Agenda

Locality Board – Meeting in Public (on Teams)

Date: 7th September 2026

Time: 4.00 pm – 6.00 pm

Venue: Microsoft Teams

Chair: Cllr E O'Brien

Item No.	Time	Duration	Subject	Paper Verbal	For Approval Discussion Information	By Whom
1.0	4.00 – 4.05	5 mins	Welcome, apologies and quoracy	Verbal	Information	Chair
2.0			Declarations of Interest	Paper	Information	Chair
3.0			Minutes of previous meeting held on 6th July 2026 and action log	Paper	Approval	Chair
4.0			Public questions	Verbal	Discussion	Chair
Place Based Lead Update						
5.0	4.05 – 4.10	5 mins	Key Issues in Bury	Paper	Discussion	Lynne Ridsdale
6.0	4.10 – 4.20	10 mins	VCSE Focus – The Big Fandango	Verbal	Discussion	Rebecca Jackson
7.0	4.20-5.00	40 mins	NCA update	Paper	Discussion	Will Blandamer, Dr Manisa Kumar, Lorna Allan, Dr Jay Naisbitt
Neighbourhood Plan						
8.1	5.00-5.15	15 mins	Locality Plan Refresh	Paper	Approval	Will Blandamer/Kath Wynne Jones
8.2			Delivery Plan – neighbourhood working	Paper	Approval	
8.3			Primary Care/Beccor proposal	Paper	Approval	
Integrated Delivery Update						
9.0	5.15-5.25	10 mins	Mental Health update • Pennine Care update	Paper	Discussion	Sarah Preedy/Rachael Osbourne
10.0	5.25-5.35	10 mins	North Manchester Redevelopment Update	Verbal	Discussion	Karen Kennedy

Committee/Meeting updates						
11.0	For info	For info	Performance & Quality Group update	Paper	Information	Kath Wynne-Jones/Catherine Jackson
Closing Items						
12.0	5.50	5 mins	Any Other Business		Verbal	
	_____	_____	**Date and time of next meeting in public - Monday, 5h October 2026, 4.00 - 6.00pm in Committee Rooms A and B, Bury Town Hall**		_____	
13.0		5 mins	Post Meeting Reflection		Verbal/All	

Meeting: Locality Board			
Meeting Date	07 September 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 7th September 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	Young Christian Workers	X			Direct	Member		Present	As per policy - see details above
				Labour Party		X		Direct	Member		Present	
				Bury Corporate Parenting Board		X		Direct	Member		Present	
				No Barriers Foundation		X		Direct	Trustee		Present	
				CAFOD Salford		X		Direct	Member		Present	
				Catenian Association		X		Direct	Member		Present	
				USDAW		X		Direct	Member		Present	
				Prestwich Methodist Youth		X		Direct	Trustee		Present	
Cllr	Tariq	Tamoor	Executive Member of the Council Adult Care and Health	Welspun UK LTD				Indirect	Spouse/Civic Partner Employed		Present	
				GMICP		X		Direct	Member		Present	
				The Derby High School			X	Direct	Governor	Apr-18	Present	
				Health & Wellbeing Board Member		X		Direct	Member		Present	
				Unite the Union		X		Direct	Community Member	May-12	Present	
				Labour Party		X		Direct	Member	Jun-07	Present	
Dr	Fines	Cathy	Place Clinical Director	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 Improvement and Personalisation	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)
Dr	Kumar	Manisha	Chief Clinical Officer, NHS Greater Manchester	Robert Darbishire Practice	X			Direct	Salaried GP	2024	Present	
				University of Salford		X		Direct	Honorary Professor University ofSalford	May-23	Present	
				Primary Eye Care Services LTD			X	Indirect	Husband is Operations Director	2021	Present	
				General Optical Council			X	Indirect	Husband is Case Examiner	2019	Present	
	Kissock	Neil	Director of Finance/Section 151 Officer	None Declared					Nil Interest	Aug-24	Present	
Voting Members (Aligned & Non-Pooled Budget)												
	Fawcus	Joanna	Director of Operations, NCA	None Declared					Nil Interest	Nov 23	Present	
Dr	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	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 treatments	X			Direct	Medical Director	1994	Present	
				Laserase Bolton - Provider of a range of cosmetic laser and injectable treatments				Indirect	Spouse is a Shareholder	2012	Present	
				Tower Family Health Care - Primary Care General Practice				Indirect	Spouse is a Director	Jul-18	Present	
	Kennedy	Karen	Director of Strategy, NCA	None Declared					Nil Interest	July 2026	Present	
	Preedy	Sarah	Chief Operating Officer, Pennine Care NHS Foundation Trust	None Declared					Nil Interest	Nov 23	Present	
	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	Place Partnership Director	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
	Vermeulen	Elaine	Associate Director of Strategic Finace - Bury & Salford	Public sector director on MAST LIFTCo Board		X		Direct	Director	01-Nov-23	31-Mar-27	As per policy - see details above. (Y,Y,Y,Y,Y)
	Bulman	Richard	Director of Nursing, Bury Care Organisation	None Declared					Nil Interest	2025	Present	
	Crook	Adrian	Director of Adult Care & Neighbourhood Delivery	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	
	Passman	Ruth	Chair of Bury Healthwatch	None Declared					Nil Interest		Present	As per policy - see details above
	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	Birchmore	Carol	Attendee of the Locality Board as Radcliffe First Councillor	Radcliffe First		X		Direct	Member		Present	
				St Phillips Community Centre Committee			X	Direct	Member		Present	
				Radcliffe Rotary			X	Direct	Member		Present	
				Barge Garden Radcliffe			X	Direct	Organiser		Present	
				St Thomas, St Johns & St Phillips			X	Indirect	Spouse is a acting Treasurer		Present	
Cllr	Rydeheard	Jack	Attendee of the Locality Board as Reform UK Councillor	Reform UK		X		Direct	Member		Present	
				Association of Reform Councillors (ARC)		X		Direct	Member		Present	
				Royal British Legion			X	Direct	Member		Present	
				Conservative and Unionist Party		X		Direct			Present	
				GMB Union		X		Direct	Member		Present	

Cllr	Walmsley	Sandra	Attendee of the Locality Board as Labour Councillor	Bury North Constituency Labour Party		X		Direct	Chair		Present	
				Labour Party		X		Direct	Member		Present	
				LGBT (Labour)		X		Direct	Member		Present	
				Labour Women's Network		X		Direct	Member		Present	
				Moorside Branch Labour Party		X		Direct	Vice Chair		Present	
				Bury Local Government Committee		X		Direct	Member		Present	
				Voluntary Trustee at the Fusilier Museum (Bury)		X		Direct	Trustee		Present	

Meeting: Locality Board			
Meeting Date	07 September 2026	**Action**	Approve
Item No.	3	**Confidential**	No
Title	Minutes of the Previous Meeting held on 6th July 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 6th July 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	☒
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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 – 6th July 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	6th July 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 Microsoft Teams 6th July 2026 4.00 pm until 6.00 pm **Chair – Dr Cathy Fines**

ATTENDANCE

Voting Members
Dr Cathy Fines, Senior Clinical Leader for the Borough (Chair) Cllr Tamoor Tariq, Executive Member of the Council for Adult Care and Health Cllr Sandra Walmsley, Executive Member of the Council for Children and Young People Ms Lynne Ridsdale, Place Based Lead Ms Lorna Allan, Chief Digital and Information Officer, NCA Ms Sarah Preedy, Chief Operating Officer, Pennine Care Foundation Trust Ms Helen Tomlinson, 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 Jeanette Richards, Executive Director of Children and Young People, Bury Council Mr Jon Hobday, Director of Public Health, Bury Council Ms Catherine Jackson, Associate Director for Nursing, NHS Greater Manchester (Bury)
Non-Voting Members
Mr Mark Beesley, Chief Officer, Bury GP Federation
Invited Members and Observers
Cllr Carol Birchmore, Leader, Radcliffe First Ms Hannah Dixon, Commissioning Manager (Bury) Mr Tori Johnson, Motherzen, Mrs Emma Kennett, Place Partnership Lead, NHS Greater Manchester (Bury) Ms Rachel Everitt, Governance, Elections and Land Charges Manager, Bury Council

MEETING NARRATIVE & OUTCOMES

1.	Welcome, Apologies and Quoracy
1.1	The Chair welcomed all to the meeting.
1.2	Apologies were received from: - • Ms Elaine Vermeulen, Associate Director of Strategic Finance – Bury & Salford • Ms Nicola Hepburn, Executive Lead, NHS Greater Manchester • Cllr Eamonn O'Brien, Leader of Bury Council • Dr Kiran Patel, Medical Director, Bury IDC • Ms Kath Wynne-Jones, Chief Officer, Bury IDC • Mr Stuart Richardson, Chief Executive, Bury Hospice • Cllr Jack Rydeheard, Leader, Reform UK • Ms Karen Kennedy, Director of Strategy, Manchester Foundation Trust
1.3	The meeting was declared quorate.

2.	Declarations Of Interest
2.1	NHS Greater Manchester 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 Greater Manchester (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 Greater Manchester (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 6th July 2026 and the previous meeting 1st June 2026.
2.9	Ms Allan reported that she had now stepped down from her trustee role at the Hospice in York and this would need to be reflected as part of the Locality Board register going forward.

ID	Type	The Locality Board	Owner
D/07/01	Decision	Received the declaration of interest register.	
A/07/01	Action	Declaration of Interest register to be amended to reflect Ms Allan's change	Mrs Kennett

3.	Minutes Of the Last Meeting and Action Log
3.1	The minutes from the Locality Board meeting held on 1st June 2026 were considered as a true and accurate reflection of the meeting.
3.2	Updates were received in respect of the Action Log and the following updates were noted: - • A/02/04 - Mental Health Gap Analysis to be brought back to future Locality Board meeting. It was noted that a Mental Health update would be brought back to the Locality Board in September 2026. • A/03/04 - 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. It was noted that this had been raised and could be closed in terms of the agenda log however Mr Beesley may also like to follow this up from a GP Federation perspective. • A/04/03 - Mr Crook agreed to check on the exact figure given to the VCFE on an annual basis. It was reported that the exact figure (£46m) had been shared with Ms Tomlinson and was highlighted that the majority of funding (99%) sat with statutory provision within charities. • A/06/01 - Meeting to be arranged with Ms Sarah Cook from Homestart to discuss future opportunities. It was noted that this meeting was being arranged and the action could be removed from the action log. • A/06/03 - Further discussion on the national Diabetes programme to be scheduled for the Major Conditions Board. This action should remain open as wasn't clear when was planned for discussion. • A/06/04 - Any changes to the Family First Partnership risk to be submitted to Ms Jackson. The Risk register had been updated therefore this action could be removed.

ID	Type	The Locality Board	Owner
D/07/03	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/07/04	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: - • In terms of the inspection of Adult Care Services at Bury Council by CQC, this had resulted in a rating of "Good". This result reflected years of hard work by staff and leadership in transforming and reforming the model of Adult Care in the borough. It was also a reflection of the commitment of Adult Care to partnership working in the borough, through for example integrated neighbourhood teams and intermediate care, and the reciprocal support received from NHS partners, provider providers, and the Voluntary and Community Sector. • In relation to the Bury SEND partnership CQC and Ofsted Reinspection**,** the Bury SEND partnership had been judged as taking 'Effective Action' in all 6 priority improvement areas in the recent SEND Reinspection by CQC and Ofsted. This had followed 2 years of intensive improvement work led by the independently chaired SEND Improvement and Assurance Board. It should be noted our DFE and NHSE advisors have indicated it was very rare for an area to have had as many as 6 improvement areas and be judged as taking effective action on all of them. This judgement was a testament to the outstanding work across the Council Childrens Services, NHS partners and education partners and other key stakeholders and all colleagues were commended for their commitment to improvement of the SEND system for children, young people and families in the borough. • In terms of the NHS Place Team Hosting arrangements, at the last two Locality Board meetings there had been 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 were hosted locally on behalf of the Place Partnership, while remaining focused on the shared outcomes of the partnership rather than any single organisation. 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 to confirm their position in writing by the 7th July 2026. Bury has been working with colleagues in Salford, Rochdale, and Oldham to consider the opportunity of a single position on the NCA footprint and the NCA have indicated a willingness to consider being the receiving

	employer for NHS GM staff on that footprint. Significant further due diligence work is required between NHS GM and NCA. Importantly, and in the context of the place partnership documentation presented at this meeting, hosting does not change the prioritisation or commitment of transformational endeavour across the breadth of the place partnership to the objectives of our locality plan – for example in relation to primary care, mental health services, intermediate care, and public health priorities. • In relation to the Integrated Neighbourhood Team Working, the Locality Board was 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. At the last meeting the link for the video describing the work of our integrated neighbourhood teams was shared and the video will be shown later in this meeting. • A number of Bury partner organisations had the opportunity to attend a GM wide meeting with Dr Clare Fuller who was leading the delivery of the NHS England Neighbourhood Strategy to review progress. GM was recognised as being relatively further ahead in developing the model but there is more to be done. NHS GM convened a system leadership meeting on Monday 29th June 2026 to reflect on next steps and the outcome of the that session will be shared shortly with the Locality Board. • In relation to Live Well – Whitefield, the Locality Board recognised the Live Well programme in Greater Manchester, intended to create the conditions for residents in all parts of the borough to be connected to the support, guidance and community assets to enable them to live well. In Bury, the principles of live well - building integrated teams in places, recognising, celebrating and promoting and investing in community capacity, and appreciating the strengths of people and communities is core to our transformation ambitions in health and care and in wider public service reform. The Live Well Centre in Besses, in Whitefield, would be open in soft launch format from mid-July. The centre would be formally opened on Sunday 16th August 2026 from 12-3pm and members of the Locality Board were welcome to attend. Ms Helen Tomlinson and Mr Will Blandamer were thanked for the joint SRO leadership of the programme. • In terms of the Uplands Medical Practice, the Council planning committee had recently provided planning permission for the conversion of the old Whitefield library site to become a replacement for the Uplands medical centre. It was noted that Colleagues who have served in Bury for some time would recognise that addressing the very poor accommodation of the Uplands practice has been a priority for nearly 30 years and we are very pleased to get to this milestone. A date for contractors to start on site this year was awaited. Colleagues across NHS and Council, and the practice itself, were thanked for their hard work and a particular thanks to Ms Clare Postlethwaite in the NHS GM Bury team for her determination and expertise.
5.2	The following comments/observations were made by Locality Board members: - • The initial discussions with the NCA in relation to the Place Transfer had been challenging however was positive that these discussions were now heading in the right direction. • There still appeared to be a tension between ‘Place’ and ‘Central’ functions following the initial ICB restructure in 2022 and most recent restructure in April 2026 which would need to be addressed further as part of the Place Transfer work.

	Type	The Locality Board	Owner
D/07/05	Decision	Received the update.	

6.	VCFE focus – MotherZen
6.1	Ms Tori Johnson from MotherZen was in attendance to provide a presentation in relation to the work of MotherZen. It was reported that: - • Mother Zen created a safe, welcoming community hub where parents could meet, form friendships, and reduce isolation. This directly supported the Let's Do It ambition to build connected, resilient communities where residents could feel a sense of belonging and mutual support. • In 2022, Tori had her first baby in a new town, 200 miles away from family and friends and was lonely & isolated. A one hour baby rhyme time at the local library wasn't sufficient for her needs as a new mother. • MotherZen currently delivered 6 no/low cost community sessions per week and provided a community living room and play space which served as a warm space last winter. • It also provided maternal wellbeing journalling & peer support sessions, birth preparation and education, breastfeeding support group, sling library and Baby bank and Signposting and connection to local voluntary and community organisations • Community days at the Play Cafe were a haven for local parents, and have been accessed by 1700 families • A query as to what opportunities there were for Mother Zen to work with statutory partners to create a more connected, accessible, and preventative support system for families to create a more connected, accessible, and preventative support system for families across Bury.
6.2	The following comments/observations were made by Locality Board members: - • MotherZen covered a lot of the areas asked about as part of the 8 week GP check for new mums which was brilliant to see. • This service aligned with the work of the Health and Wellbeing Board and wider public health agenda. • A query as to how the MotherZen style approach could be upscaled and offered in other areas and linked with the work of the Family Hubs and how messages could be developed for social media channels.

ID	Type	The Locality Board	Owner
D/07/06	Decision	Noted the update.	

7.	SEND Inspection Update and Adults CQC Inspection Update
7.1	<u>SEND Inspection Update</u> Ms Richards presented an update report in relation to the SEND inspection. It was reported that: - • Between 9 March 2026 and 11 March 2026, Ofsted and the Care Quality Commission (CQC) revisited Bury, to decide whether effective action has been made in relation to each of the areas for priority action detailed in the inspection report published on 7 May

	2024. The inspection was conducted under section 20 of the Children Act 2004. A copy of the SEND Monitoring inspection letter was enclosed which set out the key findings. • All partners recognised that while this was a very encouraging outcome there was still a lot of work to do – the circumstances of the lives of many children and young people in the borough and their families remained very challenging and we were committed to work harder. The SEND improvement and Assurance board (SIAB), focused on the delivery of the Improvement plan, will transition to become a SEND partnership board with a wider remit across the whole SEND System. • On behalf of the Locality Board, Deborah Glassbrook was thanked for her leadership in chairing the SIAB over the last few years. All partners on the board, including colleagues from the VCSE, from NHS GM, NCA, Pennine Care, and Council Children's and Adults Services were also thanked for their remarkable contributions. • In terms of next steps, a letter was due to be from government confirming that the intervention had been removed
7.2	The following comments/observations were made by Locality Board members: - • This was a significant achievement for Bury and there was a need to continue build on these achievements over future months and years.
	<u>Adults CQC Inspection Update</u>
7.3	Mr Crook provided a verbal update on the key themes arising from the inspection of Adult Care Services at Bury Council by CQC that had resulted in a rating of "Good". The inspection report itself would be circulated more widely following consideration by the Council cabinet on the 8th July 2026.
7.4	It was noted that as with the SEND work, there was a need to continue and build on the positive work and the a 3 year development plan for Adult Social Care would be submitted to a future Locality Board meeting.
7.5	The following comments/observations were made by Locality Board members: - • Mr Crook and the Adult Social Care Team were commended for all of their hard work and positive contributions to the CQC assessment.

ID	Type	The Locality Board	Owner
D/07/07	Decision	Noted the update.	

8.	Place Partnership Documentation
8.1	Mr Blandamer presented an update in relation to the Place Partnership documentation. It was reported that: - • The Bury Locality Board had reviewed draft iterations of Place Health and Care Partnership (PHCP) document suite at its meetings in recent months. • The latest version of the Place Health and Care Partnership (PHCP) document suite was discussed at the Executive Committee on the 10th June 2026 and was enclosed for Locality Board discussion/engagement.

8.2	• It was previously anticipated that final sign off of this documentation would be required in July 2026 however formal sign off would now be required by partners in Places during October 2026 with the final date for submission of feedback by Friday 21st August 2026. • The full timeline for completing this work was summarised within the report. • Feedback on the draft governance arrangements included within the report had been provided as there were a number of gaps that needed to be addressed. The following comments/observations were made by Locality Board members: - • The governance arrangements in relation to the Better Care Fund needed to be taken into consideration as at present the Health and Wellbeing Board had overall accountability for this area hence NHS Greater Manchester could technically not hold 'Place' to account in this regard. Mr Blandamer agreed to feed this element back as part of the engagement process. • Further work was required in relation to some of the funding arrangements particularly around joint packages of care

ID	Type	The Locality Board	Owner
D/07/08	Decision	Noted the update.	
D/07/09	Decision	Noted the revised version of the Place Health and Care Partnership (PHCP) document suite	
D/07/10	Decision	Agreed to provide any feedback on this documentation to Mr Blandamer ahead of the 21st August 2026 deadline	
A/07/02	Action	Feedback to be provided in relation to the governance arrangements for the Better Care Fund and in respect of the Health and Wellbeing Board.	Mr Blandamer
A/07/03	Action	The Place Partnership documentation to be sent out separately on Email to members.	Mrs Kennett

9.	Implementation of INTs in Bury
9.1	Ms Dixon was in attendance and reported that a neighbourhood video had been developed to showcase the impact of collaborative working across local partners in improving health and wellbeing outcomes for residents.
9.2	It was highlighted that the video demonstrated the neighbourhood approach in action, highlighting integrated, person-centred support, strong partnership working and community engagement across the locality.
9.3	Members were shown the video and were given the opportunity to provide and comments feedback as follows: - • This was a suburb piece of work that was showcasing what was happening in Bury. • Bury was the 2nd lowest in relation to hospital admissions which was due strig partnership approach illustrated within the video.

	• A query as to how Bury could showcase this video on a much wider regional/national footprint in the context of the public reform agenda/Live Well work. Mr Blandamer commented that the Bury position within this area was well known within Greater Manchester and the good work acknowledged. • A question as to how collaboration could go further in relation to Mental health.

ID	Type	The Locality Board	Owner
D/07/11	Decision	Noted the update/video	

10.	Integrated Delivery update
10.1	Mr Blandamer submitted the latest Integrated delivery update to the Locality Board. It was reported that: - • An IDC development session had been held to determine the left shift principles to inform future ways of working and risks to be managed • The new neighbourhood planning guidance was released on the 18th March 2026. Timescales have been agreed for the development of the plan to strengthen and deepen the work we are already doing which will be received by the IDC Board in August and Locality Board in September 2026. Each of the programmes were working up their plan on a page from 2026-2029, their detailed implementation plans for 2026/27 and the governance of their Boards and metrics for which they will be accountable from the place outcomes framework and the neighbourhood health framework. • An outline of the 4LP programme of work with the NCA had now been agreed and the content of these programmes was being scoped out. • The Partnership were invited to an event in Cheshire and Mersey and in GM to share the work we have done in the locality on neighbourhood working which was a good example of where achievements were being showcased wider.

ID	Type	The Locality Board	Owner
D/07/12	Decision	Noted the update report.	

11.	BCF Year End Report
11.1	Ms Dixon presented the Better Care Fund End of Year report to the Locality Board. It was reported that: - • The report presented the End of Year position for the BCF 2025/26. Overall, delivery against the three nationally mandated performance metrics remains on track, with the locality showing as having achieved all agreed targets. • Financially, the report confirmed that 100% of BCF funding allocated for 2025/26 had been fully utilised, demonstrating effective deployment of resources in line with programme objectives, which included the left shift strategy and joined up care through neighbourhood working. • The Better Care Fund plan is owned by the Health and Wellbeing Board (HWB) and governed by an agreement under section 75 of the NHS Act (2006). This continues to provide an important framework in bringing local NHS services and local government together to tackle pressures faced across the health and social care system and drive better outcomes for people.

	• A webinar was taking place on the 7th July 2026 to set out the process and associated metrics for 2026/27.

ID	Type	The Locality Board	Owner
D/06/13	Decision	Noted the update.	

12	Bury Mental Health Strategy 2026-2030
12.1	Mr Crook presented the draft Bury Mental Health Strategy for 2026–2030 to the Locality Board. It was reported that: - • The Bury Mental Health Strategy 2026–2030 set out a shared vision and delivery framework for improving mental health and wellbeing across the borough over the next 3 years. It had been developed in response to evidence from the Joint Strategic Needs Assessment (JSNA), population health data, community engagement and national and Greater Manchester policy priorities, the strategy provides a comprehensive whole-system approach to addressing increasing levels of mental ill-health, inequalities in access, outcome and experience and growing demand on services. • The strategy adopts a prevention-led, community-based model of care, aligned to the Greater Manchester Live Well programme and Bury's whole system Neighbourhood approach set out in the LETS strategy. It aimed to improve population mental wellbeing, strengthen early intervention and prevention, improve access to support, reduce inequalities, and deliver more integrated and person-centred care through neighbourhood-based partnerships. • Six strategic priorities have been identified for delivery between 2026 and 2030, supported by a phased implementation programme, partnership governance arrangements and an outcomes framework.
12.2	The following comments/observations were made by Locality Board members: - • A query around the level of co-production that had been undertaken when developing the strategy. It was noted that it was felt that there had been sufficient co-production as part of the strategy however there was always more that could arguably be undertaken from an engagement perspective and there was a need to strike an appropriate balance. • A question around the continuation of the funding for My Happy Mind and where the decision would be taken. It was reported that this decision would be taken at the NHS Greater Manchester Children's Group

ID	Type	The Locality Board	Owner
D/07/14	Decision	Approved the Bury 2026-2030 Mental Health Strategy and support its implementation across the locality.	

13	NCA undertakings commitment and NHSE England letter
13.1	Ms Allan provided a verbal update on the NCA undertakings commitment and NHSE England Letter. It was reported that: -

13.2	• The Northern Care Alliance NHS Foundation Trust had been served with enforcement actions by NHSE due to a number of issues in relation to quality governance over the previous 18 months. A copy of the letter could be located at NHS England • Concerns were noted in relation to spinal, gynaecology and other surgical care and wider organisational improvement. The following comments/observations were made by Locality Board members: - • A query as to whether the issues were predominantly in relation to the Salford site. Ms Allan commented that there was a Trust wide approach in relation to the governance of services therefore could not pinpoint concerns to one particular site. • How the Locality Board could be assured that the care and services being accessed by Bury patients was of the required quality and safety standards and how assurance/progress on the undertakings would be fed back through Place partnership governance structures going forward. Ms Allan stated that the NCA Board had signalled their intent to ensure that an open and transparent approach was adopted as part of future messaging to partners unless there was something highly confidential that could not be shared. Mr Blandamer reminded members about the role of the 4 Partnerships Scrutiny Committee in this areas from an accountability perspective however was important for the Locality Board to be kept fully up-to-date as well. • There was a need to ensure that the public were engaged communicated with on these issues in terms of what this may mean for care. • It was important to take into account that Bury patients could visit any of the NCA sites to access services dependant on speciality therefore the issues needed to be viewed on trust wide level.

ID	Type	The Locality Board	Owner
D/07/15	Decision	Noted the update	

14.	Population Health and Wellbeing update
14.1	Mr Hobday presented the latest Population Health and Wellbeing update to the Locality Board.
14.2	It was reported that the Bury Health and Wellbeing Board had met on the 11th June 2026. The agenda included discussions on the neighbourhood plans, the anti-poverty strategy, the health inequalities strategy refresh, the Better Care Fund, food and health and mental wellbeing.

ID	Type	The Locality Board	Owner
D/07/16	Decision	Noted the Highlight report.	

15.	Performance and Quality Group update
15.1	Members received copies of the latest report from the Performance and Quality Group meeting.
15.2	The paper provided an update to the Locality Board on meetings, activity and discussions in relation to performance, IDCB work and quality.
15.3	The risk paper detailed the locality strategic and programme risks 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.

15.4	The risk register was cross referenced with the ICB risks as presented in the Board Assurance Framework.
15.5	A deep discussion had took place at this meeting on a range of metrics on diabetes care to understand the activity and impact of diabetes on admission rates.
15.6	In terms of CQC activity, there were two visits referenced in the report in respect of Bankfield and Radcliffe House Residential Care Home that had both been given a 'good' status.

ID	Type	The Locality Board	Owner
D/07/17	Decision	Noted the report.	

16	SEND improvement and Assurance Board minutes
16.1	Members received minutes from the SEND Improvement and Assurance Board meeting held on the 11th June 2026

ID	Type	The Locality Board	Owner
D/07/18	Decision	Noted the minutes	

17.	Any Other Business
17.1	There were no items raised.

ID	Type	The Locality Board	Owner
D/07/19	Decision	Noted the information	

18.	Date and time of next meeting
18.1	**Date and time of next meeting in public - Monday, 7th September 2026, 4.00 - 6.00pm On Microsoft Teams.**

BURY INTEGRATED CARE PARTNERSHIP

Locality Board Action Log – June 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		Sept 2026	A mental health update would be brought back to the Locality Board meeting in September 2026 which would cover this item.
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. Update June 2026 - In relation to the availability of local maternity data, the risks around this had been raised with the ICB in relation to this issue and confirmation that this area of work would be prioritised had been received. It was agreed that this action

							should remain open on the action log for now until the maternity data issue has been resolved by the ICB.
13th April 2026/6th July 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		October 2026	Included on the agenda for June 2026. Final version to be brought back to the Locality Board in October 2026
1st June 2026	A/06/02	Action	It was suggested that an update on the BECCOR work/outputs be brought back to a future Locality Board meeting. *NB* – this has been scheduled for the September meeting.	Dr Fines		Sept 2026	
1st June 2026	A/06/03	Action	Further discussion on the national diabetes programme to be scheduled for the Major Conditions Board	Ms Wynne-Jones		July 2026	
6th July 2026	A/07/01	Action	Declaration of Interest register to be	Mrs Kennett		July 2026	

			amended to reflect Ms Allan's change				
6th July 2026	A/07/02	Action	Feedback to be provided in relation to the governance arrangements for the Better Care Fund and in respect of the Health and Wellbeing Board.	Mr Blandamer	✅	July 2026	
6th July 2026	A/07/03	Action	The Place Partnership documentation to be sent out separately on Email to members.	Mrs Kennett	✅	July 2026	

Meeting: **Locality Board**			
Meeting Date	07 September 2026	**Action**	Receive
Item No.	5	**Confidential**	No
Title	Place Lead Report		
Presented By	Lynne Ridsdale – Place Lead, NHS Greater Manchester (Bury) and Bury Council Chief Executive		
Clinical Lead	Dr Cathy Fines		

Executive Summary
To provide an update on key issues in the Health and Care System in Bury
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. New facilities

I'm pleased to update the Locality Board on a number of important developments in Bury that talk to the Lets Do It Strategy of addressing inequalities.

- We were pleased to open the **Bury Works neighbourhub** in the Millgate shopping Centre in August – a town-based service supporting residents to be connected to work and skills development opportunities
- Working closely with the VCFA we were delighted to open the first **Live Well Centre** in the borough – in the Whitefield neighboiurhood (Albert Drive) This provides a great space for voluntary and community services in Whitefield, a connection to a range of public services, safe and warm and welcoming café. It is now the base for the early intervention team from council childrens services and will shortly be the base for the whitefield Integrated neihghbourhood team. It is connected to host of other voluntary and community provision and is led by community 'navigators. A video is here for reference https://www.youtube.com/watch?v=R-DesxyG2po. The roll out plan for Live Well year 2 is being discussed by cabinet in October
- **Pennine Care Base – 3KP** – thankyou to Pennine Care colleagues for the invitation to the opening of the Bury town centre base for mental health teams and services. We look forward to working more closely with mental health colleagues in our reform journey together
- Bury Council have received the keys for the **Radcliffe hub** – the multi-million-pound provision of leisure centre, library, staff bases and community space at the hear of the Radcliffe Town Centre masterplan. We look forward to welcoming all colleagues to the site once open which is the focal point of Live Well implementation in Radcliffe
- We have secured **substantial investment in primary care facilities** across the borough through the utilisation management fund and are delighted to confirm planning permission approval an expected start on site date in autumn for the reprovision of the **Uplands GP practice in Whitefield**. We have also secured funding for the substantial improvement of the reception of **Radcliffe primary care centre** to meet characteristics of a live well centre with the provision of a range of community facilities.

  There are other developments in progress -for example we are shortly to open **Casewells** – the Bury town centre set piece 'flexi hall' bring new and vibrant food and beverage offer at the heart of the Bury town centre masterplan, the **new school in Radcliffe**, the continued work on the **Northern Gateway** economic development, a new **Bury transport interchange**, and ongoing town centre redevelopment in Prestwich amongst other schemes. I will keep the Locality Board update but I'm sure colleagues will recognise the transformation opportunities being created focusing on reducgting inequalituy and promoting sustainable economic growth.

2. Neighbourhood Working

Bury continues to be at the vanguard of the model of neighbourhood working in GM. Our model - consistently predicated on the 5 neighbourhoods, reflects:

- the continued maturity of integrated neighbourhood team working in health and care (and I commend the increasing alignment of Pennine care teams to that footprint)
- the maturity of public service leadership team working
- an increasing focus on childrens and families reform including best start, family hubs, families first, and SEND reform framed by our wider nieghbourhood approach
- the implementation of live well – best exemplified by the live well centres in whitefield and shortly in Radcliffe

The agenda today sees the refresh of locality plan with a strengthened focus on neighbourhood working, and a delivery plan that challenges us all to move from thematic programmes of work (e.g urgent care, mental health, adult care) to a neighbourhood focus reflecting joined up working and a strengths-based approach.

We have been pleased to host a number of visits to explore our work in this area, including Baroness Casey who visited Bury last Thursday as part of her national work on the future of adult care provision, and the NHS GM Director of Transition Jo Street in August. Both visits provided strong external validation of the progess in Bury.

3. Place Partnership Arrangements

Locality Board members will recall consideration of the different elements of the ICB articulation of place working, including a place partnership agreement, a place outcomes framework, a place team concept, and a place budget (in developing building out of the Better Care Fund). Feedback from previous locality board conversations has been provided to the ICB and a wider consultation framework has been concluded. We await final versions of documentation for the consideration of partners and hope this will be available in October or possibly November. Subject to agreement of partners we will move to recast the Locality Board to be the Place Partnership board for Bury, and retain the work of the integrated delivery board, and the work of the health and well being board focusing on health inequalities and wider population health determinants.

4. NHS GM place team hosting

Locality Board members will be aware of the ICB proposal to TUPE NHS GM place-based staff to another organisation in the context of the place partnership agreement to be finalised. This work is progressing with NCA having expressed an interest in hosting. Mobilisation arrangements at a GM, 4 localities partnership (NCA footprint) level, and local level are developing.

5. Suicide Prevention in Bury

I'm delighted to welcome Rebecca Jackson - Chief Executive Officer from the Big Fandango in Bury to the Locality Board, in our regular slot to hear about the great work of our voluntary and community sector in Bury. I would like in the meantime to highlight the "We're in This Together - Bury Suicide Prevention Conference 2026 on October 14th at The Met Theatre, Market Street Bury". This year the conference will be focusing on Suicide Prevention amongst Children and Young People. Further details are at; Bury Suicide Prevention Conference 2026 - The Big Fandango.

The Bury conference follows the Month of Hope across Greater Manchester from 10 September, beginning on World Suicide Prevention Day, to 10 October, finishing on World Mental Health Day. Further events across Greater Manchester including in Bury for the month of hope are available Greater Manchester's Month of Hope 2026 | Greater Manchester Integrated Care Partnership

6. Consultation on specialist cardiac and vascular surgery services.

NHS Greater Manchester has launched two public consultations on proposals for how these specialist services could be delivered in the future. The consultations, which run until 22 September 2026, seek views on where specialist surgery would take place, while outpatient appointments, diagnostic tests and follow-up care would continue to be provided from a range of locations across Greater Manchester.

For cardiac surgery services, NHS Greater Manchester is consulting on a proposal for all adult cardiac surgery to be provided from Wythenshawe Hospital. For vascular surgery services, the consultation is seeking views on a proposal for specialist vascular surgery to be provided from Manchester Royal Infirmary (MRI).

The consultations follow a review of specialist cardiac and vascular surgery services, which considered a range of factors including increasing demand on services, more complex patient needs and workforce challenges. The consultations give people the opportunity to comment on the proposals before any decisions are made.

To take part in the consultation visit: https://getinvolved.gmintegratedcare.org.uk

7. Health Watch Bury Annual Report 2025/26

Bury Healthwatch are valued partners in the Bury health and care partnership. I would like to commend Annual Report for 2025/26, highlighting the impact of its work in listening to local people and using their experiences to drive improvements across health and social care services in Bury. The report showcases how community insight, engagement activities, investigations, and collaborative working with providers and commissioners have helped ensure that local voices lead to real and lasting change. It also reinforces the importance of maintaining an independent voice for patients and the public at a time of uncertainty for Healthwatch nationally. https://healthwatchbury.co.uk/report/2026-06 17/healthwatch-bury-annual-report-202526

Youthwatch Bury has launched a new Bury Youth Physical Activity and Wellbeing Survey (Ages 13-25) to better understand the experiences, needs and priorities of children and young people across the borough. Developed in partnership with Public Health and the Children and Young People's Partnership Board, the survey aims to gather feedback directly from young people about physical activity, wellbeing, barriers to participation, and what support they need to live healthy and active lives. As the statutory, independent champion for people using health and social care services in Bury, Healthwatch Bury is committed to ensuring that young people's views are heard and used to influence local decision-making. The survey provides an opportunity for children and young people to share their experiences. Youthwatch Bury (www.youthwatchbury.co.uk)is keen to hear from a much wider range of young people to ensure the findings reflect experiences from across the borough.

8. North Manchester Hospital Redevelopment

I am pleased that this Locality Board will receive an update from Karen Kennedy from MFT on the progress of the North Manchester site redevelopment. We were very pleased to receive the update from Mark Cubbon on 5/8//26 confirming that MFT has formally signed contracts with the construction partner, Bovis, to progress the redevelopment of North Manchester General Hospital (NMGH) as part of the national New Hospital Programme.

This is an exciting step for the residents of North Manchester, Bury, Oldham, Rochdale, Salford and beyond, who will benefit from state-of-the-art facilities and modern care environments, including 100% single inpatient rooms. The circa £1.5 billion investment will ensure our new hospital is the most digitally advanced in the country when it opens, with the build kickstarting the wider regeneration of the area as part of the North Manchester masterplan.

Detailed work on the clinical model has been underway for some time, and the new hospital will complement community-based care, designed to help more people stay well closer to home. Our

teams will benefit from modernised working environments, the latest technology, and improved rest areas.

Under the preferred way forward for the scheme and subject to the necessary approvals, works will start next year on a new Outpatient Centre, with the main hospital build to follow. MFT expect to open the main hospital to patients during 2035.

Further information is here. Homepage - Transforming the Future at North Manchester General Hospital

9. Bury Food partnership

Locality Board members may note be aware the Bury Food Partnership is attracting national and indeed international attention for its work in securing how councils can delivery healthier, fresher and more sustainable meals. Through its work with Soil Association programmes, Bury has achieved Food for Life Served Here Gold across 56 schools, Sustainable Food Places Silver, and Green Kitchen Standard certification. Menus now include 25% organic produce, with thousands of children benefiting from healthier, more sustainable meals each day.

We were delighted that the BBC spent a day in Bury in July following Bury's school food system transformation journey, meeting suppliers, catering and Public Health teams, and hearing from children on what they felt about their school food. There has been fantastic feedback following the broadcast of The Food Programme – A Day in the Life of s Schools Catering Manager (Radio 4, 28.08.2026).

Also last week the GM region's thinking and structures about food partnership infrastructure went live: From neighbourhoods to city-region: building connected food partnership infrastructure across Greater Manchester | Sustainable Food Places.

I offer my congratulations to all involved particularly Francesca Vale and Andrew Cowan from Bury Council.

Lynne Ridsdale
Place Lead NHS GM (Bury)
Chief Executive Bury Council
4/9/26

Meeting: Locality Board			
Meeting Date	07 September 2026	**Action**	Receive
Item No.	7	**Confidential**	No
Title	Northern Care Alliance: Current Position, Improvement Activity and System Response		
Presented By	Will Blandamer – Place Partnership Director		
Clinical Lead	Dr Cathy Fines		

Executive Summary

This report provides the Locality Board an overview of recent concerns relating to the Northern Care Alliance NHS Foundation Trust (NCA), the actions being taken by the Trust and the wider NHS system, and the implications for services used by Bury residents.

The report has been prepared following significant national and local media coverage concerning patient safety, governance, organisational culture and the management of concerns within the Trust. It also reflects recent regulatory action taken by NHS England and the Care Quality Commission (CQC).

Recommendations

The Locality Board is asked to:

1. Note the contents of this report.
2. Note the actions being taken by the Northern Care Alliance, NHS Greater Manchester and NHS England Northwest.
3. Note that there are currently no proposed service changes affecting Bury residents as a consequence of the improvement programme.
4. Request a further update once the Northern Care Alliance Integrated Improvement Plan has been finalised and agreed with regulators.

Links to Strategic Objectives

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

Implications

Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☐	N/A	☒

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

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

Northern Care Alliance: Current Position, Improvement Activity and System Response

1 **Background**:

The Northern Care Alliance began operating as a group partnership in 2016 and Northern Care Alliance NHS Foundation Trust was formally established as a single NHS foundation trust in 2021 and provides hospital and community services across Bury, Rochdale, Oldham and Salford, including services delivered from Fairfield General Hospital in Bury and associated Bury Community Services.

1.1 Over recent months a number of concerns relating to patient safety, quality governance, organisational culture and leadership have received increased public attention through media reporting and regulatory scrutiny. These concerns have included:

- Historic failures in spinal surgery services that were examined through the independent Carlo Breen review.
- Concerns within gynaecology services relating to governance, administration and patient follow-up.
- Issues relating to incident management, complaints handling and organisational learning.
- Concerns regarding Freedom to Speak Up arrangements and whether staff consistently feel able to raise concerns.
- Ongoing challenges in urgent and emergency care, patient flow and workforce pressures.
- Wider concerns regarding organisational leadership, governance and improvement capacity.

1.2 Some of these issues relate to historic events and services, while others concern how effectively the organisation identifies, manages and learns from risks across the Trust. The cumulative effect has resulted in increased regulatory oversight and public concern.

1.3 Many of the issues now receiving public attention were already subject to varying degrees of regulatory oversight, review activity and improvement programmes before the recent media coverage. What has changed is the level of public visibility, the accumulation of concerns across multiple service areas and the subsequent decision by regulators to introduce enhanced improvement and assurance arrangements.

2 **Public and Stakeholder Concerns**

2.1 Recent media coverage has generated significant concern amongst patients, staff, residents, elected members and partner organisations across Greater Manchester. Concerns expressed publicly have focused on several key themes, including patient safety, delayed diagnosis and treatment, organisational culture, incident investigation, complaints handling, workforce pressures and whether staff feel able to raise concerns through Freedom to Speak Up arrangements.

2.2 For residents and patients, the primary concern is whether services remain safe and whether any historic or current failings may have affected patient care. There is also understandable concern regarding the pace of improvement and whether lessons from previous incidents and reviews have been embedded consistently across the organisation.

2.3 For staff, issues raised publicly have included organisational culture, leadership visibility, governance arrangements and confidence in internal processes for escalating concerns.

These themes have featured in both regulatory findings and Freedom to Speak Up discussions over recent years.

2.4 For elected members and system partners, the principal concern is ensuring that residents continue to receive safe, high-quality care whilst maintaining confidence that identified issues are being addressed openly, transparently and at pace through robust improvement arrangements and independent oversight. This has led to requests for additional briefings, assurance and ongoing reporting from both the Northern Care Alliance and NHS Greater Manchester.

2.5 Whilst the concerns are serious, NHS Greater Manchester, NHS England and the Northern Care Alliance have all emphasised that patients should continue to attend appointments and seek healthcare services as normal unless contacted directly by the Trust. There are currently no planned service changes associated with the improvement programme

3 Regulatory and External Review Findings

3.1 Over the last two years the Northern Care Alliance has been subject to a range of reviews and oversight processes relating to quality, safety and governance. These have included:

- Independent review of spinal services.
- Rapid Quality Reviews relating to spinal and gynaecology services.
- NHS England quality oversight activity.
- Care Quality Commission inspections and warning notices.
- Wider governance and leadership reviews.

3.2 In summer 2026 NHS England issued formal enforcement undertakings to the Trust. These identified concerns relating to quality governance, management of risk and progress in addressing known issues within certain clinical services.

3.3 The Care Quality Commission has also issued a Section 29A Warning Notice following its Well Led assessment. The notice identified concerns relating to:

- Investigation and learning from patient safety incidents.
- Complaints management and organisational learning.
- Oversight of Freedom to Speak Up arrangements.
- Governance and risk management processes.
- Workforce wellbeing and equality-related workforce issues.

4 What the Northern Care Alliance is Doing

4.1 The Northern Care Alliance has acknowledged the seriousness of the issues raised and has stated publicly that patient safety remains its primary concern.

4.2 Key actions being undertaken by the Trust include:

Integrated Improvement Plan

4.2.1 The Trust is developing a single Integrated Improvement Plan which will bring together all actions arising from:

- NHS England undertakings.
- Care Quality Commission requirements.
- Independent reviews.
- Existing patient safety and governance improvement activity.

4.2.2 The intention is to replace multiple separate programmes with a single framework that can be monitored by regulators, partners and the Trust Board.

Changes to Clinical Leadership

4.2.3 In April 2026 the Trust introduced a new clinically led operating model designed to place greater clinical leadership at the centre of decision-making and quality improvement activity.

Freedom to Speak Up and Culture

4.2.4 The Trust has appointed an independent senior nurse to strengthen arrangements for handling staff concerns and ensuring that any immediate patient safety issues are escalated appropriately.

External Review Activity

4.2.5 Further independent reviews of spinal and gynaecology services are planned, with findings expected to inform the next phase of improvement work.

Leadership Arrangements

4.2.6 The Trust is currently managing a period of leadership transition. Arrangements are being put in place to secure additional executive leadership support while improvement activity continues.

5 What NHS Greater Manchester is Doing

5.1 NHS Greater Manchester, as the Integrated Care Board, has significantly increased oversight arrangements relating to the Northern Care Alliance. This includes:

- Ongoing quality surveillance and assurance activity.
- Additional quality review meetings.
- Scrutiny of progress against improvement actions.
- Monitoring of patient safety risks.
- Monitoring of delivery against regulatory requirements.
- Regular reporting to NHS Greater Manchester governance structures.

5.2 NHS Greater Manchester has stated that its immediate focus is ensuring safe services for patients while supporting the longer-term programme of organisational improvement.

5.3 A particular focus for NHS GM has been working with NCA around service response to Industrial Action. The **action** has impacted theatre waiting lists and critical care capacity throughout July. No further strike dates have been confirmed at presented. The ICB have taken an action to support and pursue discussions with Unison and support the development of derogation and minimum service level arrangements.

6 What NHS England North West is Doing

6.1 NHS England North West is providing formal regulatory oversight of the Trust's improvement programme. Key elements include:

- Formal enforcement undertakings.
- Establishment of enhanced oversight arrangements.
- Creation of a System Improvement Board.
- Monitoring progress against agreed actions and milestones.

- Oversight of external reviews.
- Ongoing assessment of clinical quality, governance and leadership improvements.

6.2 NHS England will therefore play the principal role in assessing whether the Trust delivers the required improvements and complies with regulatory requirements.

7 Governance and Accountability

7.1 It is important to recognise that the Northern Care Alliance is an NHS Foundation Trust with its own Board of Directors and statutory responsibilities for the quality and safety of services it provides. Oversight of provider quality, performance and regulatory compliance sits through established NHS governance arrangements involving the Trust Board, NHS Greater Manchester, NHS England and the Care Quality Commission.

7.2 Locality (Bury) and place-based partnerships have an important role in understanding the implications for residents and local services but do not undertake the provider governance functions of the Trust or system regulators.

8 Implications for Bury

8.1 The concerns outlined above have understandably generated significant interest amongst Bury residents, elected members, Healthwatch and wider system partners. Given the importance of Northern Care Alliance services to the borough, local partners have sought ongoing assurance regarding patient safety, service continuity and delivery of the improvement programme.

8.2 Fairfield Hospital remains open and continues to provide services to local residents. There are currently no planned service changes linked to the improvement programme. Patients are being advised to continue attending appointments unless contacted directly by the Trust.

8.3 Bury Council, NHS Greater Manchester Bury locality partners and elected members have sought assurances that:

- Services provided to Bury residents remain safe.
- Any historic or current patient harm is identified and addressed appropriately.
- Improvement activity is robust and transparent.
- Local partners are kept informed of progress.
- Public confidence is maintained through clear communication.

8.4 Since the recent concerns entered the public domain, local partners have sought assurances from both the Northern Care Alliance and NHS Greater Manchester regarding the implications for Bury residents and services. This has included requests for information relating to patient safety, service continuity, governance arrangements, regulatory oversight and delivery of the Trust's improvement programme. These matters will continue to be monitored through existing partnership, locality, and health scrutiny arrangements

8.5 Given the importance of NCA services to Bury residents, continued monitoring and engagement through local partnership and scrutiny arrangements will remain necessary as the improvement programme progresses.

9 Conclusion

9.1 The concerns identified within the Northern Care Alliance are serious and have resulted in significant regulatory intervention and heightened public scrutiny. However, a substantial

programme of improvement, oversight and external assurance is now underway involving the Trust, NHS Greater Manchester, NHS England North West and the Care Quality Commission.

9.2 There is currently no evidence of any planned reduction in services for Bury residents as a consequence of this work. The focus of all organisations involved is on maintaining safe services in the short term while delivering sustained improvements in quality, governance, leadership and organisational culture over the longer term.

Meeting: Bury Locality Board			
Meeting Date	07 September 2026	**Action**	Approve
Item No.	8.1/8.2	**Confidential**	No
Title	Bury Locality Plan		
Presented By	Will Blandamer, Kath Wynne Jones		
Author	Kath Wynne-Jones		
Clinical Lead	Dr Cathy Fines		

Executive Summary

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

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

This document is the refreshed Locality Plan for 2026/27, developed in the context of the revised Let's Do It! Strategy for the Borough (2025), the NHS Greater Manchester Commissioning Strategy, and the launch of the national Neighbourhood Health Framework.

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

This plan outlines the next stage of our health and care reform journey, connected to the reform of wider public services and the economic ambition in the Borough. The Delivery Plan focuses on the first 12 months of delivery which includes the asks of the Neighbourhood Health Framework for 2026/27.

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

Recommendations

The Locality Board is asked to approve the Locality Plan and associated Delivery Plan.

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	☐
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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:						

- High level risks are referenced in the plan and each programme will develop a more detailed risk register with reporting to programme groups and where required the Locality Board.
- Organisational engagement has happened through thematic programme boards and IDC Board.
- It is envisaged that delivery of the plan will in the main be through existing budgets – additional resources will be subject to agreement of specific business cases or via standing organisational or

Implications						
ICB financial governance procedures.						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
• Where plans involve significant changes to services appropriate equality, privacy or quality impact assessments will be completed.						
Are there any associated risks including Conflicts of Interest?	Yes	☒	No	☐	N/A	☐
High level risks are included in the plan. Each programme will develop a more detailed risk register with reporting to programme groups and where required the Locality Board.						

Governance and Reporting		
Meeting	**Date**	**Outcome**
IDC Board	26/08/2026	For information

Bury Integrated Care Partnership Locality Plan Refreshed for 2026-2029

V0.5 - August 2026

Part of Greater Manchester Integrated Care Partnership

Presentation by:

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

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

Executive Summary –

This Locality Plan outlines the current and forecast state of the health of our population, the policy context of this plan, and describes an ambition for the further reform of our health and care system and for the improved health of all people of Bury by 2029.

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

This Locality Plan will address the 5 clear goals and reform ambitions outlined in the national neighbourhood health framework, which are reflected across the breadth of our programmes of work.

The Locality Plan is set in the broader context of neighbourhood working, however for the purposes of this plan there is a greater focus on the health and care element of neighbourhoods.

Despite significant challenges and risks (Slide 55) the Bury Integrated Care Partnership is committed to delivering on these key priorities and has confidence in our partnership arrangements to do so. We will routinely review progress.

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A message from the Leaders of Bury Locality Board

We are pleased to present this refreshed Bury Locality Plan, which sets out our shared ambition to improve the health, wellbeing and care of our population through to 2029. It reflects the current and future needs of our residents, the evolving policy landscape, and our commitment to delivering better outcomes for everyone in Bury.

Bury has made significant progress through strong partnerships across health, care, local government and the voluntary, community and social enterprise sector. By continuing to work together as one integrated system, we can build on these foundations and respond to the challenges and opportunities ahead.

This updated plan aligns with the NHS's national direction for reform, including the Neighbourhood Health Framework, and recognises that improving outcomes and achieving a clinically and financially sustainable health and care system depends on better population health, stronger prevention, transformed community care and the effective delivery of services.

While challenges remain, the Bury Integrated Care Partnership is committed to delivering the priorities set out in this plan. Through strong partnership working, a focus on neighbourhoods, and a shared determination to reduce inequalities, we are confident that we can improve the health and wellbeing of our residents and help make Bury an even better place to live, work and thrive.

Councillor Eamon O'Brien

Leader of Bury Council and the LGA Chair

Dr. Cathy Fines

Senior System Clinical Lead and Local GP

Introduction

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

This plan outlines the next stage of our health and care reform journey, connected to the reform of wider public services and the economic ambition in the Borough. The detail of the plan focuses on the first 12 months of delivery which includes the asks of the Neighbourhood Health Framework for 2026/27

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

Contents

BURY INTEGRATED CARE PARTNERSHIP

1. Locality context

BURY INTEGRATED CARE PARTNERSHIP

Summary:

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

Part of Greater Manchester Integrated Care Partnership

About Bury

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

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

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

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

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

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

The Strategy for Borough – Let's Do It!

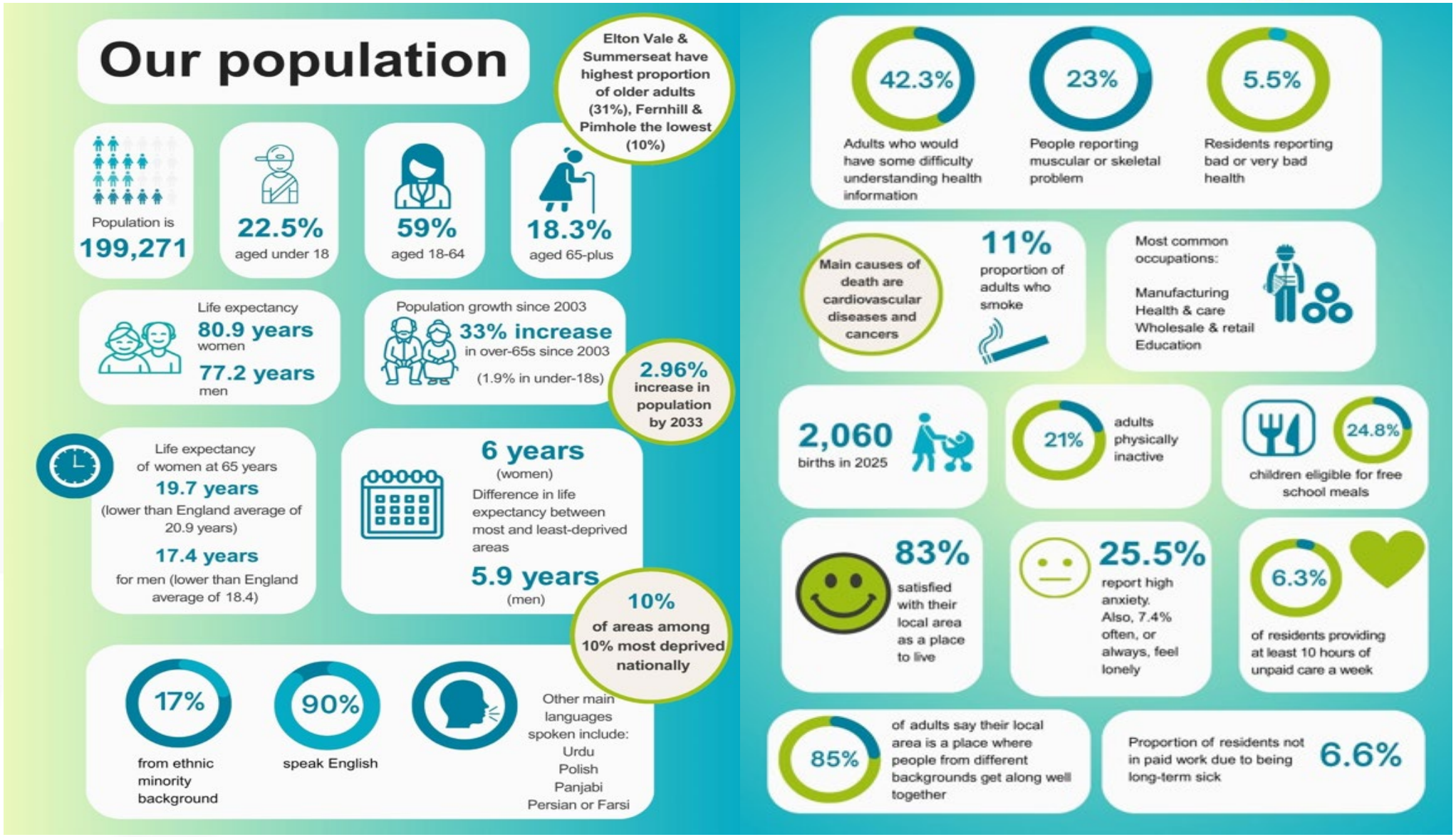
Our locality plan for health and care sits in the context of the wider ambition for the borough – the Let's Do It! strategy (refreshed 2025) – with its ambition for faster economic growth and significant reduction in health inequalities.

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

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

The Health of our Population

BURY INTEGRATED CARE PARTNERSHIP



The current health status of our population

BURY INTEGRATED CARE PARTNERSHIP

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

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

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

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

2. National context

BURY INTEGRATED CARE PARTNERSHIP

Summary:
Our plan for health and care transformation has been developed in the context of the 10 year health plan for England and the national Neighbourhood Health Framework. These plans signals a clear intent around a step change in prevention and early intervention adopting a neighbourhood approach. This locality plan has been refreshed in the context of the goals and reform ambition that are to be delivered by 2029.

Part of Greater Manchester Integrated Care Partnership

10 Year Plan : 3 radical shifts

The NHS Ten Year Health Plan outlines 3 key priorities. This is referred to as a **‘left shift’** towards prevention, community and digital care. The priorities include:

- Hospital to community
- Analogue to digital
- Sickness to prevention

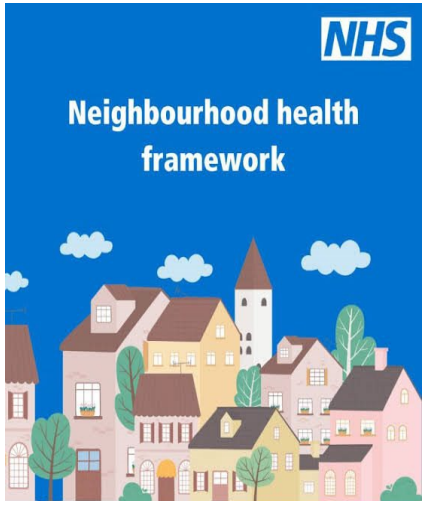
Neighbourhood Health Framework

BURY INTEGRATED CARE PARTNERSHIP

The NHS Neighbourhood Health Framework describes the future model for delivering health and care through local, Integrated Neighbourhood Teams. It aims to shift the NHS towards prevention, early intervention and proactive support, enabling people to receive more care closer to home.

The vision is a neighbourhood health model where:

- Services are designed around the needs of local populations.
- Health, care and community organisations work together.
- People are supported to stay healthy, independent and out of hospital.
- Health inequalities are actively reduced.



Core components include:

- Population health approach
- Integrated neighbourhood teams
- Prevention and proactive care
- Community partnership and co-production
- Workforce transformation
- Leadership approaches

National expectations

BURY INTEGRATED CARE PARTNERSHIP

2026/2027 **Foundational Year**	• Agree neighbourhood footprints • Agree plans to establish integrated neighbourhood teams focused on high priority cohorts • Increase urgent, rehabilitation and reablement services capacity, reduce non-elective admissions and bed days • Confirm plans to spend pooled funding under the Better Care Fund, in line with BCF guidance • Confirm the organisational ownership, governance and partnership arrangements to enable delivery • Confirm plans for having appropriate data-sharing arrangements in place to do patient identification and evaluation • Agree a plan to improve GP access and reduce unwarranted variation • Reforming elective pathways for outpatients • Improving primary and secondary care interface • Confirm plans to cut community health services waiting lists – meeting 18-weeks and eliminating 52-weeks
From 2027/28 **ICBs and local authorities should work with partners to develop a neighbourhood health plan**	• Outline how the national NHS objectives will begin to be delivered through the 3 reform agendas • Set out how neighbourhood health will support wider local goals to improve health outcomes, reduce health inequalities, and deliver on locally agreed wider public service reforms • Set out how local objectives are informed by the joint strategic needs assessment, and other relevant assessments • Confirm final geographies partners will work within • Confirm which organisations are responsible for each element of delivery • Confirm governance and operational partnership arrangements • Confirm how relevant initiatives align with the plan – such as Best Start Family Hubs, housing, mental health hubs, Pride in Place and employment support

3. NHS GM context

BURY
INTEGRATED CARE
PARTNERSHIP

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

Part of Greater Manchester
Integrated Care Partnership

Strategic Commissioning Plan 2026-2031

BURY INTEGRATED CARE PARTNERSHIP

Strategic Context

Greater Manchester Strategy 2025-2035

10 Year Health Plan (2025)

Our Vision

A thriving city region where everyone can live a good life

Our Priority System Outcomes

To improve Healthy Life Expectancy in GM so that it at least matches the NW of England by 2030

To close the gap in HLE between the most and least advantaged in GM in line with the 10-year ambition to at least halve that gap by 2035

Raise the healthiest generation of children and young people (10 Year Health Plan ambition)
Detailed Metric in Development

Our Missions

Strengthen our communities

Recover core NHS and care services

Help people get into – and stay in – good work

Help people stay well and detect illness earlier

Support our workforce and our carers

Achieve financial sustainability

Our Strategic Commissioning Priorities

Preventative and Proactive Care in Neighbourhoods

- Live Well
- The Neighbourhood Model
- Primary Care Transformation (Delivering the Blueprint)
- Community Services Transformation

Targeted Action on Population Health and Inequalities

- Population Health Transformation Programmes
- Improving Outcomes for Children and Young People
- Mental Health and Learning Disability
- Improving Cancer Outcomes

System Transformation

- Secondary Care Transformation
- Elective Care
- Urgent and Emergency Care
- Digital and Innovation
- New Models of Commissioning and Provision

Supporting Strategic Commissioning

- Financial Sustainability
- EPPR
- Cyber Security
- People and OD
- Corporate and Information Governance
- ICB Strategy
- Partnerships (System and Place)
- Patient Safety and Experience
- IT and Digital
- Data and Intelligence

GM Commissioning Plan and Left Shift

BURY INTEGRATED CARE PARTNERSHIP

- The diagram on the next slide is intended to show the **system change** that will result from the delivery of the GM Strategic Commissioning Plan over 5 Years

- It sets out:
  - ✓ What we mean by the Left Shift in GM
  - ✓ The system changes that will occur as a result
  - ✓ The key programmes to drive those changes
  - ✓ How we will commission and invest to enable the change
  - ✓ What the system will look like in 5 years

- The intention is to set this out at high level and then add to this with the year-on-year change over the 5 years and with detailed quantification of the impact

- The model for the overarching outcomes for the Strategic Commissioning Plan is being developed separately and will complement this

GM Strategic Commissioning Plan and the Left Shift

BURY INTEGRATED CARE PARTNERSHIP

What we Mean by the Left Shift

- A shift in culture, demonstrated population-level health and outcomes focus value-based healthcare, and a 'prevention first' approach
- A shift in activity from treatment in hospitals to integrated proactive care in neighbourhoods
- A shift in funding from treatment to prevention, proactive care and earlier intervention that is closer to home

Leading to a System That

- Prevents health from deteriorating and promotes a return wellness following poor health
- Delays the advancement to advance disease states, multiple morbidities, and frailty
- Reduces the avoidable need for more expensive interventions

Invest savings in left shift

Delivered Through

- Outpatient Transformation
- UEC and Elective Reform
- Live Well and Neighbourhood Model
- Population Health Programmes
- Service Reconfiguration and Virtual Care
- Primary Care Transformation

System Change by Year 5

Population Health
- Demonstrable progress against system goal – for people in GM to live in good health for longer and to reduce inequalities

Activity
- Outpatients and Follow Ups in Hospital settings reduced
- A reduction in the projected cost growth rate of avoidable hospital attendances and admissions

Performance
- Targets in Medium Term NHS Planning Framework Met

Finance:
- System in Recurrent Financial Balance
- Proportion of GM spend on hospital activity reducing over 5 years (2025/26 level is 63%)

Workforce
- Increase proportion of workforce in community roles

Strategic Commissioning
- Commissioning strategy to drive change over 5 years – with clear metrics for annual progress
- New financial and contractual mechanisms to incentivise prevention and reduce inequalities
- Long-term clinical strategy
- Market development

Strategic Investment
- National Growth Funding , SDF Funding , Capital investment, Industry Investment
- Preserve all existing Left Shift Investment and grow in line with annual NHS uplift
- Maximise health benefit of investment in social determinants: housing; education; work and skills; physical activity; transport

Reduce the Current Cost Base

Reduce Predicted Demand Growth (c£600m over 5 years)

4. Building on progress

BURY INTEGRATED CARE PARTNERSHIP

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

Part of Greater Manchester Integrated Care Partnership

Our successes

- **Choices for Living Well (Killelea) earns top CQC recognition for rehab care** - Residents at Choices for Living Well (Killelea) are benefiting from an Outstanding standard of rehabilitation care, confirmed by the Care Quality Commission (CQC) in its November 2025 assessment. The service achieved exceptional scores in both Effective (92%) and Caring (95%), with inspectors praising the multi-disciplinary team (MDT) for delivering compassionate, evidence-based support that helps people regain independence quickly.
- **Bury Community Adult Directorate got a green SAS Result** - This success reflects the purpose of the SAS Framework, which is designed to ensure services consistently meet core standards, recognise and celebrate high performance, and strengthen integrated leadership through shared learning and peer review. By helping teams understand how their service is performing and promoting collaboration and innovation, the framework ultimately drives up quality and improves patient experience, all of which has been clearly demonstrated by the Bury Community teams.
- **Bury Lung cancer Screening** - To date, over 300,000 eligible people have been invited into the GM lung cancer screening programme, resulting in almost 200,000 lung health checks and over 1,500 lung cancer diagnoses to date, of which 80% have been at an early stage. To put that into context, the people who participated in the programme would fill the Etihad Stadium almost 4 times over.
- **Neighbourhood Delivery Collaborative** – during the last 12 months system partners have come together to participate in a series of face to face workshops to share updates, explore data and strengthen collaboration across Bury neighbourhoods including HMR and NMGH, with a focus on improving integration, population health and service connectivity. Ensuring Bury residents receive the right care in the right place, reducing activity on secondary care services.
- **Neighbourhood working** – in 2025 1130 people were referred and supported through Active Case Management (ACM - *“ I got the help at the right time from the right places. I was at the stage of giving up … But that has now changed. The doctor has been really good and I am very grateful they referred me to Social Prescribing [who have] guided me to the people who care and understand my situation. Through (the Social Prescriber) contacting me, even when services were in place, I felt I hadn’t been palmed off and people care about me. I feel I can only climb now and I am very hopeful about the future*”. Patient feedback.
- **MyHappymind** - ¨ myHappymind, emotional wellbeing curriculum has been delivered in 34 primary schools reaching 9,479 children. ¨ 82% of participating schools have launched the myHappymind Parent App with 1,221 families downloading it.
- **Adult Social Care** - National recognition for adult care contribution to neighbourhood working following LGA peer review.
- **Neighbourhood Video** - The purpose of the 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. https://vimeo.com/1192181988?share=copy&fl=sv&fe=ci

Our Strengths

BURY INTEGRATED CARE PARTNERSHIP

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

5. A Population Health Approach

BURY INTEGRATED CARE PARTNERSHIP

Summary:
Bury's population health approach focuses on preventing ill health, reducing inequalities and improving wellbeing across the life course. Our Prevention Framework and Health Inequalities Strategy set out how we will achieve this through targeted prevention, action on the wider determinants of health, stronger communities and integrated neighbourhood services.
The Bury Health and Wellbeing Board oversees the delivery of the Borough Health Inequalities Strategy, working with all Team Bury partners

Part of Greater Manchester Integrated Care Partnership

Bury Health Inequalities Strategy (2026-2030)

BURY INTEGRATED CARE PARTNERSHIP

Ambition: Systematically narrow the gap in life expectancy and healthy life expectancy between communities, particularly between our most and least deprived neighbourhoods

Strategic Priorities

🏠 Wider Determinants of Health	🚭 Health Behaviours	🤝 Healthy Places & Communities	🏥 Integrated Health & Care
Employment & income	Smoking & alcohol harm	Live Well neighbourhoods	Equitable access
Education & skills	Healthy weight & activity	Community assets	Prevention & early diagnosis
Housing & poverty	Mental wellbeing	Healthy environments	Neighbourhood service integration

Success

💔 Reduced inequalities in premature mortality & HLE	👶 Improved outcomes across the life course	🌱 Stronger, more resilient communities

Bury Prevention Framework

Bury's prevention framework aims to improve health and reduce inequalities by acting early, preventing avoidable illness and supporting people to live healthy, independent lives at every stage of life.

Delivered through the Life Course

- Start Well – giving children the best start in life
- Live Well – supporting healthy lifestyles and early intervention
- Age Well – enabling healthy, independent ageing

Across Three Levels of Prevention

- Primary: Prevent illness before it starts
- Secondary: Identify and act early on emerging risks
- Tertiary: Support people with long-term conditions to prevent deterioration

Principles for Delivery

- Local – neighbourhood-based support and services
- Enterprising – data-led, innovative approaches
- Together – co-production with communities and partners
- Strengths-Based – building on individual and community assets

6. Our approach to neighbourhood working

BURY INTEGRATED CARE PARTNERSHIP

Summary:
On the basis of the strategic context described, and the need to continue and quicken our transformation in the light of potential future demand, we have identified 4 key pillars of neighbourhood working to allow us the necessary focus to deliver further and faster.

Part of Greater Manchester Integrated Care Partnership

Neighbourhood Working – our approach

BURY INTEGRATED CARE PARTNERSHIP

- Reflective of the 5 main towns in the Borough – Whitefield, Prestwich, Radcliffe, Bury and Ramsbottom – each of which has its town centre masterplan thus connecting reform to growth
- Creating opportunities for front line staff to know each other and problem solve and not just refer to each other
- Multi-agency teams having a shared appreciation of the strengths and assets of the community
- Co-location of teams and partner agencies where possible. Shared resources, skills and strengths
- Huddles and MDTs – bringing partners together to co-ordinate care, get to the root cause of issues and support those in the community most at risk
- Combining models of risk stratification to identify cohorts of avoidable risk, harm and cost, with the knowledge and experience of people in the place
- A more strategic approach to investment– for example scaled-up investment in housing with care. Investing in prevention and community resilience – including through VCFSE partners (see VCSE MOU)
- Improving economic activity and participation – for example, DWP trailblazer opportunity /Working Well/Bury Works
- A mechanism to allow us to respond to Borough, GM, or national priorities – e.g. how to improve School Readiness

Neighbourhood Working – our principles

BURY INTEGRATED CARE PARTNERSHIP

- The neighbourhood level has a specific definition for us in Bury. It recognises populations of 30-50000 as the building block for organisations to work together and the foundational unit for delivery recognised across public service organisations and working with the voluntary sector.

- This is described in the Strategy for the Borough. The Let's Do It Strategy committed to a vision of integrated working and a strengths-based approach in each of the 5 places in Bury. This is neighbourhood working.

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

- Aligning services within and around neighbourhood areas allows partners to have a shared understanding of the strengths of communities and people in that place – because our 5 places are different.

- The benefits to our populations are both better integrated and joined up delivery, which is what the public expect of us, and is a precondition for prevention and early intervention.

- Neighbourhood working also allows the identification of particular risks and harms to people in places, and provides mutli-agency and targeted approaches to enable early intervention to prevent future problems.

- This approach will help to reduce pressure on a range of public services characterised by unplanned , expensive intervention, allowing them to focus their resources on those who need it most.

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

4 Elements of our neighbourhood model

BURY INTEGRATED CARE PARTNERSHIP

1. Integrated Adult Health and Care Teams (INTS) - including co-located District Nursing and ASC Teams with an aligned Neighbourhood mental health model and MDTs linked to every GP practice involving wider partners including Social the VCSE.

2. Neighbourhood Leadership Teams - (formerly public service leadership teams) bringing together those partners with an opportunity to contribute to the wider determinants of inequality - including housing, DWP, income maximization team, GMP, schools, live well services and others, and focused of cohorts of particular risk of harm reflective of the neighbourhood

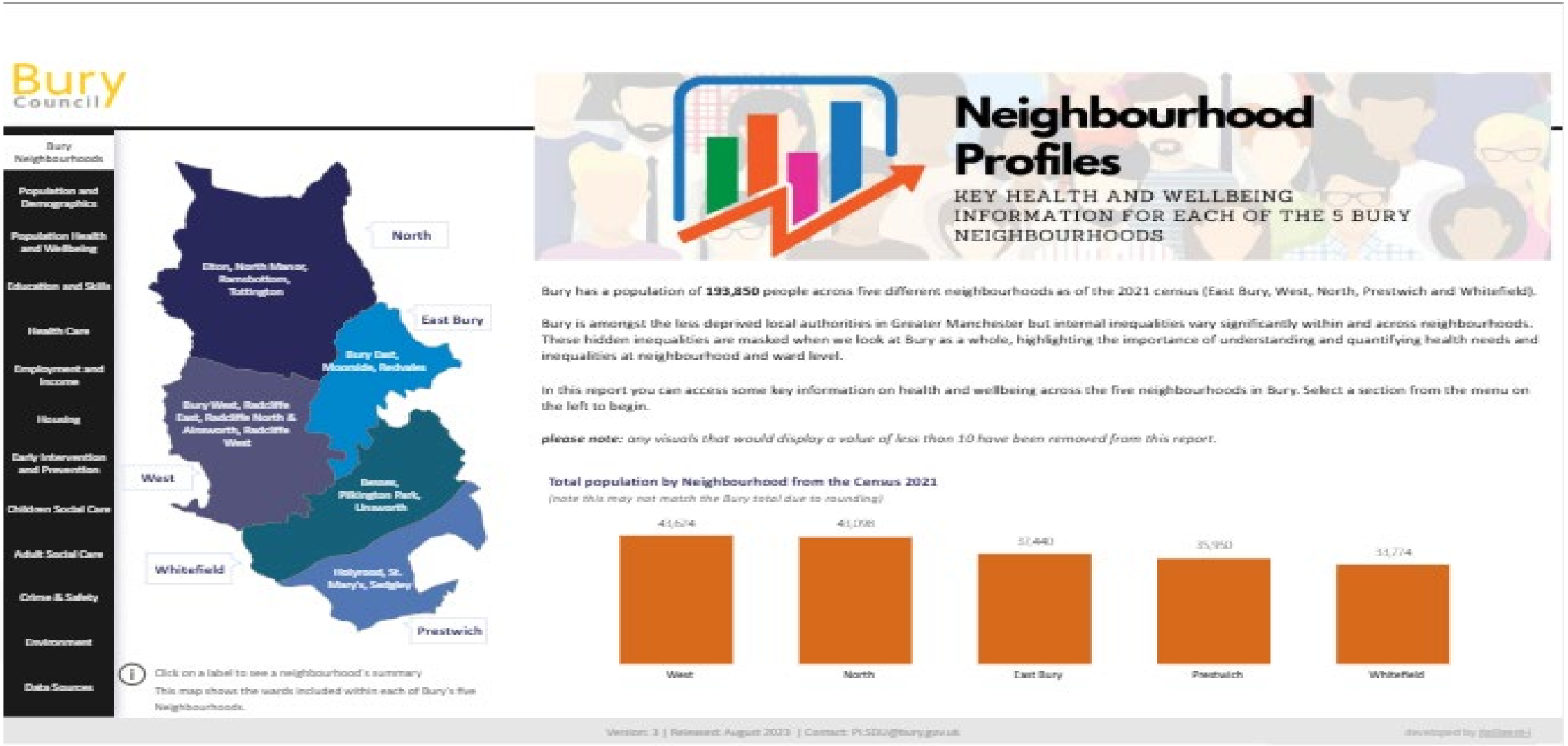
3. Implementation of the GM Live Well model – public services and the VCSE working with local communities to create conditions for people to thrive, not just survive, removing barriers to opportunity and tackling health, social and economic inequalities.

4. Neighbourhood approaches to supporting children and families - Developing a model of family hubs, bringing a range of NHS, council and wider public services to support families with young children to ensure the best start in life.

Enabled by: Neighbourhood Profiles

BURY INTEGRATED CARE PARTNERSHIP

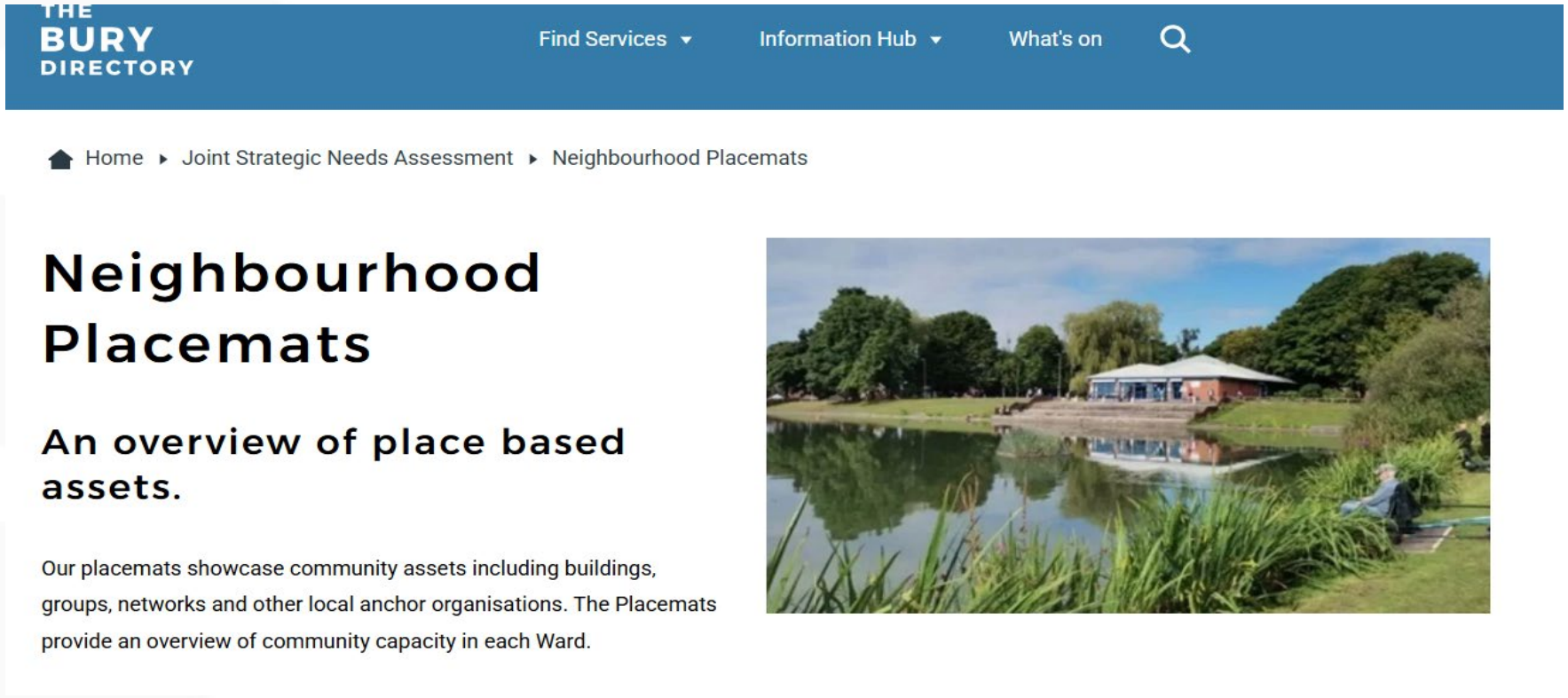
- https://www.theburydirectory.co.uk/jsna/neighbourhood-profiles



Enabled by: Neighbourhood Placemats

BURY INTEGRATED CARE PARTNERSHIP

- https://www.theburydirectory.co.uk/jsna/neighbourhood-placemats



Integrated planning & delivery

BURY INTEGRATED CARE PARTNERSHIP

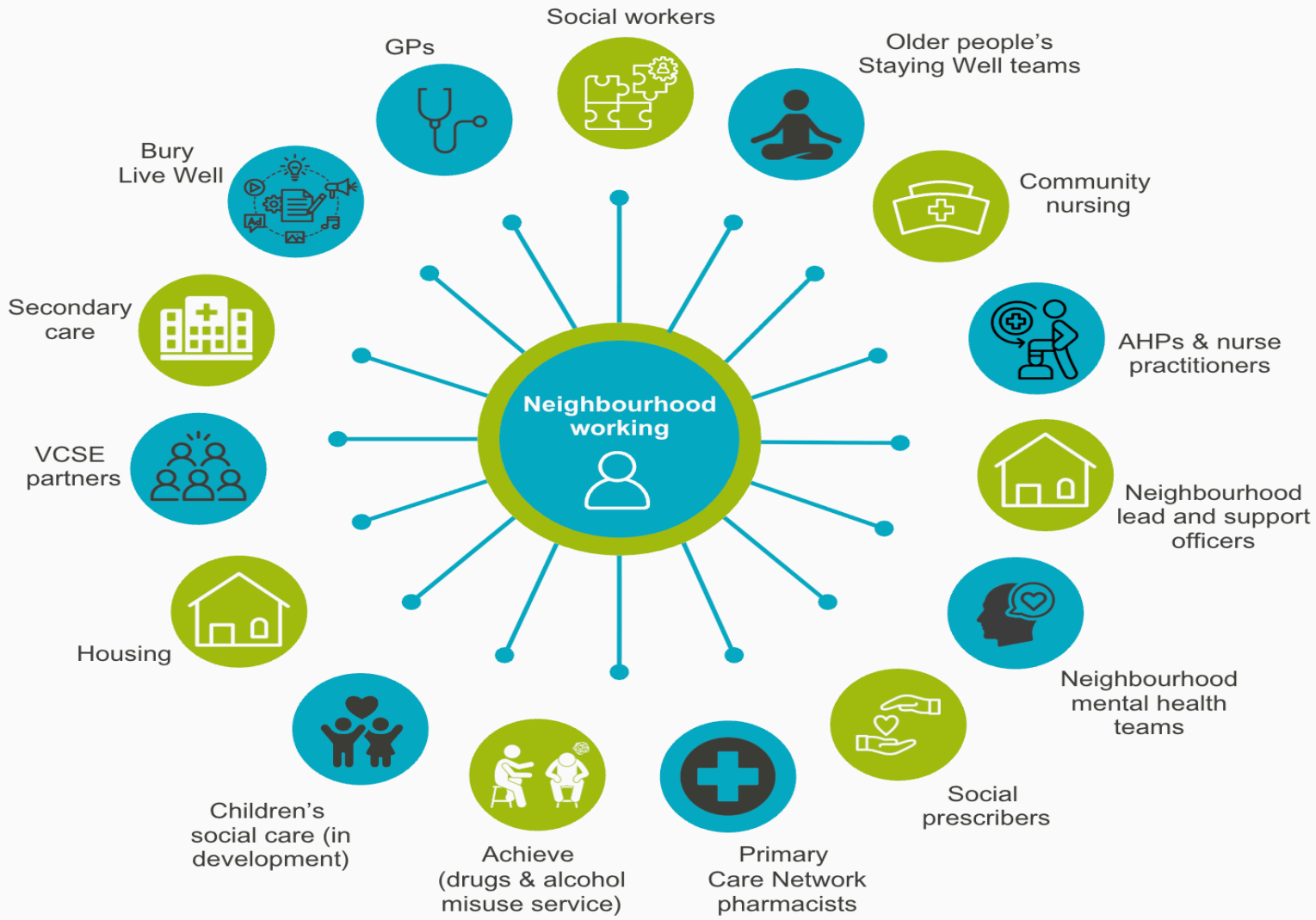
Integrated care delivery

An improvement in the health and social care system in recent years has been the introduction of active case management, with multiple agencies coming together to support people and prevent their conditions getting worse.

People are put at the centre, with a plan created around them to help them achieve their goals, gain independence and improve their quality of life.

Good progress has been made, but there is a need to quicken improvements with a sharper focus on **reducing health inequalities**, **prevention**, **transforming care in community services** and **optimising care**.

The case studies on the following pages show how we aim to support people with different scenarios in future.



What it means for our service users: The Bury family

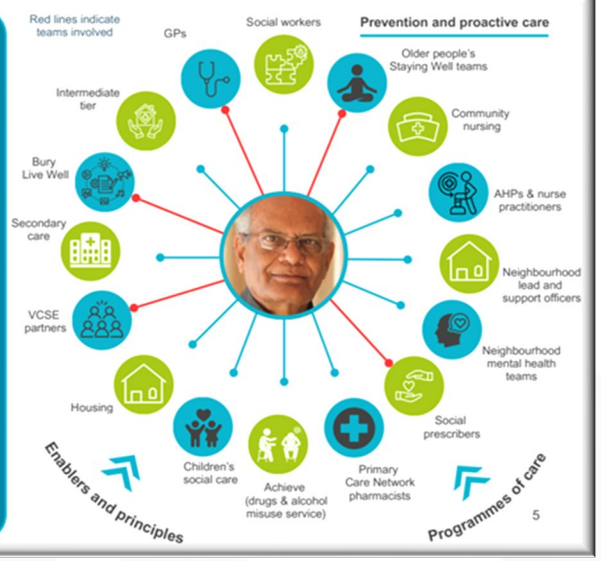
BURY INTEGRATED CARE PARTNERSHIP

Meet Mohammed

Mohammed, 68, has recently started to feel unwell. He's experiencing persistent tiredness, blurred vision and has been taking more time off work. He has also stopped exercising and his weight continues to rise. In addition, he finds himself waking frequently during the night to use the toilet.

Evolving our ambition

Mohammed gets an invitation from his GP for his routine NHS health check. He also notices a diabetes awareness poster at his local pharmacy and realises that many of the symptoms described match his own. During his health check, he shares his concerns with his GP, who diagnoses him as pre-diabetic, meaning he is at significant risk of developing diabetes. Mohammed, from Whitefield, is referred to the Live Well service for culturally sensitive support around weight management, diet and healthy lifestyle changes. He connects with voluntary sector organisations and social prescribers who help him stay active and engaged with his community. He undergoes an eye test to investigate his blurred vision. He loses five stone, feels healthier, manages his diabetes online and returns to work, raising awareness of diabetes to others.

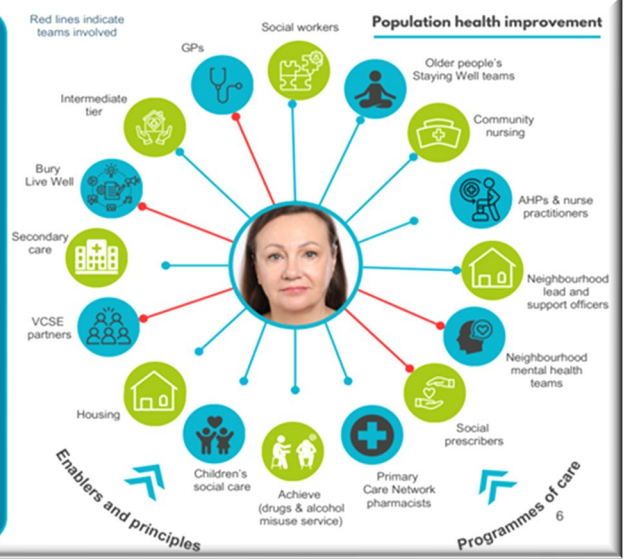


Meet Gemma

Gemma, 48, lives in Ramsbottom and has been finding life increasingly difficult as she approaches menopause. She is struggling with poor sleep, constant tiredness and low mood. As a self-employed worker, there are days she feels too unwell to work, which affects her income and overall wellbeing.

Evolving our ambition

During a routine health check offered to all women aged 40-60, her GP opened a conversation about menopause and carried out an assessment, including asking about any falls and possible fracture risk, which increases during the menopause. Blood tests are arranged, lifestyle advice is given to support stress, activity levels and sleep. Gemma is referred to the Live Well Team for ongoing community-based support. Through the Bury North social prescribing team, she becomes involved in wellbeing sessions and menopause support groups. Her symptoms and mental health improve and she shares her lived experience with others. Gemma self-manages her menopause, tracks her symptoms and works with her GP to adjust care.

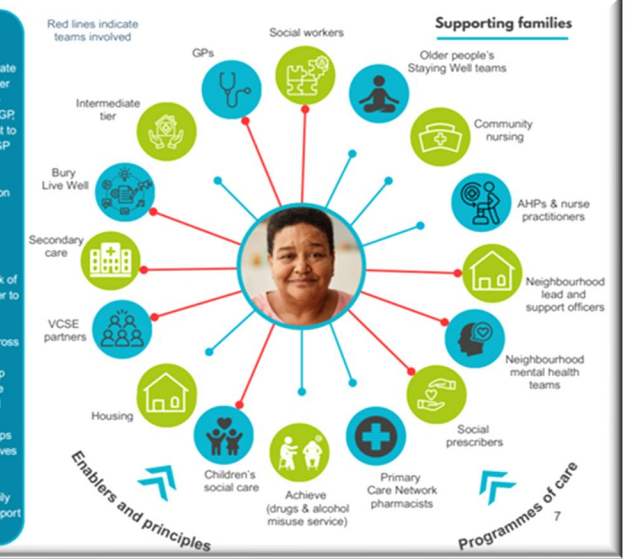


Meet Sharon and her family

Sharon, from Radcliffe, is in her late 40s and facing challenges with her mental health/diabetes. She also smokes. She regularly visits her GP, but has also started to go straight to A&E when she can't get urgent GP appointments. Her eldest son is caring for her and her younger sibling, which affects his education and mental health. They are in substantial financial debt, adding pressure.

Evolving our ambition

Her GP is concerned she is at risk of reaching crisis point and refers her to Radcliffe MDT for active case management. A key worker coordinates joined-up support across services. The Live Well team provides tailored education to help Sharon stop smoking and improve diabetes. She is referred to social prescribers and engages with voluntary walking and social groups to build confidence. Her son receives additional educational and young adult carer support. She gets information on what to eat. A family hub signposts her to financial support services, to get assistance.

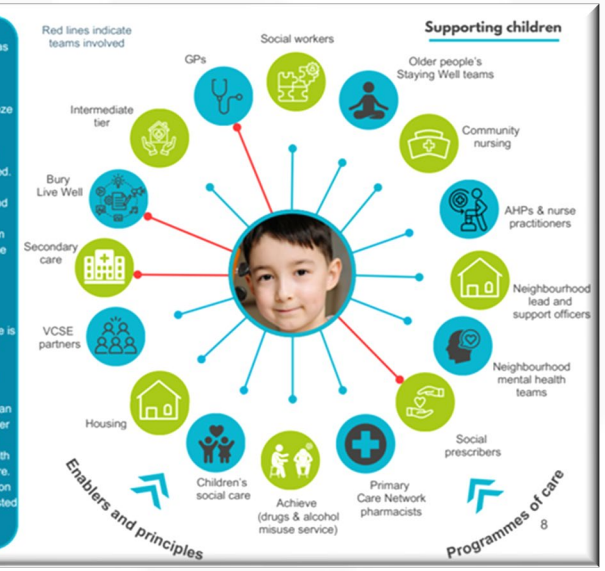


Meet Teddy

Teddy, aged 9, from Prestwich, has a history of a recurrent wheeze. Between the ages of 1-3 he experienced multiple hospital admissions for viral-induced wheeze and was started on inhalers. His mum stopped using these when symptoms improved and was not aware annual reviews were needed. He has attended two different hospitals and received inhalers and medication. A referral to the community children's nursing team was made, but his mum thought he appeared well and declined.

Evolving our ambition

Teddy has a timely, accurate diagnosis, including a FeNO test arranged through primary care. He is added to the asthma register and receives routine follow-ups. His treatment starts in line with NICE guidance, followed by an 8-week review. A paediatric asthma clinician delivers education, including inhaler technique and a personal asthma action plan, and communicates with school and primary/secondary care. The family is given clear information on when to seek help and signposted to reliable information/self-management support.

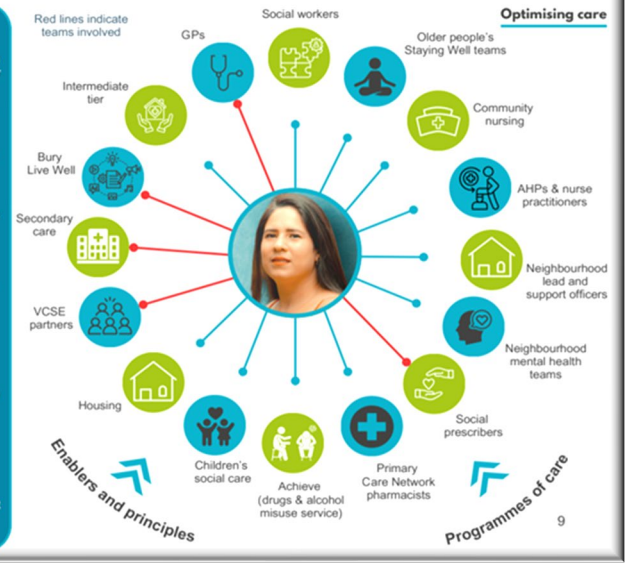


Meet Claire

Claire, 32, from Whitefield, has been living with persistent joint pain that limits her ability to play with her child or stay active. Her condition has led to frequent absences from work, weight gain, and a decline in her mental wellbeing. While awaiting a diagnostic procedure in hospital, her symptoms continue to affect her daily life.

Evolving our ambition

Through the Community Diagnostic Centre (CDC), Claire receives a specialist assessment designed to identify the most appropriate early and rapid diagnostic pathway. The CDC's one-stop approach enables Claire's tests to be completed and reported far more quickly than traditional routes, allowing her to begin treatment sooner due to significantly shorter community waiting times. Alongside her diagnostic journey, Claire is supported with personalised advice and signposting through the neighbourhood hub on how to maintain her health and wellbeing throughout treatment. As her pain begins to ease, she feels able to join a local weight-management group, reconnect socially, and experiences a marked improvement in her mental health and overall improved quality of life.

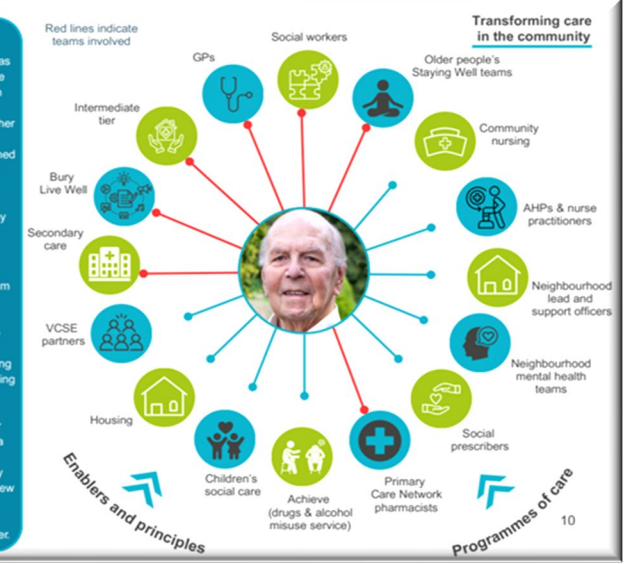


Meet Alf

Alf, 82, lives close to Bury town centre. Over recent months he has experienced several falls at home as his frailty has worsened. Each fall has resulted in long hospital stays, during which he loses further strength and confidence while recovering in bed. Alf is determined to remain living independently in his home, but his family and GP are increasingly worried that without additional support he may soon require residential care.

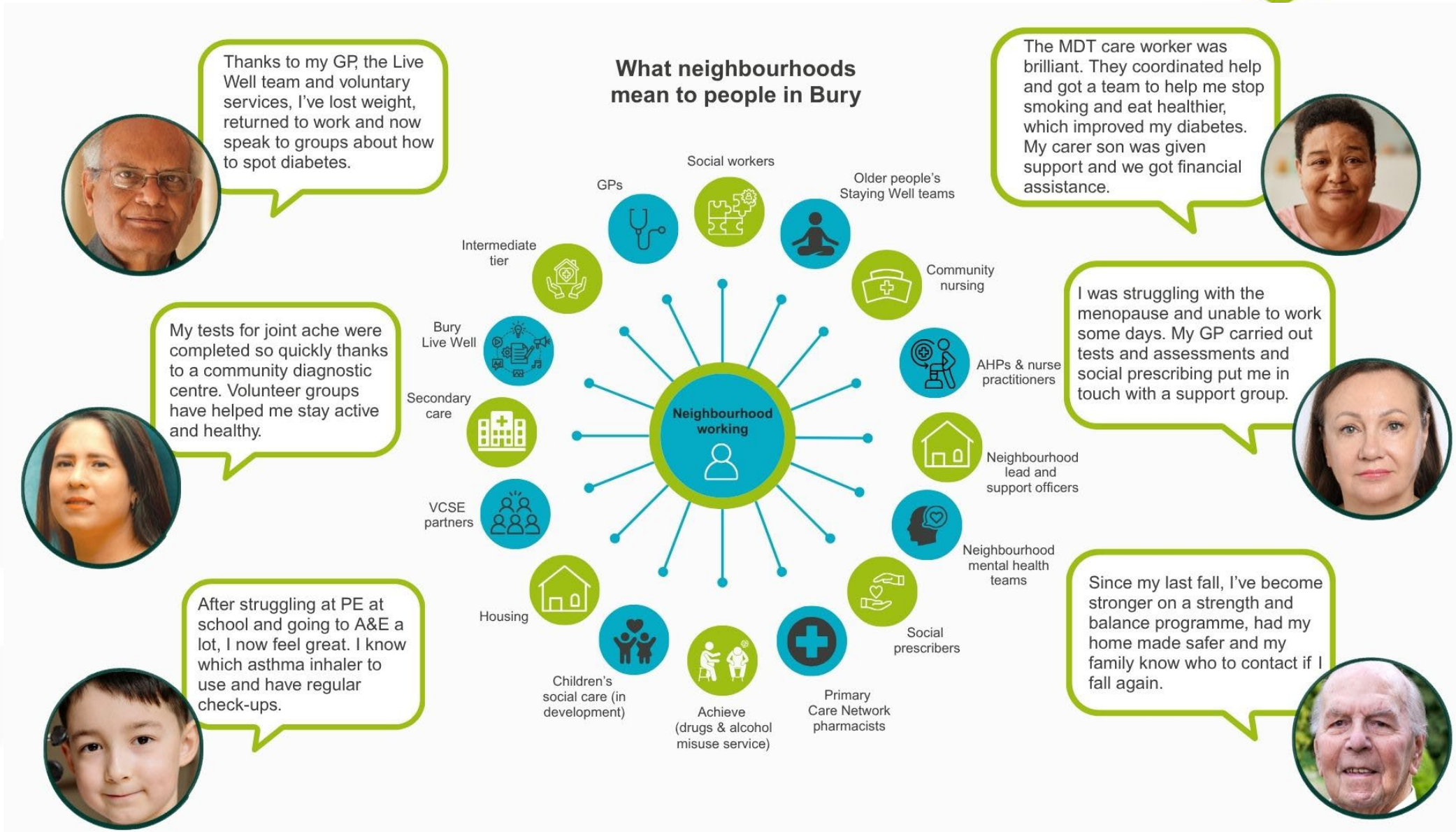
Evolving our ambition

When Alf is admitted to Fairfield Hospital after a fall, staff keep him active with light exercise, to maintain strength & support a quicker recovery. Back home, he receives a multidisciplinary falls assessment to identify contributing factors. The Older People's Staying Well Team completes a home hazard assessment, arranging adaptions, and eye and footwear checks. Live Well team delivers a 12-week strength and balance programme. GP completes frailty review, including medication review & fracture risk. Family access digital falls technology and are given falls service contact number.



What it means for our service users: The Bury family

BURY INTEGRATED CARE PARTNERSHIP



1. Integrated Neighbourhood Team - Adult Care & Health

BURY INTEGRATED CARE PARTNERSHIP

North INT


Linda Prescott
INT Lead


Dr Wissam El-Jouzi
GP Lead


Rachel Robinson
NSO

East INT


Gemma Iliadis
INT Lead


Dr Fazel Butt
GP Lead


Daniel Bower
NSO

West INT


Janet Stanton
INT Lead


Dr Ade Rotowa
GP Lead


Amanda Stott
NSO

Whitefield INT


Jane Wilson
INT Lead


Dr Alistair Webley
GP Lead


Mafooz Bibi
NSO

Prestwich INT


Clare Rayson
INT Lead


Dr Richard Deacon
GP Lead


Dawn Adderley
NSO

25 GP Practices

Neighbourhood integrated health and care model: Our priorities

BURY INTEGRATED CARE PARTNERSHIP

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

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

Priorities:

1. Review the existing model of Active Case Management and MDTs and implement recommendations including the development of improved approach to care co-ordination and impact evaluation.
2. Development and delivery of the BeCCoR Neighbourhood Health Action plans with an emphasis on proactive personalised care and secondary prevention for CVD, diabetes and COPD.
3. Maintaining active input from health and care partners into the wider Neighbourhood Leadership Teams and development and delivery of Neighbourhood People & Communities Plans to respond to the needs of the high priority cohorts identified.
4. Strengthen communication and integrated planning and delivery between key neighbourhood partners including GP Practices, PCNs leadership, community health services, adult social care, public health, care homes, community pharmacy, mental health, children's services and the voluntary sector.

2. Neighbourhood Leadership Teams

(formerly public service leadership teams)

Example risk cohorts identified requiring multi-agnecy interventions:

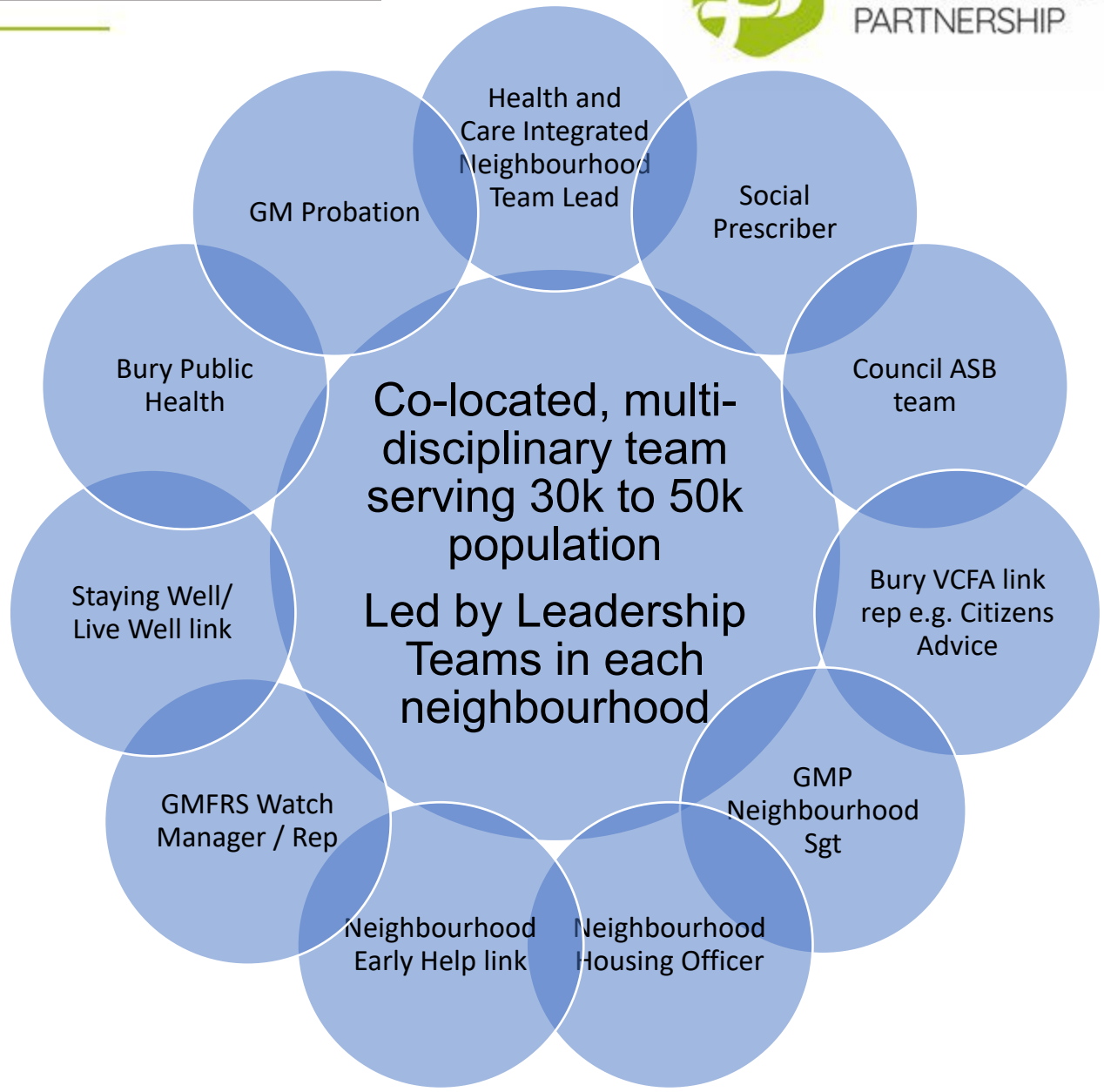
Bury East
Cuckooing
Hoarding
Repeat Domestic Abuse U21
GLD

Bury North
Social Isolation and Vulnerability
Digital Exclusion
Rent Arrears

Prestwich
Isolated older adults
Low income families with children

Bury West
Substance misuse
Those vulnerable to exploitation by organized crime gangs e.g. through Cuckooing

Whitefield
Child neglect
Youth Crime



3. Implementation of Live Well by 2030

BURY INTEGRATED CARE PARTNERSHIP

Live Well is a GM wide programme intend to provide stronger and more networked range of support to make it easier for people to help themselves, their families and those they care for in the community.

It is about building a connected and resilient network of community organisation, public services and local businesses working together.

In 2026 we have focused our Live Well implementation in Whitefield – investing in community capacity and launching a Live Well centre operating as a focal point for connecting voluntary and community and public services together

In 2027 we will focus our work on Radcliffe - building collaborative networks to support people building out of the investment in the public realm– the public service hub/leisure centre for example and connecting to the community investment in pride in place.

In 2027 we will review how best to implement live well in Prestwich, Bury, and Ramsbottom, understanding that the model of around Live Well centres and spaces, voluntary capacity investment, and networking capability will be determined by local needs and priorities.

4. Neighbourhood approaches to supporting children and families

- Children and young people experience all NHS services and our programmes of transformation (e.g. in urgent care and primary care) need to reflect that.

- There are multiple key programmes of work in Bury, often led via Bury Council, that have the potential to improve health outcomes for CYP in Bury, and NHS partners will contribute fully to their delivery through:
  - implementation of Families First arrangements by April 2027 including the establishment of family hubs in all 5 neighbourhoods
  - SEND reforms and the implementation of communities of practice around clusters of schools in neighbourhoods and focused on school inclusion
  - Targeted work on improving Good Level of Development (school readiness)

- There are also multiple programmes of work as part of the Bury health inequalities strategy seeking to support CYP and families as effectively as possible e.g. safe sleeping, obesity, vaccination uptake. Again NHS partners will work to maximise and amplify their contribution.

- This locality plan recognises and commits to those programmes and also commits to the delivery of a range of specific NHS plan targets associated with CYP, including for example the establishment of multi-disciplinary team working across NHS partners.

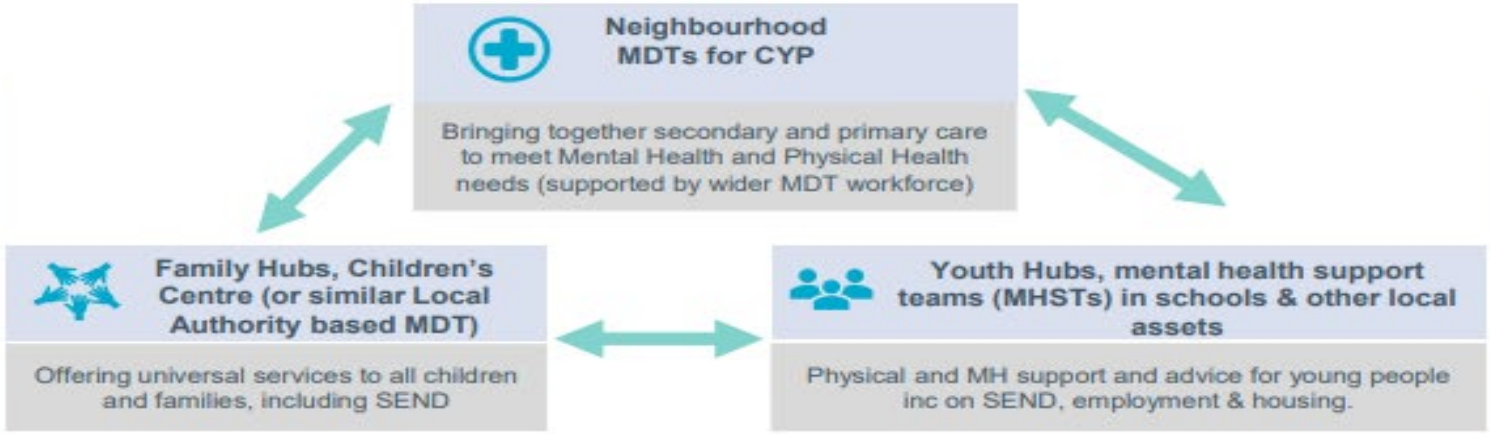
Neighbourhood Team Working for Children and Families

BURY INTEGRATED CARE PARTNERSHIP

NHS England

Greater benefits are realised when neighbourhood MDTs are also integrated with wider local services. MDTs for CYP, Family Hubs and Youth Hubs have fundamental differences in their function and purpose but collectively can offer a complementary suit of services to support CYP and their families/carers.

- **Best Start Family Hubs and MDTs** may have an overlap in workforce, including midwifery, health visiting and early years professionals, wellbeing and mental health practitioners.
- Family Hubs can link in with MDTs to refer onwards for further MH/PH support.
- MDTs to refer into Family Hubs if needs are identified.



- Staff across all models need to work together.
- Some of the workforce may overlap.

- **Local community assets and MDTs** may have some staff roles such as mental health practitioners that are shared across both.
- Local community assets and MDTs may refer into each other to broaden the range of support provided.
- MHSTs may also reach out to MDTs or Youth Hubs.

7. Design principles for health and care

BURY INTEGRATED CARE PARTNERSHIP

Summary:
On the basis of the strategic context described and the strategic objectives and 5 goals described below, we have agreed a number of key design principles for health and care that will flow though all of our work.

Part of Greater Manchester Integrated Care Partnership

Design principles for our delivery model for health and social care

BURY INTEGRATED CARE PARTNERSHIP

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

- A scaled and Marmot compliant programme addressing wider determinants of population health, prevention and addressing health inequality.
- A model of integrated team neighbourhood working that is all age and comprehensive, with a wider range of services connected as part of the integrated team, is a focal point for strengthened intermediate care, and uses more refined and targeted models of proactive primary and secondary prevention.
- A strengthened primary care offer properly and sustainably funded – with single points of access, better care navigation, more responsive services and primary care element of proactive care being more pronounced.
- The practice-based registered list is the only place within system where there is the most complete record of health. This potentially provides an invaluable resource for identifying and tackling health inequalities, personalising care and informing commissioning and planning decisions.
- Providing appropriate levels of support in the community for mental health conditions though Neighbourhood Mental Health Teams.

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

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

Design Principles for our Delivery Model for Health and Social Care

BURY INTEGRATED CARE PARTNERSHIP

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

- To introduce a new model of care, consultant/specialist opinion is crucial to effectively manage the full range of morbidity. Consultants will shift some clinic time to focus on providing community clinics, individual support to primary care and management and supervision of new community-based teams.
- Full expansion of the virtual ward with acute physicians doing virtual ward rounds but also doing physical ward rounds/clinics based with the neighbourhood teams, with graduated closure of acute wards over time.
- Only those who are acutely sick should be in hospital. This requires the capacity and a wraparound model for those including complex dementia patients.
- Strengthened SDEC frailty and SDEC function at FGH and NMGH, with community capacity to enable patients to get back to their home as safely and quickly as possible.
- The avoidance of mental health patients unnecessarily in ED through the implementation of community-based crisis response provision.
- A new mode of outpatient's services which includes significant expansion of consultant advice and guidance to GPs, digital utilisation, and a change in service location to a central hub in the town centre to support the economy & bring income to the town centre. Support the transport strategy and ease the parking burden at FGH.

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

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

Design Principles for our Delivery Model for Health and Social Care

BURY INTEGRATED CARE PARTNERSHIP

Principle 5:
Future integrated services would bring together the full range of primary care

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

Principle 6:
Unscheduled care should be simple to access and fully integrated.

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

Principle 7:
The voluntary sector, carers and our population need a strong voice in the design and sustainability of services

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

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

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

8. Our 5 strategic objectives and 5 clear goals

BURY INTEGRATED CARE PARTNERSHIP

Summary:
On the basis of the strategic context described in the Locality Plan, and the need to continue and quicken our transformation in the light of potential future demand, we will focus on 5 strategic objectives and the 5 clear goals outlined within the Neighbourhood Health Framework, delivered through the reform ambitions. Our goals should be clear to all of us and allow us the necessary focus to deliver further and faster.

Part of Greater Manchester Integrated Care Partnership

Bury Neighbourhood Health and Care Plan [2026-2029]

BURY INTEGRATED CARE

OUR VISION

To transform health and care for Bury residents by shifting the focus from illness to wellness, enabling people to live healthier, happier and more independent lives. Through neighbourhood-based partnerships, we will deliver proactive, preventative and personalised support that improves population health, tackles inequalities and builds resilient communities where everyone can thrive.

STRATEGIC OBJECTIVES

Objective 1:
We will take a population-health based approach, responding to the needs, risks and inequalities within a neighbourhood to improve healthy life expectancy and tackling the factors that drive poor health

Objective 2:
Will we have a focus on prevention though reducing prevalence and providing proactive care

Objective 3:
We will transform through co-production community care in neighbourhoods through earlier intervention, supporting independence and preventing avoidable deterioration through multi-agency team working

Objective 4:
We will optimise care pathways so that when people need to access services, they are provided efficiently and effectively

Objective 5:
We will ensure that every child has the best start in life

STRATEGIC PROGRAMMES

- Population health
- Primary Care
- Urgent and emergency Care
- Mental health
- Elective and community care,
- Major conditions
- End of life
- Neighbourhood team development
- Adult social care
- Children and young people

STRATEGIC PRINCIPLES

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

STRATEGIC ENABLERS

- VCSE Memorandum of Understanding
- Workforce
- Estates
- Digital
- Data and Intelligence
- Clinical and professional leadership
- Communications and engagement : our workforce and our residents
- Financial flows
- Partnership working and collaboration
- Locality residents
- Education system

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Defining the programmes of work to deliver the neighbourhood health framework

BURY INTEGRATED CARE PARTNERSHIP

Locality Let's strategy including:

- INTs
- Neighbourhood leadership Teams
- Live Well
- Family Hubs

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

Locality programmes of care requiring multi-provider input: neighbourhood delivery / UEC and out of hospital expansion (including H@H and EOL) / Estates / Finance)

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

5 clear national Neighbourhood Health Framework goals

BURY INTEGRATED CARE PARTNERSHIP

We work together across the Bury Integrated Care Partnership to :-	
1	Improve health outcomes
2	Improve access to General Practice
3	Improve experiences of planned care and cancer care, and support delivery of the referral to treatment (RTT) standard
4	Deliver better urgent and emergency care (UEC) performance in line with agreed standards
5	Improve patient and staff satisfaction with NHS services

9: Delivery of our ambition

BURY INTEGRATED CARE PARTNERSHIP

Summary:
We have a series of programmes which will focus on the delivery of our goals and reform ambitions. These are outlined within this section. Detailed plans on a page for programmes of care are included within the appendices

Part of Greater Manchester Integrated Care Partnership

Programme priorities

- Each of the following programmes have described their plan on a page to meet the ambitions of the national neighbourhood framework. The key deliverables for 2026/27 are included in the Locality Delivery Plan
  - Health Inequalities
  - Primary Care (including Neighbourhood Health action plans funded through the NHS GM BeCCoR contract)
  - Neighbourhood Teams
  - Urgent and emergency care
  - Mental Health
  - Elective and Community
  - Major conditions (CVD/diabetes, cancer and frailty)
  - Dementia
  - End of Life programme
  - Adult Social Care
  - Children's health
- These programmes of work include locality implementation NHS GM priorities and delivery with partner organisations who work across multiple footprints e.g. NCA, MFT and PCFT.

Enablers – Estates

- We have Borough wide estates strategy, which is supportive of our ambition of neighbourhood working. A lead officer has been identified to complete the estates framework on behalf of the Borough.
- Initial work has focused on mapping existing estates, utilisation and requirements.
- Priorities include optimising the use of existing assets and identifying solutions to create flexible Neighbourhood-based locations for Live Well spaces, INTs, Early Help and Family Hubs.
- There is an emphasis on creating spaces that enable co-location, MDT working and support Neighbourhood delivery.
- In the longer-term opportunities to reduce costs through rationalisation of the public sector estate are being explored.

Enablers – Digital

- The *'analogue to digital'* shift is one of the three core pillars of the government's 10 Year Health Plan for England. It aims to phase out paper records, reduce administrative burdens on staff, and turn the NHS App into a universal "digital front door" for patient care by 2028.
- For patients this has the potential to enable easier access to services, more joined up care and less duplication of assessments, investigations etc.
- For staff there is the potential for better access to information about patients and creating efficiencies that reduce bureaucracy.
- For the locality priorities include:
  - Better use of data and intelligence to identify need and target interventions that improve health outcomes and reduce inequalities.
  - Better use of data and intelligence to measure and evaluate the outcomes and impact we are achieving.
  - Promoting greater use of GMCR by clinical teams
  - Promoting the deployment and use of EPaCCS
  - Completing the roll-out of patient-led ordering of prescriptions
  - Supporting the roll-out of the NHS App
  - Improving information sharing arrangements to support more integrated and coordinated care in our Neighbourhoods
  - Improving the core digital and communications infrastructure in GP practices.
  - Digital transformation within Adult Social Care including the development of self-service options for residents
- Given the limited finance and digital capacity and capability at a locality level we will need the support and commitment of GMICB to identify solutions and support digital transformation at scale and the commitment of the Trusts to consider the importance interoperability with partners in the procurement of new digital systems.

10. Strategic challenges and risks

BURY INTEGRATED CARE PARTNERSHIP

Summary:

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

Part of Greater Manchester Integrated Care Partnership

Key challenges & risks

BURY INTEGRATED CARE PARTNERSHIP

- Constrained financial environment with limited funding to support transformation.
- Lack of clear financial plan to support *left shift* and shift from prevention to treatment in the short term.
- Limited locality commissioning levers to drive transformation esp in Trusts .
- Limited workforce capacity (commissioning and clinical) to support transformation.
- Recruitment and retention in some key service areas.
- The potential for the centralisation of commissioning functions in the ICB and centralised structural organisation and planning in Trusts to weaken engagement at place and neighbourhood level.
- Growing demand across health and care services limits the potential for transformation and delivery of key goals e.g. reducing waiting times.
- Sustainability of the VCSE.
- Comparatively low number of GPs per head of population.
- The ongoing impact of legacy underinvestment and services gaps in some key service areas.
- Lack of digital interoperability across key providers and information systems.
- Estates constraints.
- Lack of geographic alignment between PCNs & Neighbourhoods.

11. Assuring delivery

BURY
INTEGRATED CARE
PARTNERSHIP

Summary

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

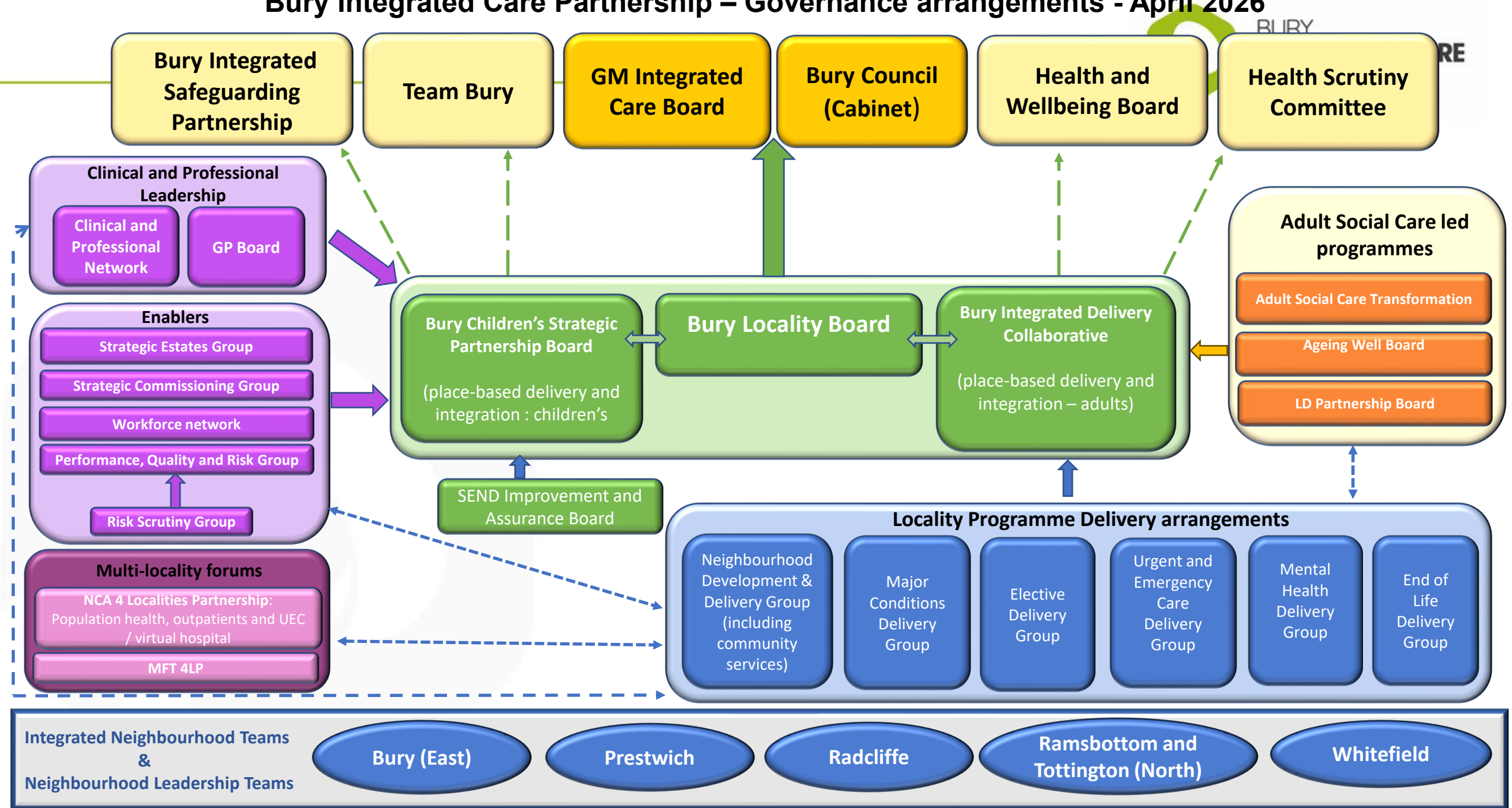
Part of Greater Manchester Integrated Care Partnership

Our Partnership arrangements

BURY INTEGRATED CARE PARTNERSHIP

- The draft Place Partnership Agreement emphasises the requirements for a Place Partnership Board, a Delivery Board and references the statutory role of the Health and Wellbeing Board.
- Bury has two key partnership boards in the Locality with responsibility for health and care - the Integrated Delivery Collaborative Board and the Bury Locality Board (soon to be transitioning to the Place Partnership Board). Both include senior leadership from all partner organisations.
- The Place Partnership Board is responsible for setting direction, agreeing priorities, overseeing the Locality Plan and ensuring alignment with the GM strategy and the Place Outcomes Framework. The Board will work in close alignment with the Health and Wellbeing Board, recognising its statutory role in setting the strategic direction for population health and tackling inequalities.
- The Integrated Delivery Collaborative Board is the oversight vehicle for the delivery of the health and care priorities on behalf of the Locality Board and oversees the localities main health and care transformation programmes.
- There are also a number of other supporting groups that provide assurance and insight into key areas such as clinical leadership, quality, finance, performance, risk, neighbourhoods, workforce - as defined in the draft Place Partnership Agreement.
- The Public Service Reform Steering Group, chaired by the Deputy Place Based Lead, drives the development of the neighbourhood model including the Live Well agenda.
- The Neighbourhood Development and Delivery Group coordinates the work of the INT and Neighbourhood partnerships in delivering neighbourhood health and care priorities in the context of the Locality Plan and agreed health and care transformation programmes.
- The INTs connect with wider public service partners through the Neighbourhood Leadership Teams including representatives from housing, the local authority, public health, Greater Manchester Police (GMP), the Fire and Rescue Service (GMFRS) and the voluntary sector.

Bury Integrated Care Partnership – Governance arrangements - April 2026



Working with the VCSE

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

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

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

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

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

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

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

Desired outcomes of our approach

BURY INTEGRATED CARE PARTNERSHIP

Increasing coordination, consistency and scale in delivering health and social care to specific sub-cohorts should result in the following benefits over time:

- Avoiding or slowing health deterioration, preventing complications and the onset of additional conditions, and maximising recovery whenever possible to increase healthy years of life.
- Streamlining access to the right care at the right time, including continued focus on access to general practice and more responsive and accessible follow-up care enabled through remote monitoring and digital support for patient-initiated follow-up.
- Maximising the use of community services so that better care is provided close to or in people's own homes
- Reducing emergency department attendances and hospital admissions, and where a hospital stay is needed, reducing the amount of time spent away from home and the likelihood of being readmitted to hospital
- Reducing avoidable long-term admissions to residential or nursing care homes.
- Reducing health inequalities, supporting equity of access and consistency of service provision.
- Improving people's experience of care, including through increased agency to manage and improve their own health and wellbeing.
- Improving staff experience.
- connecting communities and making optimal use of wider public services, including those provided by the VCFSE sector.
- Giving children the best possible start in life.

12. Summary

There is a lot to be proud of relating to neighbourhood working in Bury which we need to celebrate. This is described further in our Health and Care case study which has been developed as an accompanying product to this locality plan.

We recognise that we still have opportunities to strengthen the connection between our work on Live Well, the neighbourhood leadership teams, integrated neighbourhood teams in health and adult care, and the neighbourhood model for children and families to further improve the outcomes for our population.

The next year gives us an opportunity to bind these pillars together, whilst continuing to work on programmes of care which will also support delivery of national goal and reform ambitions in the context of our Locality strategy.

Part of Greater Manchester Integrated Care Partnership

Bury Integrated Care Partnership Locality Delivery Plan 2026-2029

BURY INTEGRATED CARE PARTNERSHIP

V0.5 - August 2026

Part of Greater Manchester Integrated Care Partnership

Presentation by:

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

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

Introduction

The Bury Locality Plan outlines the current and forecast state of the health of our population, the policy context of the Plan, and describes an ambition for the further reform of our health and care system and for the improved health of all people of Bury by 2029. This document outlines the delivery plan for 26/27 of our refreshed locality plan.

The Locality Plan highlights that improved outcomes for Bury residents and a clinically and financially sustainable health and care system is dependent on improved population health, improved prevention, transformed community care and the optimal delivery of health and care services. The Locality Plan will address the 5 clear goals and reform ambitions outlined in the national Neighbourhood Health Framework, which are reflected across the breadth of our programmes of work. This delivery plan outlines how we will do this.

The Locality Plan is set in the broader context of neighbourhood working, however for the purposes of this delivery plan there is a greater focus on the health and care element of neighbourhoods.

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

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BURY INTEGRATED CARE PARTNERSHIP

1. Our 5 strategic objectives and 5 clear goals

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Part of Greater Manchester Integrated Care Partnership

Bury Neighbourhood Health and Care Plan [2026-2029]

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Defining the programmes of work to deliver the neighbourhood health framework

BURY INTEGRATED CARE PARTNERSHIP

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2. Delivery through our pogrammes

BURY INTEGRATED CARE PARTNERSHIP

Summary:
We have a series of programmes which will focus on the delivery of our goals and reform ambitions. These are outlined within this section .Detailed plans on a page for programmes of care and associated metrics are included within this section.

Part of Greater Manchester Integrated Care Partnership

Programme priorities

- Each of the following programmes have described their plan on a page to meet the ambitions of the national neighbourhood framework. The key deliverables for 2026/27 are included in the Locality Delivery Plan
  - Health inequalities
  - Neighbourhood Health & Care - Primary Care
  - Neighbourhood Health Action Plans (BeCCoR)
  - Neighbourhood Teams - INTs & integrated delivery
  - Major conditions:
    - CVD / diabetes
    - Cancer
    - Frailty
    - Dementia
  - Palliative & end of life care
  - Mental Health
  - Elective and Community
  - Urgent & emergency care
  - Adult Social Care
  - Children's health
- These programmes of work include locality implementation NHS GM priorities and delivery with partner organisations who work across multiple footprints e.g. NCA, MFT and PCFT.

Tackling health inequalities

BURY INTEGRATED CARE PARTNERSHIP

AIM / SCOPE

Systematically narrow the gap in life expectancy and healthy life expectancy between communities, particularly between our most and least deprived neighbourhoods

STRATEGIC PRIORITIES (2026-2030)

1. **Wider Determinants:** Improve employment, income, education, housing and tackle poverty.
2. **Health Behaviours:** Reduce smoking, alcohol harm, obesity and improve mental wellbeing through prevention and early intervention.
3. **Healthy Places & Communities:** Develop neighbourhood-based Live Well models, strengthen community assets and create healthier environments.
4. **Integrated Health & Care:** Ensure equitable access, strengthen prevention and align services around neighbourhoods.

Neighbourhood Health and care [primary care]

BURY INTEGRATED CARE PARTNERSHIP

AIM / SCOPE

To position primary care as the integrator, coordinator and trusted local anchor of neighbourhood health, enabling a shift:

- From hospital to community-based care.
- From reactive treatment to prevention and population health management.
- From fragmented services to integrated multidisciplinary neighbourhood teams.
- From organisational accountability to shared outcomes for residents.

PRIORITIES - Year 1 (2026-27)

1. Refresh of GP Board role, responsibilities and membership
2. Agree shared priorities and reporting metrics/framework
3. Work with DII to establish an automated monitoring process
4. Baseline current performance and identify/reduce unwarranted variation (including use of pharmacy services)
5. Develop forward plan for deep dive focused sessions by board
6. Single neighbourhood delivery plans in place (with targeted prevention and anticipatory care interventions)
7. Maximise achievement within BeCCoR/QoF/IIF
8. Engaging with Acute Sector to explore care pathways and facilitate left shift models of care
9. Engage with community pharmacies as a core partner in NHD health.

Neighbourhood Health Action Plans (BeCCoR)

BURY INTEGRATED CARE PARTNERSHIP

- A core part of neighbourhood plan for primary care led preventative interventions is funded by NHS GM primary care funding streams in the context of the GM GP contract [BeCCoR]. It has a particular focus on the major clinical causes of poor health and health inequalities, such as Cardio-vascular disease [CVD], diabetes and Chronic Obstructive Pulmonary Disease [COPD].
- Plans have been developed at a Neighbourhood level with partners – building on previous year's work funded through the local GP contract.
- Each of the Neighbourhoods have determined a key health improvement / secondary prevention priority for their populations. This work will focus on improving health outcomes for those with the highest needs in the target cohorts through reviews and treatment optimisation in primary care and wider engagement, education and health improvement initiatives supported by partners from other services including Social Prescribing, Staying Well, Public Health and the VCSE.

NEIGHBOURHOOD	FOCUS
East	High respiratory need / COPD. Stretch to cover patients with co-morbidity in relation to CVD. Focus on 'missing pts', from COPD cohort and remaining 5 cohorts. Includes focus on reviews, vaccination uptake, self-management and engaging missing patients involving community partners.
West	CVD, high QRisk and childhood asthma. Includes community outreach, prevention initiatives and health promotion.
Prestwich	CVD Need cohort focused on high-risk patients with significant cardiovascular unmet need. Includes targeted outreach to improve engagement and completion of high need reviews.
Whitefield	CVD cohort (including hypertension, AF and diabetes). Includes engagement with *hard-to-reach* groups through the Whitefield Live Well Hub and neighbourhood events.
North	CVD Core, CVD Stretch and primary prevention cohorts. Focus on proactive identification and engagement of patients who have historically not attended reviews

Core themes across neighbourhood action plans

BURY INTEGRATED CARE PARTNERSHIP

- Proactive identification of unmet need using population health data
- Engagement of patients not responding to traditional recall methods
- Prevention and early intervention for cardiovascular and respiratory disease
- Tackling health inequalities and barriers to access
- Neighbourhood-based delivery using community assets
- Social prescribing, Live Well and Staying Well support
- Community outreach beyond practice settings
- Flexible access models including community venues and enhanced access
- Collaboration across primary care, INTs, VCFA and pharmacy
- Reduction in avoidable hospital activity

Neighbourhood Health and care [INTs & integrated delivery]

BURY INTEGRATED CARE PARTNERSHIP

AIM / SCOPE

1. Improve people's health and care outcomes, reduce health inequalities and help them stay well at home.
2. Provide more accessible personalized and joined up care.
3. Cut waste and duplication.

PRIORITIES - Year 1 (2026-27)

1. Develop Partnership agreement between PCNs and wider Neighbourhood Partners.
2. Develop refreshed target operating model for Integrated Neighbourhood Health & Care provision.
3. Develop and deliver BeCCoR Neighbourhood Health Action Plans.
4. Agree what we are going to monitor and how – development of Neighbourhood Dashboard.
5. Agree cohorts of need and action plans for Public Service Leadership Teams.
6. Extend the use of EPaCCS in primary and community services.
7. Launch the Whitefield Live Well Hub and develop the offer.
8. Develop the Radcliffe Live Well Offer.
9. Review the effectiveness and operating model of Active Case Management [ACM].
10. Improve the alignment between Neighbourhood Mental Health Team and wider Neighbourhood partners.
11. Implement patient-led ordering of prescriptions Borough-wide.
12. Review safeguarding arrangements for ACM and develop improvement plan.
13. Undertake Data Privacy Impact Assessment and develop data sharing agreement to support Active Case Management.
14. Complete leadership development work and agree job descriptions and work plans for GP and Neighbourhood Leads.

CVD / diabetes

BURY INTEGRATED CARE PARTNERSHIP

AIM / SCOPE

Preventing and managing diabetes and cardiovascular disease by increasing uptake of prevention programmes, education, technologies, and care processes, improving hypertension and lipid management and delivering measurable improvements in diabetes and CVD outcomes.

PRIORITIES - Year 1 (2026-27)

1. Increase referrals to Know Your Risk, NDPP and Pathway to Remission programmes
2. Evaluate SDE referral form and undertake further work with practices
3. Support roll out of hybrid closed loop and CGM technologies
4. Improve uptake of diabetes 8 care processes in line with Neighbourhood Health Framework
5. Strengthen hypertension and lipid management pathways, including hypertension case finding
6. Support delivery of BeCCoR neighbourhood action plans

Cancer

BURY INTEGRATED CARE PARTNERSHIP

AIM / SCOPE

To improve cancer outcomes and patient experience across Bury through earlier diagnosis, increased screening uptake, strengthened primary-secondary care collaboration, personalised care support, and delivery of GM Cancer Alliance/NCA cancer priorities.

PRIORITIES - Year 1 (2026-27)

1. Enable PCNs to create an early cancer diagnosis action plan.
2. Build on NHS Health Checks to increase cancer awareness.
3. Strengthen personalised care pathways through an improved navigator network.
4. Support GM Cancer to improve uptake of bowel, breast and lung cancer screening programmes.
5. Deliver the Neighbourhood Cancer Live Well Fund and associated outcomes.
6. Represent the locality as the PBCL for GM Cancer, engaging with support offer and ensuring local alignment with the GM Cancer Alliance plan.
7. Amplify cancer prevention campaigns and share GM Cancer comms campaigns e.g. Get Cancer Clever and This Van Can.

Frailty

BURY INTEGRATED CARE PARTNERSHIP

AIM / SCOPE

To improve outcomes for people living with frailty through a proactive, whole-system approach focused on prevention, early intervention, personalised care, rehabilitation, and proactive end-of-life care planning.

PRIORITIES - Year 1 (2026-27)

1. Strengthen proactive prevention, early identification and intervention for frailty and falls across neighbourhoods to support healthy ageing and reduce future escalation of need.
2. Expand and optimise 7-day rapid access frailty pathways to improve timely assessment and intervention, reducing avoidable hospital attendances and admissions.
3. Progress the development of an integrated neighbourhood frailty model [encompassing care homes] across health and social care partners, including geriatrician in-reach, exploration of multidisciplinary frailty teams (MDTs), strengthened collaboration with NMGH and Intermediate Care services, and delivery of community frailty awareness initiatives.
4. Embed personalised care planning approaches, including wider adoption of Electronic Palliative Care Coordination Systems (EPaCCS) and Advance Care Plans (ACPs), whilst maximising digital solutions to support coordinated care.
5. Enhance workforce capability and confidence in frailty care through shared learning, education, and multidisciplinary training opportunities.
6. Improve the experience and outcomes of people living with frailty and their carers by delivering person-centred, coordinated and responsive services.
7. Support the development of the NCA Fracture Liaison Service (FLS) business case to strengthen secondary prevention and improve bone health outcomes for Bury residents.

Dementia

BURY INTEGRATED CARE PARTNERSHIP

AIM / SCOPE

To improve the health, wellbeing, and quality of life of people in Bury living with dementia and their carers.

PRIORITIES - Year 1 (2026-27)

Priority 1: Promoting Health and Wellbeing
- Map current availability of post-diagnostic support and interventions across all services [inc. VCSE] / Neighbourhoods.
- Develop a pathway of care for memory assessment which is compliant with GM Dementia and Brain Health Quality Standards.

Priority 2: Ensuring People with Dementia have Equitable Access to Appropriate Health and Care Services.
- Finalise the review of the pathway of care for memory assessment which is compliant with GM Dementia and Brain Health Quality Standards.
- Map current availability of post-diagnostic support and interventions across all services [inc VCSE] / Neighbourhoods.

Priority 3: Supporting People Affected by Young Onset Dementia
- Ensure that Young Onset Dementia is included in the review of the diagnostic pathway.
- Support the ongoing development of the YOD Admiral nurse, funded by the 10 localities.

Priority 4: Supporting Carers of People with Dementia
- Develop and deliver a package / programme of support for carers through the commissioned carers hub.
- Support the development of the Carers coproduction network and link into this to establish mechanisms to support all carers.

Priority 5: Preventing and Responding to Crisis
- Review current pathways for preventing and responding to crisis and understand what could support people living with Dementia and their carers.
- Work with providers to understand possible opportunities to redesign services to support the needs of communities.

Priority 6: Developing Dementia-Friendly Communities
- Work with partners to support and progress GM Live Well and Ageing in Place.
- Contribute to Ageing well and support ongoing Public Health initiatives.

Priority 7: Establishing a Dementia Co-production Subgroup through the Bury Older People's Network.
- Develop and embed mechanisms to work in co-production with people with lived experience.
- Commission and provide ongoing support to the Dementia Coproduction Network.

Palliative & End of Life Care

BURY INTEGRATED CARE PARTNERSHIP

AIM / SCOPE
Bury patients, their families and carers receive high quality, timely, effective services that meets needs and preferences as far as possible, ensuring that respect and dignity is preserved both during and after the patient's life.

PRIORITIES - Year 1 (2026-27)
1. Increased use of the EPaCCs platform across Bury's services with a focus on GPs, OOH and FGH specialties. 2. Improve integrated working and community pathways and the provision of specialist palliative care – Co-location of community services. 3. Workforce development – enable the delivery of the Palliative training and education programme (Hospice led). 4. Support NCA's Business Case for community palliative seven-day service.

Mental Health

BURY INTEGRATED CARE PARTNERSHIP

AIM / SCOPE

The Bury Mental Health Programme will deliver a prevention-led, neighbourhood-based and integrated mental health system that improves population wellbeing, reduces inequalities and enables people to access timely, person-centred support throughout their lives.

PRIORITIES - Year 1 (2026-27)

1. Describe and promote a core offer of mental wellbeing initiatives and services at a place and Neighbourhood level.
2. Increase uptake of suicide prevention training in context of Bury Suicide Prevention Strategy.
3. Sustain existing provision of myHappyMind & myMindcoach in Bury schools.
4. Optimisation of graduated approach to sensory processing support as part of a redesigned service offer and develop commissioning intentions.
5. Locality implementation of GM CYP Neurodevelopmental [ADHD / ASD] programme.
6. Extend Mental Health Support Teams in schools.
7. Develop commissioning intentions for the provision of support to children and young people who have experienced domestic abuse.
8. Improve access to mental health assessment and support for young people involved in the criminal justice system.
9. NHS Talking Therapies - access & waiting time improvement.
10. Implement transformed pathways for neurodevelopmental assessments [ADHD / ASD] for adults.
11. Audit the compliance of the current pathway of care for memory assessment with GM Dementia and Brain Health Quality Standards.
12. Establish a community-based crisis response team.
13. Sustain and enhance community-based mental health support through integrated Neighbourhood MH Teams.
14. Targeted action to increase uptake of SMI health checks.
15. Improve patient flow on adult acute MH wards with a focus on reducing long LOS and reducing proportion of bed days occupied by people who are clinically ready for discharge.
16. Commence review of Section 117 funding arrangements and develop recommendations for improvements to ensure people get the support they need in a financially sustainable way.
17. Establish primary / secondary interface group to improve integrated working.

Elective & Community Services

BURY INTEGRATED CARE PARTNERSHIP

AIM / SCOPE

The co-ordination of Elective Community services across the Bury locality to deliver improved access and reduced waiting times in key pathways

For this programme of work there will be very close alignment with the NCA and MFT to deliver the GM priorities for implementation including tier 2 provision , single point of access routes and advice and guidance.

PRIORITIES - Year 1 (2026-27)

1. Implementation of the GM Specialist Advice & Guidance pathways to align GM strategy for A & G (BeCCoR).
2. Implementation of GM Dermatology Model of Care.
3. Locality's IS 2026/27 contracts are in place for IS Community health services.
4. Enable the FLP NCA Community Service reviews.
5. Reduction in Pediatrics community waiting times – scope Pediatrics services, co-produce/develop initiative to reduce waiting times.
6. Participating in GM Community MSK Review
7. National SPA (eRS) implementation (10 service lines) starting with 4 pathways (Gynae/ENT).

Urgent & Emergency Care

BURY INTEGRATED CARE PARTNERSHIP

AIM / SCOPE

To oversee the delivery of improvements across the Bury UEC system for the patients. Supporting improvements towards the delivery of national targets and development of urgent care neighborhood approaches.

PRIORITIES - Year 1 (2026-27)

1. **System Redesign**
    1. Work with GM DII to redesign UEC measurement to reflect new targets. Monitor UEC metrics.
    2. Prioritise the redesign and delivery of the Bury UEC System to support the neighbourhood agenda and to reflect organisational restructures.
2. **Attendance and Admission Avoidance**
    1. Develop HIUs/Frailty/Care Homes schemes to support reduced ED activity and admissions.
    2. Work with LA and system partners on Better Care Fund priorities (also Improving Discharges and Community Support).
    3. IMC review recommendation to improve Re-ablement capacity (also Improving Discharges and Community Support).
3. **In Hospital Pathways**
    1. Implementation of the 2025 FGH UEC Pathways Review recommendations.
    2. NCA UEC Improvement Plan, including priority on Corridor Care.
    3. DKAFH Improvements including NMGH Programme of Work (also Improving Discharges).
4. **Improving Discharges and Community Support**
    1. DKAFH Improvements including NMGH Programme of Work (also In Hospital Pathways).
    2. Work with LA and system partners on Better Care Fund priorities (also Attendance and Admission Avoidance).
    3. Implementing the IMC review recommendations to improve Re-ablement capacity (Also Attendance and Admission Avoidance).

Adult Social Care

BURY INTEGRATED CARE PARTNERSHIP

AIM / SCOPE

Vision: “The people of Bury will have independent lives, involved and connected to their communities”

Priorities:

1. Promote independence
2. Deliver excellent services
3. Make Bury a great place to work
4. Improve financial sustainability

PRIORITIES - Year 1 (2026-27)

1. Develop a new model of reablement.
2. Embed a Strengths-Based Practice Framework for social workers.
3. Develop a Supported Living Allocation Framework
4. Develop a co-produced Autism Strategy.
5. Develop and commence a Carers Strategy Improvement Programme
6. Implement a new care home contract.
7. Redesign mental health pathways and Section 117 arrangements.
8. Design an improved digital front door and prevention model for adult social care.

Children’s health

BURY INTEGRATED CARE PARTNERSHIP

AIM / SCOPE

To improve timely access and outcomes in line with national requirements and local engagement with children & families

NB: This programme of work will connect closely with the Council and other partners to ensure he full contribution of the NHS to partnership children’s reform including SEND, Families First, the Youth Justice Board, and Good level of development

PRIORITIES - Year 1 (2026-27)

Theme 1 – Urgent Care:

- Reducing NEL/Bed days of 1 day plus
- Reduction in CYP attending ED

Theme 2 – primary care:

- Reduction in high unmet need for asthma
- Reduction in dental extractions
- Increase uptake in childhood vaccinations

Theme 3 – Secondary Care:

- Reduction in acute outpatient appoints

Theme 4 – Community Services:

- Reduction in community waiting times for children

Theme 5 – Mental Health and Learning Disabilities:

- Increased coverage of mental health support teams in schools.
- Optimisation of graduated approach to sensory processing support as part of a redesigned service offer and develop commissioning intentions.
- Locality implementation of GM CYP Neurodevelopmental [ADHD / ASD] programme.
- Develop commissioning intentions for the provision of support to children and young people who have experienced domestic abuse.

Specific Priority:

Establish MDT team working in NHS as per NHS plan

Year 1 – scope, engage and co-produce

3. Assessing progress against minimum requirements

BURY INTEGRATED CARE PARTNERSHIP

Summary:
A series of expectations have been set for 26/27 within the Neighbourhood Health Framework. The final ICB place partnership agreement is yet to be finalised and further work is needed to determine the location of responsibility for delivery of the 10 stage 1 requirement [GM, Provider, 4LP, Place]. These slides provide an overview of the requirements and a provisional status update on current compliance.

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Minimum requirements [Neighbourhood Health Framework 2026/27]: Assessing our progress

BURY INTEGRATED CARE PARTNERSHIP

REF	LABEL	FRAMEWORK WORDING	DRAFT LEAD RESPONSIBILITY / SCOPE	CURRENT LOCALITY STATUS
S1	**Urgent, rehabilitation and reablement capacity**	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.	Place	Good progress in implementing Urgent Community response co-ordinated with virtual wards and in understanding baseline activity. Further work to do on system co-ordination
S2	**General practice access and variation**	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.	GMICB	Access and unwarranted variation is understood and monitored locally. Further work needed to understand GM / locality responsibilities and sharing data in public forum.
S3	**Neighbourhood footprints**	Agree neighbourhood footprints around natural communities for the future development of integrated neighbourhood teams (INTs).	Place	Footprints defines and approved. Further work to do to align wider MH and community services to Neighbourhood footprints and strengthen alignment with PCNs.
S4	**INTs for priority cohorts and devolved budgets**	Agree plans to establish INTs focused on high-priority cohorts, including how devolving care budgets could work in their area.	Place	Care co-ordination / escalation through Active Case Management in operation. Further work to do to embed systematic approach to proactive care.
S5	**Neighbourhood approach to elective pathways**	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.	Place	Some progress made in developing new streamlines pathways of care but further work needed to implement and spread across high volume elective specialities

Most elements complete	Further work to do

Minimum requirements [Neighbourhood Health Framework 2026/27]: Assessing our progress 2

BURY INTEGRATED CARE PARTNERSHIP

REF	LABEL	FRAMEWORK WORDING	DRAFT LEAD RESPONSIBILITY / SCOPE	CURRENT LOCALITY STATUS
S6	**Community waits**	Confirm plans to meet 18-week community waits and eliminate 52-week waits.	GMICB	Improvement trajectories agreed at GM level. Further work needed with Trusts to develop improvement plans and to start to demonstrate impact.
S7	**Better Care Fund pooled funding**	Confirm how ICBs and local authorities intend to use pooled funding under the Better Care Fund in line with BCF guidance, including the required increases in ICBs' minimum contributions to adult social care.	Place	BCF plan 2026.27 agreed and approved. Further work needed to define and evidence approaches to reducing health inequalities.
S8	**Primary and secondary care interface**	Continue to improve the primary and secondary care interface in line with the red tape challenge.	Place	Primary / secondary interface forums established with NCA and PCFT. Further work needed to ensure concrete improvement plans are in place with dedicated resource to support delivery and embed Consultant outreach to community.
S9	**Organisational ownership**	Confirm organisational ownership of planned deliverables.	GMICB	further work needed to define organisational leadership and ownership and governance arrangements.
S10	**Data sharing for identification and evaluation**	Confirm plans for having the appropriate data-sharing arrangements in place to do robust patient identification and evaluation.	GMICB	Greater Manchester Care Record provides good foundation for data sharing. Further work needed to strengthen local arrangements and expand access to GMCR

Most elements complete	Further work to do

4. Assuring delivery

BURY
INTEGRATED CARE
PARTNERSHIP

Summary

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

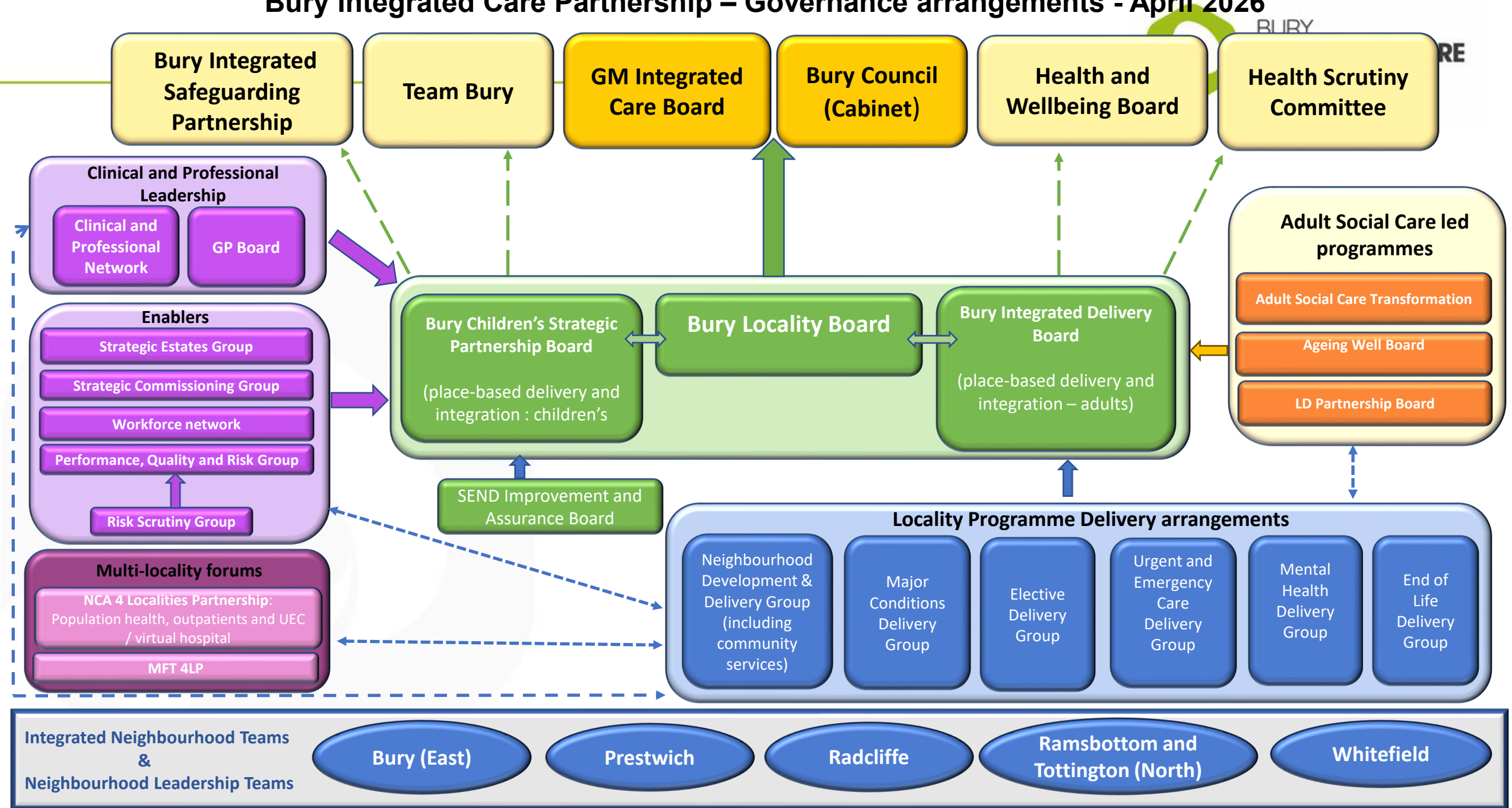
Part of Greater Manchester
Integrated Care Partnership

Our Partnership arrangements

BURY INTEGRATED CARE PARTNERSHIP

- The draft Place Partnership Agreement emphasises the requirements for a Place Partnership Board, a Delivery Board and references the statutory role of the Health and Wellbeing Board.
- Bury has two key partnership boards in the Locality with responsibility for health and care - the Integrated Delivery Collaborative Board and the Bury Locality Board (soon to be transitioning to the Place Partnership Board). Both include senior leadership from all partner organisations.
- The Place Partnership Board is responsible for setting direction, agreeing priorities, overseeing the Locality Plan and ensuring alignment with the GM strategy and the Place Outcomes Framework. The Board will work in close alignment with the Health and Wellbeing Board, recognising its statutory role in setting the strategic direction for population health and tackling inequalities.
- The Integrated Delivery Collaborative Board is the oversight vehicle for the delivery of the health and care priorities on behalf of the Locality Board and oversees the localities main health and care transformation programmes.
- There are also a number of other supporting groups that provide assurance and insight into key areas such as clinical leadership, quality, finance, performance, risk, neighbourhoods, workforce - as defined in the draft Place Partnership Agreement.
- The Public Service Reform Steering Group, chaired by the Deputy Place Based Lead, drives the development of the neighbourhood model including the Live Well agenda.
- The Neighbourhood Development and Delivery Group coordinates the work of the INT and Neighbourhood partnerships in delivering neighbourhood health and care priorities in the context of the Locality Plan and agreed health and care transformation programmes.
- The INTs connect with wider public service partners through the Neighbourhood Leadership Teams including representatives from housing, the local authority, public health, Greater Manchester Police (GMP), the Fire and Rescue Service (GMFRS) and the voluntary sector.

Bury Integrated Care Partnership – Governance arrangements - April 2026



Governance for delivery through IDC Board

BURY INTEGRATED CARE PARTNERSHIP

Goals	Key tasks	Lead	Governance
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 and GP Board
Goal 2: Improve access to General Practice (Primary Care)	1. Baseline data 2. Agree improvement plan	Zoe Alderson	GP Board
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	Damien Aston	Elective Delivery Group and GP Board
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
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

Desired outcomes of our approach

BURY INTEGRATED CARE PARTNERSHIP

Increasing coordination, consistency and scale in delivering health and social care to specific sub-cohorts should result in the following benefits over time:

- Avoiding or slowing health deterioration, preventing complications and the onset of additional conditions, and maximising recovery whenever possible to increase healthy years of life.
- Streamlining access to the right care at the right time, including continued focus on access to general practice and more responsive and accessible follow-up care enabled through remote monitoring and digital support for patient-initiated follow-up.
- Maximising the use of community services so that better care is provided close to or in people's own homes.
- Reducing emergency department attendances and hospital admissions, and where a hospital stay is needed, reducing the amount of time spent away from home and the likelihood of being readmitted to hospital.
- Reducing avoidable long-term admissions to residential or nursing care homes.
- Reducing inequalities in access and outcomes.
- Improving people's experience of care.
- Improving staff experience.
- Reducing duplication and waste through more joined up and co-ordinated care.
- Connecting communities and making optimal use of wider public services, including those provided by the VCFSE sector both in addressing the wider determinants of health and the delivery of more joined up services in the context of the Live Well model.

5. Summary

Summary

There is a lot to be proud of relating to neighbourhood working in Bury which we need to celebrate. This is described further in our Health and Care case study which has been developed as an accompanying product to this locality plan.

We recognise that we still have opportunities to strengthen the connection between our work on Live Well, the neighbourhood leadership teams, integrated neighbourhood teams in health and adult care, and the neighbourhood model for children and families to further improve the outcomes for our population.

The next year gives us an opportunity to bind these pillars together, whilst continuing to work on programmes of care which will also support delivery of national goal and reform ambitions in the context of our Locality strategy.

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BeCCoR: Section 3 Neighbourhood Plans 2026/27

Prevention, Population Health & Neighbourhood's: Cohort Based Multimorbidity Reviews

Locality Board

September 2026

Purpose

To identify and engage patients with high unmet need or poor engagement with traditional primary care pathways

Requirement 3c Neighbourhood Prevention Allocation (Funding)

Each place partnership has a neighbourhood prevention allocation (a financial allocation) to fund additional costs for partnership activities in the Neighbourhood Plans

For the purposes of financial flows, the default position is that this allocation goes via GP Practices (the alternative option being partial or full reimbursement via the PCN)

North, West, East and Whitefield Neighbourhoods have opted to retain reimbursement via the practice. Prestwich have opted for the funding to go via the PCN

The ICB will support the release of funding once the plans have been approved by Locality Board

Neighbourhood Plan Development Process

Development Timeline:

- May 2026: BeCCoR launch and cohort analysis
- May-July 2026: Stakeholder engagement and neighbourhood workshops
- June-July 2026: Identification of priority cohorts
- July 2026: Development and agreement of action plans
- Sept 2026: Q2 submission
- March 2027: Evaluation and Q4 reporting

ICB Input:

- Standing BeCCoR agenda item at NDDG since March with extensive discussion and a requirement to share draft plans in June 26 following which extensive feedback was given
- Drop-in sessions delivered with the GP and Neighbourhood Leads to provide further support, advice and scrutiny of the plans.
- The timeline in relation to governance inc at GP Board has been repeatedly shared with the Neighbourhood Leads across Q1
- Communications sent to GP Leads providing advice and guidance, responding to queries, giving feedback re-iterating the requirements and assessment criteria
- Attendance at Neighbourhood meetings to support the process
- Individual GP Lead meetings to aid plan production as requested

The neighbourhood plans have been developed through a collaborative process involving:

- GP Practices and PCNs
- Integrated Neighbourhood Teams
- Staying Well Services
- Live Well Services
- Community Pharmacy
- VCFA and Community Organisations
- Mental Health Services
- Adult Social Care
- Local Authority Partners

Governance

- 15 July 26 – GP Board Initial Plan Review (East, West, Prestwich Neighbourhoods)
- 23 July 26 – Extraordinary GP Board Initial Plan Review (Whitefield & North Neighbourhoods)
- 7 August 26 - Final Plan Submission
- 19 August 26 - GP Board Rubber Stamp
- 27 August 26 - IDC Board
- 6 September 26 - Locality Board for final approval
- 30 September 26 - Neighbourhood Lead submission of plan to GM

Neighbourhood Plan Summary

- North – CVD Core, CVD Stretch and Primary Prevention cohorts. Focus on proactive identification and engagement of patients who have historically not attended reviews
- East – High Respiratory Need COPD. Stretch to cover CVD pts, focusing on ‘missing pts’, from COPD cohort and remaining 5 cohorts. Focus on reviews, vaccination uptake, self-management and engaging missing patients.
- West – CVD, High QRisk and Childhood Asthma. Community outreach, prevention and health promotion.
- Whitefield – CVD cohort (including hypertension, AF and diabetes). Focus on hard-to-reach groups through the Whitefield Hub model and neighbourhood events.
- Prestwich – CVNeed cohort focused on high-risk patients with significant cardiovascular unmet need. Targeted outreach to improve engagement and review completion.

North Neighbourhood

Focus

- CVD core, CVD stretch and primary prevention cohorts
- Patients who have historically not engaged with routine reviews or preventative care
- Approx 1200 patients in the CVD (core and stretch) cohort and a further 1600 in the primary prevention area

Delivery

- Data-led identification of unmet need
- Neighbourhood-wide collaborative working
- VCFA, pharmacy and Staying Well involvement
- Alternative communication and outreach approaches

Expected Outcomes

- Increased reviews completed
- Reduced admissions
- Improved cardiovascular and respiratory outcomes

East Neighbourhood

Focus

- High respiratory need COPD cohort
- Stretch to cover CVD patients focusing on missing patients from COPD and from remaining 5 cohorts
- 635 identified patients (COPD only)

Delivery

- Enhanced COPD reviews
- Neighbourhood COPD awareness campaign
- Community pop-up events
- Pharmacy engagement
- Community grant scheme
- Monitor the numbers of ‘missing’ pts reviewed in each cohort at Neighbourhood meeting

Expected Outcomes

- Improved COPD management
- Increased vaccination uptake
- Reduced hospital admissions

West Neighbourhood

Focus

- High need CVD patients, CVD stretch patients, high QRisk patients, children with asthma
- Patients missing cardiovascular reviews
- Approx 4500 patients

Delivery

- Community drop-in clinics at Growing Together Radcliffe
- Enhanced Access evening and weekend reviews
- Community pharmacy and VCFA engagement
- Live Well, Staying Well and Mental Health Team involvement
- School nursing collaboration

Expected Outcomes

- Increased CVD review completion
- Improved QRisk assessment
- Increased referrals to community services

Whitefield Neighbourhood

Focus

- CVD cohort
- Hypertension
- Diabetes
- Atrial Fibrillation
- Approx. 1,000 patients including hard-to-reach groups

Delivery

- Whitefield Live Well Hub model
- Two neighbourhood engagement events
- Community-based health checks
- Enhanced Access clinics
- Social Prescribing, Staying Well and VCFA support

Expected Outcomes

- Reduced missingness
- Improved access and engagement
- Increased social prescribing referrals
- Improved cardiovascular outcomes

Prestwich Neighbourhood

Focus

- CVNeed cohort
- Non-engaging, frail, housebound and isolated patients
- 190 patients with significant cardiovascular unmet need

Delivery

- Data-led stratification and outreach
- Social prescribing and community engagement
- Acute Visiting Service support
- Community pharmacy involvement
- MDT and neighbourhood partner delivery

Expected Outcomes

- Engage 100% of identified patients
- Complete optimisation reviews in at least 80% of non-responders
- Improved review completion and cardiovascular outcomes

Strategic Themes Across All Plans

- Proactive identification of unmet need using population health data
- Engagement of patients not responding to traditional recall methods
- Prevention and early intervention for cardiovascular and respiratory disease
- Tackling health inequalities and barriers to access
- Neighbourhood-based delivery using community assets
- Social prescribing, Live Well and Staying Well support
- Community outreach beyond practice settings
- Flexible access models including community venues and enhanced access
- Collaboration across primary care, INTs, VCFA and pharmacy
- Reduction in avoidable hospital activity

All plans align with BeCCoR objectives and Place priorities and demonstrate a neighbourhood approach to addressing unmet need

Risks

Risk Theme	Strategic Risk
Practice Buy-In	Insufficient practice participation and investment limits achievement of neighbourhood objectives.
Delivery Capacity	Funded partners lack capacity to deliver agreed interventions and outcomes.
Accountability	Weak incentives for delivery reduce focus on achieving agreed outcomes.
System Collaboration	Lack of wider partner engagement undermines delivery of whole-system neighbourhood solutions.
Timescales	Limited remaining delivery period constrains implementation, evaluation and impact realisation.
Impact & Benefits Realisation	Benefits are not evidenced sufficiently to demonstrate programme success.
Future Investment	Failure to evidence impact reduces the likelihood of future GM investment in neighbourhood programmes.
Workforce & Operational Pressures	Competing priorities and workforce pressures affect delivery capacity across partners.

Sign-Off Criteria

- Value for Money: ✓ all plans
- Focus on BeCCoR Cohorts: ✓ all plans
- Co-produced with Partners: ✓ all plans
- Supports Neighbourhood Working: ✓ all plans
- Aligns with Place Priorities: ✓ all plans

Assurance

All plans meet the minimum requirements for neighbourhood funding approval, subject to finalisation of local financial governance arrangements and ongoing monitoring

Recommendations

Locality Board is asked to note that the GM recommendation is that we take a pragmatic approach and proceed with sign-off, recognising that this year is intended to be a learning and testing period for the model. Locally, we are assured that the plans collectively support delivery of:

- BeCCoR objectives
- Neighbourhood health priorities
- Population health improvement
- Reduction in health inequalities

Board Decision Required: Approval

Pillar 3 Prevention Population Health and Neighbourhoods - BeCCoR neighbourhood action plan DRAFT v2
(This is an offline version for info – the form for submission will be developed in MS Forms and will be accessible in June)

Quarter 2 Report (Sept 30th 2026)

Purpose of this form:

GP practices/PCNs will be expected to attend Neighbourhood forums and to collaborate with key neighbourhood partners to reach a shared understanding of local neighbourhood priorities and the BeCCoR patient cohorts, especially the groups that general practice is finding it most challenging to reach and/or to address the health needs of because of wider issues.

BeCCoR Neighbourhood Plans will be developed through Neighbourhood engagement and co-production activities, aiming to better reach and serve these groups, with likely additional benefits beyond the defined cohorts. Funding for engagement and plan development is described as 3b in BeCCoR specification.

This document provides a format for your Neighbourhood Action plan, and acts as the template for your Q2 and Q4 submission.

A Neighbourhood Prevention Allocation (3c) is available to fund the elements of the BeCCoR Neighbourhood Plans that require resource.

This form must be submitted via MSForms **by 30th Sept 2026** with section 1 completed**.** The submission date for resubmission with section 2 completed is **30th March 2027.**

If you are submitting collectively (e.g. through a PCN) only one copy needs to be sent in.

General Practice Name(s): *(Please list all practices included in this submission)*	Huntley Mount Medical Centre Walmersley Road Medical Practice Townside Surgery Knowsley Medical Centre Rock Healthcare

	Peel GPs Ribblesdale Medical Centre Tower Health Care - Minden
Is this a PCN response? if so, please provide name of PCN:	
Locality/Place:	Bury
Name(s) and roles of practice leads involved in this work:	This is the neighbourhood plan for primary care led preventative interventions in this neighbourhood. It is funded by NHS GM primary care funding streams and has a particular focus on the major clinical causes of poor health and health inequalities, such as CVD, COPD and Diabetes. It reflects programmes of joint prioritisation, targeting and investment across the GP practices in the neighbourhood. While this proposal is at this stage very primary care delivery focused, GPs in the neighbourhood teams recognise and commit to supporting the work of all partners in the neighbourhood to improve the circumstances of peoples lives , creating opportunities for all people to be well, independent and connected to their communities, and where health and care, and wider public services, are joined up more effectively. Each neighbourhood in Bury is: • developing its model of integrated health and care team working, including adult care, community nursing , neighbourhood mental health teams and voluntary and community partners. • Harnessing its public service leadership teams bringing together those partners with an opportunity to contribute to the wider determinants of inequality - including housing, DWP, income maximization team, GMP, schools, live well services and others, and focused of cohorts of particular risk of harm reflective of this neighbourhood

	• Developing a plan for the implementation of the GM Live Well programme - ensuring vibrant and connected community capacity to support people to be connected to advise support and care where they need it • A developing model of family hubs, bringing a range of NHS, council and wider public services to support families with young children to ensure the best start in life. Huntley Mount Medical Centre – Dr Fazel Butt Walmersley Road Medical Practice – Dr Afzal Hussain Townside Surgeries – Dr Stoddart Knowsley Medical Centre – Dr Honnappa Rock Healthcare – Dr Rasheed Hussein Peel GPs – Dr Rachel Hubber Ribblesdale Medical Centre – Dr Jonathan Chernick Tower Health Care - Minden - Dr Marc Chapman
Name of Neighbourhood (*alignment to closest / most appropriate neighbourhood) :*	East Bury Neighbourhood
Which organisations were involved with the co-design of this plan? (i.e. Provide details of neighbourhood partners involved)	All 8 GP practices as named above Bury East INT Lead and NSO Bury PCN & Horizon PCN East District Nurse Team INT Nurse Liaison Team Staying Well Team Social Prescribing Team PCN/practice Pharmacists Achieve Local Pharmacies Social Service Colleagues Live Well Service Bury GP Federation

Name and dates of neighbourhood forum/ meeting has this been discussed and agreed at:	***2025:*** *Last year INT leads were asked to start looking into areas of work our Neighbourhoods may focus on from April 2026. We had a detailed discussion on these next steps at our COPD Rescue Pack Audit Peer Review meeting, where all 8 practices were present. Feedback was practices felt we needed to have a sustained concentrated effort on one area of work to make an impact.* ***APRIL 2026:*** *BeCCoR Neighbourhood plan introduced to the attendees, previous feedback from 2025 suggested to concentrate on the same area, i.e. COPD, so we can make an impact, rather than jumping from Bowel Cancer to COPD then to another focus.* ***MAY 2026****:* *BeCCoR introduced at Neighbourhood meeting in May 26 – data suggested potential issue with older cohort of COPD pts having higher rates of, and longer admissions; attendees invited to share thoughts/ideas.* *Most practices in attendance, as well as* ***Staying Well Team, DNs, INT Nurse Liaison, Social Prescribers, Pharmacists, Achieve*** *Dr Butt also discussed the same at Bury PCN Meeting in May –* ***these 2 meetings captured all practices.*** *East, West & North INT Leads, NSO's and Clinical Leads also met to discuss BeCCoR proposal and potential joint working,* ***May 26.*** *East INT Lead attended 2 x BeCCoR webinars* *East INT Leads discussed BeCCoR at NDDG meetings and other ICB/GM meetings.* ***JUNE 2026****:* *June Neighbourhood Meeting – updates provided to attendees by Dr Butt. (outlining plan in more detail & welcomed further suggestions and input from attendees).* ***11th June*** *– Further East, West, North INT BeCCoR catch up meeting.* *Bury PCN meeting in* ***June 2026*** *– further discussion around Section 3 of BeCCoR and Neighbourhood Plan.* *Several ICB level engagement/leadership meetings in June.*

	ARRS staff also informed of plan and how they can help, as well as Lindsay Mooney from Bury GP Fed and COPD community team. *INT lead met & discussed with community wider stakeholders regarding the plan & how they could support – positive feedback received.* ***JULY 2026**:* *July Neighbourhood Meeting – updates provided to attendees by Dr Butt and Gemma Iliadis, presentation & discussion, with ICB in attendance.* ***July 2026** all 8 practices met to agree one focus – COPD, and wider related matters (CVD), as well as agreeing to share costs (to be detailed)*

ID	Question (prompt text)	Choices / fields (to be developed into MS forms as drop down menu where possible)
1.1	Which BeCCoR cohort is the main focus of this neighbourhood plan?	• Respiratory (RespNeed) COPD
1.2	What is the approximate or known size of the main cohort?	*635 patients across the 8 practices in East Bury*
1.3	Rationale: Why has this cohort been prioritised, and what is the main issue or barrier this plan is trying to address?	In the East Bury BECCOR Neighbourhood plan, we plan to focus on the COPD cohort of Section 3. We have recognized COPD as a local priority area with the support of Public Health colleagues and recognize we have higher rates of COPD compared to national averages as well as higher admission rates and higher costs for this condition. The 8 practices in East Bury have a total of 635 pts in their collective High Need COPD BeCCoR cohort. Additionally, we plan to stretch our plan to cover CVD pts, and will have a particular focus upon the 'missing pts', from within the COPD pt cohort and the missing pts from the remaining 5 cohorts (CVDx2, QRISK, Asthma x2). We anticipate our pts with High Need COPD and pts on our COPD QOF registers will benefit from this work and higher rates of these pts will undertake detailed COPD reviews. We also anticipate a significant and impactful number of these pts will receive relevant immunisations and additional CVD checks (BMI, BP, manual pulse checks to

		rule out atrial fibrillation, any relevant blood testing in relation to QRISK or CVD High Need cohorts). These pts will be offered longer appointments in order to carry out the additional checks and answer any relevant queries. This time can also be utilised efficiently to carry out NHS Health checks where appropriate. We feel this focused work shows good value for money, with our Make Every Contact Count (MECC) approach and efficient and effective use of resource. We feel involving wider stakeholders and practices in the design and implementation of this plan will further help us gain value for money as we will work more effectively and reduce duplication. Reaching our goals of reviews, vaccinations, wider CVD identification, missing pts, referrals to INT and other services will further demonstrate value for money. Practices will be regularly updated and monitored on progress in this work and will also be informed of their 'missing pts' and how many of those have undertaken the relevant reviews in all 6 cohorts of Section 3 of BeCCoR. We plan to explore the barriers to healthcare for our older COPD pts and explore if offering them a holistic approach including community support, social activities and wider stakeholder engagement will reduce their risk of hospital admission and improve their COPD related quality of life. This will be done via pop-up events and educational material. Additionally, we will ask our wider community stakeholders to help us encourage COPD pts to attend their surgeries to ensure they undertake their annual COPD reviews. We plan to improve pt understanding around COPD with dialogue & education. We plan to identify and target the 'missing' pts and >80 yr old pts in the High Need COPD cohort & better understand their barriers to seeking health intervention at the appropriate time to avoid complications and hospital admissions. Despite Bury East concentrating on COPD pts over the last 2 years – why is there still significant and, in some age groups, disproportionate admission rates in our COPD pts? Are there additional reasons for reduced uptake of COPD related health care? Social isolation? Housebound? Hesitancy to seek medical advice (older pts)? Poor health literacy? Appropriate use of Rescue packs? Vaccine hesitancy (post Covid)? Older pt digital-exclusion to accessing health care? Language barriers? Lack of understanding & ability to navigate healthcare system? - This needs further exploration.

		We also know deprivation rates in East Bury are linked to high rates of smoking & respiratory diagnosis. Therefore, this is an important and worthy piece of focused work. We plan to: • *Raise COPD awareness (through education material, pop up events, COPD health reviews)* • *Encourage pts to register on digital platform MyCOPD to help them understand and monitor their condition* • *Encourage COPD self-management to reduce burden upon services* • *Empower pts to take ownership of their condition* • *Encourage pts to engage with practices for QOF COPD reviews & Enhanced High Resp Need COPD reviews.* • *Encourage pts to have flu/pneumo vaccs/RSV/COVID 19, widening our offer* • *Involve Burys wider community stakeholders in pt care & promote their services to help reduce COPD related admissions and exacerbations and improve pt Quality of Life*
1.4	What improvement(s) is this plan aiming to achieve by 31 March 2027?	**Q1:** Main improvement / outcomes to improve **Q2:** Current position / baseline (if known) **Q3:** Planned target or intended improvement by 31 March 2027 • *Raising COPD awareness (through education material, pop up events, COPD health reviews)* • *Encouraging pts to register on digital platform MyCOPD to help them understand and monitor their condition* • *Encouraging COPD self-management to reduce burden upon services* • *Empowering pts to take ownership of their condition* • *Encouraging pts to engage with practices for QOF COPD review & Enhanced High Resp Need COPD reviews – this will increase practice achievement in this area and generate income* • *Encouraging pt to have flu/pneumo vaccs/RSV/COVID 19, widening our offer, benefitting pts and generating income for practices*

		• *Involve wider Bury community stakeholders in pt care & promote their services to help reduce COPD related admissions and exacerbations and improve pt Quality of Life* • *Monitoring pts CVD risks during MECC appointments – again benefitting pts and generating income for practices* • *Focus on 'Missing pts', and aim for >80% achievement of BeCCoR High Need COPD reviews in this section*
1.5	Which measures will be used to monitor progress against the planned improvement above?	**Q1:** Main improvement / outcomes to improve **Q2:** Current position / baseline (if known) **Q3:** Planned target or intended improvement by 31 March 2027 • *Number of COPD and enhanced High Resp Need reviews undertaken by each practice can be measured* • *Flu/pneumo vaccs/RSV/COVID 19 uptake rates can be measured* • *COPD admission rates (emergency, 30 day readmission) can be measured* • *Referral numbers into INT/MDT can be measured* • *Referral numbers to wider stakeholders (e.g. Staying Well or Social Prescribers) can be measured* • *Numbers of leaflets distributed can be measured* • *Attendance numbers at pop-up events can be measured* • *Case finding rates – diabetes, hypertension, atrial fibrillation can be measured* • *Outcomes from Grant applicants (relevant statistics and kpi's) can be measured* • We will meet monthly at our East Neighbourhood Meeting with all practices present and wider stakeholders, with support from ICB where needed. We will highlight achievement in the COPD cohort of pts. • Practices will be regularly updated and monitored on progress in this work and will also be informed of their 'missing pts' and how many of those have undertaken the relevant reviews in all 6 cohorts of Section 3.
1.5a	Additional notes on selected measures (optional)	*Free text.*

1.6	How will this work be delivered?	- ***1.*** *All practices will carry out enhanced COPD reviews as per individual practice High Resp Need EMIS lists – for the High Resp need COPD pts they will be offered discussion on LABA or LAMA prescription, smoking status, pulmonary rehab, flu vaccination and pneumococcal vaccination. Additionally, as these same pts are also at a higher CVD risk in general, they will also be offered BP checks to identify new hypertensive pts, and manual pulse checks to identify new pts with Atrial Fibrillation, as well as BMI measurement. Pts will be offered extended appts for the above purposes. If these pts are on CVD High Need list, they may use this appt to have relevant blood and urine tests done also. Pts may also undertake NHS Health checks if relevant during these extended appts. Relevant vaccinations can also be offered during these longer appts – MECC. We can engage our AVS visiting scheme colleagues for housebound pts. 80+ aged pts & 'missing pts' are to be our highest priorities. Encouraging EA appt use may be particularly useful especially for pts who are 'missing' due to work commitments.* - ***2.*** *With support from our wider Bury stakeholder partners, we will improve education and awareness for COPD pts via a Bury East COPD Campaign. We will create a one page, colour coded, simple language flyer/leaflet that our wider stakeholders can give to all the pts they see who have a diagnosis of COPD. This leaflet will explain their COPD diagnosis, have links to digital platforms, and encourage the pts to ensure they have their annual COPD review undertaken and relevant vaccinations. We will ask community pharmacists to remind pts to have these reviews also – coloured leaflets to be funded by practices using their Neighbourhood resource.* - ***3.*** *We plan to identify all the 'missing' pts from each of the x6 BeCCoR High Need cohorts in each of our 8 East Neighbourhood practices. We will then continue to monitor the numbers of 'missing' pts reviewed in each cohort at our monthly East Neighbourhood meeting, to ensure the 'missing' pts reviews are specifically prioritised, within the cohort of pts reviewed. We can share any best practice and ideas on how to target these hard-to-reach pts. We can also consider home visit reviews if these pts are house bound. Additionally (GDPR permitting), we may share these pts with our wider community stakeholders so that when they see them for their own work, they can also*

		remind the pts to book in with their respective practice for their relevant High Need review. - ***4.*** *We plan to undertake several Community pop-up events across Bury East, advertised by our wider stake holders, community pharmacies, and GP practices, as well as other appropriate forum. In these pop-up events, we plan to provide education around COPD (?COPD Community nurse team? GP? Pharmacist? Smoking cessation team etc giving talks), as well as providing stands for our wider stakeholders who may benefit our older COPD pt population, e.g. Age UK, Staying Well, Social Prescribing, Bury Carers Hub, Live Well etc. We will also provide opportunistic health checks (BP, weight, oxygen sats, blood sugar checks) at the events. The purpose of these events will be to highlight and educate attending pts and their families/carers on COPD and the importance of having their COPD reviews and vaccinations at their surgeries. It will also allow pts to engage with peers who have the same condition and engage with support networks that can help to improve their quality of life. We envisage these pop-up events will lead to an increased footfall at practices so that pts undertake their enhanced COPD reviews and QOF COPD reviews, other health related activity and attend for their vaccinations – pop-up events to be funded by practices using their Neighbourhood resource.* - ***5.*** *We plan to create a Funding Opportunity: Grant Scheme For Community-Led COPD Patient Initiatives. We will be pleased to invite local community groups, charities, and stakeholders to submit proposals for new COPD Patient Support Grants. We will ask stakeholders to apply for funding to deliver impactful support for pts living with COPD in our local area with the purpose being to improve pt understanding of their condition, to help reduce barriers to accessing the community and healthcare, to encourage attendance at the pop-up events so they can access wider healthcare stakeholders, and to encourage pts with COPD to undertake their annual COPD reviews and vaccinations. There will be a tender process & interviews to decide successful applicants – grants to be funded by practices using their Neighbourhood resource.*
1.7	Who will you work with to deliver this plan?	All 8 Bury East GP practices as listed above

		Bury East INT Lead and NSO Bury PCN Horizon PCN East District Nurse Team INT Nurse Liaison Team Staying Well Team Social Prescribing Team PCN/practice Pharmacists Achieve Local Pharmacies Social Service Colleagues Live Well Service Bury ICB Bury GP Federation
1.8	Is this work also expected to reach or benefit a wider population beyond the main BeCCoR cohort?	Yes
1.8a	If yes, please describe extended benefits.	*Additionally, as these same pts are generally also at a higher CVD risk, they will be offered BP checks to identify new hypertensive pts, and manual pulse checks to identify new pts with Atrial Fibrillation, as well as BMI measurement. Pts will be offered extended appts for the above purposes. If these pts are on CVD High Need list, they may use this appt to have relevant blood and urine tests done also. Pts may also undertake NHS Health checks if relevant during these extended appts. Relevant vaccinations can also be offered during these longer appts – MECC. We can engage our AVS visiting scheme colleagues for housebound pts.*
1.9	Please detail your proposal for spend of the Neighbourhood Prevention Allocation. Please detail: Amount/ costed item; who will deliver; basis of costing; Lead for this activity	Ask respondents to format as: • Costed item (s) • Amount requested/agreed • Basis of costing • Who will deliver

		• Lead for this activity • a) Cost for leaflets, b) cost for pop-up events c) grant costs – e.g. 4 x £1000 grants available. Time for grant application perusal and interviews will carry a cost. Additional costs to practices for their clinicians to organise and undertake clinical reviews in their practices and related invites, monitoring etc will carry a cost. Training and upskilling staff to understand the BeCCoR ask will also carry a cost. Backfill costs for practice participation in pop-up events and data analysis and health promotion also needs to be factored in. Therefore, practices may use remaining resource of £1.80 per head to cover these hidden costs, and/or hire additional staff to for this purpose, to ensure achievement of x6 High Need cohorts – to be monitored at Neighbourhood meetings monthly - Estimated cost £0.20 per head of practice population. • We do not plan to pay community stakeholders to participate in handing out COPD educational leaflets, but they can have a stall at pop-up events free of charge. They may also apply for a grant. • We envisage appropriate use of resources by maximising output of resource utilised (MECC) and by all eight practices achieving intended outcomes and objectives. This way the pts and wider stakeholders benefit from this work, as well as the practices. Pt education, empowerment and engagement, wider stakeholder involvement, and improved COPD care – all are key components to a healthier cohort of pts, with reduced admissions and hospital activity in the High Resp Need group. • The East Neighbourhood Lead Team (Dr Fazel Butt, Gemma Iliadis) with NSO support will monitor progress, and other stakeholders will be involved regularly. The actual High Need Resp reviews and CVD work will be conducted by individual practices, and they are responsible for the implementation of this plan within their practices.
1.10	Any other comments (optional)	Free text.

Quarter 4 Report (March 31st 2027)

ID	Question (prompt text)	Notes (build)
2.1	Summarise progress over the year:	—

	What was delivered? how was your selected cohort engaged?	
2.2	What progress was made against the planned improvement set out in Q1? Add evidence/detail/examples of what has gone well	Add description: “Summarise the main outcomes and learning. Core quantitative metrics will be reported centrally where available, so only add local context or additional outcomes here.”
2.3	What were the main challenges, and what would you do differently next time? Add detail/examples	—
2.4	How has this work supported wider neighbourhood relationships, partnership working or ways of working? What feedback have you had?	Make required if you need consistent learning capture.
2.5	Has the neighbourhood work supported you to carry out more unmet need reviews on your BeCCoR cohort than conventional LTC/QOF recall alone?	
2.6	What will continue, change or be embedded as a result of this work?	—
2.7	What funding or resources supported delivery, and what additional support would have improved this work?	If you need structure, split into (a) “Resources used” and (b) “Additional support needed”.
2.8	Any other comments (optional)	—

Locality sign off and assurance:

Funding required from your plan will be from the 3c BeCCoR allocation - the Neighbourhood Prevention Allocation.

The sign-off of plans, to authorise funding, will be overseen by Place teams and through place-based partnership governance. Funding decisions will take place at Place in collaboration and agreement with the local GP board (or equivalent mechanism where there is no GP board), to align with strategic priorities, including Neighbourhood Health Plans.

The sign off will provide assurance (as a minimum) that the plans:

- Represent good value for money
- Focus on improving outcomes for core BeCCoR cohorts (with wider benefits where possible)
- Are co-designed and delivered with neighbourhood partners
- Support neighbourhood working and key Place priorities

Please contact enhancedserviceses1@nhs.net if you have any queries about who your place team contact is.

Pillar 3 Prevention Population Health and Neighbourhoods - BeCCoR neighbourhood action plan DRAFT v2
(This is an offline version for info – the form for submission will be developed in MS Forms and will be accessible in June)

Quarter 2 Report (Sept 30th 2026)

Purpose of this form:

GP practices/PCNs will be expected to attend Neighbourhood forums and to collaborate with key neighbourhood partners to reach a shared understanding of local neighbourhood priorities and the BeCCoR patient cohorts, especially the groups that general practice is finding it most challenging to reach and/or to address the health needs of because of wider issues.

BeCCoR Neighbourhood Plans will be developed through Neighbourhood engagement and co-production activities, aiming to better reach and serve these groups, with likely additional benefits beyond the defined cohorts. Funding for engagement and plan development is described as 3b in BeCCoR specification.

This document provides a format for your Neighbourhood Action plan, and acts as the template for your Q2 and Q4 submission.

A Neighbourhood Prevention Allocation (3c) is available to fund the elements of the BeCCoR Neighbourhood Plans that require resource.

This form must be submitted via MSForms **by 30th Sept 2026** with section 1 completed**.** The submission date for resubmission with section 2 completed is **30th March 2027.**

If you are submitting collectively (eg through a PCN) only one copy needs to be sent in.

General Practice Name(s) : *(Please list all practices included in this submission)*	Woodbank Surgery Tower Family Health Care Tottington Tower Family Health Care Greenmount Ramsbottom Medical Practice Garden City Medical Practice

Is this a PCN response? if so, please provide name of PCN:	Neighbourhood response
Locality/Place:	Bury North
Name(s) and roles of practice leads involved in this work:	Kirsty Harrison – manager Woodbank Dr S Javeg – GP Woodbank Melanie Webb – manager Tower Dr A Ali – GP Tower / Horizon PCN Annette Addison - manager Ramsbottom Dr H Sadi – GP Ramsbottom Nicola Guffogg – manager Garden City Dr Ajayi – GP Garden City Dr Wissam El-Jouzi – GP lead North Bury Gemma Illiadis – Neighbourhood Lead Rachel Robinson – NSO Lucy Angus – Staying Well Team Demi Kinsella – Social Prescribing Jess Marshall – Pharmacy team Amy Waters – Horizon PCN
Name of Neighbourhood (*alignment to closest / most appropriate neighbourhood) :*	North Bury
Which organisations were involved with the co-design of this plan? (ie. Provide details of neighbourhood partners involved)	All practices Staying Well Team VCFA Neighbourhood pharmacy team Neighbourhood Mental Health team Horizon PCN Bury PCN While at this stage very primary care delivery focused, GPs in the neighbourhood teams continue to recognise and commit to supporting

	the work of all partners in the neighbourhood to improve the circumstances of peoples lives, continuing to create opportunities for all people to be well, independent and connected to their communities, and where health and care, and wider public services, are joined up even more effectively
Name and dates of neighbourhood forum/ meeting has this been discussed and agreed at:	North Neighbourhood meeting 13/07/2026

ID	Question (prompt text)	Choices / fields (to be developed into MS forms as drop down menu where possible)
1.1	Which BeCCoR cohort is the main focus of this neighbourhood plan?	North neighbourhood will look at predominantly the CVD area This will include the core and stretch areas for CVD targets It will also include the primary prevention element of the targets This was reached as an agreement after all practices noted that the individual data confirmed this to be the primary area for focus in terms of patient numbers, patient need and financial allocations
1.2	What is the approximate or known size of the main cohort?	**Numbers of patients below are those required for us to hit 80% from our current position** **CVD (Core and Stretch)** Tottington – 188 Greenmount – 199 Garden City – 195 Ramsbottom – 353 Woodbank – 200 (aprox) **Primary Prevention (CVN01 and CVN02)** Tottington – 383 Greenmount – 326

Garden City – 338
Ramsbottom – 428
Woodbank – 350 (aprox)

Details on further break down of targets are readily available from practices and we are collating shared data to meet same criteria so that monthly monitoring on progress will be done – below is a copy of the latest data extract from 1 practice in the neighbourhood. Searches are available from all practices and will be collated on a shared spread sheet going forward to ensure monthly monitoring on progress towards all targets

BeCCor CVD Core as at 31.7.26

Sector	Practice Code	Practice	Total number of HRR patients	No of HRR pts who have had full review as at 31.07.26	% No of patients who have had a full review	Current achievement level (as per guidance below*)	80% target (Full reward)	Number needed to meet highest target/full reward	Meeting 5 out of 6 elements	Meeting 4 out of 6 elements
Bury	P83006	Ramsbottom HC	317	101	32%	42%	254	153	10	13

BeCCor CVD Stretch as at 31.7.26

Sector	Practice Code	Practice	Total number of HRR patients	No of HRR pts who have had full review as at 31.07.26 (All 7 elements)	% No of patients who have had a full review	Current achievement level (as per guidance below*)	80% target (Full reward)	Number needed to meet highest target/full reward	Patients who require ACR only	Meeting 6 out of 7 elements	Meeting 5 out of 7 elements	Meeting 4 out of 7 elements
Bury	P83006	Ramsbottom HC	317	60	19%	19%	254	194	41	43	12	12

1.3	Rationale: Why has this cohort been prioritised,	All these cohorts are groups we have historically struggled to get into the practice

	and what is the main issue or barrier this plan is trying to address?	The data for practices show that these are the areas of greatest need consistently across all the 5 practices in the neighbourhood North Neighbourhood has an average patient age that is higher than the Bury average and therefore associated prevalence of cardiovascular disease and issues are higher The Government Health Of The Region Explorer 2025 shows that in Bury early mortality from CVD is 90/100,000 compared to an England average of 72/100,000
1.4	What improvement(s) is this plan aiming to achieve by 31 March 2027?	The improvement in proactive care for patients with CVD will reduce complications and further cardiovascular events. This will reduce comorbidities and hospital admissions We will improve proactive health care in a group of patients previously hard to engage with We will measure the improvement by reviews completed on the key cohorts We have all agreed as a neighbourhood to tap into resources for IT support to help with this We will target the hard to reach groups and promote self care and better medical engagement
1.5	Which measures will be used to monitor progress against the planned improvement above?	• **Standard BeCCoR measures:** ○ Track cohort identified (denominator) ○ Track cohort reached ○ BeCCoR Review undertaken ○ Decrease in missingness ○ People treated to target in cohort ○ A&E attendances from cohort ○ Unplanned care admissions for cohort ○ Patient recorded outcomes recorded and improved ▪ Health Confidence Score ▪ Personal Wellbeing Score ▪ 3 item loneliness scale ○ Social prescribing referrals and type of support / Live Well intervention • **Additional local measures (optional selections):** ○ Increase in patients diagnosed with condition ○ Increase in patients receiving yearly reviews ○ Increase in QOF achievement / reduction in exception reporting ○ Reduction in fit notes / total sickness days lost ○ Staff confidence / annual survey on neighbourhood working ○ Improvement in demographic recording (e.g. ethnicity, sexual orientation) to strengthen equity analysis

1.5a	Additional notes on selected measures (optional)	
1.6	How will this work be delivered?	We have broken this down into the following areas: **1 – Identification of patients:** - This will include data searches to target each group - Horizon PCN will be using in house data teams through the managers listed above - Bury PCN will be using Lindsey Mooney to do this on a wider foot print - We will align the data searches and agree to maintain same targets so that data is comparable easily and quickly **2 – Inviting the patients in:** - These are harder to reach groups so we need to work innovatively - Horizon PCN have capacity available to provide admin support with this - We will be proactively contacting patients into existing slots - Historically letters and text messages have been less successful for these groups so we will explore direct calling - We will promote the work through our neighbourhood groups. The Staying Well Team and Social prescribers will plug and promote this through drop in clinics that are already running - We will tap into the existing work of the ACM/MDT meetings and if patients being reviewed there are also within the BeCCoR targets we will highlight these and ensure proactive contact through the ACM program to encourage these patients to engage - Our neighbourhood meetings used to have patient representation present but this has not been the case for some time – we aim to re establish this so that word of mouth can be spread through the neighbourhood - We want to explore a social media campaign through existing neighbourhood groups on social media platforms – for example the “What’s on in Tottington, Greenmount and Walshaw” group on Facebook currently reaches more that 40,000 patients locally. - We have been assured of available admin time being available within Horizon PCN to allow this invite work to take place. This is within existing capacity freed up following the work that was needed for last years LCS targets which are now not being done. **3 – Clinical work up:** - The patients will need input of a HCSW for this domain - This is to do the outstanding areas such as blood tests, BP, BMI, ACR etc

		- We will work on clinics to deliver these - Estimates based on reviews needed to deliver the 80% target above with appointments based on 15minutes per patient shows we need approximately 300hours of HCSW time - Discussions with Horizon PCN has given us assurance this work can be also delivered within existing workforce. There is currently 46% capacity available within the HCSW roles on weekend clinics so no further staff likely to need recruiting. If extra staff are needed we have had a verbal expression of willingness to look at recruitment through the ARRS monies. - We want to work innovatively and look at using evening and weekend clinics as well as in hours clinics to allow flexibility and options for patients to engage with - There will be a process to flag urgent results to GP practices **4 – Clinical Intervention:** - This will be relating to issues flagged from section 3 above and the primary prevention cohort when patients are identified who need statin prescribing - This area will require a clinical pharmacist input - To reach the 80% target above we calculate approx. 400 hours of clinical time - Horizon PCN have again advised that capacity exists within current workforce to help deliver this - We want to proactively speak as a neighbourhood promoting the importance of primary prevention and statins – this message will be promoted through SWT and Social prescriber drop in clinics and community groups - We want to again promote this through a social media campaign to have our neighbourhood thinking and talking about this even before it has happened. **5 – Monitoring of delivery:** - Although practices will be using different people to monitor data we have all agreed that we will standardise data searches so that outcome and progress data will be easily monitored - Data will be checked and published monthly to show collective progress. - Monthly neighbourhood meetings will take place to ensure we are all progressing as planned **6 – Wider neighbourhood working and strengthening relations** - Staying Well Team and Social Prescribers to use drop in clinics to promote engagement - The ACM/MDT will screen patients under them to check any within the BeCCoR cohorts and promote engagement there - We are tapping into existing leafleting to promote the program

		- We want to use our community pharmacy colleagues to promote direct leafleting to eligible patients when medications being given - There are existing social medial platforms that have a wide community reach – we have been linking in with them to get information out - Our new local MP has been appointed as a Minister for Health – he has an active social medial presence in the area. Once we establish some comms we will contact him to see if he can promote this as well. **7 – Cost Breakdown** - Estimated admin cost based on 10mins per patient required to hit 80% = 494 hours admin time - Estimated HCSW cost based on 15mins per patient for CVD to hit 80% = 283 hours HCSW time - Estimated pharmacist cost based on 15min per patient for PP to hit 80% = 456 hours pharmacist time - Data monitoring - For BURY PCN practices – funding agreed for Lindsey Mooney - - For Horizon PCN practices – this will be delivered by in house practice IT leads. - Wider neighbourhood admin costs for leafleting and engagement will be from agreed £0.5/patient funding sited above – unused funds to remain with practices at year end.
1.7	Who will you work with to deliver this plan?	1 – **The GP practices** – all engaged and freely sharing data 2 – **PCNs** – very constructive meetings taken place with Horizon PCN and workforce support has been agreed as above 3 – **INT / MDT** – we have a well established group meeting weekly – any patients flagged in this arena will be proactively contacted to promote importance of this work 4 – **Staying Well Team / social prescribers** – we will use local drop in clinics and groups to proactively promote this work and raise awareness. We will have clinical input there to share progress 5 – **Extended working clinic** – identified capacity noted here from the weekend HCSWs and we have been given agreement from the local PCN that we can utilise this capacity to allow more flexible and weekend access for patients to be seen 6 – **Social media support** – there are numerous groups where messages can be promoted. We have local groups from our INT willing to support with promotion of material relating to the purpose of this work 7 – **Patient representatives** – we used to have patient representation at our neighbourhood meetings but this has stopped for some time – we will be re starting this
1.8	Is this work also expected to reach or benefit a wider population beyond the main BeCCoR cohort?	Yes

1.8a	If yes, please describe extended benefits.	Reduction in adverse events and complications will reduce health and social care pressures on family members of patients It will also lead to a reduction in hospital attendance which means less pressure on primary and secondary care services for other users.
1.9	Please detail your proposal for spend of the Neighbourhood Prevention Allocation. Please detail: Amount/ costed item; who will deliver; basis of costing; Lead for this activity	As a neighbourhood we have expressed a willingness to pool some resources to help with delivery. This has been worked out and agreed on the basis of £0.5/patient We have agreed that this money will be available to use to help deliver room hire, comms, leafleting etc. Any unused funds will then be redistributed to practices at year end if needed We need to work out governance of who holds the money and allocates out – eg would it be by a lead practice in the neighbourhood or by Bury Fed etc? The principles for now are agreed and for now practices are holding on to the funds but these can be released if required. Release will be on a fair share based on patient cohort size.
1.10	Any other comments (optional)	This is a Bury Wide project and speaking to other neighbourhood there seams to be a mostly unified drive to work on CVD as the priority area. As such it would be useful for Bury Wide promotion of this from the ICB directly – I would encourage and ask the ICB to support with doing this through patient forums, social media and even local media and local advertising campaigns as well

Quarter 4 Report (March 31st 2027)

ID	Question (prompt text)	Notes (build)
2.1	Summarise progress over the year: What was delivered? how was your selected cohort engaged?	
2.2	What progress was made against the planned improvement set out in Q1? Add evidence/detail/examples of what has gone well	
2.3	What were the main challenges, and what would you do differently next time? Add detail/examples	
2.4	How has this work supported wider neighbourhood relationships, partnership working or ways of working?	

	What feedback have you had?	
2.5	Has the neighbourhood work supported you to carry out more unmet need reviews on your BeCCoR cohort than conventional LTC/QOF recall alone?	
2.6	What will continue, change or be embedded as a result of this work?	
2.7	What funding or resources supported delivery, and what additional support would have improved this work?	
2.8	Any other comments (optional)	

Locality sign off and assurance:

Funding required from your plan will be from the 3c BeCCoR allocation - the Neighbourhood Prevention Allocation.

The sign-off of plans, to authorise funding, will be overseen by Place teams and through place-based partnership governance. Funding decisions will take place at Place in collaboration and agreement with the local GP board (or equivalent mechanism where there is no GP board), to align with strategic priorities, including Neighbourhood Health Plans.

The sign off will provide assurance (as a minimum) that the plans:

- Represent good value for money
- Focus on improving outcomes for core BeCCoR cohorts (with wider benefits where possible)
- Are co-designed and delivered with neighbourhood partners
- Support neighbourhood working and key Place priorities

Please contact enhancedserviceses1@nhs.net if you have any queries about who your place team contact is.

Pillar 3 Prevention Population Health and Neighbourhoods - BeCCoR neighbourhood action plan DRAFT v2
(This is an offline version for info – the form for submission will be developed in MS Forms and will be accessible in June)

Quarter 2 Report (Sept 30th 2026)

Purpose of this form:

GP practices/PCNs will be expected to attend Neighbourhood forums and to collaborate with key neighbourhood partners to reach a shared understanding of local neighbourhood priorities and the BeCCoR patient cohorts, especially the groups that general practice is finding it most challenging to reach and/or to address the health needs of because of wider issues.

BeCCoR Neighbourhood Plans will be developed through Neighbourhood engagement and co-production activities, aiming to better reach and serve these groups, with likely additional benefits beyond the defined cohorts. Funding for engagement and plan development is described as 3b in BeCCoR specification.

This document provides a format for your Neighbourhood Action plan, and acts as the template for your Q2 and Q4 submission.

A Neighbourhood Prevention Allocation (3c) is available to fund the elements of the BeCCoR Neighbourhood Plans that require resource.

This form must be submitted via MSForms **by 30th Sept 2026** with section 1 completed**.** The submission date for resubmission with section 2 completed is **30th March 2027.**

If you are submitting collectively (eg through a PCN) only one copy needs to be sent in.

General Practice Name(s) : *(Please list all practices included in this submission)*	General Practice Name(s) Fairfax; Whittaker Lane; Greylands; The Birches; Longfield; St Gabriel's
Is this a PCN response? if so, please provide name of PCN:	Prestwich
Locality/Place:	Prestwich (Bury), Greater Manchester

Name(s) and roles of practice leads involved in this work:	Dr Richard Deacon – GP, St Gabriel's Medical Centre; Dr Lawrence Sherman, GP – Greylands; Dr Edyta Lipska, GP (temp Birches); Melissa Lam, GP – Whittaker Lane MC; Charles Philbin, GP - Fairfax; Krystyna Kelly, Practice Nurse - Longfield
Name of Neighbourhood (*alignment to closest / most appropriate neighbourhood) :*	Prestwich
Which organisations were involved with the co-design of this plan? (ie. Provide details of neighbourhood partners involved)	This is the neighbourhood plan for primary care led preventative interventions in this neighbourhood. It is funded by NHS GM primary care funding streams and has a particular focus on the major clinical causes of poor health and health inequalities, such as CVD, COPD and Diabetes. It reflects programmes of joint prioritisation, targeting and investment across the GP practices in the neighbourhood. While at this stage very primary care delivery focused, GPs in the neighbourhood teams continue to recognise and commit to supporting the work of all partners in the neighbourhood to improve the circumstances of peoples lives, continuing to create opportunities for all people to be well, independent and connected to their communities, and where health and care, and wider public services, are joined up even more effectively. Each neighbourhood in Bury is: • developing its model of integrated health and care team working, including adult care, community nursing , neighbourhood mental health teams and voluntary and community partners. • Harnessing its public service leadership teams bringing together those partners with an opportunity to contribute to the wider determinants of inequality - including housing, DWP, income maximization team, GMP, schools, live well services and others, and focused of cohorts of particular risk of harm reflective of this neighbourhood • Developing a plan for the implementation of the GM Live Well programme - ensuring vibrant and connected community capacity to support people to be connected to advise support and care where they need it • A developing model of family hubs, bringing a range of NHS, council and wider public services to support families with young children to ensure the best start in life.

	GP Practices – see names and roles of practice leads in this work above; VCFSE (Julie Marshall , Social Prescriber; Helen Tomlinson (awaiting contact but made aware of ambition via communication via emails); GP Fed/PCN (Alaina Hanson; Charles Philbin; Lindsey Mooney); Neighbourhood Lead Clare Rayson, Neighbourhood Support Offcie Dawn Adderley; GM Data Quality Managers – Mindy Isaacs;
Name and dates of neighbourhood forum/ meeting has this been discussed and agreed at:	Series of meetings throughout June/July 2026 – face-2-face between Neighbourhood and PCN as a whole; meetings between Dr Richard Deacon (Clinical Lead for Neighbourhood INT) and Dr Charles Philbin (PCN CD); meetings between practice leads (Dr Lam, Dr Philbin, Dr Deacon, PM from the Birches; Alaina and PCN team; Lindsey Mooney , data analyst). Discussion with Neighbourhood ACM team – present including the core team; meetings between Dr Deacon and GM who are leading in the BeCCoR work (Dr Claire Lake,Deputy Chief Medical Officer, NHS GM IC, Khallada Abdullah, Strategic Lead – Population Health, Zoe Porter, Associate Director: Live Well and Neighbourhoods; Dr Aseem Mishra, Senior CVD Lead, Manchester Achieved agreement and approval of the ambition between PCN team , Clinical Lead for Neighbourhood, Lindsey Mooney as the neighbourhood support

ID	Question (prompt text)	Choices / fields (to be developed into MS forms as drop down menu where possible)
1.1	Which BeCCoR cohort is the main focus of this neighbourhood plan?	• CVD (CVNeed) - the data shows from dashboard and searches that there is a significant cohort of very high and high unmet need Our target group comprises 190 patients across Prestwich PCN practices who are identified within the CVNeed cohort as having high cardiovascular unmet need, having completed only 0 or 1 of the 6 core cardiovascular review elements during 2025/26. The group includes patients that following further detection might demonstrate poor engagement with routine recall pathways, including

		housebound, frail, socially isolated and hard-to-reach individuals whose wider social, economic or access barriers may be contributing to unmet need.
1.2	What is the approximate or known size of the main cohort?	*see table in 1.4 * highlights the denominators per practice* The neighbourhood practices currently have 45% of our CVD(Need) registered population who were not reviewed in 25/26. The plan will focus on these patients.
1.3	Rationale: Why has this cohort been prioritised, and what is the main issue or barrier this plan is trying to address?	**Why has this cohort been prioritised?** Cardiovascular disease remains one of the leading causes of premature mortality and ill-health in Bury and is a major contributor to health inequalities across the borough. Focusing improvement activity on CVD aligns with both local and national priorities, delivers measurable population health benefits, and offers one of the greatest opportunities for primary care to reduce premature mortality, improve healthy life expectancy and narrow health inequalities across Prestwich. **What is the main issue or barrier this plan is trying to address?** This cohort represents patients with the highest level of unmet cardiovascular need and/or poor engagement with routine practice recall processes. The purpose of the neighbourhood plan is to understand barriers to engagement and co-design solutions with neighbourhood partners to improve completion of high-risk cardiovascular reviews and reduce inequalities in access to care. This cohort focuses on unmet need/non-engagement as we are focusing on all patients at high risk who met only 1 or 0 elements of the review in the preceding 12 months. Data suggests that the BeCCoR cohort will pick up: • a population who are not engaging with services, specifically those who did not attend CVD reviews 2025/26 • or are engaging but have wider needs affecting their health and wellbeing in conjunction with unmet CVD needs. Barriers have historically been DNA rates, housebound patients, frailty, social isolation, inequality of access (multiple reasons) and cross-boundary service access issues – the CVNeed cohort will highlight these existing barriers.

1.4	What improvement(s) is this plan aiming to achieve by 31 March 2027?	**Q1: Main improvement / outcomes to improve** Understand the barriers to access (to and from) and the wider factors that influence these groups; whilst understanding and sharing with neighbourhood organisations the clinical needs that need addressing then getting an appreciation about the wider determinants from other resources within the neighbourhood who can provide an understanding of local insights; what currently exists or could exist with resource and understand what the priorities could be – we need to understand this from a baseline and then focus work to agree on targets that can be improved; to Identify opportunities to work differently with neighbourhood partners to better reach and support these patients; to focus on improving outcomes; to consider actions that can be delivered with existing resources and consider what actions may require additional funding. The cohort comprises patients with high cardiovascular unmet need who have only completed 1 or none of the six core review elements and have demonstrated limited engagement with routine recall processes. Initial analysis could suggest barriers including non-response to standard invitations, difficulties accessing services, social and economic pressures, low health literacy, previous negative experiences of healthcare, and wider determinants of health. A proportion of patients have unknown barriers ("missingness"), which the neighbourhood approach will seek to identify through targeted outreach, community engagement and partnership working. **Q2: Current position / baseline (if known)**

Sector	Practice Code	Practice	Total number of HRR patients 0/6 & 1/6	Had 0/6 or 1/6 in 25/26 and eligible in 26/27	HRR patients who have had all 6 elements in 26/27	Housebound
Prestwich	P83001	Fairfax GPs	99	92	10	1
Prestwich	P83025	St Gabriels MC	16	16	4	0
Prestwich	P83027	Greylands MC	18	15	3	1
Prestwich	P83605	Whittaker Lane MC	26	23	1	1
Prestwich	P83609	The Birches MC	12	11	2	1
Prestwich	P83623	Longfield MP	36	33	2	1
Total			**207**	**190**	**22**	5

		Q3: Planned target or intended improvement by 31 March 2027 Having explored the demographics and characteristics of the cohort (Key inequality characteristics of this cohort include age, frailty, mental health needs, health literacy challenges, social isolation and deprivation-related barriers to access. Further profiling will be undertaken during delivery to better understand the impact of ethnicity, language needs and wider social determinants); understanding and breaking down barriers to access; adapting community resources to continue to support with the wider population but ensuring that patients who had unmet needs have less of them. By March 2027 Prestwich will try to engage 100% of identified CVNeed patients and complete optimisation reviews in at least 80% of those who have not responded to standard recall pathways. 1. An agreement that identified patients within the cohort that require support can be discussed at or with: ○ ACM ○ AVS ○ Wider partners 2. Monthly (or more frequent) meetings as we did with LCS to discuss data and progress with GP Federation (Lindsey Mooney) 3. Meetings between Neighbourhood and PCN to further discuss when we discover more of how to improve engagement and access 4. Engagement with Fed to provide comms and build on the work Prestwich Neighbourhood has been doing on social media and other media 5. Engage with community pharmacies to continue to provide their support to our current clinical pathways e.g. BP Monitoring; messaging for patients via pharmacies when issuing relevant repeat medications
1.5	Which measures will be used to monitor progress against the planned improvement above?	To show improvement in:* • Engagement with cohort; improvement in reviews started/completed; • Improvement in clinical data collection; • Neighbourhood service interventions created or adapted to meet the needs of this cohort; • Further improvement in co-working across the Neighbourhood and a better understanding of how each part can work together to provide seamless care and support for our Neighbourhood. **Measures:**

		• Number identified see above
		• Number contacted
		• Number engaged
		• Reviews completed - particularly for identified non-engaging patients) and reducing the proportion of patients who have previously declined CV interventions
		• Number completing all 6 review elements
		• BP improvement (including utilisation of Community Pharmacy Pathway)
		• HbA1c improvement
		• Lipid optimisation
		• Social prescribing referrals - further improve appropriate referrals or show active encouragement to self-refer
		• Increased detection of unmanaged disease
		• AVS interventions
		• Learning measures that include:
		  ○ Documented barriers identified:
		  ▫ Access
		  ▫ Health literacy
		  ▫ Social factors
		  ▫ Mental health
		  ▫ Physical frailty
		  ▫ Unknown/other

1.5a	Additional notes on selected measures (optional)	Primary measure: Percentage of identified CVNeed patients completing all six cardiovascular review elements. Baseline (July 2026): 22 of 190 eligible high-risk review patients (11.6%) have completed all six review elements in 2026/27 as of writing.
1.6	How will this work be delivered?	Data gathering, analysis with clinical and managerial support to help understand the problem of meeting unmet need – without relying on anecdote or gut- feel; focusing on a stepwise approach to absolutely understand the problem before initiating interventions which may not form part of the solution; meeting with key partners determined by the data analysis over time to establish who the right resource us to address the needs and working with the population getting a better understanding of how they feel those needs can be met – we will activate all our current neighbourhood partners and bring in additional support when identified. For example, by: Access • Discussions with EA provider regarding targeted outreach sessions to support working patients/carers

		• Using the Acute Visiting Service to target housebound patients • Referring to wider services/interventions available via Live Well (smoking cessation etc) • Targeted comms with links to book directly into clinics • Consider opportunities to work with faith and community organisations Digital literacy – Providing signposting to support including NHS App General awareness – Work with our neighbouring neighbourhood leads to produce promotional materials which can be given to patients who we know attend wider services (Community Pharmacy, Mental Health Providers etc) Language barriers – Providing communications in the relevant format/easy to read etc. Or onward signposting for support where English is not someone's first language (where appropriate) Specific workstreams will be created to focus on, where found to be appropriate: • Cohort identification • MDT review • Non-engager pathway • Housebound pathway • Social prescribing pathway • Community outreach Governance will monitor via: • Monthly reporting • Neighbourhood oversight • INT reporting • Q4 Year-end evaluation **POTENTIAL ACTION PLAN PRIORITIES PENDING APPROVAL AFTER DISCUSSION WITH PARTNERS** 1. Using search – target patients not responding to CV invitations and share details with VCSE with bespoke comms **(MEASURE:** improvement in patients taking up invitations compared to previous non-responders) 2. Improve awareness of neighbourhood offers – to include Social Prescribing, community services **(MEASURE:** further improve appropriate referrals or show active encouragement to self-refer**)**

		3. Improvement in tackling the common issues that create barriers to access **(MEASURE:** achieve completion of more CV reviews for identified non-engaging patients) and reducing the proportion of patients who have previously declined CV interventions 4. Identify more sustainable neighbourhood pathways operating by the end of the year – this will depend on what services and networks the neighbourhood feels would be useful to improve outcomes for CVD.3 FIRST STEPS: **Stratify the cohort** **Group 1 – Not contactable** • Invalid phone numbers. • No mobile. • Repeatedly unanswered calls. • Undelivered SMS. **Interventions** • Verify contact details opportunistically. • Postal letter with named contact. • Community link worker outreach.* • Check records across partner services.* **Group 2 – Repeated DNA / working-age non-attenders** Often know they need review but cannot prioritise it. **Interventions** • EWH* • Community Pharmacy * • Walk-in cardiovascular review sessions/ attendees at VCSE community services * • Book into existing appointments (prescriptions, LTC reviews, flu clinics). **Group 3 – Housebound / frail** Often physically unable rather than unwilling. **Interventions** • Frailty team support.* • Community nursing visits.* • AVS (Acute Visiting Service)* for: ○ BP

		○ Weight/BMI ○ Bloods ○ Smoking assessment **Group 4 – Health literacy barriers** Patients do not understand: • What CV risk means. • Why monitoring matters. • Why they have been called. **Interventions** • Simple-language invitation*. • Multilingual information. • Community-based education sessions *. • Peer champions.* **Group 5 – Deprivation and social complexity** Typical issues: • Debt. • Caring responsibilities. • Housing instability. • Mental health concerns. **Interventions** • Social prescribing.* • Welfare rights advice.* • Integrated neighbourhood MDT discussion.* **Group 6 – Low trust / resistant attenders** Patients who have repeatedly declined engagement. **Interventions** • Personalised GP or nurse invitation. • Trusted clinician contact. • Motivational interviewing approach.* • Focus on patient's priorities rather than "compliance".* (“what matters to you” MDT approach) *Neighbourhood partners

1.7	Who will you work with to deliver this plan?	PCN, INT, Local Authority, VCFSE, Pharmacy, MH, Public Health, the patients
1.8	Is this work also expected to reach or benefit a wider population beyond the main BeCCoR cohort?	The focus is on improving outcomes for the core cohorts – the hope would be an improvement in wider benefit • Case finding • Prevention • Inequalities reduction • Sustainability Using the models that are in place or adapted or created as a response to this work in other clinical and social domains
1.8a	If yes, please describe extended benefits.	Improvement in other bodies of work that are co-designed and delivered by partners; further support to the established working of our neighbourhood and the hope that future strategies will build on this.
1.9	Please detail your proposal for spend of the Neighbourhood Prevention Allocation. Please detail: Amount/ costed item; who will deliver; basis of costing; Lead for this activity	Aim of the plan that enables spend detail: To reduce the target cohort by identifying and addressing the barriers preventing completion of the six cardiovascular review elements, using neighbourhood-based outreach, community partnerships and personalised engagement approaches. In order to easily distribute money according to need, the PCN Practices and Clinical Neighbourhood Lead have agreed that Part 3C monies will be held by the PCN. Funding will follow need – with view to consider: • Possible outreach workers – eg Social Prescribers – to engage non-engagers • Wider community engagement – working with the current community offers and adapting them if necessary (e,g, Live Well) • Production of any promotional materials/leaflets • Acute Visiting Service provision for housebound patients within CVNeed cohort • Wider involvement in community clinical pharmacists if clinical need suggests benefit • Data analyst support – Lindsey Mooney
1.10	Any other comments (optional)	The proposed spend is targeted at a clearly defined cohort of 190 patients with significant cardiovascular unmet need. Resources are focused on outreach, engagement and review completion activity that cannot be delivered through routine recall processes alone. Improving review completion and optimisation within this high-risk group has potential to reduce avoidable cardiovascular events, improve health outcomes and reduce future healthcare utilisation, while strengthening neighbourhood partnership working

Quarter 4 Report (March 31st 2027)

ID	Question (prompt text)	Notes (build)
2.1	Summarise progress over the year: What was delivered? how was your selected cohort engaged?	—
2.2	What progress was made against the planned improvement set out in Q1? Add evidence/detail/examples of what has gone well	Add description: “Summarise the main outcomes and learning. Core quantitative metrics will be reported centrally where available, so only add local context or additional outcomes here.”
2.3	What were the main challenges, and what would you do differently next time? Add detail/examples	—
2.4	How has this work supported wider neighbourhood relationships, partnership working or ways of working? What feedback have you had?	Make required if you need consistent learning capture.
2.5	Has the neighbourhood work supported you to carry out more unmet need reviews on your BeCCoR cohort than conventional LTC/QOF recall alone?	
2.6	What will continue, change or be embedded as a result of this work?	—
2.7	What funding or resources supported delivery, and what additional support would have improved this work?	If you need structure, split into (a) “Resources used” and (b) “Additional support needed”.
2.8	Any other comments (optional)	—

Locality sign off and assurance:

Funding required from your plan will be from the 3c BeCCoR allocation - the Neighbourhood Prevention Allocation.

The sign-off of plans, to authorise funding, will be overseen by Place teams and through place-based partnership governance. Funding decisions will take place at Place in collaboration and agreement with the local GP board (or equivalent mechanism where there is no GP board), to align with strategic priorities, including Neighbourhood Health Plans.

The sign off will provide assurance (as a minimum) that the plans:

- Represent good value for money
- Focus on improving outcomes for core BeCCoR cohorts (with wider benefits where possible)
- Are co-designed and delivered with neighbourhood partners
- Support neighbourhood working and key Place priorities

Please contact enhancedserviceses1@nhs.net if you have any queries about who your place team contact is.

Pillar 3 Prevention Population Health and Neighbourhoods - BeCCoR neighbourhood action plan DRAFT v2
(This is an offline version for info – the form for submission will be developed in MS Forms and will be accessible in June)

Quarter 2 Report (Sept 30th 2026)

Purpose of this form:

GP practices/PCNs will be expected to attend Neighbourhood forums and to collaborate with key neighbourhood partners to reach a shared understanding of local neighbourhood priorities and the BeCCoR patient cohorts, especially the groups that general practice is finding it most challenging to reach and/or to address the health needs of because of wider issues.

BeCCoR Neighbourhood Plans will be developed through Neighbourhood engagement and co-production activities, aiming to better reach and serve these groups, with likely additional benefits beyond the defined cohorts. Funding for engagement and plan development is described as 3b in BeCCoR specification.

This document provides a format for your Neighbourhood Action plan, and acts as the template for your Q2 and Q4 submission.

A Neighbourhood Prevention Allocation (3c) is available to fund the elements of the BeCCoR Neighbourhood Plans that require resource.

This form must be submitted via MSForms **by 30th Sept 2026** with section 1 completed**.** The submission date for resubmission with section 2 completed is **30th March 2027.**

If you are submitting collectively (eg through a PCN) only one copy needs to be sent in.

General Practice Name(s) : *(Please list all practices included in this submission)*	Mile Lane Surgery Monarch Medical Centre Radcliffe Medical Practice Redbank Group Practice Tower Family Healthcare Spring lane

Is this a PCN response? if so, please provide name of PCN:	No
Locality/Place:	Bury
Name(s) and roles of practice leads involved in this work:	Dr Ajay Kotegaonkar: GP Tower Spring Lane Dr Peter Thomas: GP Mile Lane Dr Kannawadi Baskar: GP Monarch Ms Janice Wood: Lead Nurse Practitioner Redbank Dr Anthony Ho: GP Radcliffe Medical Practice Mrs Yvette Hodges: Practice Manager Radcliffe Mrs Nagina Awan: Practice Manager Monarch Medical Practice Mrs Morag Smith: Practice Manager Mile Lane Mrs Julia Markendale: Practice Manager Redbank Ms Janet Stanton: Radcliffe Neighbourhood Lead Dr Ade Rotowa: Radcliffe Neighbourhood Clinical Lead Mrs Amanda Stott: Neighbourhood Support Officer Mrs Henna Salim: Horizon PCN Pharmacist Mrs Layla Aziz: Tower Healthcare Pharmacist Mrs Melanie Webb: IT Manager Tower Family Healthcare
Name of Neighbourhood (*alignment to closest / most appropriate neighbourhood) :*	Radcliffe

Which organisations were involved with the co-design of this plan? (ie. Provide details of neighbourhood partners involved)	Growing Together Radcliffe Bury Live Well Team Bury Staying Well team Bury VCFA Calico Home Group Adult Social Care Neighbourhood Mental Health Team Horizon PCN Assistant Director of Medicines and Pharmacy While at this stage very primary care delivery focused, GPs in the neighbourhood teams continue to recognise and commit to supporting the work of all partners in the neighbourhood to improve the circumstances of peoples lives, continuing to create opportunities for all people to be well, independent and connected to their communities, and where health and care, and wider public services, are joined up even more effectively
Name and dates of neighbourhood forum/ meeting has this been discussed and agreed at:	Neighbourhood Forum Meetings to discuss current plans, feedback from wider neighbourhood partners, explain issues around comprehension of BeCorr Neighbourhood contract. 12/05/26 19/05/26 16/06/26 30/06/26 07/07/26 14/07/26

	03/08/26 04/08/26 06/08/26 Formal Meetings with other services to develop the plan. 21/05/26: Bury East, North and West Neighbourhood 13/07/26: Bury Live Well Team 28/07/26: Health Trainers 03/08/26: Assistant Director of Medicines and Pharmacy 06/08/26: Social Prescribing 06/08/26: Horizon PCN 11/08/26: Christian Wakeford MP Bury South Ad-hoc meetings with: VCFA Calico Staying Well Team Adult Social Care representatives Achieve Meetings planned: 08/09/2026: Head of Children's Nursing Services (rescheduled) Formal Meetings to be organised: Community Pharmacies in Radcliffe Achieve Local Mosques

ID	Question (prompt text)	Choices / fields (to be developed into MS forms as drop down menu where possible)
1.1	Which BeCCoR cohort is the main focus of this neighbourhood plan?	Adults registered with Radcliffe neighbourhood practices who have cardiovascular disease or elevated cardiovascular risk and have not completed key cardiovascular reviews within the previous two years, particularly those experiencing barriers to access, engagement or prevention support: • Primary Cohort: CVD (CVNeed) and CVD (CVD Stretch) with missed reviews • Secondary Cohort: High QRisk • Development Workstream: Respiratory (Asthma in Children) This is also in keeping with Joint Strategic Needs Assessment Data for the West (Radcliffe) Neighbourhood. (2025 data) Total Population 43651 with: • Increased prevalence of cardiovascular disease in comparison to the rest of Bury (eg. Hypertension 16.8% versus 14.8%) • Increased mortality from cardiovascular disease in comparison to the rest of Bury (eg. Circulatory disease in under 75 1.29 : 1) • Prevalence of overweight in children (our future adults): 41.5% versus 37.8% • Emergency Hospital admissions for coronary heart disease in comparison to the rest of Bury and England 1.23 : 1.19 : 1

1.2	What is the approximate or known size of the main cohort?		**CVD (High Need)**	**CVD (Stretch)**	**High Qrisk**	**Asthma (CYP)**
		Mile Lane Surgery	245	245	296	22
		Monarch Medical Centre	168	168	554	21
		Radcliffe Medical Practice	151	147	240	48
		Redbank Group Practice	368	369	314	46
		Tower Family Healthcare Spring Lane	303	303	657	65
		Total	**1235**	**1232**	**2061**	**202**
		Above are the numbers of patient pertaining to each surgery based on existing BeCorr searches. We know that a proportion of these patients are non-attenders and the focus is on that cohort in the knowledge that individual GP surgeries are likely to achieve 50% - 60% of their individual targets.				
1.3	Rationale: Why has this cohort been prioritised, and what is the main issue or barrier this plan is trying to address?	1. The barriers felt to be relevant were ○ Non-attendance (which services could we use to find the relevant patients) ○ Low engagement (which services could we utilise for health promotion) ○ Working hours (is there an extended access offer that could be utilised) ○ Health literacy (can this be promoted/improved via outreach work?) ○ Poor awareness of support services (can this be promoted/improved via outreach work?) 2. Local Need: Looking at JSNA data, there is significant disease prevalence with respect to cardiovascular disease. Ischaemic Heart Disease Peripheral vascular Disease Cerebrovascular Disease Chronic kidney Disease Vascular Dementia				

		3. The reviews are essentially QoF reviews. Practices were asked to look at the cohort of patients who have missed reviews in the last two years. The main cohort missing reviews were CVD patients. 4. Locality Priority 1: Improvement in cardiovascular disease reviews theoretically improved cardiovascular disease management and subsequent outcomes thus reducing the likelihood of progression of disease and subsequent secondary care attendance. 5. Locality Priority 2. The numbers of SMI Health checks performed could be improved as we can duplicate processes used to target missingness within the cohorts, to target SMI patients for their health checks. 6. A minor focus on asthma in children starts to improve the links between the school nursing teams and general practice. The focus here is less around reviews, but more about the school nursing team knowing who the relevant GPs are in the area and encouraging an exchange of ideas between both groups as to how patient management can be improved. This is particularly important in the context of Radcliffe and the new high school as improvement in direct communication between health and education in Radcliffe will be useful once the new high school is built. This is particularly pertinent with respect to improvement in childhood obesity rates (according to Public Health, 48% of primary school children in Radcliffe are obese. Why do GPs not know who these children or more importantly who these families are so that they can be involved in the process of improving family outcomes). It is acknowledged that this is not strictly within the remit of the current BeCCoR contract and will be looked at as a separate workstream. 7. The large cohort of patients will inevitably involve work across numerous public facing partners dealing with adult patients. There already exists a forum within which relevant patients can be identified by relevant partners. Their contacts with the patients can be utilised for health promotion thus encouraging a wider ‘every contact counts’ approach to healthcare. It is noted that use of existing structures does not fully utilise the funding allocated in

		section 3c as a neighbourhood plan. the majority of this funding has been returned to GP surgeries to utilise as they see fit in order to complete the relevant reviews (based on the neighbourhood team encouraging the relevant cohort to attend these reviews). 8. When surgeries 'drilled' into their data, there was generally no 'stand-out' group noted with respect to 'missingness'. The exception to this was Monarch Medical Practice for whom the lead GP noted patients missing reviews within a particular ethnic section of his population; hence a request to hold outreach activities at a relevant mosque. 9. Which population characteristics actively shaped the plan: The most important characteristics are felt to be deprivation and health literacy. Deprivation obviously being a major factor in all causes of cardiovascular mortality and morbidity. Health literacy is also felt to be an important aspect here as this may be generational. Improving health literacy in children and families by use of public health data to identify relevant families will have long term benefits in population health as alluded to in point 6.
1.4	What improvement(s) is this plan aiming to achieve by 31 March 2027?	**High QRisk and CVD** Improvement in the number of patients who have never had a QRisk calculated. Increase in referrals to the Bury Live Well Service Improvement in the number of patients appropriately offered lipid lowering therapy Increase in the number of patients with lipid levels, BMI and blood pressure within target parameters. Increase in referrals from Community Partners to the suite of Health Promotion Resources in Radcliffe  Radcliffe Community Resources.docx

		Asthma in Children As per BeCCoR, increase in the number of children who have asthma reviews by utilising school nursing services. As mentioned earlier, this is really a 'trojan horse' to improve links between school nursing services and GPs in Radcliffe with the intent of eventually creating a health/education interface between the primary school and GP surgeries in Radcliffe, and eventually the secondary schools and GP surgeries. **Health Awareness** In discussions around schools, it was noted that public health hold data for the weight and BMI of most children in Bury. This data shows that approximately 50% of children in the Bury West Neighbourhood are overweight. This data effectively allows health and education to take a whole family approach to improving healthcare. **SMI Health Checks** Improved SMI health checks via health promotion with Neighbourhood mental Health Team. Where needed, the ACM in the community team can offer drop-in clinics/visits in conjunction with relevant community mental health teams.

1.5	Which measures will be used to monitor progress against the planned improvement above?	• **Standard BeCCoR measures:**
		  ○ BeCCoR Review undertaken
		  ○ People treated to target in cohort
		
		• **Increase in referrals to:**
		  ○ Social prescribing
		  ○ Community Live Well service
		  ○ Radcliffe Community Resources
		
		  This data can be collected using appropriate Live Well SNOMED codes as per the BeCCoR document.
		
		• Capturing the number of people who we reach via outreach work, irrespective of whether their issues pertained to BeCCoR or other health work

1.5a	Additional notes on selected measures (optional)	Primary Measure: Number and percentage of identified CVNeed/CVD Stretch patients receiving a completed BeCCoR review.
1.6	How will this work be delivered?	**Agreed activities:** 1. We have already started to use our MDT/Active case management forum to disseminate details of relevant patients and cross check databases thus commencing health promotion activities. 2. Creation of fortnightly to monthly drop-in clinic at Growing Together Radcliffe to be staffed by neighbourhood INT Team to undertake outreach work and health promotion. 3. Utilisation of PCN enhanced access weekend and evening services provided by the PCN to complete reviews in patients who cannot attend in normal working hours. There has been agreement from both neighbourhood PCNs on this. 4. Utilisation of PCN visiting staff to target appropriate housebound patients. There has been agreement from both neighbourhood PCNs on this. 5. Attendance of neighbourhood GPs at Radcliffe Hub to increase visibility and inevitably hold 'ACM MDT in the community for the community'. 6. Creation of a PDF that can be sent to patients in Radcliffe preferably as a PDF attached to a text message of relevant neighbourhood activities. 7. Blood pressure training to be provided to Staying Well Team and VCFA staff to monitor blood pressures of relevant patients utilising modified version of the NHS Community Pharmacy Blood Pressure Scheme which has clear guidance for non-clinical staff. BP checks are only performed with patient consent at the end of non-contentious consultations. The thresholds for entering into GP records are: a. Stage 1: Patient is encouraged to see the pharmacist for a repeat BP check a fortnight later b. Stage 2: Information is sent to the surgery via GP connect with a task to highlight this c. Stage 3/Malignant hypertension (smaller numbers): urgent task to surgery with the patient being encouraged to attend accident and emergency if BP greater than

		220/120 8. Community Pharmacies in Radcliffe to improve health promotion. Interrogation of the Electronic Prescribing Service tells us about the relevant pharmacies for our individual patients. Use of their contact with relevant patients can drive health promotion, as highlighted in the community pharmacy manifesto. We will highlight to pharmacies which patients require a BeCCoR review and the type of review in order that pharmacies can participate in health promotion. 9. All the practices in West neighbourhood have joined the Active Practice's Scheme. This allows extension of an existing 'community fun run' for adults which is being run by Tower Family Practices to be extended to all other practices in Radcliffe. 10. The data on childhood obesity is going to be used to encourage relevant families to participate in a 2k fun run in Radcliffe. Relevant practices have agreed to engage with this. 11. Use of the Facebook 'What's on Radcliffe' to promote BeCCoR, ACM in the community and Radcliffe community runs **Issues to be resolved:** 1. Gaining access to PCN enterprise EMIS to allow the clinical lead to undertake any relevant clinical work during outreach sessions. We need to draft an appropriate GDPR agreement. 2. Gaining access to the Bury Live Well Service DCRS system as this holds the data that on school age children's weight/BMI/centiles. o Officer(s) time in getting data sharing agreements sorted o Licence agreements with all parties if this can be done o Training and upskilling INT / Primary Care staff
1.7	Who will you work with to deliver this plan?	• Neighbourhood / INT team • Live Well / social prescribing • VCFSE / community groups

		• Community pharmacy • Neighbourhood Mental Health Team • Calico Floating Housing Support • Achieve • PCN • GP Practices
1.8	Is this work also expected to reach or benefit a wider population beyond the main BeCCoR cohort?	Yes
1.8a	If yes, please describe extended benefits.	Health promotion via all public facing bodies increases visibility meaning that a wider cohort of patients will engage with Neighbourhood Healthcare. This allows capture of: • missing patients • patients with comorbidities that are not covered under the neighbourhood plan • patients with comorbidities not recognised in BeCCoR • Improved health awareness within the neighbourhood. Direct engagement with the neighbourhood in an open forum ACM in the community setting will help to restore general trust in healthcare as it emphasizes the fact that healthcare is accessible to the community on an ad-hoc basis on their terms. Improvement to population health by establishing a regular community run for adults and families. The short-term and long-term effect of this will be a decrease in admissions and an improvement in long term morbidity.
1.9	Please detail your proposal for spend of the Neighbourhood Prevention Allocation. Please detail: Amount/ costed item; who will deliver; basis of costing; Lead for this activity	**Cost of activities associated with access to Bury Live Well/Public health data:** We have overestimated the current cost at £1000 to be spread across the surgeries on a BeCCoR population based pro-rata basis. The financial focus relates to costs associated with accessing wider healthcare data held in the public health database. The basis of costing is a current estimate provided by Lee Buggie (Public Health). Dr Rotowa and Ms Stanton will be the leads for this activity. **Cost of activities associated with active practices/community runs:**

		The current estimated cost is £2500 to be spread across the surgeries on a BeCCoR population based pro-rata basis. The basis of costing is a current estimate provided by Dr Ajay Kotegaonkar who is the lead for this activity. The benefit here is in higher QRisk patients, CVD patients and with a newly identified childhood obesity focus.
1.10	Any other comments (optional)	I feel that this plan is value for money considering: 1. size of cohort (>3000 CVD/Qrisk patients) 2. use of existing assets 3. prevention of future cardiovascular events 4. leveraging existing community infrastructure for health promotion 5. the creation of a neighbourhood activity to improve population health 6. the tertiary focus on childhood obesity which will have a ripple effect on long term health outcomes of the affected families

Quarter 4 Report (March 31st 2027)

ID	Question (prompt text)	Notes (build)
2.1	Summarise progress over the year: What was delivered? how was your selected cohort engaged?	—
2.2	What progress was made against the planned improvement set out in Q1? Add evidence/detail/examples of what has gone well	Add description: “Summarise the main outcomes and learning. Core quantitative metrics will be reported centrally where available, so only add local context or additional outcomes here.”
2.3	What were the main challenges, and what would you do differently next time? Add detail/examples	—
2.4	How has this work supported wider neighbourhood relationships, partnership working or ways of working? What feedback have you had?	Make required if you need consistent learning capture.

2.5	Has the neighbourhood work supported you to carry out more unmet need reviews on your BeCCoR cohort than conventional LTC/QOF recall alone?	
2.6	What will continue, change or be embedded as a result of this work?	—
2.7	What funding or resources supported delivery, and what additional support would have improved this work?	If you need structure, split into (a) “Resources used” and (b) “Additional support needed”.
2.8	Any other comments (optional)	—

Locality sign off and assurance:

Funding required from your plan will be from the 3c BeCCoR allocation - the Neighbourhood Prevention Allocation.

The sign-off of plans, to authorise funding, will be overseen by Place teams and through place-based partnership governance. Funding decisions will take place at Place in collaboration and agreement with the local GP board (or equivalent mechanism where there is no GP board), to align with strategic priorities, including Neighbourhood Health Plans.

The sign off will provide assurance (as a minimum) that the plans:

- Represent good value for money
- Focus on improving outcomes for core BeCCoR cohorts (with wider benefits where possible)
- Are co-designed and delivered with neighbourhood partners
- Support neighbourhood working and key Place priorities

Please contact enhancedserviceses1@nhs.net if you have any queries about who your place team contact is.

Pillar 3 Prevention Population Health and Neighbourhoods - BeCCoR neighbourhood action plan DRAFT v2
(This is an offline version for info – the form for submission will be developed in MS Forms and will be accessible in June)

Quarter 2 Report (Sept 30th 2026)

Purpose of this form:

GP practices/PCNs will be expected to attend Neighbourhood forums and to collaborate with key neighbourhood partners to reach a shared understanding of local neighbourhood priorities and the BeCCoR patient cohorts, especially the groups that general practice is finding it most challenging to reach and/or to address the health needs of because of wider issues.

BeCCoR Neighbourhood Plans will be developed through Neighbourhood engagement and co-production activities, aiming to better reach and serve these groups, with likely additional benefits beyond the defined cohorts. Funding for engagement and plan development is described as 3b in BeCCoR specification.

This document provides a format for your Neighbourhood Action plan, and acts as the template for your Q2 and Q4 submission.

A Neighbourhood Prevention Allocation (3c) is available to fund the elements of the BeCCoR Neighbourhood Plans that require resource.

This form must be submitted via MSForms **by 30th Sept 2026** with section 1 completed**.** The submission date for resubmission with section 2 completed is **30th March 2027.**

If you are submitting collectively (eg through a PCN) only one copy needs to be sent in.

General Practice Name(s) : *(Please list all practices included in this submission)*	Unsworth Medical Centre The Elms The Uplands Blackford House Medical Centre
Is this a PCN response? if so, please provide name of PCN:	Whitefield PCN

Locality/Place:	Bury
Name(s) and roles of practice leads involved in this work:	Dr Alistair Webley – Neighbourhood Lead Jane Wilson Practice Managers from each practice above
Name of Neighbourhood (*alignment to closest / most appropriate neighbourhood) :*	Whitefield
Which organisations were involved with the co-design of this plan? (ie. Provide details of neighbourhood partners involved)	Social Prescribers, GP practices, Staying Well GP Fed Socialised plan with VCFA and working well While at this stage very primary care delivery focused, GPs in the neighbourhood teams continue to recognise and commit to supporting the work of all partners in the neighbourhood to improve the circumstances of peoples lives, continuing to create opportunities for all people to be well, independent and connected to their communities, and where health and care, and wider public services, are joined up even more effectively
Name and dates of neighbourhood forum/ meeting has this been discussed and agreed at:	4/6/26 – neighbourhood, 9/6/26 Whitefield Practice Managers, 11/6/26 neighbourhood, 18/6/26 PCN Whitefield Board, 2/7/26 neighbourhood, 9/7/26 neighbourhood

ID	Question (prompt text)	Choices / fields (to be developed into MS forms as drop down menu where possible)
1.1	Which BeCCoR cohort is the main focus of this neighbourhood plan?	

		CVD (CVNeed) comprising of CVD, hypertension, AF, diabetes however some of the patients may have more comorbidities than outlined in this list which we will endeavour to support through the process
1.2	What is the approximate or known size of the main cohort?	See attached Whitefield%20%20Unsworth%20Neigbou
1.3	Rationale: Why has this cohort been prioritised, and what is the main issue or barrier this plan is trying to address?	**Why has this cohort been prioritised?** • This is a key priority identified locally as well as nationally. • Continues to build on the great work done already • It meets our neighbourhood priorities • Opportunity to make a difference to those hard to reach and vulnerable groups **What are the main issues / barriers the plan is seeking to address** • Inability to access services to obtain a health check for a cohort of "hard to reach" patients • From the data this appears to be due to time constraints for those of working age and physical and psychological inability to get to the practices for patients who are housebound or have severe mental health issues **Consideration of any particular health inequalities issues e.g. SMI, deprivation, ethnicity etc** • It would help reduce health inequalities in the Whitefield Neighbourhood – flexibility in times, access, location, demographics, health conditions, age, circumstance, • Help raise awareness of the services and support available in our community. • Continue to positively build on the foundations of our collaborative neighbourhood working
1.4	What improvement(s) is this plan aiming to achieve by 31 March 2027?	**Q1: Main improvement / outcomes to improve / Q2: Current position / baseline (if known)** **Initially:** • To obtain baseline figures for 26/27 across Whitefield Neighbourhood (see attachment with figures for Whitefield) • Practices are already focused on contacting patients via their recalling system. 2x invites and then identify those who are 'missing', 'not engaging' and collating reasons • Identifying those who failed to engage or attend reviews in the previous 12 months. To look at the themes, if any, to help tailor the neighbourhood events and discuss innovative ways of engaging with those 'hard to reach' groups/patients.

		Then progress to: • Launch of Whitefield Hub – July'25/ August – initially to raise awareness • Followed by two events planned throughout the year (Sept and Feb) to reach out within our neighbourhood 'missingness' – obtain feedback at these events as to lack of engagement, coincide delivery of flu /covid autumn/winter programme, MECC • Provide support to the events for patients who lack confidence to attend alone, housebound • Utilise the newly implemented EA service – for patients to access care outside of the core GP hours • Social prescribing team, VCFA, community teams, practices : Making every contact count • Utilise the initiatives currently in place to raise awareness, capture feedback as to lack of engagement and to undertake reviews out in community where possible (eg Van – raising awareness for cancer – can we raise awareness for health conditions and capture reasons for 'missingness'? Access young carers, Andy's man club, AA groups, local pharmacies, ?Morrisons **Q3: Planned target or intended improvement by 31 March 2027** • Increase the number of patients treated within the target cohort • Capture data on why patients choose not to engage with services • Identify innovative ways across the neighbourhood in which we can deliver services in a way in which reaches a wider population of high/very high unmet need in a collaborative approach • Record patient outcomes • Promote social prescribing and other local neighbourhood support available for all ie SMI, LD, Young people/children, older people, patients, carers, families, deprived, affluent, cultures, accessible morning, afternoon, evenings, weekends •
1.5	Which measures will be used to monitor progress against the planned improvement above?	• **Standard BeCCoR measures:** ○ Track cohort identified (denominator) ○ Track cohort reached ○ BeCCoR Review undertaken ○ Decrease in missingness ○ People treated to target in cohort

		○ Social prescribing referrals and type of support / Live Well intervention • **Additional local measures (optional selections):** ○ Increase in patients receiving yearly reviews ○ Increase in QOF achievement / reduction in exception reporting
1.5a	Additional notes on selected measures (optional)	Although the focus is around patients identified within the CVD cohort, often these patients have other comorbidities which we will support. (see attached sheet) The patients may have relatives, friends, carers who may participate in the programmes of work or events that we deliver.
1.6	How will this work be delivered?	All patients in this cohort will be messaged by the practice admin team via accuryx to arrange an appointment with a nurse or HCA within the practice for an assessment Patients who are in this cohort and are of working age and are unable to get in to the practice during normal hours will be identified by the practice administration staff. They will be messaged initially via accuryx and invited to attend an appointment with a practice nurse or HCA in an extended access appointment (not in working hours) who will undertake the relevant clinical assessments and capture the relevant data. If the patient does not respond to accuryx message, phone calls and letters will be sent to the patient by the practice admin team to advise them on the need to attend for their assessment. All patients who have not responded initially will be invited to a community event at Whitefield hub in September and February this will be via accuryx and via letter for those patients who cannot receive messages. At the community hub have agreement to have representation from all members of the INT MDT – Staying well team, VCFA, pharmacy, social care, live well team, nursing, neighbourhood lead and GP. Patients will be able to gain information about what these various members are able to offer to them to enable better access in the future and we will aim to run a drop in clinic that patients can have their assessment done and also we aim to capture why patients are unable or unwilling to access practices. Patients that are still not accessing the surgery will be identified as the year progresses and then more targeted approaches can be taken. It is expected that these cohorts may involve patients with learning difficulties and mental health issues in which case we plan to utilise our LD and MH worker who has an ARRS role to visit these patients and either obtain any data needed or educate and encourage the patient to attend a health check at the practice. Similarly it is expected housebound patients would struggle to get to the practice and so these will be allocated to practice nurses to visit and do the health checks on.

		There will be other patients who have difficulty accessing the services and we will utilise the appropriate member of the INT or ARRS role as is needed to help these specific patients. Education of all patients by the various teams will take place through the year to encourage any patient that may need a health check to contact the GP surgery to arrange this. All members of the neighbourhood team are aware of the plan and actively engaging patients and the message is being sent out to the other teams in the community to ask them to encourage patients too.
1.7	Who will you work with to deliver this plan?	• PCN / MDT • Neighbourhood / INT team • Local Authority • Live Well / social prescribing • VCFSE / community groups • Community pharmacy • Mental health services • Secondary care / specialist services • Other – Cancer awareness van, AAA screening team, PPG word of mouth,
1.8	Is this work also expected to reach or benefit a wider population beyond the main BeCCoR cohort?	Yes
1.8a	If yes, please describe extended benefits.	As raised above – although the focus is CVD – this overlaps with other comorbidities and we will raise awareness and offer support where we can.
1.9	Please detail your proposal for spend of the Neighbourhood Prevention Allocation. Please detail: Amount/ costed item; who will deliver; basis of costing; Lead for this activity	*Whilst the actual funding is not finalised we hope to minimise the financial impact of this plan on practices. Please see attached budget sheet* ***Community Hub*** *We have run community hub events similar to this for previous projects with little or no expenditure using the goodwill and time of our team members* *However we are aware there is a potential; cost allocated to this and so have the below figures* *Venue Hire - Whitefield Live Well Centre*

		Event Room – £20 per hour approx for cost 2 event x3 hours each and clinical rooms at £10 per hour with a total cost of £180 for 2 event of 3 hours each ***Extended Acccess*** *Regarding the use of extended access, the use of extended access is part of the collaboration of the PCN practice and their current workforce so there should be no additional costs incurred*
1.10	Any other comments (optional)	Free text.

Quarter 4 Report (March 31st 2027)

ID	Question (prompt text)	Notes (build)
2.1	Summarise progress over the year: What was delivered? how was your selected cohort engaged?	—
2.2	What progress was made against the planned improvement set out in Q1? Add evidence/detail/examples of what has gone well	Add description: “Summarise the main outcomes and learning. Core quantitative metrics will be reported centrally where available, so only add local context or additional outcomes here.”
2.3	What were the main challenges, and what would you do differently next time? Add detail/examples	—
2.4	How has this work supported wider neighbourhood relationships, partnership working or ways of working? What feedback have you had?	Make required if you need consistent learning capture.
2.5	Has the neighbourhood work supported you to carry out more unmet need reviews on your BeCCoR cohort than conventional LTC/QOF recall alone?	
2.6	What will continue, change or be embedded as a result of this work?	—

2.7	What funding or resources supported delivery, and what additional support would have improved this work?	If you need structure, split into (a) “Resources used” and (b) “Additional support needed”.
2.8	Any other comments (optional)	—

Locality sign off and assurance:

Funding required from your plan will be from the 3c BeCCoR allocation - the Neighbourhood Prevention Allocation.

The sign-off of plans, to authorise funding, will be overseen by Place teams and through place-based partnership governance. Funding decisions will take place at Place in collaboration and agreement with the local GP board (or equivalent mechanism where there is no GP board), to align with strategic priorities, including Neighbourhood Health Plans.

The sign off will provide assurance (as a minimum) that the plans:

- Represent good value for money
- Focus on improving outcomes for core BeCCoR cohorts (with wider benefits where possible)
- Are co-designed and delivered with neighbourhood partners
- Support neighbourhood working and key Place priorities

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NHS
Pennine Care
NHS Foundation Trust

Mental Health Update
Bury Locality Board
September 2026
Sarah Preedy – Chief Operating Officer.

CQC Well Led

Leadership rated ‘good’

Visible, compassionate leadership with commitment to continuous improvement recognised

Strong partnership working, engagement with people with lived experience and robust governance arrangements were noted

Trust strategy to continue improvement journey to ‘outstanding’

24/7 Crisis Resolution & Home Treatment Team

NHS
Pennine Care
NHS Foundation Trust

The new CRHTT is a standardised crisis response service across PCFT localities

The service will provide a consistent, 4- hour community crisis response including rapid assessment.

Short term crisis resolution support alongside home treatment will be available as an alternative to admission.

NHS
Pennine Care
NHS Foundation Trust

CRHTT

Supports national and local priorities for faster access to mental health crisis care (Left Shift).

The NHS Long Term Plan sets an ambition for more comprehensive crisis pathways in every area that is able to meet the continuum of needs and preferences for crisis care.

Integrated with NHS 111 Mental Health (Option 2) self-referral crisis line supporting diversion from primary care and ED

Direct booking of crisis assessments with mental health professionals.

Refreshed partnership with VCFA – Bury peer led crisis service – non- clinical crisis support providing early intervention and crisis de-escalation

NHS
Pennine Care
NHS Foundation Trust

3 Knowsley Place Opens

Official opening and ribbon cutting 23 July supported by system partners

NHS
Pennine Care
NHS Foundation Trust

3 Knowsley Place

Community hub in the heart of Bury bringing together a range of mental health and learning disability services

The hub will strengthen partnership working and make it easier to provide joined up care and support across Bury

The building includes 15 consultation rooms and will support more than 8000 appointments each year.

Mental Health Neighbourhood Model

NHS
Pennine Care
NHS Foundation Trust

Multi-agency model (NHS providers, social care and VCSFA) operational for almost 2 years.

Risk remains around commissioned service capacity

Aim: address wider determinants of health and embed mental health support within neighborhood delivery.

Pilot evaluation will inform long-term sustainability and future strategic focus.

NHS
Pennine Care
NHS Foundation Trust

Questions

Meeting:			
Meeting Date	07 September 2026	**Action**	Receive
Item No.	11	**Confidential**	No
Title	Report from the Performance & Quality Meeting for Locality Board – including quarterly risk report		
Presented By	Kath Wynne-Jines 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, quality and risk.

The risk paper details the locality strategic, and programme risks as determined by the Performance and Quality Committee 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 content and make recommendations to the Performance and Quality Group to ensure robust transparency, oversight and mitigation of locality strategic and performance risks and locality performance or quality issues.

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		

Bury Integrated Delivery Collaborative Performance Report Summary

1. Context

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

2. Performance – July 2026

2.1 Below Target Performance

Autism average wait in weeks from referral to first assessment MH patients - Average wait has decreased significantly from 129 in April to 68 in May.

ADHD average wait in weeks from referral to first assessment – MH patients - Bury – ADHD Average Wait (Referral to First Assessment). Average wait has decreased to 76 weeks (May 2026), down from 109 weeks in April. Waits remain consistently high, with most of the past year in the 80–100+ week range. Bury sits towards the higher end across GM, with longer waits than most localities. Overall trend indicates sustained pressure. Note: Figures may differ locally due to methodology differences; a review paper is in development

Percentage of CYP receiving Autism assessment within 18 weeks of referral - Bury – CYP ADHD Assessment within 18 Weeks. Performance remains at 0.0% since April 2026, indicating no patients seen within the 18-week standard. Delivery remains consistently very low and highly variable, with multiple months at or near 0% over the past year. Trends show no sustained improvement, with only sporadic short-term increases followed by deterioration. Bury remains well below the GM average (11.0%) and continues to sit among the lowest-performing localities. Overall performance indicates significant and ongoing capacity challenges within the assessment pathway.

Percentage of CYP receiving ADHD assessment within 18 weeks of referral - Bury – CYP Autism Assessment within 18 Weeks. Performance remains at 0.0% in May 2026, unchanged from March, indicating no patients seen within the 18-week standard for a third consecutive month. Performance continues to be highly volatile, with multiple months at 0% over the past year and intermittent short-lived improvements. Trend shows no sustained recovery, with performance fluctuating between 0% and 25%, indicating inconsistent pathway delivery. Bury remains well below the GM average (11.1%) and sits among the lowest-performing localities across GM. Data should be interpreted with caution due to known methodology differences between national and local reporting, with further work underway to address this.

Talking Therapies Second Treatment Waits - Talking Therapies second treatment waits in Bury have decreased to 54.5% (May 2026) from 62.2% in April. Performance remains substantially above the 10% national target (higher is worse) and continues to be in the lower quartile (89th/101). Trend shows clear deterioration over the past 18 months, rising from around 15–25% during 2023/24 to consistently 40–60% in 2025/26. Bury remains above the GM average (45.2%), indicating sustained systemic pressure in second treatment access.

Talking Therapies 6 Week Waits: Talking Therapies 6-week waits in Bury have increased to 58.1% (May 2026) from 50.0% in April. Performance remains well below the 75% national target. Over the past 12 months, performance has stabilised at a lower level (~50–60%), with limited recovery. Bury continues to perform significantly below the GM average (73.1%), with a persistent gap to peers.

28-day wait from referral to faster diagnosis (all patients) – 28-day Faster Diagnosis performance increased to 80.1% in May 2026, from 72.3% in March. Performance is currently above the 80% national standard but below the GM average (81.9%)

2.2 Average Performance

Access to individual placement and support services – Mental Health Patients - Bury – Access to IPS (Employment Support). Activity has increased to 300 in May 2026 (up from 290 in April), continuing a strong upward trajectory. Numbers have more than tripled over the past 12 months (from 90 in May 2025). Bury remains mid-range nationally (57th of 106), indicating average relative performance despite rapid growth. Benchmarking shows Bury's rate (1.42 per 1,000) ranks 5th in GM. Overall, Bury demonstrates sustained expansion in access, with further opportunity to improve relative position within GM.

Talking Therapies Access Rate - In May 2026, 260 people in Bury accessed Talking Therapies services, a decrease from 290 in March. Bury's rate of 1.2 per 1,000 population is below the Greater Manchester leaders and ranks 10th across GM.

2.3 Maintained Performance

Percentage of CYP receiving Autism assessment within 18 weeks of referral - Bury – CYP Autism Assessment within 18 Weeks. Performance remains at 0.0% in May 2026, unchanged from March, indicating no patients seen within the 18-week standard for a third consecutive month. Performance continues to be highly volatile, with multiple months at 0% over the past year and intermittent short-lived improvements. Trend shows no sustained recovery, with performance fluctuating between 0% and 25%, indicating inconsistent pathway delivery. Bury remains well below the GM average (11.1%) and sits among the lowest-performing localities across GM. Data should be interpreted with caution due to known methodology differences between national and local reporting, with further work underway to address this.

Talking Therapies 18 Weeks Wait - Talking Therapies 18-week waits in Bury remain 100% in May 2026, sustaining full compliance with the 95% national target. Performance has been consistently at or near 100% since 2023, demonstrating sustained high delivery and stability. Bury is ranked 6th nationally (upper quartile), reflecting strong comparative performance. Over recent months, performance has remained stable with minimal variation, indicating robust pathway management. Bury continues to perform above the GM average (97.7%), with only marginal variation across localities.

Talking Therapies Recovery Rate - Bury Talking Therapies recovery rate is 54.0% (May 2026), up from 52.0% in April. This remains above the 50% national target. Longer-term performance shows fluctuation between ~45%–60%, with no sustained upward trend. Recovery rates have consistently varied month-to-month, indicating instability in outcomes. Bury currently ranks 2nd for performance across GM localities.

Percentage of Patients aged 14+ with a completed LD health check - Bury's performance has increased by 6% since last month and is above the GM average (8.7%), ranking 4th across localities.

Total number of specific acute non elective spells - Non-elective activity reduced to 1,816 in June 2026 (from 1,993 in May). Bury sits in the mid-ranking within GM (8.6 per 1,000 population).

Length of stay for adults (60+days) mental health patients - In May 2026, 33.3% of adult mental health discharges in Bury had a length of stay exceeding 60 days, an increase from 25.0% in March.

Bury's performance is below the Greater Manchester average of 29.4%.

Access to Children and Young People MH Services - In May 2026, a total of 3,640 attendances for Children and Young People's Mental Health Services were recorded among patients registered in Bury. This represents a decrease compared with the 3,665 attendances reported in April 2026 but is higher than the 3,475 attendances recorded in May 2025. Bury currently reports an access rate of 81.5 per 1,000 population, ranking fourth highest among the Greater Manchester localities.

RTT Incomplete 65+ weeks Waits – In May 2026, 12 Bury-registered patients were reported as waiting 65 weeks or more, up from 3 patients in April March 2026. Highest figure for Bury since March 2025. Bury ranks as the 4th highest locality across Greater Manchester for the number of 65+ week waits.

Diagnostics Waiting 6 weeks + The proportion of patients waiting over 6 weeks decreased to 10.6% in May 2026 (from 11.8% in April)

A&E 4-Hour Performance - This metric is monitored daily to support timely performance oversight. In June 2026, Bury achieved a 4-hour emergency care performance rate of 71.6%, decreasing from 74.4% in May 2026. This represents a year-on-year improvement compared with 69.7% in June 2025. Bury's performance exceeds the Greater Manchester average of 70.0%, ranking 4th highest among GM localities.

A&E Attendances – In June 2026, Bury recorded 7,811 A&E attendances, a increase from 7,640 attendances in May 2026. Attendances in June 2025 were lower than current levels, with 7,034 attendances recorded. Bury's attendance rate is 37.0 per 1,000 population, ranking 5th lowest across Greater Manchester localities.

Dementia: Diagnosis Rate (aged 65+) - As of March 2026, 76.3% of patients aged 65 and over in Bury have received a dementia diagnosis. Bury's diagnosis rate is higher than the Greater Manchester (GM) average, which stands at 73.9%, and ranks 2nd highest among the GM localities. Both Bury and GM exceed the national target for dementia diagnosis, which is set at 66.7%.

No update in dashboard data from previous month.

Number of MH Patients with no criteria to reside - This metric is monitored daily to ensure timely oversight and responsiveness. In June 2026, the number of mental health patients in Bury recorded as having no criteria to reside (NCTR) increased to 9, from 8 in May. This equates to a rate of 0.043 per 1,000 population, which is slightly above the Greater Manchester (GM) average of 0.037. Bury's rate is therefore broadly in line with the GM average and comparable with several better-performing localities, indicating relatively strong system performance.

Percentage of MH Patients with no criteria to reside – As of June 2026, 11.5% of mental health patients in Bury are reported as having no criteria to reside (NCTR), representing an increase from 9.3% in April 2026. Bury's performance is just below Greater Manchester (GM) average of 11.4%, with Bury ranking as the sixth lowest locality across GM.

Access to community mental health services for adults and older adults with severe mental illness - In May 2026, 3,080 adults and older adults with severe mental illness in Bury received two or more contacts from community mental health services, down from 3,100 in April. Bury's rate of 18.5 per 1,000 population is the second highest in Greater Manchester

Percentage of Patients with no criteria to reside as % of occupied beds – This metric is monitored daily to support ongoing performance oversight. NCTR has decreased to 16.2% in June 2026 (from 17.6%), indicating an improvement in discharge performance. Bury is performing below the GM average (14.0%).

Women Accessing Specialist Community Perinatal Mental Health Services - In May 2026, 200 women in Bury accessed specialist community perinatal mental health services, up from 195 in March 2026. Bury's rate of 4.9 per 1,000 population is the second highest in Greater Manchester, indicating strong relative performance within the system.

E. Coli blood stream infections - Over the 12-month period ending May 2026, a total of 124 cases of E. coli bloodstream infections were recorded among patients registered in Bury. This represents a slight increase compared with April 2026, when 121 cases were reported, and is notably lower than the 139 cases recorded in May 2025. Bury currently reports an infection rate of 0.59 per 1,000 population, ranking as the 3rd lowest rate among the Greater Manchester (GM) localities.

Quality

1. Northern Care Alliance (NCA) Undertakings

Background

In December 2022 the Care Quality Commission (CQC) rated the Licensee (NCA) as 'Requires Improvement' for both Overall and Well-led. The findings from the CQC report highlighted a significant number of breaches of regulations, demonstrating a failure of governance arrangements including a failure to establish and maintain systems and/or processes to ensure compliance with the Licensee's duty to operate efficiently and effectively with healthcare standards. The quality and patient safety concerns raised in the report and specifically the pace at which the Licensee had progressed the required improvements, provided reasonable grounds to suspect a breach of licence conditions.

In January 2025 the ICB placed the Licensee into a Rapid Quality Review Process (RQR). The RQR process related to: (1) The reports of Barrister, Mr Carlo Breen's, independent investigation into events at the trust relating to spinal surgery. (2) Screening, accreditation and patient backlogs within services, including Spinal and Gynaecology.

The Licensee had been unable to provide consistent and accurate information relating to numbers of patients requiring either lookback and/or clinical review with quantification of the restorative work needed, nor the timescales, governance and actions required to resolve and reduce the likelihood of patient harm. In March 2025, the Licensee was moved to an intensive level of surveillance led by NHS England under the RQR process to support the Licensee with delivering rapid and sustainable improvement. Between May 2025 and November 2025 several further incidents relating to patients delays/ lost to follow up incidents were identified by the licensee; those incidents were reviewed as part of the RQR.

In September 2025 the CQC, inspected Salford Surgical Services. The CQC issued a section 29A Warning Notice on 21 October 2025. 1. The Licensee does not have effective systems and processes to ensure surgical wards have sufficient and suitably qualified staff to meet the needs of all service users. This requires significant improvement. 2. The Licensee does not have effective systems and processes to identify and address risks affecting the quality and safety of the surgical wards which required significant improvement.

As part of the RQR Terms of Reference, the Licensee commissioned the Good Governance Institute (GGI) to undertake a full quality governance review across the organisation. The report makes 43 recommendations, indicating a need to build a system of quality governance that is clear and consistent across the whole organisation and supports the new organisational structure and ways of working that the Clinical Leadership Model (CLM) will introduce.

The report concludes that there is clear recognition by the Licensee of the need to act and a willingness to make these changes.

There have been a series of escalating quality concerns over the previous 18 months, for which the Licensee has been unable to respond at the expected pace. The cumulation of quality concerns and the Licensee's response has resulted from a fundamental failure in quality governance.

August 2026 - Governance of Undertakings

- NHSE will convene a System Improvement Board led by NHSE at Region.
- NHS GM Executives will support the Regional System Improvement Board.
- Activity, data and local intelligence will be collated by the ICB central Quality team and will inform the System Improvement Board.
- The ICB existing assurance oversight processes will remain in place for example the Provider Oversight meetings (POMs), contract meetings and Quality and Safety Assurance meetings (QuASMs).
- Place Partnerships will support with local intelligence and support for their locality provider sites.

NB – further information on the meeting agenda.

2. Local Quality Improvement – Early Cancer Diagnosis

The Rapid Cancer Registration dataset, which is used to measure performance against the Early Cancer Diagnosis standard, has now been updated to reflect the March 2026 position.

There has been a significant improvement in Bury's performance. We have exceeded the 3% improvement target set by GM Cancer for 2025/26 and have also moved above the Greater Manchester average.

- April 2025: 56.7% (8th position in Greater Manchester)
- March 2026: 62.0% (4th position in Greater Manchester)

This represents an improvement of 5.3% over the year and a rise of 4 places within the Greater Manchester ranking, reflecting the positive impact of the work undertaken to support earlier cancer diagnosis across the system.

Whilst it is challenging to attribute this improvement to any single initiative, it is clear that it reflects a sustained collective effort across the system. A range of interventions through programmes in Bury have contributed to strengthening early cancer diagnosis performance over the past year, including:

- Development and delivery of Early Diagnosis Action Plans across all four PCNs, supported by GM Cancer Primary Care Facilitators.
- Full rollout of the Lung Cancer Screening Programme across all PCNs.
- Inclusion of cancer emergency presentation and referral activity within the Primary Care Quality Visits to support identification and reduction of unwarranted variation.
- Delivery of tumour-specific education through the GP Clinical Masterclass programme, led by NCA Consultants which has been extended to other NCA localities through our training hub.
- Embedding cancer awareness and prevention messaging within NHS Health Checks as well

as practitioner training, supported by the Public Health Team.
- Cancer awareness campaigns developed by GM Cancer shared through VCFA, PSLTs, council and Primary Care.

The improvement in performance is a testament to the collaborative work undertaken by Primary Care, GM Cancer, Public Health, Secondary Care partners and VCFA supported through the neighbourhoods and wider system to improve earlier diagnosis and outcomes for our population.

Whilst this improvement is very positive and reflects the collective efforts across the system, there is still more work to do as the GM Cancer improvement target remains at 3% for 2026/27.

3. Local CQC Activity

Whitefield House – rated as GOOD

Whitefield House is a residential care home accommodating up to 40 people in single ensuite rooms. At the time of the inspection, 40 people were living at the home.

Summary

People's support needs were assessed with a focus on enabling them to live fulfilled lives through a wide range of inclusive activities that met varying preferences and abilities. Opportunities were also provided for people to access local community groups. People remained at the centre of all decisions about the service and were given opportunities to contribute to shaping and improving their home.

People received their medicines as required; however, there were some shortfalls in the level of detail recorded within administration records. Some basic environmental safety measures were not consistently in place, although these were promptly addressed prior to the second day of the inspection. Overall, systems were in place to help ensure the safety of people living at the service, supported by reflective practice and ongoing improvements.

Staff received a range of training tailored to both the service and the individual needs of the people they supported. However, Mental Capacity Act (MCA) assessments were not always decision specific. These documents were subsequently reviewed and improved to ensure greater clarity and compliance. Staff contributed to reflective processes, which supported continuous learning and development within the service.

People and their families unanimously reported that staff were genuinely caring, kind, and approachable. Staff demonstrated a compassionate approach in their day-to-day interactions, helping people feel valued and supported.

The management team was approachable and fostered an open and honest culture. They ensured that staff understood and consistently conveyed the service's values, including creating a family feel and delivering person-centred care. A variety of quality assurance systems were in place, providing opportunities for reflection. Management and staff maintained strong working relationships with partner agencies, ensuring people's needs were met safely and effectively.

Cygnet Bury Hudson – rated as GOOD

Cygnet Bury Hudson was registered with the CQC in October 2021 to deliver the regulated activities: Assessment or medical treatment for persons detained under the Mental Health Act 1983, Diagnostic and Screening procedures and Treatment of disease, disorder or injury.

Summary

The service had made significant improvements since the last inspection. Seclusion rooms had been upgraded to ensure patients had ease of access to toilets and showers. Medicines had an expiry date clearly displayed. There was strong oversight of the service with daily ward-based safety review meetings and the hospital wide daily brief meetings to ensure senior leaders had oversight of staffing, incidents, maintenance, housekeeping, catering, complaints and compliments.

The service involved patients in the development of the service and had improved the involvement of carers in the service, with a carer ambassador who attended the carer meetings and delivered carer awareness training to staff. Leaders listened to feedback from patients, carers and staff and acted on the feedback.

However, at this inspection, we found 3 breaches of regulations in relation to medicines monitoring, sharing of risk and incidents and cleanliness and maintenance of the environment. The service had the systems, processes and oversight to address these promptly and had started to address this following feedback during the inspection.

Mental Health Act and Mental Capacity Act Compliance Summary

Staff received training in the Mental Health Act and Mental Capacity Act. Compliance for the service was 96% for Mental Capacity Act and 100% for Mental Health Act.

There were policies and procedures in place for both the Mental Health Act and Mental Capacity Act.

Staff we spoke with understood their role in relation to the legislation.

Medicines administration records were clearly completed and where needed the appropriate Mental Health Act authorities for prescribing were in place.

Records evidenced examples of capacity assessments completed for decisions including treatment for physical health conditions and dietary intake.

<u>Greyland Medical Centre – rated as GOOD</u>

Greyland Medical Centre is a GP practice and delivers services to approximately 1800 people under a contract held with NHS England. It is situated in a parade of local shops in south Bury. According to the latest available data, the ethnic make-up of the service area is approximately 82.8% White, 8.7% Asian, 3.2% Mixed, 2.4% Black and 2.9% Other. Information published by the Office for Health Improvement and Disparities shows deprivation within the service population group is in the 6 decile (6 of 10). The lower the decile, the more deprived the service population is relative to others.

Summary

Staff kept facilities clean and maintained equipment appropriately to ensure people using the service were kept safe. However, some areas only accessible to staff were in need of repair as they were a health and safety risk. Leaders and staff assessed and managed the risk of infection well and took steps to control the risk of it spreading.

There were enough staff with the right skills, qualifications and experience.

Staff supported people to live healthier lives, monitoring their care and treatment to ensure they received positive and consistent outcomes.

Staff treated people with kindness, empathy and compassion, and respected their privacy and dignity.

People could access care, treatment and support when they needed it. Leaders and staff were alert to discrimination and inequality that could disadvantage groups of people who used the service and sought ways to address any barriers.

The service had a clear vision and strategy, which considered the needs of the people who used their service and the wider community. Staff understood their individual roles and responsibilities. Leaders accounted for the actions, behaviours and performance of staff through clear and effective governance processes.

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			
1	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	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.
2	Quality of Services 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	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
3	Widening inequalities 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	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.
4	<u>Workforce</u> 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,	12	16	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

		reduced staff wellbeing, lower morale and inequality of opportunity. This will further impact on service delivery and leadership capacity to manage change.									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
~~5~~	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 commissioned services.	16	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 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.
6	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 system needs. This will result in the inability to deliver on the ICP	20	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/sprint team, 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 showing

		Strategy, reducing our ability to invest in preventative care which will drive demand, and continued inequalities and variation in health and care.										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: CIP, Independent Sector, Package of Care, 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.
7	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	16	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 2026 including: • Front door streaming review • Re launch of Bury Patient Flow Collaborative • Avoiding needless in patient/emergency care" Deflection from ED

		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).										• 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 • Falls Pilot in the Community • Rochdale Pathways • Weekend SDEC Frailty • Implementation of Hot Clinics Review of a 24-hour Assessment area
8	Services for Children, including SEND To be removed after LB	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	16	12	8					↓	8	Ofsted and the CQC have recognised the effective action taken in all 6 areas of the priority impact plan, a reflection of the collaborative hard work undertaken by the partnership on our improvement journey. Inspectors will reach an

		to ensure they reach as good outcomes as all children. The increase in requests for ND assessments is being felt nationally and locally.										effective action outcome if, having gathered and evaluated evidence, they find that the local area partnership has taken reasonable steps to address the area for priority action since the full inspection, based on the relevant evaluation criteria. Effective action does not mean that the area for priority action is no longer a concern or that the local area can stop taking action to address it. Areas for priority action that receive an effective action outcome may still be identified as areas for priority action in future inspections. The SEND Improvement and Assurance Board (SIAB) will continue to meet and be independently chaired to support the onward improvement journey.
9	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	16	12	10					↓	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

		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 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.										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.
10	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	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. No current identified landing place post ICB reforms for the DSR .

11	<u>Safeguarding workforce</u> To be removed after LB	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 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	12	12	8					↓		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 input into the design. Mutual aid covering statutory functions.

12	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 of Bury	12	12	12					↔	8	Despite receiving confirmation of funding and budget value for several services which sit outside of BeCCoR, we are being asked to renegotiate contracts with providers at lower rates as part of the STAR/PSR process. This is not only creating additional unnecessary work but is also creating reputational damage between place and providers and is putting these smaller value contracts under significantly greater scrutiny than much larger services funded through other contractual means. Should providers believe these contracts are no longer deliverable this will result in service loss and a need to redirect patients to secondary care
13	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	12	12	10					↔	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

		acceptable level and is already impacting on patient experience and staff within the practice.										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.
14	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	12					↔	8	Risk score maintained for Q2 However, the number of bed days lost due to being occupied by patients who are clinically ready for discharge has been above plan since the start of the financial year [cumulative = 571; plan = 348]. OAPS remain rare but there is persistent use of a small number of contract and spot purchase beds. GM, PCFT and locality level improvement plan in place. Weekly locality and GM PCFT

												MADE meetings in place to support flow in MH wards using agreed escalation procedures. GM crisis programme to increase / improve community-based crisis provision and pathways. Actively monitored through Bury MH Programme Board.
15	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	12					↓	8	Budgets for ADHD / ASD provision have been centralised and are closely monitored. 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 implemented with *right to choose* providers with an accreditation process underway. This is limiting the number of right to choose providers who

												meet the eligibility providers able to receive referrals of GM patients. Expenditure limits / activity caps are in place 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. A procurement process is underway to identify the triage provider. Optimise Healthcare have now been contracted to provide assessments for ADHD and ASD for adults in Bury which provides a commissioned pathway which should reduce the demand for referrals to right to choose providers. **Recommendation:** As budgets are now centralised this should be closed as a locality risk as the risk will be monitored and managed at a GM level.
16	Mental health programme	If demand and waiting times for CYP neurodevelopmental assessments are not reduced this will lead to	16	16	16					↔	8	Waiting times remain long – further work required to ensure standard routine reporting of waiting times.

		continued delays in diagnosis and follow up treatment and support for children and families, and risk of further poor OFSTED / CQC inspection outcomes.										Progress monitored as part of the SEND improvement programme with regular reporting to Send Partnership Board. PCFT CAMHS are implementing prioritisation criteria. Work has been done to temporarily increase capacity to undertake ADOS assessments in Community Paediatrics. This has potentially reduced the waiting time for autism assessments from 24 months to 15 months. GM triage / prioritisation criteria for ADHD / ASD assessments are being implemented within CAMHS and community pediatrics as part of a wider neurodevelopment transformation programme. In Bury the Multi-agency triage panel was piloted in June and will commence in September. The Bury Neuro 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.
17	Mental health programme	If Bury is unable to commission a provider of adult ASD assessment and ADHD assessment and treatment for 2026.27 there will be complete reliance on the right to choose pathway resulting in: - risk to the continuity of care for patients on ADHD medication. inability to implement a managed transitions pathway for children who require ongoing treatment for ADHD. - inability to implement a managed pathway for patients who were part way through a process of assessment with LANK UK when it was effectivtly closed by the CQC. - poor patient experience. - potential poor outcome for patients. - reliance on right to choose with the associated inequality in access and cost pressures. - ongoing reputational impact.	12	9	6					↓	8	Optimise earlier have now been given approval through the ICB to accept routine adult ADHD and ASD assessment referrals from Bury GPs under their new contractual arrangements. There is a cap on the budget so they will build up a waiting list but it means that we have a fully commissioned provider in place for the first time in over 3 years. The transitions pathway from CAMHS is BAU. **Recommendation:** close the locality risk and monitor as all commissioning now centralised and commissioned provider in place.

18 NEW	Mental health programme	If additional funding is not secured it will not be possible to sustain the current level of VCSE capacity within the Neighbourhood MH Team resulting in increased waiting times and a reduction in the number of people who can be supported				12						Current contract extended to March 2027. Risk raised with GMICB MH Finance review Group.

4 Recommendations

The Locality Board are asked to note the contents of this report.