these are two separate items. Will Blandamer noted the importance of remaining cautious; there is a marginal judgement between outcomes should remain positive, rather than leaning toward a negative outcome. The Chair noted that there is to be significant scrutiny to ensure areas are not overly optimistic, suggesting that if there is evidence to back up claims, it should be well referenced. Ben Dunne suggested adding a column to the table to give opportunity to comment on where we should be and why, and that this is sent to members of the Board for comments to be collated and worked into a revised draft, to then be presented to and reviewed by Kevin Burns. The Chair agreed Ben Dunne's suggestion, with Board members taking time to review content and suggest changes. The Board agreed to provide this feedback. The Chair requested this be sent out today, collated by close of play Tuesday and brought to the scrutiny meeting next Thursday. Helen Corbishley updated on the SEND Data Template. She spoke about the baseline which had been worked on with Ben Dunne and Kevin Burns. She continued to review each area of the template and asked the Board for any questions. Ben Dunne noted an upcoming workshop to bring together multiple workstreams under this template. It was confirmed the finished template would be brought to the June SIAB. Ben Dunne highlighted key challenges and risks that are being reviewed. He advised that future planning is built around the four building blocks of an inclusive system. He continued to describe the Experts at Hand model and its strategic and wider systems approach to the school rather than individualised provision. He spoke on the importance of school leaders understanding the model and how it fits into the framework of universal support across Health, Social and Education. With a view to triangulating this around universal, targeted and specialist support. Lynne Ridsdale raised questions about the level of capacity and funding available to deliver the ambitions set out in the plan, and the risk that increasing demand and wider system pressures would outpace reforms. She asked for clarity on the various funding streams, what they would realistically buy in terms of posts and services and noted her understanding that there would be a GM model for Experts at Hand. Ben Dunne noted that Will Blandamer may know more about GM wide plans, noting that funding is currently unclear and asked him for insight. Will Blandamer noted a risk, specifically that all funding for Experts at Hand comes into the Council and not into the NHS. Noting the need for an ICB wide

	approach and that Local Authority's would need to plan to put aside funding. This is an ongoing discussion. Wendy Young underlined that Bury already had a strong universal offer through communities of practice, which provided early identification and support, and that there was significant unexploited scope to work more collaboratively across existing services, including joint CPD, before adding new programmes. She emphasised that Experts at Hand was about addressing commonly occurring needs at the earliest stage and that their three-tiered framework was a foundation for this. Robert Arrowsmith came back to risk and noted that the plan stretched to 2028/29 and the DfE have stated EHCPs will be kept until 2030, therefore any modelling needs to look at how this will impact, he suggested the system might not change fundamentally and we therefore need to show moderate and continued growth within this time scale. The Chair agreed this may be true but noted the need to tilt the system so that parents and carers get earlier assessment/support as a part of a larger cultural shift. The Chair noted the tiered system, pointing out a gap in alignment with the White Paper, Ben Dunne advised this can be added. Wendy Young stated that this is because of how the work is currently understood, The Chair agreed but noted it will be important to differentiate between targeted and targeted plus. Kevin Burns noted the importance of reviewing and checking funding for years one and two. Suggesting it is important to clearly understand the commitment as scrutiny around this will be much greater than it was on Project Safety Valve, therefore any promises made in the plan must be realistic. James Franklin-Smith suggested that there needs to be explicit expectations on schools' role in inclusion and early identification, and clarity on what the local authority would and would not do. Ben Dunne outlined work with secondary leaders on suspensions, attendance and inclusion, and plans for new senior leader networks across early years, primary, secondary curriculum and secondary pastoral, which would be led by school leaders and aligned with the Experts at Hand model. **Action 328 – Helen Corbishley –** A finished SEND Data Template is to be brought to the June SIAB.
6	**ANNUAL ENGAGEMENT EVENT UPDATE**
	This item was not discussed in detail.
12	**AOB**
	At the close, the Board agreed on the next steps and timelines. A 'working final draft' is expected by the 5th of June, for Lynne Ridsdale and James Franklin-Smith to review ahead of signing off at SIAB on the 11th of June. For submission of the final plan on the 19th of June following chief executive and ICB approval.

13	**UPCOMING MEETING DATES**
	Upcoming meeting dates: - 11th June 12.30 – 13.30 (Online) - review LARP submission - 14th July 10.00 – 13.00 Town Hall- agenda to be agreed - September 10.00 – 13.00 Town Hall (Date to be agreed with Chairperson) - November 10.00 – 13.00 Town Hall (Date to be agreed with Chairperson) -