BURY OLDER PEOPLE'S NETWORK

BURY VOLUNTARY, COMMUNITY & FAITH ALLIANCE

Bury Older People's Network (BOPN)
10th June 2026
Bury Unitarian Church

Attending	Jo Mawdsley (chair); David Barnes (Bury VCFA – action notes); Joan Abbott (resident); Mike Bondi (Bury model boat club); Gill James (resident); Mark Harrison (Bury model boat club); Carol Kemp (resident); Jane Lees (Age UK Bury); Dr Sarkar (resident); Gillian Stainthorpe (resident); Jacqui Waite (Bury Council); Shirley Waller (resident); Jan Wiczkowski (resident); Brian Williams (resident)
Apologies	Steph Boyd; Hannah Crompton; Chris Darrock; Hilary McColl; Annemari Poldkivi; Jean Pound; Trish Ribchester; Pauline Smith; Julie Southworth; Barbara Stafford; Mike Standbridge

Overview

The meeting covered a review of previous actions and then moved into wider discussion about health checks, mental health support for older people, the role and definition of associate members within the Older People's Network, adult safeguarding, falls prevention, and digital access barriers. Jo noted that the intended review of the action plan was only partly completed because substantial discussion was taken up by concerns about inconsistency in health checks and mental health provision, with further discussion also shaping future work on safeguarding, associate membership, and a planned loneliness-focused event.

Matters Arising and service updates

Jo Mawdsley, as Chair, opened by checking apologies and then reviewed matters arising from the previous minutes.

Re the Bury Directory.

The previous notes said that the issues had been resolved; this does not reflect the understanding of all members. Jo said she had spoken with Matt Peluch and had gained the impression that the matter was not fully resolved.

ACTION: Jo will discuss with Matt again, particularly now that Sarah Turton had returned from maternity leave, and seek clarification on behalf of Carol Kemp and the Friends of Radcliffe Manor.

Re the Health checks.

Jo then revisited points arising from an earlier presentation by Anne Marie about health checks. She reported back from her own Patient Participation Group at Tower Health and clarified that there are two different forms of health check. The first is the NHS Health Check, which she described as a free check-up for adults aged 40 to 70 in England who do not have pre-existing conditions such as heart disease, diabetes or kidney disease. She explained that this is intended to identify early signs of stroke, dementia and vascular problems, that invitations are normally issued every five years, and that people can also request this check themselves. By contrast, she said that the annual health check is not NHS-led but practice-led, with invitations sent to people whom a practice considers vulnerable or with particular conditions, meaning this is much less consistent and not something people can generally request unless they believe they should be included.

Re Digital inclusion

Jo added to the previous discussion on digital inclusion. She confirmed that support is available at the Jubilee Centre on Mondays from 10.00 to 12.00 and added that, although not previously recorded, there is also a session at the Green Café on Tuesdays from 10.00 to 12.00, both being options for people in the area. After checking whether anyone else had comments on the minutes, the meeting moved to the main agenda.

Further discussion on Health Checks, preventive care and mental health services

The meeting had an important discussion on these matters, as follows.

- It was queried what exactly is included in the NHS Health Check; invitations should clearly state what will happen during the appointment so that people can prepare and make best use of the time, rather than arriving without understanding what is going to be covered. It also needed to be made clear that the check is preventative, because otherwise some people may assume they only need to see a GP when something is wrong rather than attending proactively. At one GP practice people do receive a letter explaining what will happen, but others said they had never received such information, reinforcing the point about inconsistency between areas and practices.

- The meeting then focused on the separate annual practice-led checks and said this model was "open to all sorts of problems" because it creates total inconsistency across practices. Wide variation was noted in the quality of appointments, from a proper 20 to 30-minute review in some places to a very brief and superficial interaction in others; an example was given of receiving what was felt to be only a cursory overview attached to a blood test appointment. If the NHS is to offer health checks, they should be delivered professionally and consistently, with a clear list of what will be covered and a standard approach rather than what he described as random practice.

- The discussion then moved to age limits and eligibility gaps. It was noted that pharmacists can also provide free health checks for people in the relevant age group and several attendees said they had sometimes had better experiences there than with GP services. What happens once people are over 70? A member said they did receive an annual invite to see the practice nurse but went on to explain that where statutory requirements exist for certain conditions such as diabetes or hypertension, those people are included on registers and should receive annual health checks. However, this highlighted a gap for people over 70 who have had relatively good health and do not meet those statutory categories, as they may then receive no routine review despite increasing risks with age. The NHS Health Check should at least be extended beyond 70 to reflect increased life expectancy and the opportunity to identify serious conditions earlier.

- Problems were also identified with threshold-based criteria in other areas of care. An example was given of asking about weight loss medication and being told that the person did not qualify, despite having a BMI over 40, because their blood pressure and cholesterol were controlled by treatment and therefore did not count towards the criteria. This was presented as another example of how risk can be overlooked if systems rely too narrowly on current thresholds rather than broader prevention.

- The discussion broadened significantly into mental health within primary care and health checks. Members identified that in contacts with GPs, nurses and health checks, mental health is usually not raised yet mental health is a major reason why people attend primary care, sometimes behind apparently physical symptoms, and that checks should therefore

include some form of mental health questions or intervention. One challenge is the absence of a standardised national questionnaire, and

that existing tools are controversial because some are very negative and depend heavily on self-report. This was considered unacceptable given how longstanding and widespread mental health need is within the NHS.

Mental health problems can be hidden because people may try to pretend everything is fine. Then it can only become apparent when someone has a visible crisis in front of someone else, and that without that others would not have known because she had been "pretending". The challenge for health services is of finding a single inclusive screening approach. Unlike with physical health it is not possible simply to "put a plaster on" because the underlying issues take time to work through and there is no one-size-fits-all treatment.

Despite accepting the complexity, it is nevertheless the case that mental health is still not routinely raised in primary care reviews. It could be that too much investment has gone into secure and specialist services rather than promotion, prevention and primary care mental health, and perhaps most GPs and practices know very little about mental health. Therefore, there should always be some element of mental health in any health check if the NHS is serious about destigmatising it and giving it equal status with physical health. GP training in mental health can be very limited; some trainees may only have a two-week placement, unacceptable in relation to the prevalence of mental health needs.

A practical suggestion was made that GP practices should have a psychiatric nurse or mental health professional to undertake triage, provide regular mental health checks, identify issues earlier and connect people with support such as social prescribing, outpatient psychiatry or counselling. Having properly trained mental health professionals in each practice to do triage and direct people to the right services could reduce pressure on GPs and help stop some people reaching crisis point.

Volunteer and community services are in practice already providing some of this early support because people often self-refer to them without stigma, although some people still do not know how to find or access those groups.

A key question was then raised about self-recognition, noting that unlike physical pain or injury, it is much harder for someone to know whether they have a mental health problem and need to self-refer. There is much more public information about staying physically healthy in older age than about maintaining mental health, beyond general advice to engage socially and attend activities. This reinforced the group's view that mental health support and information remain insufficiently visible and joined up.

- Re mental health services, a further example from a member's experience, was given of a young person had been who had been brought to an appointment with the crisis team at the Irwell Unit but could not be persuaded to go into the building or attend A&E. Staff tried for two hours to engage the young person while they paced outside, eventually being moved on by security. It was suggested that a GP practice-based route might have worked better for someone in that situation, as a more familiar and less intimidating setting where home treatment teams or other services could then be involved.

- The discussion was linked to wider work through the Greater Manchester Older People's Network which has done a great deal of work around mental health. Older people in group settings had often become able to identify and talk openly about their experiences once they were in the right supportive environment, including through activities such as poetry sessions and it was felt that this demonstrated the value of collective and community-based approaches. It was suggested that BOPN should hold a dedicated

future session with expert input and a potential speaker was identified who might be willing to speak to the network in future.

ACTION – Mental health should return as a planned BOPN agenda item, with specialist contributions and a focus on pathways into support, early intervention and the role of community and voluntary groups in helping people before crisis occurs.

Review of the Older People's Network action plan and associate membership

Jo explained that the meeting had intended to review the Older People's Network action plan, but only limited progress could be made because earlier discussion had taken up most of the available time. She noted that the first section on key roles would be left until later in the year for logistical reasons, and the group moved to the action about formalising a process for the recruitment and remit of associate members. The discussion ensued as following.

- Should associate membership primarily be for representatives of statutory agencies attending the network and should that also extend to larger charities and voluntary organisations such as Age UK. It was suggested the group should decide that point.

- A separate issue is about care providers and care agencies asking to attend the meeting. These are generally declined and a view was expressed that individual providers should not be regarded as members.

- Jo suggested that providers could perhaps be engaged separately through an annual event where they would be updated on the Older

People's Network's work and could meet the network in a more structured way, rather than attending ordinary meetings as members. David said that if a formal association or forum of care providers in Bury existed, a single representative from that collective body might appropriately be treated as an associate member. Jo replied that such a forum was expected once the care tender process had been completed, and that this might allow one representative to come forward later.

- It was proposed that the issue should be handled through a formal process, with the network identifying which organisations it would benefit from having as associate members and then inviting them through a written approach setting out what the group is and why their involvement is wanted.

- A view was expressed that members should be people who wanted to raise issues about being an older person and contribute to discussion on policy and how it affects older people, whereas associate members should have a degree of influence or "clout" and be able to listen to what older people are saying, take those messages away, and potentially help secure change. The difference was the ability to communicate issues into the right systems and influence outcomes, because individual members did not have that power on their own.

- Members noted that bringing in the right people for particular agenda items could help the group influence policy before decisions were finalised, rather than only responding after the event. Examples were given of previous issues where older people's perspectives had highlighted practical consequences that decision-makers had not considered, including on products marketed to older people and concerns raised previously about digital telephone changes.

ACTION – David will draft a proposal on associate membership and circulate it to the group for review at the next meeting, which was accepted.

Digital access barriers, travel concessions and difficulty using public services

The meeting had a discussion about concerns re digital inclusion and exclusion as follows.

- There is an increasing expectation that older people should use online systems to access essential services often without enough face-to-face alternatives. One member said older people were "being forced to do everything digitally now", including interactions with GP surgeries, and described needing to go in person simply to learn how to use the system. Another member described a bank repeatedly issuing pop-up requests to "legally" check details. But the online form log-in did not work properly for a retired person with pension income rather than employment income, leaving them needing further help.

- A substantial part of the discussion focused on Blue Badge applications and renewals, which members described as difficult and unnecessarily complex. Age UK Bury often complete Blue Badge applications for clients who were unable to manage them themselves, and she noted the burden of arranging payment where people could not do a direct transfer. The forms are complicated, requiring photographs and multiple documents to be scanned and uploaded, and many older people could not complete this without direct help.

- The linked issue of transport concessions was then raised. It was explained that if a person has a Blue Badge, they do not need to pay the £10 annual charge associated with the travel pass, but the Transport for

Greater Manchester form to obtain that exemption was almost as burdensome as applying for a new Blue Badge.

- Members identified the importance of face-to-face community support. The wider lesson is the need for community groups where older people could speak to somebody directly about practical issues such as a Blue Badge application. Communication through telephone or digital systems is not the same as speaking with someone in person, reading body language and understanding the full context.

Adult safeguarding, exploitation and learning from reviews

Janine Campbell was introduced as Designated Nurse for Adult Safeguarding with NHS Greater Manchester in Bury and introduced a discussion about the work of the Adult Safeguarding Board and Adult Safeguarding Reviews. The discussion covered the following points.

- Safeguarding is about both protection and prevention, supporting adults to live lives free from harm and abuse. Janine said she had not come to provide a formal training session but wanted to begin a discussion about what safeguarding meant to the group and how the Safeguarding Adults Board could share information with community networks more effectively.

- Janine then explained the statutory basis for safeguarding adults work. She said the key legislation is the Care Act 2014, under which the council must establish a Safeguarding Adults Board. She outlined that the statutory members are the police, the local authority and the health system, with wider partners including probation, mental health, drug and alcohol services and housing. She added that where there is a death or

serious incident involving an adult with care and support needs, the Board may undertake a safeguarding adult review to identify learning, in a similar way to former serious case reviews for children.

- An example was given of a local review involving a 93-year-old woman living with her son in his 70s, where both had care and support needs and cared for one another. Janine said the review found learning for agencies around the failure to complete Care Act needs assessments and carers' assessments for either person despite the legal framework requiring those assessments where appropriate.

- Members said practical examples would be more useful than theory alone including a presentation on what is actually in the safeguarding policy, because people often do not understand the range of abuse types, particularly self-neglect, cuckooing and trafficking, and there is now greater recognition of financial abuse and controlling behaviour as well. An earlier course on abuse in later life, delivered through council training, had been excellent because it covered every type of abuse and helped her reflect differently on conversations she was already having with clients.

- The group then explored specific abuse themes in more detail. The previous training had included scenarios and a film about "walking on eggshells", which illustrated how unsafe a person could feel in their own home and how abuse could include medication being withheld by a carer, as well as psychological abuse rather than only physical violence.

- There has recently been extensive radio coverage about cuckooing, which had helped bring the issue more into public awareness. This involves taking over another person's property and using it as a base for criminal activity, sometimes through intimidation, debt or fear. The term

itself may not clearly communicate the reality of the abuse, and the discussion highlighted that people may not recognise the behaviour from the label alone. Information about methods of grooming would also be useful because prevention depends on recognising warning signs at an early stage.

- Members linked these risks with loneliness, social isolation and dependency. People who become vulnerable to this sort of exploitation are often lonely and living alone, and may initially be looking for friendship, which then becomes a route into control, financial exploitation or criminal use of their home. An example was given of relatives regularly using a disabled person's mobility car for work, depriving the person of the chance to attend activities, and described this as another form of exploitation that can occur in everyday life.

- Janine asked whether the group would want to hear the detailed findings from local safeguarding adult reviews, while noting that some involved very distressing circumstances. Members said the group would be able to cope with difficult material and that the reality of local cases could be eye-opening and necessary for learning. Janine then asked whether she could return for a future session. Jo said the group would need to arrange this through its forward planning because speakers were booked well in advance but suggested that on a future occasion Janine could have a longer dedicated slot after the network's own business had been completed. Janine said this would be feasible but that topics such as self-neglect and domestic abuse were substantial enough to require separate sessions. The meeting closed this item with thanks to Janine and agreement that future safeguarding sessions should be considered.

Falls prevention, frailty and joined-up local support

The meeting had a discussion about these issues as follows.

- A recent report has stated that GPs are so overloaded that they are failing to identify and support enough older people at risk of falling, despite contractual obligations to assess people over 65 with moderate or severe frailty. Only 17% of these patients were assessed in 2024/25. This issue was linked to an earlier discussion in the meeting about prevention, arguing that simple measures such as the TUG test could be incorporated into routine health reviews for older people and could identify frailty in a short amount of time.

- It was noted that there was work taking place locally behind the scenes through a falls and frailty service. People who attended A&E following a fall were now being monitored, meaning that some residents were being identified after incidents, although this would not capture people who fell once and minimised it or did not present for help.

- A member described an example of good support. Their referral to the falls service, meant that a physiotherapist visited them at home over a number of weeks, provided balance exercises, and that doing these exercises daily had helped significantly.

- It was noted that the first point of contact for frailty concerns should be the Staying Well team rather than the GP. The Staying Well team can assess people at home, look at whether the right adaptations and equipment are in place, and arrange free equipment through the council such as grab rails and other aids. Age UK Bury's handy person service had worked closely with the Staying Well team, including fitting rails and

carrying out practical home safety work when the council had a backlog of referrals.

- Earlier work in another area was implemented where frailty screening by the fire service led to large numbers of referrals into falls prevention, which then overwhelmed the service. In response, local leisure services had offered balance and mobility programmes for people who were on the verge of frailty, while more complex cases or people with repeated falls were directed to specialist falls services. Pathways need to be structured so that lower-level support is available and specialist services are not overloaded unnecessarily.

- Members discussed whether local professionals consistently signpost people into these services. Most older people would usually contact their GP first if they had a health concern, and it was questioned whether practices automatically signpost people to the Staying Well team. Dementia support is another example, stating that people were not always being directed to the Alzheimer's Society even though it was the commissioned service.

- There was related discussion about hospital discharge and support after falls. Everyone admitted after a fall should ideally be connected automatically to the home from hospital service and receive an assessment, although it is not clear that this was happening consistently. The council had recognised backlogs and had used Age UK Bury's services to help. It is also not clear whether Bury Carers might also be identifying needs on the wards, as they were present in hospital regularly.

- The group then moved into a wider discussion about social prescribing and access to information. It was recalled that at an earlier meeting one of the main suggestions had been to have somebody linked to every GP

practice whose role would be to signpost people to local support. This would help because most people can get to their GP practice, even if they cannot access other services easily. Social prescribers had attended previous meetings and were not short of referrals, suggesting that people were reaching them through a range of routes. Another member described a positive personal experience of being directed by a social prescriber to a local church coffee morning and receiving a weekly activities calendar, though they also stressed that individuals still need to take some responsibility for engaging with what is offered.

- The limitations of information materials were also highlighted. A recent falls prevention leaflet has relied on a QR code for further information and did not include a telephone number, email address or postal contact, describing this as inaccessible. Feedback had already been given on the leaflet and BOPN members views would be conveyed to the leaflet owner. People are regularly warned about the risks around QR codes and questioned how residents are supposed to know whether one is safe to use.

- Overall, this section of the meeting showed broad agreement that a range of local falls, frailty and wellbeing services are available, including clinical support, home adaptation services, social prescribing and community-based exercise. However, members consistently returned to the view that prevention should begin earlier, routes into support should be simpler, and information about available services should be clearer, more joined up and more accessible to older residents.

Any other business

Wider partnership working and external forums

- It was reported that Age UK Bury had recently joined a Northwest forum of Age UK organisations called Ageing Positively. The purpose of the collaboration was to bring organisations together around similar aims to this group so they could collectively influence what should happen next and raise the issues that older people are reporting. There had already been one meeting on 01/06/2026 and that further meetings were planned later in the year, approximately every four months. Age UK Bury can send details for circulation and, if the network wished, issues raised locally could be fed into this wider forum as another route for influence. Jo confirmed that she also attends that group, reinforcing that it may be a useful connection between the local network and wider regional or national conversations about ageing and older people's priorities.

Proposal for a conference on loneliness

- Jo updated members on plans that had developed from discussion at the network's away day in January, where companionship, communication and loneliness had been raised as concerns. Following those earlier discussions, and the council's poverty summit at the start of the year, it has been explored whether a loneliness summit should be organised locally. The purpose would not be to focus simply on the existence of loneliness, but to examine what practical action could be taken to address it and help people engage with support.

- Jo said that progress had now been made and that a working party was being established to take this idea forward, with the event now likely to take place in September 2026. She emphasised that she did not want the event to consist mainly of professionals and wanted involvement from people with direct lived experience or knowledge of loneliness and isolation. She invited any member interested in joining the working party to let her know. The discussion indicated that the proposed summit is

intended to focus on practical solutions, lived experience and improving people's ability to connect with services and community life.

- A member asked which day in September the event might take place, noting that availability would depend on the date. Jo replied that the timing was still being discussed and that there had been some suggestion of a weekend event, which she was not in favour of, but she repeated that people could still contribute views in advance even if they could not attend on the day.

ACTION – members should contact Jo with any expressions of interest in respect of this proposed event.

Summary of Actions

Jo Mawdsley:

- To go back to Matt Peluch regarding the unresolved Friends of Radcliffe Manor issue and confirm the current position.
- To feed back the group's concerns and comments about health checks and mental health provision to Tower Health as residents' views from Bury.
- To consider inviting Mark Harrison's wife, once in post as a mental health crisis lead, to attend a future meeting to speak about mental health wraparound services.
- To note mental health as a potential topic for a full future meeting with expert input.
- To revisit the wider action plan at a later meeting because there was not enough time to continue with it at this meeting.
- To let interested members know about involvement in the working group for the proposed loneliness summit, now likely to take place in 09/2026.

David Barnes:

- To draft a formal process for identifying, inviting and defining the remit of associate members, circulate it to the group, and bring it back to the next meeting.
- To circulate information from Age UK Bury about the Northwest Age UK 'Ageing Positively' forum after receiving the details from Jane Lee.

Gillian Stainthorpe:

- To contact her contact about potentially speaking to the group at a future meeting on mental health, if this is taken forward.

Jane Lees:

- To send David the details of the Northwest Age UK 'Ageing Positively' forum for circulation to the group.

Janine Campbell:

- To return for a future meeting, with timing to be agreed, to deliver a longer session on safeguarding topics such as self-neglect, domestic abuse and learning from safeguarding adult reviews.

Next meetings of BOPN

Wednesday 8th July 2026 at Bury Unitarian Church

NO MEETING in August

Wednesday 9th September 2026 at Bury Unitarian Church