Intermediate Care Strategy

2025-2027

BURY
INTEGRATED CARE
PARTNERSHIP

Contents

1. Let's do it… Bury 2030

Our borough is the place we are proud to call home. It includes six towns built within areas of extraordinary natural beauty. It is a place rich in possibility which we must preserve, improve, and cherish for future generations.

We want to recognise the distinct identities of our townships and the diversity of each community; to invest in our town centres; create more spaces where people can meet and enable access to affordable decent housing for all. As we do this, we are committed to becoming eco leaders, ensuring future generations can enjoy our green spaces and breathe clean air.

Overall, our borough is relatively less deprived than our statistical neighbours, but our trend is a negative one. Deprivation is highly concentrated and was reported to be getting worse in both 2019 and 2015. To reverse this trend and close the inequalities gap we will target our resources locally, in the places that need them most. Public services and others will work together better, seamlessly and with knowledge of communities.

We will create public service hubs which work within and across townships on a neighbourhood footprint, to bring different agencies together to target resources around greatest need, understand and galvanise community assets and focus on prevention as well as management of risk.

This local approach provides a foundation stone to develop a different relationship with residents and communities to connect people together. To do this, all our work in neighbourhoods will be guided by the LETS principles: taking a local approach; driving enterprise; working together and with a strengths-based approach.

Local Neighbourhoods	Economic Growth and Inclusion
1. Improved access to services 2. Cleaner environment through improved waste management 3. Increase in affordable, good quality homes 4. Reduction in overall crime rates 5. Improved feelings of safety	1. Improved business start-up and survival rates 2. Increased economic activity rates 3. Improved attendance and attainment in education and training 4. Improved quality ratings for schools, colleges and training providers 5. Increased investment in regeneration
Delivering Together	**Strength-based approach**
1. Increased engagement in volunteering / community aid 2. Increased participation in social and cultural activities 3. Increased participation in democracy and decision making 4. Improved digital connectivity and inclusion 5. Improved infrastructure and sustainable transport options	1. Improved population health and wellbeing 2. Increased participation of all equalities groups in decision making and delivery 3. Increased referrals to social prescribing 4. Increase in successful outcomes from Active Case Management within Integrated Neighbourhood Teams 5. Increase in ownership of community assets

The Intermediate Care Strategy will align to the 4 principles and will ensure that the golden thread is maintained throughout all actions and across all system partners.

2. Intermediate Care Partners

Bury Metropolitan Borough Council

Bury Council is one of 10 metropolitan local authorities in Greater Manchester, serving approximately 190,108 people and providing, among other things, social care services

across the Borough. The borough comprises of six towns: Bury, Radcliffe, Whitefield, Prestwich, Ramsbottom and Tottington.

Northern Care Alliance NHS Group

The Northern Care Alliance NHS Group (NCA) brings together four hospitals, specialist and acute services, together with community health with community health services, and 17,500 staff across Salford Royal and Pennine Acute Hospitals NHS Trusts under a Group arrangement. The NCA serves a population of over 1.1m people across Salford, Oldham, Bury, and Rochdale which includes Fairfield General Hospital provided through its Bury Care Organisation.

BARDOC Ltd

Providing out of hours medical and dental care to the local communities of Bury, Heywood, Middleton, Rochdale and Bolton. BARDOC's vision is to achieve excellence in all that it does, through delivering high quality integrated care by working with other health and social care agencies which best meets the needs of patients and commissioners and delivers value for money.

Bury GP Federation

Bury GP Federation was created to enhance the delivery of health and care services to the local population. It now has 30 of the town's 31 general practices in membership and covers 97% of the 200,000 people of Bury. It believes community-based services which are high quality, consistent and joined up are the solution to many of the pressures on today's NHS and that general practice is ideally placed to lead this community-based provision.

Bury Voluntary, Community and Faith Alliance

The Bury Voluntary, Community and Faith Alliance (VCFA) is an infrastructure organisation providing volunteering and development support to the VCF (also known as VCS) in Bury, enhancing their ability to support local communities. VCFA also promotes the VCS sector and advocates on their behalf at a strategic level with other stakeholders.

Pennine Care NHS Foundation Trust

Pennine Care serves a population of 1.3 million with more than 4000 dedicated and skilled staff delivering care from around 200 different locations in five boroughs, with mental health and learning disability services.

The mental health teams provide care and treatment for people with mild to moderate conditions such as depression, anxiety or dementia, or more serious mental health illnesses such as schizophrenia and bi-polar disorder. Provided in the community and through inpatient services.

Learning disability services are provided for people with a moderate to profound level of learning disability, such as those with downs syndrome.

Persona Care and Support Ltd

Persona Care and Support Ltd is a local authority trading company set up in 2015 to operate services previously provided by Bury Council. Persona provides high-quality Adult Social Care services for young people with additional needs, people with learning disabilities, people with physical disabilities, older people, people living with dementia, people with autism, and carers. Persona focuses on three key service areas: days, stays and lives.

'Bury Integrated Care Partnership'

Bury's ambition is to be one of the best boroughs in Britain to live, work and study. A lot of progress has been made in recent years to ensure that local health and care services make a real difference to people's lives. Services are now more connected, with four Primary Care Networks (groups of local GP practices) working together across five neighbourhoods, integrated teams provide more personalised and coordinated care.

'Bury Integrated Care Partnership' describes the joint work of all local partners in the health and care system to deliver the Bury Locality Plan. This plan focusses on improving health and supporting people to be well and independent; ensuring children have the best start in life; access to quality, connected services in the community and to timely hospital services. It's one part of the Let's do it strategy for the Borough, which seeks to improve life outcomes for all residents.

Bury Integrated Care Partnership is overseen by a Board with membership from Bury Council, the NHS, the voluntary sector and wider partners.

3. Bury's vision for Superb Intermediate Care.

The aim of this strategy is to work to improve the health, wellbeing, and quality of life for people living in Bury. It places a strong emphasis on prevention and early intervention by taking a strength-based approach – which means identifying an individual's strengths and capabilities and to support people to maximise those strengths to promote independence and improve quality of life, this will be achieved by:

1. A formal demand, capacity, and future projections plan to assess current and future need which will be linked to the JSNA, Major conditions strategy, Mental health plan, Dementia strategy and other workstreams as appropriate.

2. Developing clear pathways across the system to ensure all parts understand the role of Intermediate Care, which enables integrated service delivery and strong working relationships.
3. Providing clarity around data which can be scrutinised to understand the needs of people coming through Intermediate Care and to use this data to predict future developments and changes required.
4. To ensure there is sufficient capacity within Intermediate Care to meet demand across all services, both present and in the future.
5. To provide evidenced reasoning as to what the future landscape of Intermediate Care will look like, and how the services will need to change and adapt in the future to meet the needs of Bury residents.

Bury Adult Social Care Vision and Priorities

The Adult Social Care department has set out the vision and priorities to ensure that the services offered are high quality, that transformation and improvement are embedded in practice to develop areas across Bury, ensuring we work in co-production, providing support, ensuring safety and through having strong leadership across the department.

Superb Intermediate Care is one of the key priorities.

4. National Overview

The Intermediate care framework for rehabilitation, reablement and recovery following hospital discharge has provided good practice guidance for integrated care boards, commissioners and providers. As part of Greater Manchester, a focus group has been tasked with interpreting this guidance and developing a set of standards to assess what good Intermediate care looks like across Greater Manchester, considering the differences across the 10 localities.

The national guidance focuses on 4 priority areas which have been derived from learning taken from several frontrunner programmes which have taken place nationally but also include the 4 localities partnership through Northern Care Alliance, a part of Greater Manchester, in which Bury were heavily involved with:

Priority area 1: Improve demand and capacity planning

The frontrunners have developed joint executive leadership and system agreements across health and social care partner organisations to ensure shared decision making and governance arrangements. Joint demand and capacity planning has been essential to determine the 'right sizing' of intermediate care services to meet people's needs. Ensuring a flow of data from all partners into the care transfer hubs is key to operationalising this.

Priority area 2: Improve workforce utilisation through a new community rehabilitation and reablement model

Mapping the existing workforce has been key to understanding if professionals are able to give the right care in the right place. Maximising therapy input, supported by new and blended roles, has helped to reduce community rehabilitation and reablement waiting times and increase capacity to support a greater number of people

Priority area 3: Implement effective care transfer hubs

Executive leadership and visibility of care transfer hub operations at partnership board level is critical to improve system flow. An integrated multi-disciplinary team across the health, social care and voluntary sectors within the hubs is key to ensuring all partners are involved in delivery.

Priority area 4: Improve data quality and prepare for a national standard

The frontrunners have developed integrated IT systems to share data, ensure visibility and assist with operational demand and capacity modelling to deliver services within their joint project boards. This has required overcoming information governance issues through data sharing agreements and training.

Over the last few years, the National Audit Office, Local Government Association and County Councils Network in association with Newton have produced several reports about the state of Intermediate Care from a national perspective.

They consistently report amongst, other issues that there are several blockages in the intermediate care pathway. In 2023, at least 1 in 4 people expecting to receive home-based intermediate care and nearly half of those intended for bed-based intermediate care were delayed in hospital waiting for care. People receiving bed-based intermediate care in community hospitals also face delays when they are ready to leave – this affected 1,700 people a week in 2023. Bed occupancy is increasing, 6.75% in acute and general/critical care beds as is length of stay in hospitals.

Nearly a third (31%) of hospital attendances and 30% of admissions of older adults aged 65 or above were deemed to be inappropriate or avoidable. These people would have been better treated by alternative services in the community, such as primary care and community health. The most common route for these inappropriate attendances was via ambulance conveyance and was most often down to a lack of knowledge of alternative services or risk averse decision-making. In line with national NHS and social care trends costs have increased the pressure on intermediate care. Average local authority spends on a single episode of care in 2022/23 was 27% higher in real terms than in 2019/20. This is an unsustainable picture and is time limited in terms of the change required to remedy the situation.

More globally, increasing emergency admissions to hospital is an established issue facing health-care systems internationally. A key factor underpinning the increase is the complex needs of older people with frailty and multimorbidity. The continuing global demographic transition implies that urgent solutions are required. In England, the National Audit Office has reported that over half of the growth in emergency admissions is related to older people.

4.1. Greater Manchester Integrated Care Board (GM ICB)

GM ICB recently initiated a conurbation wide programme to support the implementation of NHS England's Intermediate care framework for rehabilitation, reablement and recovery following hospital discharge in each locality. This work will aim to support locality approaches to Intermediate Care development based on the national framework. Bury has worked with ICB colleagues closely and is actively providing resources into the programme to move it forward.

4.2. Bury Locality Intermediate Care

More locally in Bury, we had a series of transformation schemes developed in 2019/20 which heralded new services and significant investment in the Intermediate Care pathways. Over time we have witnessed the impact of Covid-19, the workforce challenges across social care and the financial issues impacting all public services.

Our Intermediate Care system now requires change to update the transformation seen and to ensure there is a clear, agreed vision and strategic direction moving forwards.

4.3. Intermediate Care Challenges

The most challenging issue we face as an integrated system is the continual rising costs across almost all services but particularly in social care costs.

The second most pressing challenge is waiting times. Fully integrated solutions need to be identified and considered across the whole Intermediate Care system in impact and cost. Currently, Bury has anywhere between 24 and 50 residents per day awaiting differing levels of Intermediate Care services. They are in hospital beds or in other inappropriate locations across the wider Greater Manchester health and care system conurbation. Whilst some of these patients will be awaiting other non-Intermediate Care service inputs the reality is that they are more than likely experiencing increased waiting times for all pathways. In Bury locally, we have Ward 24 at Fairfield Hospital which provides beds for patients awaiting a variety of service inputs including although, not exclusively Intermediate Care packages and placements.

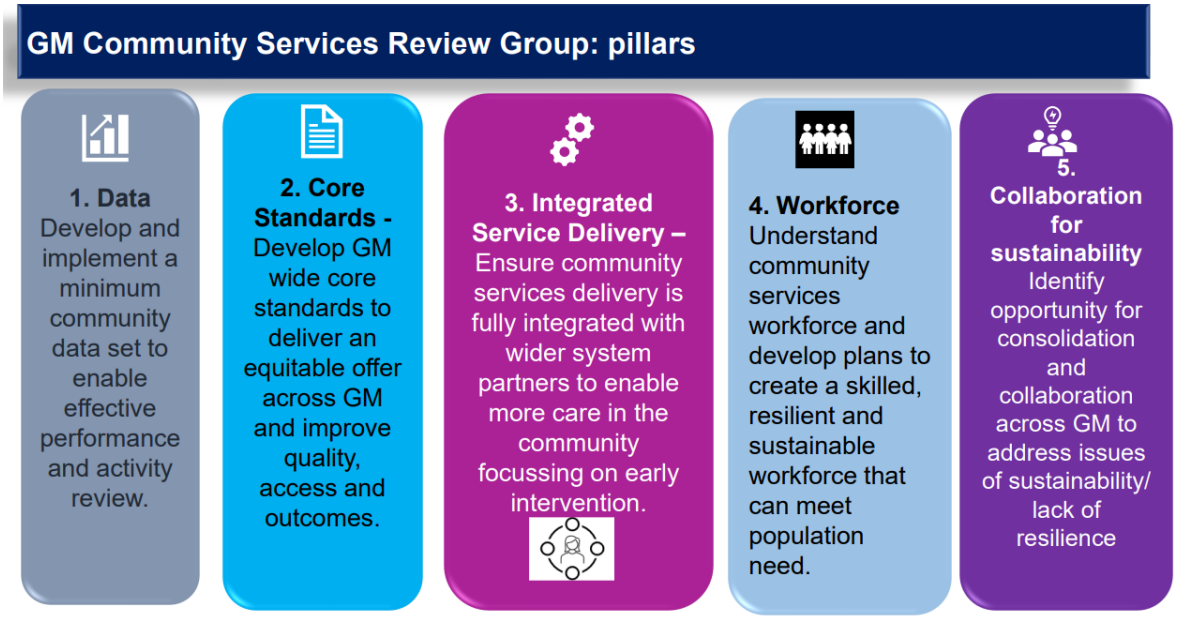
The third challenge relates to the complex, rapidly moving and dynamic system of organisations with internal governance and political priorities that are not aligned or at times are in conflict. The reality is that this can result in inefficiency through the lack of a single line managed system with a clear and coordinated strategic approach.

5. Greater Manchester work programmes

The ongoing task group for Greater Manchester will provide a set of common standards to assess what good Intermediate care looks like across Greater Manchester. Bury's current services will need a further review to ensure that they are performing in these areas.

A review of Intermediate Care is also being undertaken within Northern Care Alliance across the 4 localities: Bury, Oldham, Salford and Rochdale. The review is only considering the health elements at present but learning and feedback from this may need to be considered and reviewed with priorities potentially changing in the future.

Work commenced in 2024 on the GM Community Services review however the planning and priorities for the NHS framework for rehabilitation, recover and reablement has taken priority. The community services review incorporates the following, and as above, learning and feedback from this will likely impact this strategy and will need review and changes in the future:



Note: each locality will have priority areas and gaps to address.

Through engagement with system wide partners, there have been various areas for service redesign and improvement raised which would support the residents of Bury and the wider system and ongoing pressures that are seen within the Acute setting.

These areas will be captured as part of a programme delivery plan and will be held by the delivery group, prioritised, and explored on an individual basis, to determine whether they are viable options to deliver in the future.

The aspirations of those who have contributed to the development of the strategy are to overhaul the system and to take a preventative approach to identify people at risk of entering the system, by providing early intervention and identifying them earlier in their journey. This can achieve admission avoidance which better supports the individual's health and wellbeing and reduces pressure on the system.

<u>The areas identified for development are:</u>

1. Prevention and early intervention pathways and services, working with system wide partners to promote the public health agenda, tackle inequalities and ensure there is a range of information, advice and services to support our diverse communities.
2. Exploring how Intermediate care can support admission avoidance including pathway development and upskilling of workforce where required. Intermediate Care in Bury has been involved with the pilot of the NHS England, Discharge Integration Frontrunner Programme. People living with dementia who have been admitted to hospital are identified early in the journey, to access an enhanced care at home service. This minimises disruption to the person by supporting them back to their home earlier, this also reduces the likelihood and

severity of deterioration of health and wellbeing and supports reorientation to their home with a range of holistic assessments to improve their ability to remain at home. This work has had excellent outcomes, the opportunity to explore how pilots such as this can intervene before admission are being considered across the Intermediate Care Services.

3. Development of 'Step up' support from the community to capture admission avoidance, community mental health offer, Age UK Home from Hospital and virtual wards, including reviewing the speed of assessments and assessments on wards, OT, and Physio.
4. Developing pathways and support offer with the VCFA.
5. Development of the care transfer hub to be in line with national guidance, including arrangements for brokerage and the Integrated Discharge Team.
6. Development of specialist support services such as bariatric, complex dementia, learning disability and Autism, Stroke and how it works together with the current Intermediate care services.

6. Data Availability and Quality

6.1. When comparing national, GM and locality perspective data on intermediate care, it is evident that data is limited and fragmented. This is unsurprising given the wide range of organisations with competing demands involved in the funding, planning and delivery of intermediate care.

6.2. There are many gaps in the insights we can draw from data. There is very little information about the people receiving intermediate care – for example, their health needs or socioeconomic backgrounds. This means the data cannot be used to inform decision making about what resources intermediate care services need. The available datasets also only cover certain types of intermediate care – for example, step-up care is missing. These datasets also only tell us about activity that happens and is recorded, for example, how many people are discharged to step-down care. But we cannot determine whether the care people receive is appropriate or beneficial, nor identify unmet needs, also we cannot always be clear about timing in terms of patient and carer needs being met.

6.3. The open data is insufficient to interpret geographical variation. Patient-level data would allow us to explore whether differences in intermediate care services are due to differences in need between communities within Bury or indicate possible inequalities. The strategy will utilise the current available data however, as part of service improvement, datasets will be assessed

and where required, new data requested to ensure that it is representative of how Intermediate Care operates taking into account individual needs of the people, equality and diversity of our communities, and wider Greater Manchester data requests.

In Bury projections for future capacity required across the Intermediate Care services have been completed. This has been assessed by:

- Using the average number of referrals across the last 3 years of available data and calculating differences year on year
- Using ONS census data from 21/22, the percentage of average referrals and admissions has been calculated against the Bury population data for working age adults and older adults, to understand what proportion of 18 years + within Bury, each Intermediate Care service serves, averaged across the last 3 years.
- Using JSNA projections for 2023-2033, the ONS population figures for working age adults has been increased by 1.2%, and by 15.4% for older adults to give an estimate for 2033.

The projections highlight that there will be a higher complexity of people coming through the Intermediate Care services by the increase in Rapid Response and IMC at Home referrals and admissions, where there is a need for clinical oversight and intervention. The data supports the 'Home First' approach and so the focus should be primarily focused on investment and expansion of the community services to ensure the 'Home First' approach can be initiated with sufficient resource and capacity to meet with demand. This would also mean that the Reablement service requires investment and expansion to meet with demand as people are stepped down from Rapid Response and IMC at home. A programme of work is ongoing to ensure that the capacity and productivity of our Reablement service is meeting the needs of our residents.

The data shows that there is a slight increase in the number of referrals and admissions for the bed-based service Killelea however, this would not require additional bed capacity and could be maintained within the current settings as the data shows that the average number of admissions is 29 per month on average across the last 3 years.

Through the work of the Discharge Integration Frontrunner programme, we have learning to evidence that working in collaboration with our system partners can provide reassurance which supports a less risk averse approach for the individual requiring Intermediate Care. By developing clearer pathways and maintaining good working relationships, the 'Home First' approach can be expanded further, which will keep the bed-based services available for the most complex needs.

7. Current Intermediate Care offer

Intermediate Care in Bury consists of several different areas of support. These include:

Bed-based services

Killelea is specialist provision managed by Bury Council, with clinical oversight from Northern Care Alliance. Killelea provides support to people through promoting independence, to assist them to regain skills and confidence following a period of illness, hospital stay or general decline in health and ability. Both nursing and therapy professionals are on site, and able to support residents with reaching their rehabilitation goals. All customers are aged from 18 years old onwards and live in the Bury area. The beds within Elmhurst are supplied and managed by Bury Council's LATCO, Persona, who provide care, support, and therapy across 13 dedicated beds to support system flow.

Elmhurst beds	13
Killelea beds	36
Total beds	49

IMC at Home:

IMC at Home provides support to people in their own homes, they work closely with the Reablement service where there is a joint need for therapy and social care but also have a cohort of patients whom they support with therapy needs only. The service aims to promote independence using a strengths-based approach to assist them to regain skills and confidence following a period of illness, hospital stay or general decline in health and ability. Both nursing and therapy professionals are available within the community team to support residents with reaching their rehabilitation goals. All customers are aged from 18 years old onwards and live in the Bury area.

Reablement:

The Reablement service supports individuals in their own home to return to their baseline following a period of sickness or hospitalisation. Their aim is to support with confidence, access to equipment and/or adaptations so that the individual can be as self-managing as possible. All customers are aged from 18 years old onwards and live in the Bury area. The service supports individuals to regain the ability to support themselves to wash, dress, manage their own continence needs, meal preparation, moving around their home, getting into and out of bed or a chair. This is a short-term service potentially lasting 6 weeks, but length of stay is typically around 3-4 weeks.

Rapid Response:

The Rapid Community Response service primarily offers timely intervention to individuals, with the aim of preventing unnecessary acute admissions to hospital or residential care homes. Intensive short-term, holistic support is provided in people's home by a multi-disciplinary team addressing urgent health/care needs as required (medical, nursing, therapy, and social care input). The service is available at short notice for people experiencing a crisis or after an event in their life making it more difficult for them to continue to stay at home. The rapid community response team currently has a mixed grade MDT staffing model.

Hospital at Home (H@H)

The NHS is increasingly introducing Hospital at Home, sometimes known as virtual wards, to support people at the place they call home, including care homes. This service allows patients to get the care they need at home safely and conveniently, rather than being in hospital.

The Bury multidisciplinary team ensures people receive high quality care, including senior clinical reviews, the use of monitoring devices, and clinical advice. The team may also visit a patient's home to provide face-to-face care.

There are several benefits for patients who are suitable for this service. The option to stay in the comfort of their own home, whilst being closely monitored by the MDT, can lead to faster recovery, and improved mental wellbeing. It can also give patients greater independence and empower them to work alongside clinicians and carers to manage their condition.

Hospital at Home is one of Greater Manchester's top priorities, and through close collaboration with staff, patients and their families and carers, Hospital at Home will become a successful and well-established service across Greater Manchester.

Falls Response Team

If a patient has had a fall and sustained no injuries; services, patients and relatives are facing extended waiting times for ambulances to be available to attend these calls. Our service will fill this gap. Where there are no injuries, our team will attend within TWO HOURS of each call and using our range of equipment, complete an assessment, support patients from the floor and prevent ambulances and hospital admissions. Our team will then complete any onward referral required to best support the patient.

With the full backing of the UCR Teams, we aim to keep the patient out of hospital. For example, our nurses can take bloods and have them reviewed and monitored without initially admitting the patient to a lengthy A&E visit following an extended length of time of the floor.

Therapy and Nursing input:

The IV Therapy service provides community based IV therapy for patients registered with a Bury GP to enable:

- People to have care closer to home or in the home of their choice.
- Reduce length of stay in hospital for patients requiring IV treatment.
- Enable discharge of patients at the earliest opportunity for patients requiring IV treatment.
- Manage long term infections/ conditions effectively and efficiently in the community setting.

Therapy Input:

Across the intermediate tier, the core business revolves around providing therapy services to people accessing Intermediate Care at Home, Rapid Response & Hospital at Home.

The services cater to a diverse demographic, including individuals of varying ages, backgrounds, and medical conditions. We serve people who require therapy support following a hospital discharge, those who are safe and able to receive therapy and care in the comfort of their own homes, as well as individuals in need of rapid response interventions to address acute medical needs.

Therapy programmes are tailored to meet the unique needs of each individual, incorporating evidence-based practices to optimise outcomes and enhance quality of life. We prioritise person-centred care and ensure that our services are responsive to the specific goals and preferences of those we serve.

A team of occupational therapists and physiotherapists and technical instructors, alongside the wider multi-disciplinary professionals, strive to promote independence, mobility, and overall health and wellbeing for everyone accessing our services. By delivering high-quality therapy interventions, we aim to facilitate recovery, prevent re-hospitalisation, and support people to achieve their maximum potential for health and function.

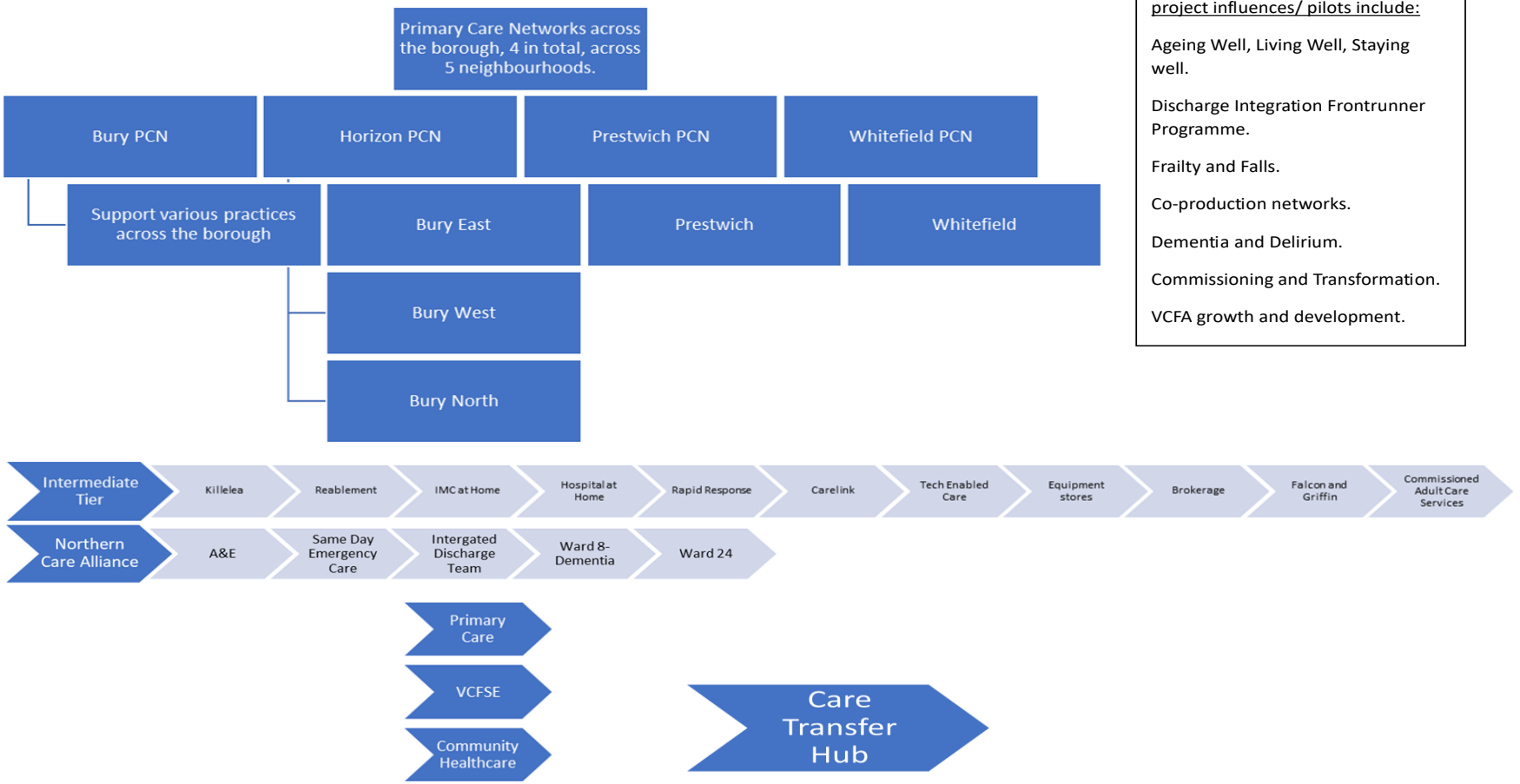
The overall goal of having therapy provision within each team is to promote rehabilitation, independence, and improved quality of life.

Nursing input across the Intermediate Care Services:

To assess, develop, implement, and evaluate specialist nursing care programmes from admission to discharge within the Intermediate Tier.

To undertake specialist nursing interventions consistent with evidence-based practice, transferring and applying knowledge and skills to meet patients' needs, evaluating, and modifying interventions as appropriate.

Intermediate Care System partners



Overarching areas of work and project influences/ pilots include:

Ageing Well, Living Well, Staying well.

Discharge Integration Frontrunner Programme.

Frailty and Falls.

Co-production networks.

Dementia and Delirium.

Commissioning and Transformation.

VCFA growth and development.

BURY INTEGRATED CARE PARTNERSHIP

8. Strategic Priorities 2025-2027

Intermediate Care will provide tailored, holistic support to individuals, promoting independence, rehabilitation, and recovery, while maximising their strengths and capabilities. Through collaborative person-centred approaches, the aim is to facilitate smooth transition between acute care and community living, enhancing overall well-being and quality of life for individuals receiving care and support.

Our priorities for 2025/26 are to:

1. Implement the Electronic Care Record System across the Tier.
2. Increase the contact time in the Reablement Service.
3. Reduce the waiting times in the Disability Service (reduce occupational therapy waiting lists to meet required standards).
4. Continue to increase the number of people leaving the Intermediate Tier independently increasing the use of technology enabled care (TEC).
5. Deliver outstanding rating in Rapid Response and Good for Reablement, Killelea House and Falcon and Griffin.
6. Develop a system for seeking feedback from people using all services this will improve service delivery and co-production.
7. Contribute to the GM community services review.
8. Analysis of capacity and resource currently available within reablement to support increase in efficiency of the service.

Our priorities for 2026/27 are to:

1. Implementation of actions based on the wider review work from the GM Community Services review and Northern Care Alliance reviews.
2. Build a business case to increase the number of hours of reablement available which will deliver more reablement to meet with the growing needs of the residents of Bury, reducing the length of stay within the hospital setting and maximising the ability to support early intervention.
3. Develop pathways for working in co-production with Bury residents to enable them to have a voice in the services supporting them. Utilising the already established Bury Older People's Network and Dementia Co-production Network and gathering feedback from across the system using a range of different methods.
4. Assess and analyse data to ensure that Intermediate Care Services have sufficient future capacity and are modernised to meet the growing needs of the Bury population. Utilising this information will inform exploration of various opportunities to enhance the services; such as to explore a business case for a new build.
5. Develop a long-term strategy for Intermediate Care.

9. Delivering the strategy

Accompanying the strategy will be a delivery plan, which contains the specific actions required to meet the priorities. Each action will have an owner across the integrated system and Intermediate Care Senior Leadership Team.

The actions of the Strategy will be reviewed monthly through internal mechanisms, and through the Joint SLT meeting. A highlight report will be submitted to the Ageing Well Partnership Board for governance to evidence good practice, celebrate achievements, highlight gaps and escalate any concerns or risks.